HOSPITAL REIMBURSEMENT SYSTEMS USED BY PRIVATE THIRD-PARTY PAYORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

SEPTEMBER 16, 1982

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

11-627 O WASHINGTON : 1983 HG 97-120

COMMITTEE ON FINANCE

ROBERT J. DOLE, Kansas, *Chairman*

BOB PACKWOOD, Oregon
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVEN D. SYMMS, Idaho
CHARLES E. GRASSLEY, Iowa

RUSSELL B. LONG, Louisiana
HARRY F. BYRD, JR., Virginia
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine

ROBERT E. LIGHTHIZER, *Chief Counsel*
MICHAEL STERN, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

DAVID DURENBERGER, Minnesota, *Chairman*

ROBERT J. DOLE, Kansas
BOB PACKWOOD, Oregon
JOHN HEINZ, Pennsylvania

MAX BAUCUS, Montana
BILL BRADLEY, New Jersey
RUSSELL B. LONG, Louisiana

CONTENTS

PUBLIC WITNESSES

	Page
Birnbaum, Roger W., treasurer, Group Health Association of America, Inc.	131
Blue Cross and Blue Shield Association, Bernard R. Tresnowski, president	81
DiPrete, Henry, vice president, John Hancock Mutual Life Insurance Co	6
Group Health Association of America, Inc., Roger W. Birnhaum, treasurer	131
Health Insurance Association of America, James L. Moorefield, president	4
John Hancock Mutual Life Insurance Co., Henry A. DiPrete, vice president	6
Kaiser-Georgetown Community Health Plan, Inc., David Pockell, regional manager	146
Moorefield, James L., president, Health Insurance Association of America	4
Pockell, David, regional manager, Kaiser-Georgetown Community Health Plan, Inc	146
Pyle, Thomas, O., vice president, Group Health Association of America	156
Tresnowski, Bernard R., president, Blue Cross and Blue Shield Association	81

ADDITIONAL INFORMATION

Committee press release	2
Combined statement of James L. Moorefield, Henry A. DiPrete and Buston E. Burton	9
Answers to questions from Senators Durenburger and Baucus by the Health Insurance Association of America	36
Prepared statement of Bernard R. Tresnowski	93
Answers to questions from Senators Durenberger and Baucus by Blue Cross and Blue Shield	124
Prepared statement of Roger W. Birnbaum	134
Answers to questions from Senators Durenberger and Baucas by Roger W. Birnbaum of the Group Health Association of America	142
Prepared statement of David G. Pockell	149
Prepared statement of Thomas O. Pyle	161

COMMUNICATIONS

American Personnel and Guidance Association	172
Johns Hopkins University, James Studnicki, Sc. D.	178
Health Insurance Association of America	201

HOSPITAL REIMBURSEMENT SYSTEMS USED BY PRIVATE THIRD PARTY PAYORS

THURSDAY, SEPTEMBER 16, 1982

U.S. SENATE,
COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The committee met, pursuant to notice, at 9:40 a.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing follows:]

Press Release No. 82-160

PRESS RELEASE

FOR IMMEDIATE RELEASE
August 19 , 1982

COMMITTEE ON FINANCE
UNITED STATES SENATE
Subcommittee on Health
2227 Dirksen Senate Office Bldg.

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON HOSPITAL REIMBURSEMENT SYSTEMS USED BY PRIVATE THIRD PARTY PAYORS

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the subcommittee will hold a hearing on the systems used by private third party payors to reimburse hospitals and other institutional providers. The hearing is another in a series focused on the future of the Government's two largest health care programs--medicare and medicaid.

The hearing will begin at 9:30 a.m. on September 16, 1982 in Room 2221 of the Dirksen Senate Office Building.

Senator Durenberger noted that, "we are at a crossroads in national health policy. The current proposal to extend the so-called 223 limits to ancillary service operating costs, modify the current medicare reimbursement system to include case-mix adjustments, and relate payments to a cost-per-case basis is the first step toward a reimbursement system which would reward efficient providers of health care. As part of the Tax Equity and Fiscal Responsibility Act of 1982, the Secretary of Health and Human Services will be required to develop medicare prospective reimbursement proposals for hospitals, skilled nursing facilities, and other providers, and to report on those proposals in the near future.

"This hearing will provide, in anticipation of the Secretary's report, an opportunity to assess the various reimbursement systems, including prospective payments, used by private third party payers. There is a great deal to learn from third party payers before we begin consideration of any proposal the Secretary may advance."

Future hearings in the subcommittee's series will examine the role of the consumer in the health care marketplace, especially the use of cost-sharing, vouchers, or other incentives that encourage the individual to make wise health care choices. The subcommittee will also look at the role of the health care provider--physicians as well as nurses, psychologists and other nonphysician providers--in delivering quality, cost effective care.

Senator DURENBERGER. The hearing will come to order. I apologize for the delay this morning, and the inconvenience to any of the witnesses.

At my urging, the Senate Finance Committee included a provision in the recently enacted Tax Equity and Fiscal Responsibility Act which requires the Secretary of Health and Human Services to develop a medicare prospective payment proposal for hospitals and nursing homes. Secretary Schweiker is already hard at work drafting that proposal, and this subcommittee will be working closely with the Department in the coming months as the details are refined.

Today we are continuing our series of hearings on health system reform. The purpose of this hearing is to draw upon the experience of the private sector in the area of hospital reimbursement. The experience of Blue Cross, the commercial insurers, and HMO's can help clarify and hopefully resolve the many issues we face in reforming hospital payments under medicare. When we consider prospective payment legislation for medicare early in 1983, we want it to work.

There is little disagreement that cost-based reimbursement under medicare has not worked. It has destroyed the financial reasons for hospitals to be efficient. Prospective payment promises to correct that disincentive. By agreeing to a payment amount in advance, hospitals will be rewarded for keeping costs down.

In the first of our hearings on future directions for health care financing, we heard from States and hospitals that have had experience in prospective reimbursement. Today we will hear from the health plans that must live with both prospective and retrospective payment systems.

I am anxious to learn about the various reimbursement systems used by private party payors. I would like to know more about the process by which health plans negotiate with hospitals over rates. Is there a critical mass of patients below which plans have no negotiating leverage? What are the differences between negotiating with all hospitals in a community as opposed to selected ones only?

We would like to devise a medicare program which encourages hospitals to be efficient, but which does not unfairly limit the ability of health plans to negotiate rates and to effectively compete for business. We must be careful not to look only at the hospitals and the incentives operating on them to be efficient; we must also take into account the incentives operating on health plans to keep patients out of the hospitals. Total mix of services is the bottom line, and we must be careful not to overlook that fact in our drive to straighten out hospital payment.

Finally, I think it's important to emphasize that our ultimate objective must be to assure that our elderly citizens have access to quality health care at an affordable price.

I look forward to the comments of the witnesses, all of whom come with stellar reputations; many of whom have been here before. And I welcome all of you back today.

Because Senator Baucus, who is a ranking member of this subcommittee, is tied up on the Senate floor and because other members of the Finance Committee are engaged in debate over tuition tax credit, I doubt very much whether we are going to have a lot of

attendance at this hearing this morning. And for that reason, we have encouraged the witnesses to take a little more time in explaining their positions. Normally, we give you 5 minutes, and then jump all over you with prepared questions. Today, we have tried to reverse that procedure, and ask you to go in depth into some of these issues; take more time in your presentation.

And I will be asking each of you some questions, all of which will be aimed at trying our best to find some common denominator that will help us shape a prospective system.

Our first set of panelists will be from the commercial insurers. That's Mr. Henry DiPrete, vice president, group operations, John Hancock Mutual Life Insurance Co. of Hartford, Conn.; and Mr. James Moorefield, president, Health Insurance Association of America, Washington, D.C.

Would you like to come on up?

STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. MOOREFIELD. Thank you, Mr. Chairman. My name is James L. Moorefield and I am president of the Health Insurance Association of America, which is a trade association representing approximately 350 of the commercial insurers of this country.

With me today, as you have noted, is Henry DiPrete who is vice president of group operations of the John Hancock Mutual Life Insurance Co. As you have also noted, Gene Burton, who was a signature on the full statement we filed with you, unfortunately was not able to attend today so Hank and I will carry on the discussion from that point.

Mr. Chairman, we are firmly convinced that this Nation and its population enjoys the highest standards of health care of any country in the world. But because the cost of such care continues to escalate well beyond the cost of all other goods and services in this country, some reforms of the system are really needed.

In this oral presentation, we will present an overview of where our industry is today, a review of recent activities in the several States, and specific recommendations that we believe are necessary.

Modern health care, as you will recall, began back in the Great Depression years of the early 1930's really to assure the solvency of the Nation's hospitals. The real boom in the sale of group health insurance took place during the time of World War II. There was a tremendous growth. By the end of that great war, there were some 32 million persons that were covered for hospital expenses and in-hospital surgical expenses.

The emphasis on a prepayment mechanism to primarily cover the cost of hospital related costs changed with the introduction of major medical insurance by the Nation's insurance companies in 1955 when some 5 million persons were provided with coverage that covered the cost of both in and out of hospital health care that was prescribed by a physician.

Today, more than 154 million are covered by major medical insurance policies. Our recent survey conducted by our association indicated that 73 percent of the employees with major medical ex-

pense policies had maximum benefits of $250,000 or more. And that 66 percent had out-of-pocket limits of $1,000 or less.

The trend today, however, is to emphasize more outpatient coverage to avoid more costly inpatient care.

Mr. Chairman, we are a competitive industry with over 700 private or commercial insurance companies competing with some 70 Blue Cross and Blue Shield plans, with alternative delivery systems, such as health maintenance organizations, IPA's, provider plans, and a variety of uninsured plans that are sponsored by employers, labor unions and third party administrators.

The recent trend toward uninsured or self-insured plans, if you prefer, is a relatively new and rapidly expanding form of competition. It has resulted in part from the enactment of ERISA, which enables self-insurers to get out from under State insurance laws which mandate specific costly health insurance benefits. It is also the result of employers seeking to reduce their cost of money by avoidance of State premium taxes and the required holding of reserves of insurance companies.

Our companies, to meet this fierce competition, have developed new cost containment devices to reduce the cost of health insurance and, in turn, to contain the cost of the Nation's health care. We employ the use of coordination of benefits, second surgical opinions, preadmission testing, ambulatory surgery and nursing in home care. More than 90 percent of our business includes the use of deductibles and coinsurance, which seeks to make the consumer a more prudent, more cost conscious purchaser of health care services.

Many of our companies are also supporting various alternative delivery systems including HMO's and preferred provider plans.

Finally, a number of our companies have joined together recently to advance the state of the art in claims processing through the use of modern computer networks that are hooked into hospital terminals to produce the electronic transmission of claims, which we feel has a tremendous cost saving potential.

In other ways we are trying to modify health care behavior of the consumer. Through the HIAA, we have financed a study by Dr. Charles A. Berry, the former Medical Director of the U.S. space program, which found that worksite disease-prevention programs are achieving significant cost reductions for employers in terms of improved productivity, reduced absenteeism, and lower health care costs. Insurers have taken the result of this study to their group health clients in an effort to start disease prevention programs such as smoking cessation, high blood pressure detection, exercise programs, and the like.

In addition, the association recently initiated and is financing a 3 year project that will develop cost effective and efficient health procedures that could be easily used by doctors in their practices. This study seeks to motivate people to improve their behavior by dieting, exercising, smoking less and controlling their use of drugs and alcohol.

Although our business is doing its best to deescalate the rising cost of health care from both the supply and the demand side by the design of its products and otherwise seeking to be a prudent purchaser of health care services, we feel the urgent need to get all

parties together to look at possible long-range payment reform. For this reason, we have called for the appointment of a Presidential Commission which would include all parties of interest from both the public and the private sector—the providers, business, labor, insurers, and Government. And we would ask them to report back within a year with recommended reform.

At the same time this study would be underway, we have urged the adoption by the several States at the earliest possible date of hospital prospective budget review systems, whether they be voluntary or mandatory, which would seek to dampen hospital inflation. And finally, we request authority to enable our member companies to join together in negotiating with the providers.

Mr. Chairman, in order to tell you what is going on in the States, Hank DiPrete is here with me and I ask you to recognize him at this time.

STATEMENT OF HENRY DiPRETE, VICE PRESIDENT, GROUP OPERATIONS, JOHN HANCOCK MUTUAL LIFE INSURANCE CO.

Mr. DiPRETE. Thank you, Jim.

Mr. Chairman, I would like to briefly stress three points this morning with you. First, regulation of our industry; second, access to coverage by consumers; and, third, reimbursement form issues primarily related to hospitals.

Insurance, and particularly health insurance, is one of the most stringently regulated and supervised of businesses. State insurance codes deal with virtually every phase of a company's operations, including specific provisions for domestic and foreign companies, unauthorized insurers, information and privacy, investments, holding company systems, mergers and consolidation, reinsurance, unfair trade practices, claims procedures, and detailed chapters dealing with health insurance product itself—including individual, group, franchise, and blanket forms of insurance.

The enforcement procedures under State regulation are varied and effective. The authority of a carrier to transact business in a State can be suspended or revoked for violation of statutory or regulatory requirements. And the insurance commissioners can impose fines and penalties. Additionally, most States have statutory authority to obtain injunctions against any act or conduct of a health insurer that is in violation of the law or regulation, or may be considered to be unfair or misleading to the public.

Furthermore, approximately 85 percent of all health insurance is provided for through group contracts and the demands of the policyholder, whether expressed because of product choice, the needs of its covered members, or through the mandates of collective bargaining that must be met. The marketplace thus performs a highly effective regulatory function.

John Hancock goes head to head daily with Blue Cross plans and companies like Aetna, Travelers, and Prudential in competition for group accounts. The marketplace affords us no opportunity for shoddy performance or otherwise we would not only fall short of our new business goals, but also our own customer base would be at risk.

In addition to regulating health insurance, some States have also moved into the areas of guaranteeing its availability. Nine States since 1974 enacted what are generally referred to as State health insurance programs. Maine, Minnesota, New York, and Rhode Island have enacted State catastrophic plans. These plans pay for the medical expense of eligible citizens—eligibility being determined by the exhaustion of health insurance benefits the person has, plus the expenditure of a specified amount of money, usually expressed in terms of minimum dollar amount or percentages of annual earnings.

Connecticut, Indiana, Minnesota, North Dakota, and Wisconsin have enacted comprehensive insurance availability plans. Under these plans, a prescribed level of health insurance coverage is established that carriers must offer in addition to other coverages the carriers may write. Associations in these States have been established through which such coverage is made available to persons who are uninsurable and member carriers share the excess losses of these pools. In these States there are no uninsurables because there is guaranteed access to coverage.

Various programs for hospital reimbursement reform are also underway at the State level. In 1982, Massachusetts and New York joined Maryland and New Jersey as States which have established comprehensive statewide programs for cost review at hospitals. Although each State differs considerably in details and mechanics, they all have these six characteristics in common:

One, a statewide prospective budget review process for all hospitals in the States.

Two, incentives and penalties for hospitals designed to encourage and reward cost-effective management.

Three, equality of treatment as to payment for all patients regardless of the third party involved.

Four, uniform reporting requirements for all hospitals.

Five, utilization review for all patients in the hospital.

And, sixth, a system of payer discount based on objective factors which result in actual cost savings to the hospital.

The new private sector initiative in Massachusetts is particularly exciting because it was inspired by the business community. This new program means less State regulation and creates incentives to down-size the system, to reduce hospital utilization, and to shift more care from inpatient to outpatient settings.

On Monday of this week, Massachusetts was granted its medicare waiver only 4 weeks after filing its amended waiver application. And the coalition is indebted to the administration for putting them on an incredibly fast track in order to meet its implementation deadline.

Waivers like that recently granted for Massachusetts, and earlier for Maryland and New Jersey, are important because it means that equity is created in the payment system for all patients, however insured, effectively stopping the cost shifting phenomenon which threatens the viability of private health insurance in this country.

In the coming months you will hear arguments favoring the New Jersey DRG approach or the Maryland approach or the Massachusetts plan. We submit that each State should determine which ap-

proach works best. We further submit that there is likely no single approach which will work best everywhere.

Finally, too, a word about a bill signed in July by the Governor of California which authorizes insurance companies to negotiate preferred provider and exclusive provider contracts. This legislation will permit an insurance company to seek out and contract with hospitals, physicians, or other health providers who operate efficiently and whose utilization patterns reflect concern about health care cost. An insurer will be able to offer lower cost plans which lock in participants to using only services of participating providers.

The implications of this legislation are significant for the health insurance industry. The legislation provides companies flexibility in determining reimbursement practices. Thus, true market forces will be stimulated at the provider level.

Mr. MOOREFIELD. Thank you, Hank.

[The combined prepared statement of James L. Moorefield, Henry A. DiPrete, and Burton E. Burton follows:]

Prepared Statement of James L. Moorefield, Henry A. DiPrete, and Burton E. Burton, Representing the Health Insurance Association of America

My name is James L. Moorefield. I am President of the Health Insurance Association of America. The 350 member companies of the Association write about 85% of the private health insurance business in the United States. With me today are Henry DiPrete, Vice President, Group Operations, of the John Hancock Mutual Life Insurance Company and Burton E. Burton, Senior Vice President, of the Aetna Life and Casualty.

We appreciate this opportunity to share our thoughts with you as you continue your examination of different methods to bring reform to the nation's health care system. We are firmly convinced that this nation and its population enjoys perhaps the highest standard of health care of any country in the world. Yet, primarily because the costs of such care continue to escalate well beyond the costs of other goods and services in this country, some reforms of the system are needed. We believe that all parties--government, providers, insurers, and consumers--can and should join together in the development of the needed reforms.

We will present an overview of where our industry is today, a review of recent activities in the several states, and specific recommendations for necessary action.

Modern health insurance began during the Great Depression of the early 1930s. To assure the solvency of the nation's hospitals in those days, the Blue Cross movement was born as a prepayment mechanism to cover the costs of hospital care. By 1940, some 12 million Americans had hospital expense protection and some 5 million were covered for the costs of in-hospital surgical expenses.

The real boom in the sale of health insurance coverage took place during World War II. Inasmuch as wages were frozen and fringe benefits were not, employers and unions bargained on the basis of fringe benefits; and group health insurance experienced a tremendous growth. By the end of World War II, there were some 32 million persons covered for hospital expenses and in-hospital surgical expenses.

The emphasis on a prepayment mechanism to primarily cover the costs of hospital-related care changed with the introduction of major medical insurance by the nation's insurance companies in 1955, when some 5 million persons were provided with coverage that covers the costs of both in- and out-of-hospital health care prescribed by a physician. Subject to deductibles and coinsurance designed to provide consumers with continued interest in the cost of health care, these policies provided broad benefits against catastrophic episodes of illness. Today, more than 154 million Americans are covered by major medical expense policies. Insurance companies alone provide such protection to more than 107 million persons, or well over 90% of the people covered by insurance companies against health care costs. A recent survey conducted by the Association indicated that 73% of the employees with major medical expense policies had maximum benefits of $250,000 or more and 66% had out-of-pocket limits of $1,000 or less.

Besides major medical insurance policies, which reimburse individuals on the basis of usual and customary charges of health care providers, insurance companies today also provide hospital

indemnity coverage (dollars per day of confinement) and disability income protection (short- and long-term), which provides periodic payments when the insured is unable to work as a result of sickness or injury. Many varieties of these forms of coverage have been initiated and expanded over the years.

Today, insurance companies together with Blue Cross plans and other insurers provide health insurance protection to more than 186 million persons or some 8 out of every 10 Americans. Included among the benefits provided are dental and, to a lesser extent, preventive care services. The trend today is to emphasize more outpatient coverage to avoid more costly inpatient care.

We are a competitive industry with over 700 private insurance companies, some 70 Blue Cross and Blue Shield plans, alternative delivery systems such as Health Maintenance Organizations, IPAs, preferred provider plans, and a variety of uninsured plans sponsored by employers, labor unions, and third party administrators. This recent trend towards uninsured or self-insured plans is a relatively new and rapidly expanding form of competition. It has resulted, in part, from the enactment of ERISA, which enables self-insurers to get out from under state insurance laws mandating specific costly health insurance benefits. It is also the result of employers seeking to reduce their costs of "money" by the avoidance of state premium taxes and the holding of reserves by insurance companies.

To further illustrate how much competition exists, the maximum market share of an individual insurer does not exceed 15% in any state and is usually less than 10%.

Our companies, in order to meet the fierce competition that exists, have developed a number of new cost containment devices and undertaken significant efforts to reduce the costs of health insurance coverages. As examples, we employ the use of coordination of benefits, second surgical opinions, pre-admission testing, ambulatory surgery, and nursing and home care. As has been indicated, more than 90% of our business includes the use of deductibles and coinsurance which seek to make the consumer a more prudent, cost-conscious purchaser of health care services. Many of our companies are supporting various alternative delivery systems, including health maintenance organizations and preferred provider plans. Finally, a number of our companies have joined together to advance the state of the art in claims processing through the use of modern computer networks hooked into hospital terminals to produce the electronic transmission of claims, which we feel has a tremendous cost savings potential.

At both the institutional level through the Association and at the individual company level, we are seeking to modify the health care behavior of the consumer. Through the HIAA, we have financed a study by Dr. Charles A. Berry, former Medical Director of the U.S. Space Program, which found that worksite disease-prevention programs are achieving significant cost reductions for employers in terms of improved productivity, reduced absenteeism, and lower health care costs. Insurers have taken the results of this study to their group health clients in an effort to start disease prevention programs such as smoking cessation, high blood pressure

detection, exercise programs, and the like. The Association also recently initiated and is financing a three-year project that will develop cost effective and efficient health procedures that could be easily used by doctors in their practices. The study seeks to motivate people to improve their behavior by dieting, exercising, smoking less, and controlling their use of drugs and alcohol.

Although our business is doing its best to de-escalate the rising cost of health care from both the supply and demand side by the design of its products, and otherwise seeking to be a prudent purchaser of health care services, it feels the urgent need to get all parties together to look at possible long-range reform. For this reason, we call for the appointment of a Presidential Commission which would include all parties of interest, from both the public and private sectors, and would report back within a year with recommended reforms. At the same time, while this study would be underway, we urge the adoption by the several states, at the earliest possible date, of hospital prospective budget review systems, whether voluntary or mandatory, which would seek to dampen hospital inflation. Finally, we request authority to enable our member insurers to join together in negotiating with providers. Henry DiPrete will now discuss some of the activities going on in the several states designed to address needed reform in the health care system.

As Jim mentioned, I am going to discuss three areas of potential concern to this Committee and indicate how, at a state level, they are being addressed, with what success, and where improvements may be needed. The areas are:

1. responsiveness of health insurance to consumer needs and protection of the consumer;

2. availability of health insurance coverage; and

3. control of the claim-cost component of health insurance premiums so that available coverage is also affordable.

The first of these areas has been of concern to states since the inception of health insurance. With the exception of relatively recent inequities resulting from ERISA preemption for self-insured plans, which Mr. Burton will discuss, regulation and the dynamics of the marketplace already address this area.

Insurance, and particularly health insurance, is one of the most stringently regulated and supervised of businesses. Every aspect is totally prescribed and continuously scrutinized. The typical state insurance code consists of chapters of laws dealing with virtually every phase of a company's formation and operation including specific provisions for domestic and foreign companies, unauthorized insurers, insurance information and privacy, investments, holding company systems, merger and consolidation, reinsurance, unfair trade practices, claims procedures, and detailed chapters dealing with the health insurance product itself--including individual, group, franchise, and blanket forms of coverage.

These laws are implemented through a complex system of regulatory requirements adopted by the Insurance Commissioner of each state. These regulatory requirements span the entire scope of the company's operation from policy form content, filing and approval, marketing techniques and practices, advertising, premium rates, claims procedures, and overinsurance to various disclosure requirements and notification procedures.

The enforcement procedures under state regulation are varied and effective. The authority of a carrier to transact business in a state can be suspended or revoked for violations of statutory or regulatory requirements, and the Commissioners can impose fines and penalties. Additionally, most states have statutory authority to obtain injunctions against any act or conduct of a health insurer that is in violation of the law or regulation, or may be considered to be unfair or misleading to the public.

Furthermore, as Jim Moorefield has indicated, insurance is already highly competitive and its products, marketing methods, and service goals are greatly influenced and directed by demands of consumers. Approximately 85% of all health insurance is provided through group contracts; and the demands of the policyholder, whether expressed because of product choice, the needs of its covered members, or through the mandates of collective bargaining, must be met. The marketplace thus performs a highly effective "regulatory" function.

In addition to regulating health insurance, some states have also moved into the areas of guaranteeing its availability and moderating its cost.

In the area of guaranteed availability, nine states have, since 1974, enacted what are generally referred to as state "health insurance programs." For example, a Hawaiian Act required employers to provide to their employees, as a minimum, a prescribed level of prepaid health care coverages. This Act was rendered null and void by a Federal District Court opinion on the grounds that state laws imposing such requirements on employee welfare benefit plans are preempted by the Federal Employee Retirement Insurance Act (ERISA) and was affirmed on appeal.

Maine, Minnesota, New York, and Rhode Island have enacted state "catastrophic" plans. Under these acts, the plans pay for the medical expenses of eligible citizens--eligibility being determined by the exhaustion of any health insurance the person has, plus the expenditure of a specified amount of money, usually expressed in terms of minimum dollar amounts or percentages of annual earnings. These plans are state funded; Minnesota, Rhode Island, and New York being funded from the states' general revenue, and Maine being funded by a special tax on the sale of cigarettes.

Connecticut, Indiana, Minnesota (two plans), North Dakota, and Wisconsin have enacted comprehensive health insurance availability plans. Under these plans, although there are differences, a prescribed level of health insurance coverage is established that carriers must offer in addition to other coverages the carriers may write. State associations in these states have been established through which such coverage is made available to persons who are uninsurable and member carriers share the excess

losses of these pools. From an operational point of view, the Connecticut plan has functioned the most efficiently. The Wisconsin and Indiana plans, enacted in 1980 and 1981 respectively, have not yet become operational.

Although none of the state plans are identical, they can, except for Hawaii, be viewed as falling into one of two categories, depending on their purpose. The purpose of the state comprehensive plans (Connecticut, Minnesota, Indiana, North Dakota, and Wisconsin) is to address the problem of the uninsurable. The social-medical-economic problems of these two categories of persons are obviously quite different.

In any discussion of possible solutions to the nation's health care cost problems, HIAA believes that it is proper to place heavy emphasis on a flexible and workable state role based on successful prototypes. This emphasis is consonant with the Administration's expressed desire to revamp the federal-state partnership in government and also allows for varying programs among states with unique cost and delivery problems.

Finally, regulation and availability would be moot points if health insurance were not affordable. States have begun to work on this problem as well.

In 1982, Massachusetts and New York joined Maryland and New Jersey as states which have established comprehensive statewide hospital cost review programs. Although each state differs considerably in detail and mechanics, they all have these characteristics:

1. a statewide prospective budget review process for all hospitals in the state;

2. incentives and penalties for hospitals designed to encourage and reward cost-effective management;

3. equality of treatment as to payment for all patients regardless of the third party payor (private or governmental) involved;

4. uniform cost and utilization reporting requirements for all hospitals;

5. utilization review for all patients in the hospital;

6. a system of payor discounts based upon objective factors which result in actual cost savings to the hospital.

In addition, the Massachusetts and New York programs establish relief funds for hospitals which incur large losses due to bad debt and charity care.

It is important to focus on how these laws were developed. For instance, in Massachusetts, a negotiating team of insurers, providers, state government, and business met for nine weeks in intense sessions and reached agreement on complex amendments to a bill which HIAA had originally drafted. HIAA firmly believes that the Massachusetts program will be effective because all parties with a direct stake in hospital payment reform actively participated in designing a solution. In New York, a special commission of the legislature with similar multiparty participation created the New York approach. It is only on a state level that such participation and such imaginative and progressive solutions can be found, allowing maximum flexibility for a state to meet its own health care needs.

In developing these bills, the critical role of the federal government in health care financing was recognized. In both Massachusetts and New York, federal waivers are required to trigger fully-effective operation of the cost control programs. Both waiver applications are under review programs. Maryland and New Jersey already have such waivers which permit Medicare and Medicaid to pay hospitals along the same lines as other payors, as defined by state law.

Such waivers, along with the provisions mandating equity of payment for all patients, however insured, effectively stops the cost-shifting phenomenon which threatens the viability of private health insurance in this country. Perhaps more important to this Committee is that legislation like this and waivers have saved Medicare and Medicaid programs significant sums while assuring quality care. It is not surprising, then, that HIAA believes strongly that the federal government should recognize the role of state solutions to the health care financing crisis and encourage and participate in more of these innovative responses to this problem.

Finally, a word too about a bill signed in July by the Governor of California which authorizes insurance companies to negotiate preferred-provider and exclusive-provider contracts. This legislation will permit an insurance company to seek out and contract with hospitals, physicians, and other health care providers who operate efficiently and whose utilization patterns reflect concern about health care costs. An insurer will be able to offer lower cost plans which "lock" participants in to using only the services provided by participating providers.

The implications of this new legislation are significant for the health insurance industry. The legislation provides companies with that flexibility in developing reimbursement practices which is essential for interjecting true competitive forces into the health care market. It is a hopeful alternative to "regulated pro-competition" which would try to achieve cost containment through onerous, expensive regulation of insurers, hospitals, and employers.

There are, however, many unanswered questions about how insurers will be able to take full advantage of this new authority. In particular, recent Supreme Court decisions subjecting various health care reimbursement functions to antitrust scrutiny will have to be analyzed very carefully to guard against possible violations. Also, as Mr. Moorefield indicated, no single insurer is likely to have enough leverage in a given market area to inspire providers' wholehearted cooperation; we are not Medi-Cal. Medi-Cal, on the other hand, will have this leverage; and, to the extent that Medi-Cal negotiated "discounts" reflect its buying power rather than its ability to insist on efficiencies, the monies Medi-Cal "saves" will be shifted to the bills of patients insured by the private sector. Although insurers will also have to evaluate the novel administrative challenges inherent in negotiating and monitoring, this bill may offer insurers an opportunity to make a significant contribution in controlling health care costs. California's experiment has not yet been implemented--the bill is not effective until January 1983--and the results must be monitored to ensure that it is saving money not merely shifting cost; but it is an intriguing concept which deserves a trial.

Gene Burton will now address what we feel needs to be done.

The health care financing system has matured considerably over the last decade. In the first stage of development, the emphasis was on growth and expansion of access and coverage. It was during this first stage that we witnessed the burgeoning of employer group coverage, the introduction of large-scale governmental programs and the ignition of the subsequent explosion in medical technology.

We have now entered stage two in which we are all having to come to grips with the economic consequences of the astounding growth and success of our health care system. The new focus is on cost containment. It is surprising to find that we must now reexamine some of the economic and regulatory assumptions that supported our growth stage and to ask which of them may no longer be compatible with our readjusted priorities.

The health insurance business shares your strong commitment to cost containment. Nevertheless, we find that we must struggle under some formidable handicaps. The field on which we compete is strewn with regulatory and economic obstacles that significantly interfere both with our ability to serve our customers and with efforts to improve the efficiency of the health care financing and delivery system as a whole.

Put another way, what would the insurance industry like to do and what are the barriers to their doing it?

Let us first identify these handicaps, all of which are externally imposed upon us. Then we will return to a discussion of each of them. Our customers are the ones who absorb most of the cost shift

that results from underpayment of providers by Medicare and Medicaid. As you know, these shortfalls in government payments have been growing steadily larger and more burdensome for private patients. Then, unlike the noninsured plans with which we compete, we are subject to stringent state regulation. Our product design creativity is also stifled by a range of provider protection laws. Unlike our chief competitors in many instances, we pay state premium taxes and federal income taxes on the earnings on our reserves. In addition, the highly competitive nature of our business and the antitrust laws preclude us from collaborating effectively for cost containment purposes.

If the efficiency of our health care system is ever going to be improved through more meaningful patient participation, we must first make certain that the choices available to consumers are not economically biased because of governmental constraints. When individuals or employers choose a third party payment mechanism, the choice should be among realistic alternatives. This is not fully possible today.

What we would like to see is a "level playing field" for all third party payors including Medicare and Medicaid. When Medicare pays less, private payors pay more--in effect constituting a hidden tax on non-government patients which will amount to almost $6 billion in 1982 and is expected to double by 1985.

We find that many individuals and employers are increasingly frustrated when they realize that a large and growing portion of their health care expenses is paying not for their own care--over

which they have at least some control--but for care given to public patients. We estimate that 16 percent of the hospital expenses incurred by our policyholders is being paid for care rendered to Medicare and Medicaid patients.

In addition, the cost shift severely impedes the ability of private payors to compete with government programs under a voucher system.

We want Medicare to pay on the same basis as other payors. We believe the provision in the recently-enacted tax bill providing for Medicare recognition of qualified state hospital payment programs is a major step in the right direction. We are also pleased to see that a consensus is rapidly building for hospital payment reform which includes agreement on the need for a prospective rather than retrospective method of reimbursement; the need for a target budget which includes incentives to reduce unjustified utilization; and a uniform definition of reimburseable costs which includes all legitimate items of hospital expenses. The prospective payment system being developed by the Department of Health and Human Services is an important step toward Medicare health care reform, and we strongly recommend that it be applied to all payors.

Another possibility would be to require Medicare-approved hospitals to allocate equally among all private patients that portion of their budgets not reimbursed by Medicare or Medicaid.

Second, as with the Medicare cost shift, state regulation does not apply evenly to various classes of payors. Employers that self-insure employee welfare benefit plans are exempted from

state regulation by the preemption clause in Section 514(c) of ERISA. Such noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. These requirements, which vary considerably from state to state, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly. Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

In order to nurture competition in the health care field, we should assure that all competitors are subject to the same rules. Insurance laws and regulations serve a beneficial purpose in protecting the insured public. However, ERISA now precludes the states from regulating the affairs of noninsured health plans, but at the same time the federal government has failed to regulate these health plans.

The very fact that these plans are unregulated makes them increasingly attractive funding alternatives for employers. Indeed, as much as 50 percent of the new health-related business written by Aetna and other major insurers is no longer conventional health insurance. This is an obstacle to competition that we are not able to overcome without Congressional support.

It is also a very real impediment to innovative plan design by insurers. My own company, Aetna, is encountering considerable difficulty as we continue trying to adapt to existing state laws an original benefit design called CHOICE, which we think combines

the best features of conventional health insurance and an HMO in one plan.

We recommend that Congress require that state taxation and regulation apply equally to all funding mechanisms. We are not proposing a substitution of federal for state regulation. However, our business does support, for example, Section 3605(a)(ii)(I) of S. 1541 (the Retirement Income Incentives and Administrative Simplification Act, introduced by Senator Nickles) which would amend ERISA to preempt state mandated benefit laws for insured as well as for non-insured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design.

For example, we would like to set up programs in every state, as we have done in Connecticut, to guarantee the availability of health insurance to all individuals. Nine states to date have some kind of state pool for uninsurable individuals. However, again, ERISA is a major barrier to our seeking state laws setting up these programs. We feel strongly that all competitors in the employee health benefit market should share proportionately in any pool losses. However, ERISA preempts state laws to the extent those laws require self-insured plans to participate in the state pools. Thus, self-insured plans are effectively shielded from the economic burden of the pools, a burden which falls on an ever-decreasing base caused by existing legal barriers to equitable competition. The problem could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools and requiring all employee

health benefit plan funding mechanisms to participate in such a pool as a condition of income tax deductibility.

In a similar vein, there are any number of state laws enacted to protect the interests of different classes of providers. These laws often operate to prevent the establishment of preferred provider plans by insurers and stand in the way of negotiations between insurers and providers. As Hank DiPrete mentioned, an interesting experiment is beginning on this subject in California; and we should know before too long whether competition among providers will be enhanced by California's effort to stimulate negotiations.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, the development of physician profiles and patterns of care, and other such activities. Specifically:

1. Insurers should be authorized jointly to collect, analyze and use information on the quality, cost, or utilization of health care services, including the development of reasonable, or preferred utilization practices as guides for insurance reimbursements to providers. In other words, commercial insurers should be able to join together to assemble data.

2. Insurers should also be empowered collectively to negotiate with health care providers to develop utilization standards. It should further be possible for insurers jointly to contract with review organizations to provide peer review and concurrent hospital review for private patients and to provide data to such organizations.

As Jim Moorefield mentioned earlier, we feel that the magnitude of the health cost problem demands the involvement of all affected parties--government, providers, insurers, business, and consumers.

Mr. Chairman, this Committee has some difficult problems. The HIAA is ready to commit time and resources to develop a solution. Be assured that we will help in any way we can.

Mr. MOOREFIELD. Mr. Chairman, the health insurance business shares your strong commitment to cost containment. Nevertheless, we find that we must struggle under some very formidable handicaps. Put another way, we might ask what would the insurers like to do, and what are the barriers to their doing it?

What we would like to see is a level playing field, if you will, for all third party payers, including medicare and medicaid. When medicare pays less, private payers pay more. And, in effect, this constitutes a hidden tax on non-Government patients, which will amount to almost $6 billion in 1982. And because of the recent enactments of Congress could possibly double by 1985—$6 billion to possibly $12 billion.

We find that many individuals and employers are increasingly frustrated when they realize that a large and growing portion of their health care expenses is paying not for their own care over which they at least have some control, but for the care given to the public patients. We estimate that 16 percent of the hospital expenses incurred by our policyholders is being paid for care rendered to medicare and medicaid patients. This cost shift—as we have termed it—severely impedes the ability of private payers to compete with Government programs under any voucher system. We want medicare to pay on the same basis as other payers.

We believe that the provision in the recently enacted tax bill providing medicare recognition of qualified State hospital payment programs is a major step in the right direction.

We are also pleased to see that a consensus is rapidly building for hospital payment reform, which includes, agreement on the need for a prospective rather than retrospective method of reimbursement, the need for a target budget, which includes incentives to reduce unjustified utilization, and a uniform definition of reimbursable costs, which includes all legitimate items of hospital expenses.

The prospective payment system being developed by the Department of Health and Human Services, to which you referred, could be an important step toward medicare health care reform. But, Mr. Chairman, we strongly recommend that that system be applied to all payers.

Another possibility would be to require medicare approved hospitals to allocate equally among all private patients that portion of their budget which is not reimbursed by medicare or medicaid. Second, as with the medicare cost shifts, State regulation does not apply evenly to various classes of payers. Employers that self-insure employee welfare plans are exempt, as we have already noted, from State regulation by the preemption clause in section 514(c) of ERISA. Self-insured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans. Insured plan requirements, which vary considerably from State to State, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options, which are often quite costly.

Now employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans. This is an obstacle to competition that we are not able to overcome without congressional support.

Now we are not proposing a substitution of Federal for State regulations. However, our business does support, for example, section 3605(a)(ii)(I) of S. 1541, the Retirement Income Incentive and Administrative Simplification Act introduced by Senator Nickles. That would amend ERISA to preempt State-mandated benefit laws for insured as well as noninsured employee benefit plans. This simple change would be a first step along the way to more equitable competition and more rational benefit design

We would like to see programs in every State as have been set up in Connecticut, which Hank just referred to guarantee the availability of health insurance to all individuals. Five States, as he referenced, to date have some kind of State pool for uninsurable individuals. We feel strongly that all competitors in the employee health benefit market should share proportionately in any pool losses.

However, ERISA preempts State laws to the extent that those laws require self-insured plans to participate in the State pool. Thus, self-insured plans are effectively shielded from the economic burdens of the pool. The problem could be solved either by an amendment to ERISA or by legislation authorizing insurers to set up such pools, and requiring all employee health benefit plans funding mechanisms to participate in such a pool as a condition of income tax deductibility.

In a similar vein, Mr. Chairman, any number of State laws operate to prevent the establishment of preferred provider plans by insurers, and stand in the way of negotiations between insurers and the providers. As Hank DiPrete mentioned, an interesting experiment is beginning on this subject in California. And we should know before too long whether competition among providers will be enhanced by California's efforts to stimulate negotiations.

Last, we would like to share data and engage in joint cost containment activities, such as negotiating with health providers, by developing physicians' profiles and patterns of care, and other such activities.

Mr. Chairman, this committee has some difficult problems. The HIAA is ready to commit time and resources to develop a solution. Be assured we will help in any way we can, and we ask to be called upon.

I have filed with the committee, Mr. Chairman, several publications of our association which may be helpful to you in the way of background, including a revised copy with our proposed solution on the cost-shift problem.

To be better able to answer your questions, I do have several associates from industry and member companies and from staff who are technicians in this area. And with your pleasure, I may refer some of the questions you direct to us to them for answers. They are seated right here behind me: John Ahearn, who is counsel for the Aetna Life; Dick Mellman, who is vice president and actuary of the Prudential; Joe Peel, the association's general counsel; Dave Robbins, the association's vice president and controller; and John Troy, I think you know, who is vice president of the Travelers.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much for your testimony.

In reviewing the testimony of the three types of payers who we have invited to come here today, I know we are going to hear a lot about level playing fields. I don't know who invented that term. It seems to be of rather recent origin. I was tempted to ask Gene McCarthy about it on the plane yesterday.

I don't know how much we need to get into questions on the level playing field issue because each of the three groups has done a pretty good job in the prepared testimony. But I know we could get into a debate here today about State rate setting for example, and I have some fairly strong feelings on that myself. And we did have at least part of a hearing on that subject earlier.

As we look at the issue of the playing field, one of the things we could probably agree on is that there ought to be some equality in the competition among health plans as far as the application of Government legislation and Government regulation. And you have cited the problem created by ERISA relative to competition with the self-insured. You cited the distinctions regarding premium taxes. You mentioned the issue of antitrust. And I am glad you speak to these issues in this context.

But there have to be those out there who are interested in, No. 1, keeping people healthy, and No. 2, making sure they receive only the amount of sick care they really need and they get that care in the most appropriate setting. Some of these people might believe that carrying the level of playing field too far is going to work against accomplishing the objectives of access, efficiency, and holding down costs. I guess I am not one of those who believes right off the bat—unless you can persuade me otherwise during the course of testimony today—that it is necessary for every hospital to charge exactly the same amount for a procedure regardless of where it may occur in the country, where it may occur in the community or for which payer it is performed.

What level of business—of patient coverage—is necessary for an insurance company to apply some leverage in negotiating hospital rates? Furthermore, I'd be interested in your comments on charge-based payment systems.

Mr. MOOREFIELD. Hank.

Mr. DIPRETE. OK. I'll start. It's a tall order, Mr. Chairman, but let me start on that because several light bulbs were going on as you were speaking.

I think we are probably, in terms of competition at the provider level perhaps, all reaching in the same direction. One of the objectives is to get the consumer or the patient back in the act, if you will, so that he can exercise what limited rational choices are available to him. A start in that direction would be to get away from the retrospective cost-based reimbursement system where he is totally insulated, as is the payer, from the hospital or the provider's cost of doing business, if you will. That's one start in the right direction.

Another would be, through education and through marketplace forces, begin to effect benefit plan redesign so that the patient will have some incentive to make more rational choices—using an outpatient setting when it is more cost effective to do so than an inpatient setting, ambulatory surgery, and that kind of thing.

11-627 O - 83 - 3

All of these things are beginning to gel as a result of a massive educational effort. Inflation of health care costs, accelerating as they have been, is helping to change attitudes. But at the provider level, whether the prospective payment system is expressed in terms of charges or something else, we certainly feel that negotiations should be a part of the environment.

What we are concerned about is what currently exists today—that the negotiation is really only one sided. The provider, as long as he can negotiate and give something up with one payer because he can shift that to somewhere else in the system, isn't really a system savings at all. It's a shell game. That's what concerns us. So we have to make some starts, prospective reimbursement being one. Another one being plan redesign, education, and getting all parties in the act.

Senator DURENBERGER. Let me follow up on that. My impression is that in most cases when you talk negotiations, you are largely negotiating with a customer who buys one of your health plans rather than negotiating with a health care provider. Now there are some changes coming into the industry. Most of them that I am aware of appear to be related to physicians, the people who are making the choices among ambulatory and hospital services. And that's an appropriate place to start.

I'm curious to know how often insurers pay the beneficiary and how often they directly reimburse the hospital?

Mr. DIPRETE. There may be others with more specific statistics on this, but in my own company's experience, John Hancock, over the years the shift has gone away from direct reimbursement, particularly in hospital care, to assigned benefits. It's almost impossible for a person to be admitted to a hospital today without the patient assigning whatever benefits are payable to the hospital so that the hospital is paid directly.

On the medical side, particularly major medical, the patient does receive direct reimbursement for the most part from companies like mine.

Senator DURENBERGER. But, in effect, what's the next step? Say you have an assigned benefit. Is the next step to negotiate with the hospital the payment of the benefit? And how often is payment simply made on the basis of a reasonable and customary charge?

Mr. DIPRETE. There is some negotiation. And I must say that because there are some 7,000-some odd hospitals out there, and we are only one company—the negotiating process will center around where there are large market shares more so than where there are not. A simplistic example would be where my company for one has successfully negotiated what we will call "prompt payment discounts." Because of a mechanized claim payment system we can assure the hospital that they will receive the payments within 5 working days, if you will, or 10 working days. The value of that money is worth something to them and they are willing to reduce charges by a negotiated amount for that. But it's very small. And it's a relatively new phenomenon.

Senator DURENBERGER. I wonder if any of the other people have examples. What other forms of hospital reimbursement have members of the association used and with what success or lack of success? Does anybody else want to step up and respond?

Mr. TROY. Senator, John Troy from Travelers. I think except where you have a patient base that you can assign to a specific hospital—there are virtually no examples of negotiations by insurance companies with hospitals other than in this prompt payment area. There is virtually none. Now I think the hospital wouldn't dare negotiate with Travelers to give us a discount because they know that our other associates would be there the next day trying to get the same kind of consideration. The differentials that Blue Cross has are based on large part on State statutes so that they are exempt from the antitrust laws.

But if Travelers went in and got a discount, then the hospital wouldn't be able to refuse to negotiate with Aetna or Prudential or any of the other insurance companies.

Senator DURENBERGER. Why wouldn't they be able to refuse to negotiate with them?

Mr. TROY. Because of the antitrust laws. The antitrust laws are protecting the ability of the hospital to negotiate solely with Blue Cross as far as patients that are not under preferred provider plans. Usually it's the State action exemption of the antitrust laws that is protecting the hospitals from not going beyond that. And a lot of history is behind it as well. So I think the reason the hospitals don't negotiate with any one insurance company is that they know they will have to negotiate with all of the insurance companies.

And with the Federal Government shifting $6 billion and some cost shifting involved with the Blue Cross contracts and the HMO contracts, obviously the hospitals can't give a discount to everybody. They have to pay for this discount that they are giving to the other payers. That increases charges. Some of the differences in charges to patients are enormous.

Senator DURENBERGER. This is all very helpful. Let me be sure that I understand the position of the association. Is it the position of the association that you would like to see commercial insurers having the same opportunities to negotiate discounts as are currently provided, in some cases, the HMO's, and in most cases, Blue Cross?

Mr. MOOREFIELD. And we further need the joint negotiation authority. And that's where the antitrust problems hang us up now. Now the California experience is not for two or more companies to join together. It's single. It specifically permits a single company, if it has the leverage to negotiate, to do so. We feel that we have to have the joint negotiation authority. As the statement will show, in any given State there is no commerical insurer that has more than 15 percent of the market. And that's of all the private; leaving out the public sector. And most of them are down in the 4- and 5-percent range nationally, at most. And as represented here, we have got the giants of the industry.

In 1980, there was only one company that had just slightly in excess of 4 percent of the market share. So no single company has the leverage to really negotiate in a community or nationwide as the Blues and the Government have.

Senator DURENBERGER. Your testimony seems to be strongly supportive of State rate setting. Later this morning we will hear about some of the anti-discount, anti-incentive results of rate setting in

some States—I could read your testimony to say that while you are against negotiating period, you would rather substitute some kind of a State process in which everybody is going to get paid the same thing. And, in effect, the State will negotiate annually for either reductions in payments or discounts or whatever.

Mr. MELLMAN. Mr. Chairman, Richard Mellman of the Prudential. My company is the 4 percent. I think it's important that we define terms because as you know, we are talking about——

Senator DURENBERGER. Please do, because I don't understand half of them.

Mr. MELLMAN. We are talking about more than $100 billion expenses by Americans per year. This word "discount" is a good place to start. All Americans love a discount. Everytime we buy a car or refrigerator, we seek a discount. And what we are really talking about here is underpayment in relation to the true cost, which necessarily results in overcharging other people.

Now to the extent that a payer can provide certain economies to the hospitals which results in savings to that hospital—I believe we will all agree that it is proper that there be a differential in cost for that. And Hank talked about prompt payment discounts. Since the hospitals get paid faster, they are entitled to more money, and less money from the payer. That's an example.

But there are many more things involved here. For example, some negotiations involve the unwillingness to recognize certain dollars of cost that the hospital incurs. And to the extent that some payers, be they covered or private, don't pay for those things, the hospitals are loaded onto the others.

And we have differentials today which amount to $300 per day per patient where insurance companies are paying out at the rate of $800 per day per patient. And the Government and Blue Cross are paying that same hospital at the rate of $500 per day for the patient for the same kind of treatment. That's the kind of thing to which we object when we talk about a level playing field.

Senator DURENBERGER. Dick, I understand that. None of us likes the cost shift that is inherent in differential payment schemes or discounts. Let's not talk discount because I know that is a bad antitrust word. We will just presume there is another word for it like "level playing field."

If you also believe in a marketplace for the provision of health care, one of the purposes for changing the way medicare reimburses is to try to help everybody in the system—all payers—impact favorably on the cost of hospital based health care. And unless we all get on the same playing field and we all have the same opportunities to negotiate with hospitals, it is going to be very difficult to effectively contain hospital costs. There will always be some shifting.

If all the third party payers, whether it is us or you or the Blues or HMO's, are on the same playing field negotiating and the hospital is still left with a gap, then that gap is either eaten by the individual or by a good hospital administrator or by a good set of hospital trustees or by a community. That pressure will drive hospitals to seek less expensive ways of providing health care. And I think it's that kind of force in this system that we are trying to build. We are not aiming to set just one fee for health care in this country

and force the whole system to bring its quality down—but unless we get real life market forces working out there, we are left with State rate setting or federally imposed regulatory processes that do just that: reduce quality and encourage inefficiency.

Mr. MELLMAN. I would like to leave you with one illustration. If you think in terms of the way gas stations operate. If I drive my car around with an empty tank of gas, I can see the prices posted at the stations. And I can buy my gasoline for $1.24 or $1.23 or $1.22. At some stations they give you 5 cents a gallon off for cash instead of credit cards. That's a reasonably level playing field, which is competitive. But I don't have to drive in and bargain at the pumps. That's what we are trying to avoid.

Senator DURENBERGER. Was there one other comment? I do want to ask a question or two about whether or not the signs are ever going to go up in front of hospitals or doctor's offices. [Laughter].

Mr. TROY. I think it would be a good question to ask because we don't want a level playing field, which we feel would come out of the prospective reimbursement system, to provide all players with allowances. And if we don't want that, what do we think is going to be produced in terms of the public policy by allowing a given set of payers to have differentials? In other words, why would a hospital give a payer a differential? Not for having less patients in the hospitals—for putting more patients in the hospitals.

I just don't see anything coming out of these massive negotiations except some——

Senator DURENBERGER. Before I get to the price of gasoline, let me ask you what experience the industry has had negotiating with physicians. Is there any opportunity in the arrangement between an insurer and a physician, the physician being the one that ultimately makes the decisions relative to hospitalization? Are there opportunities that ought to be explored by us along that particular line?

Mr. DIPRETE. Again, this is part of the historical evolution that has taken place in society largely as the result of marketplace forces. Until 20 or so years ago, almost all, if not all, commercially insured programs had fixed fee schedules for medical, primarily surgical, procedures. The patient, then, could determine from the doctor what the actual charge was and the plan typically paid a fixed amount based on that diagnosis.

Collective bargaining and marketplace demands have changed over the years so now the vast majority of plans are what we would call "reasonable and customary." To one degree or another, medicare and other programs are on that kind of a program.

I believe marketplace forces—through benefit plan design—led us to where we are today. And they will have to lead us to where we are going if we are going to post prices or pay out a fixed amount for a diagnosis, or an illness, or a specific procedure, putting the consumer back in the process of negotiating, if you will, the difference, if any.

Mr. MOOREFIELD. Mr. Chairman, there is also a recent example of an obstacle to such negotiations. Joe Peel, our general counsel, could recite that.

Mr. PEEL. Yes, sir. Through the years, there have developed a series of laws throughout the States, we call the freedom of choice

laws. In essence, the insurance code in those States says that in the private health insurance business you cannot make your benefits contingent upon the insured person going to a particular hospital or particular doctor. This element certainly has been a dampening influence upon the attempt of single insurers to negotiate directly with the hospitals or doctors.

Senator DURENBERGER. How many States?

Mr. PEEL. I would say around 30 to 35. We have not completed our research on that. We are currently involved in this due to the developments in California that Mr. Moorefield indicated. I just want to point out that the California legislation did specifically amend the California insurance code to repeal this impairment.

Senator DURENBERGER. What experience has the industry had with diagnostic grouping? I ask that because HHS is exploring that option.

Mr. MELLMAN. They have this program in New Jersey, which is my home State. There are very few hard data that the State department of health has come out with yet. They do have reports on the 1980 experience which represented approximately one-third of the hospitals. The hospitals are phasing it in over a 3-year period. They are in the third year right now.

The 1981 statistics are expected shortly, I am told. We are confident that the system is working well. And it is cost effective. The hospitals have learned to live with it and like it. And it is producing significant savings for the public in terms of holding inflation well below the national average. And it does that because it simply changes the incentives. They treat the patient and get him out. There's more preadmission testing going on. There is shorter length of stay.

Senator DURENBERGER. What kind of information and data do you think should be available to payers and in what form should it be available? What would be helpful, for example, in negotiations, as we talked about earlier? And you might even expand that to what kind of information and data might be helpful to consumers.

Mr. MOOREFIELD. If I may, I will call on Vice President/Controller Dave Robbins to tell what is now going on. And then maybe some of the others.

Mr. ROBBINS. We have been collecting data on the range of surgical charges, which we do make available to our member companies. We do not, however, have specific data as to what hospital durations are, what the utilization rates are, or by type of payer or diagnosis. We believe that if such data could be collected we could get a better handle on what is happening with respect to hospital care. That is one of the reasons why we are suggesting that.

Senator DURENBERGER. But the only experience, is in States that collect the data?

Mr. ROBBINS. I think Dick is probably more familiar with Maryland than I am.

Senator DURENBERGER. Dick?

Mr. MELLMAN. Well, I can summarize it. The data to which Dave Robbins just referred that we would like to collect on the diagnosis, discharge, payer category, the Maryland system has been collecting. But there was a question of how it might be used. And although I don't have the full particulars—maybe counsel can fill me

in—but this past June the Justice Department did grant a letter to the State agency, the rate setting commission, that it could be used and distributed for that peer type of comparison. They are eagerly looking forward to the result. And, hopefully, if it is valid and useful in containing the cost, as has happened in Maryland, then it might be extended to other States. But there is that antitrust question. You have to have Justice clearance on it.

Mr. DiPRETE. Mr. Chairman, I might add that for some years the HIAA has been collecting medical-surgical data from the various carriers that participate in this data pool. But on advice of our own counsel, we have not provided or issued provider specific data. So it has limited value. If one can't hang out their sign in front of the right gas pump, if you will——

Senator DURENBERGER. Let me ask a final and related question. We are going to have some difficulty, I assume, with the AAPCC—the average adjusted per capita cost formula. What information is available to you now with regard to the kinds of things we are looking for in the AAPCC? And what kind of difficulty do you think we might have in coming up with appropriate cost formulas?

Mr. MELLMAN. I believe the AAPCC is a nice adjustment method. The problem, however, is how you overcome the pressure from the fact that the people who are paying on the basis of charges have a 16-percent subsidy to pay built in, which Mr. Moorefield alluded to. Somehow, you have got to come up with a 16 percent saving to offset that.

Senator DURENBERGER. And that is going to differ by diagnostic procedures, I imagine. It is going to differ by community. It is going to differ by hospital. Is that right?

Mr. MELLMAN. No question about it. In many States, the Blue Cross pays on the basis of charges, and so the governmental part is spread over the entire private sector. And it is less than 16 percent. In some States it is concentrated on just the amount Blue Cross doesn't pay, so it is more than 16 percent in some cases. So it definitely depends on that.

Senator DURENBERGER. Other than that problem, do you see any other problems or opportunities for us right now?

Mr. MELLMAN. My opinion would be that without solving or reducing the cost shift problems the opportunity for insurance carriers to participate will be extremely limited. However, it is conceivable that in HMO's you might be able to produce utilization savings such that offset that.

Senator DURENBERGER. Let the record show that the questions that I wasn't able to ask for reasons of time will be submitted to you for the record. And any other additional information beyond your statement that you would like to submit would also be helpful. Senator Baucus also has some questions which we will submit to you for the record.

[The questions from Senators Durenberger and Baucus and the answers from Mr. James Dorsch of the Health Insurance Association of America follow:]

HEALTH INSURANCE ASSOCIATION OF AMERICA
1750 K Street, N.W., Washington, D.C. 20006-2391, (202) 331-1336

James A. Dorsch
Associate Washington Counsel

October 8, 1982

Mr. Robert E. Lighthizer
Chief Counsel
2227 Dirksen Senate Office Building
Washington, DC 20510

Dear Bob:

In response to the Chairman's letter of September 22 enclosing questions to be answered for the record of the Health Subcommittee hearing on September 16, 1982, the attached questions and answers are submitted.

Sincerely yours,

James A. Dorsch

JAD/jfd

Enclosures (7)

Questions from Senator Durenberger

1. To hold down your premium costs, do you have any experience with or plans to offer insurance which emphasizes preferred (lower-cost hospital or physician) providers and which includes out-of-pocket beneficiary payments if care is delivered by non-preferred providers?

Answer

In general, our member companies have had little experience with preferred provider plans because of the legal barriers to insurance companies setting up such plans. We know that many of our members are examining with great interest the new law in California to see what opportunities it provides. We would not necessarily be privy to any plans they intend to inaugurate there since that is a very competitive market place and our members are in competition with one another.

Aetna Life and Casualty has initiated a type of preferred provider plan in Chicago called "Choice." Explanatory material from their press conference earlier this year follows:

Aetna LIFE & CASUALTY **NEWS**

For Release:

NOT BEFORE 4 P.M., FEB. 1, 1982

CONTACT: Bob Norton
(203) 273-3388

WASHINGTON, Feb. 1 -- Aetna Life & Casualty said today it has developed the first new concept in employee medical care programs since the introduction of health insurance and health maintenance organizations (HMOs).

Aetna President William O. Bailey said the program, called CHOICE, "marks a major step by the private sector towards stimulating constructive competition in health care delivery and financing."

Leslie Levy, M.D., president of Aetna Healthcare Systems Inc., said CHOICE combines the best features of HMOs and traditional health insurance.

"Unlike pre-paid group practice HMOs, CHOICE provides people freedom to choose their own personal, private physician for primary care. Unlike traditional insurance and Blue Cross/Blue Shield, it also assures cost-effective specialty and referral care by physicians and hospitals who are recognized for their excellence," he said.

Pending Illinois regulatory approvals, CHOICE will be available later this year in the Chicago area and Aetna expects to extend it into other major metropolitan areas over the next several years.

- more -

Bernard J. Lachner, president and chief executive officer of the Evanston (Ill.) Hospital Corp., said that as the first participants in CHOICE, the members of the hospital's professional staff "are very proud to take such an active role in joining Aetna to bring an exciting new concept to the health care field."

Lachner, who is immediate past chairman of the Board of Trustees of the American Hospital Association, expressed confidence that other leading doctors and hospitals would become involved. He added that "CHOICE could provide a powerful stimulus for other physicians and hospitals to become more cost effective."

Dr. Levy said CHOICE is a new concept for two principal reasons. First, it strengthens primary care relationships by having patients establish and maintain an ongoing relationship with a primary care physician.

Under CHOICE, the primary care physician is the patient's link to all non-emergency medical care. This relationship, Dr. Levy said, which is similar to pre-paid group practice HMOs, provides continuity of care and helps control unnecessary treatment.

"However, it accomplishes this without limiting patients to physicians employed by an HMO and without limiting physicians to a particular mode of practice," Dr. Levy said.

Second, while strengthening the primary care relationship, CHOICE extends patients' freedom of choice by providing them an opportunity to select physicians and hospitals they might not otherwise have access to through their own doctors, Dr. Levy said.

3

"CHOICE provides an opportunity for physicians and hospitals working with Aetna to demonstrate that excellent medical care can be less costly than average care," Bailey said.

Aetna said that employees and employers will share in the savings realized under CHOICE.

(Editor's Note: This announcement was made at a news conference in the National Press Club, Washington, D.C. Aetna Life & Casualty is based in Hartford, Conn.)

/ / /

CHOICE NEWS Conference
Washington, D.C.
February 1, 1982

CHOICE

QUESTIONS AND ANSWERS

1. Q. Don't other insurance companies or hospitals have programs similar to CHOICE?

   A. NO. There is no program we know of like CHOICE. Kaiser-Style HMO plans do offer comprehensive structured services, and some insurance companies and hospitals are involved -- but these programs do not offer freedom of choice in personal physician services. This, combined with CHOICE's emphasis on primary care, and its assured access to recognized referral, specialty, surgical and hospital care make CHOICE unique!

2. Q. What are the main things that make CHOICE so innovative?

   A. CHOICE is a way to harness the proven strengths of fee-for-service private practice medicine to meet individual patient needs with excellent and personal care at affordable costs. Unlike other programs, CHOICE emphasizes the personal needs of patients by offering simultaneously the promise of freedom of choice and cost-effectiveness. CHOICE aligns the strongest of drives and motivations already present in the mainstream of responsible medicine with producing the right bottom line financial result for those who pay the bill.

3. Q. I don't have a "personal" physician. Can I still join the program?

   A. The CHOICE program feels that personal physicians -- or primary care physicians as they are sometimes called -- are essential both to assure the best care for each patient, and to assure the most appropriate cost for each patient's care. CHOICE, therefore, requires specification of a personal physician at the time of enrollment. For people who don't already have personal physician relationships they value, CHOICE will make available names and other particulars about some selected physicians who have established a relationship with CHOICE precisely for the purpose of caring for patients who don't yet have personal physicians.

4. Q. How do you define a personal physician?

   A. A personal physician is the doctor a person goes to see first. He or she is someone who knows you over a period of time and determines whether and when a person may need various kinds of medical services including the determination as to the need for referral care. Most people will choose an internist, pediatrician, obstetrician-gynecologist, family practitioner or general practitioner for this purpose. However, CHOICE will permit patients to arrange for any licensed physician to serve as their personal physician.

5. Q. Do you think you'll encounter difficulties convincing the public it's in their interest to have you choose their surgeon and hospital?

   A. Aetna is not "choosing" anyone's surgeon or hospital. In fact the situation is quite to the contrary. Often when people develop a worrisome problem they feel they have little choice but to go to the surgeon or hospital that has been recommended, or the one where their personal physician has staff privileges.

   CHOICE provides patients an opportunity to select a recognized set of referral physicians and surgeons and a recognized hospital before they encounter a threatening problem -- thus avoiding the situation of someone else choosing for the patient. If a patient -- or his or her personal physician -- desires a particular referral physician from among the CHOICE referral physicians, the program will make every effort to honor that request. Within the CHOICE program there will often be a great number of physicians from which to choose. For example, the CHOICE program with members of the Evanston Hospital professional staff will include over 200 highly qualified referral physicians.

6. Q. What if someone in my family requires some special care that's not available at a CHOICE hospital? Will CHOICE pay my bills?

   A. CHOICE's contracting referral specialty physicians and surgeons and the hospitals they use will be well equipped to deal with almost any medical condition. In those rare cases where in the judgement of the CHOICE referral physician other physicians or hospitals are needed to provide the right care for a patient, the CHOICE program will pay for such services.

7. Q. Will Aetna's relationship with doctors and hospitals or other medical facilities be exactly the same in all locations?

   A. So far as enrollees are concerned it might appear so -- all CHOICE physicians and hospitals will have reputations for excellence and personal attention for patients. However, though the kind of care and doctors and hospitals will be the same, the specifics of their relationships with Aetna will be very different -- because different physicians and hospitals -- whether in the same metropolitan area or a different one, will have different needs and concerns. Aetna's CHOICE program is flexible enough to comfortably accommodate these differences.

8. Q. Will CHOICE cost me less than the traditional insurance or Blue Cross/Blue Shield plan or the HMO plans available where I work?

   A. This will depend largely on the type of benefit package your employer selects and, of course, on whether or not you contribute to the cost of your health plan. If you do contribute to a traditional insurance or Blue Cross/Blue Shield program, we think you'll pay less or receive more valuable benefits. CHOICE will be priced competitively with HMO's.

CHOICE -- 3

9. Q. Will CHOICE provide coverage for dental care?

A. At present the plan covers medical care related services and the oral surgery services covered by traditional insurance plans only.

10. Q. Will CHOICE cover prescription drugs?

A. Yes, prescription drug coverage is included.

11. Q. Will CHOICE provide a better benefits package than other plans relative to its price?

A. We think it will in several ways. CHOICE benefit packages will be very comprehensive and competitively priced. CHOICE will include coverage of preventative services, it will have no deductibles and it will have limited cost-sharing by the enrollee. Many services will be provided with no cost-sharing by the enrollee. This will be particularly true of situations where the enrollee has no control himself over the "need" for care -- in the case of serious illnesses needing referral care, for example. We anticipate savings from CHOICE's emphasis on primary care and preventive services -- and especially from the cost-effective medical practice by the specialty referral physicians and hospitals from which enrollees will receive anticipated care. These savings are built into our benefit design and pricing.

###

Leslie Levy, M.D., President

Aetna Healthcare Systems, Inc.

CHOICE Press Conference

February 1, 1982

Washington, D. C.

Thank you, Mr. Bailey. And thank you all for joining us here today.

In a few minutes I'm going to describe for you the concept of our new program, CHOICE. I'll talk about how it compares to HMOs and traditional insurance and tell you why we think it will work. Before I do that, however, I want to tell you about some of the thinking that has gone into CHOICE.

Some of our considerations will surprise you --- so I ask you to reflect for a moment as a patient, before jumping headlong into the usual facts of who, what, when, and where.

Medical care, and patient-doctor relationships are a highly emotionally charged subject. The very strongest of human emotions are center stage in health care transactions. A patient's fear of death and disease --- and physicians' devotion to patients and pride in their skills are among those emotions --- you write their stories daily.

Yet when people --- whether they are policymakers, physicians, employers or insurance executives - talk about health care problems and new programs to address those problems, inevitably they talk as if the problems and solutions are completely within the realm of economics. In doing this they almost totally ignore the much broader scope of human behavior involved. Such a narrow focus upon economic solutions is a universal characteristic, whether proposed programs are public sector or private sector.

This fundamental issue is our first point of departure:

While it is clear that the most vexing contemporary health care problem is the cost of health care --- an economic result --- it is just as clear that altering that economic result requires something much broader than a program conceived merely in economic terms.

The economic result -- the cost of health care -- is a result of many more complex behaviors than the subset of economic behavior.

In order to address as complex a problem as health care costs, one needs an approach that can address the broad scope of non-economic behavior, as well as the economic behavior.

To put this in a medical perspective --- to design a program aimed at treating health care costs we need to treat the whole patient not just the economic disease!

Having said that, you might have formed the impression that I'm about to tell you we will endeavor to build a chain of HMOs cast in the image of the Kaiser plan.

That is not what we are about.

Like anyone looking at providing alternatives to traditional group health insurance, we looked at Kaiser --- and we admired their success at cost containment. But we concluded that, in addition to enormous start-up-costs, as seen in the federal HMO program, that the model's appeal would be too limited for the clients a national company like ours serves.

We also observed that neither of the two HMO models in existence, the Kaiser style HMO nor the IPA, would be the best competitor that Aetna could put in the marketplace.

This statement shouldn't shock or surprise us --- the Kaiser-style HMO was never designed or intended to be a competitor.

Recently, writing in the November, 1981 issue of The Internist, Kaiser's own Dr. John Johnson put it this way:

> "It should be remembered that the prototypical prepaid group practice did not arise denovo after a preconceived grand plan; but rather under unique circumstances, in certain places and times, when traditional systems were unprepared or unwilling to provide the medical care needed at an affordable price. It was much later, when some of these plans had shown remarkable success in the private sector with no federal funding, that an administration in need of new proposals to control runaway medical costs devised legislation to encourage their foundation and growth by creating health maintenance organizations."

Dr. Johnson's emphasis on circumstances, times and places is highly significant Kaiser's historical success is a function not only of its good staff and energy but also of the times, places and circumstances. Kaiser's growth can be related closely to the westward migration of our population after World War II.

With an apology and request for tolerance for my beginning with such a philosophical approach I want to move directly to highlighting some specific considerations that have gone into our program as a result of

this outlook. Broadly classed there are patient concerns and physician concerns.

Patient care is what the system is about, so let's talk about that first.

PATIENT CONCERNS - PERCEIVED QUALITY

The Kaiser style model of prepaid group pracrtice HMOs and a number of other mature prepaid group practices enjoy reputations for high quality care. However, it is often difficult, regardless of the facts, for miniature copies elsewhere to convince "consumers," as the economists like to call people, that their physicians and hospitals can match the quality of physicians and hospitals with established reputations in the community. --- We concluded from this that Aetna must provide a program with unquestioned quality of care.

PATIENT CONCERNS - FREEDOM OF CHOICE

Another patient concern that is at least as important to address is freedom of choice. While Kaiser benefited greatly in the period after World War II from the westward migration of our population, and today's Sun Belt migrants are a good market for similar plans --- in most of the country lots of people have relationships with personal physicians which they value. The Kaiser HMO can do a superb job of meeting the needs of the medically unattached. But it doesn't meet others' needs as well. This was

identified as an area where we must be very different from prepaid group practice HMOs. The Kaiser model requires people to give up most of their freedom to choose a personal physician --- indeed, the freedom to keep the physician they now have.

This drawback in the competitive appeal of the mini-Kaiser-style HMO is so powerful and well recognized that some proponents of competition have begun suggesting that freedom of choice itself is one of the root evils of our health care system. As you'll see in a few moments, when I revisit this point --- we disagree --- we propose instead to strengthen freedom of choice.

PHYSICIAN CONCERNS - FREEDOM OF PRACTICE MODE

It is certainly true that compared to 20 and 30 years ago, significantly more young physicians are willing and even eager to practice as employees or as part of other collectives such as large partnerships or corporations. However, we mustn't forget the also increasing number of physicians in solo and very small group practices.

In the heat of the health policy debate, physicians are often relegated to being "providers," the economist's counterpart for "consumers." Providers those depersonalized technology driven automatons are devoid of problematic, noneconomic needs.

But physicians are people --- and --- if they are to meet the very personal needs of their patients, their own personal needs cannot be forgotten. (This is a good example of what I meant when I talked earlier of a broader approach than merely economic considerations.)

Consequently, we decided that here too we should part company with the Kaiser model. Copying, it even in miniature, doesn't provide for the type of practice environment that most physicians (and patients I might add) find comfortable and supportive of their needs.

Moreover, copying the Kaiser model HMO restricts us to competing with similarly directed developers for the services of a minority of physicians.

To create the strongest competitive program, then, we will accommodate the varying practice environment needs of the majority of responsible physicians.

PHYSICIAN CONCERNS - PLURALISTIC PAYMENT ARRANGEMENTS

Like the mode of practice, methods of physician payment are the subject of vigorous inquiry and debate. Some have singled out fee-for-service as a root evil. Generally the critics of fee-for-service give short shrift to its strengths and ignore the abuses that have occurred under other methods.

The focus on imputed virtues and evils of various payment methods has unfortunately diverted attention from a much more basic issue --- the motivations, professional integrity, and clinical competence of the physicians involved in any system.

To create the strongest competitive program in the marketplace, we think that first considerations should be clinical competence, professional integrity and motivation and genuine concern for patients --- the particular method of physician payment is then simply what is mutually agreeable to the parties involved in creating the program. While we will use many payment methods, fee-for-service will be a primary one so long as that is the desire of responsible physicians.

SIMULTANEOUS COST CONTAINMENT AND FREEDOM OF CHOICE

So, what I've been saying about patient and physician concern all boils down simply to the idea that to be an effective competitor a program has to provide simultaneously, both cost containment and freedom of choice.

This is an important notion --- Traditional insurance and similar programs do well on the freedom of choice --- less well on cost containment. The prepaid group practice is in the opposite condition.

To understand how CHOICE solves the problem of having both, let's consider for a moment what freedom of choice <u>really</u> means.

THE REAL MEANING OF FREEDOM OF CHOICE

We think we know all about it -- like motherhood, apple pie -- but do we really? Let's consider freedom of choice for a moment.

Under traditional insurance it's a right many people enjoy and use constructively for their own benefit. People choose and maintain relationships with personal physicians for a whole host of subjective personal reasons -- whatever their reason they are important to a patient's sense of well-being.

In contrast to the meaningful use of freedom of choice with personal physicians --- when it comes to referral and specialty care, freedom of choice is more a <u>potential</u> right than an actuality. While people are relatively good judges of personal physicians --- because they can tell if a physician listens and cares --- most people are not able --- especially after they have developed a potentially serious and threatening problem --- to take an active part in seeking and choosing an outstanding quality referral physician or surgeon. Instead, they depend on family members or friends --- or if they are so fortunate, they depend on their personal physician.

However, the nature of medical practice in most major metropolitan areas is such that the professional contacts of the personal physician may become the limiting factor in freedom of choice. While some personal physicians do refer widely most limit referrals to their own particular circle of professional contacts. The results are uneven. Some patients get excellent care. But sometimes excellent care may instead be with another physician a few miles away --- and at another hospital.

The distinction in the operation of freedom of choice between personal physician services and referral care services is at the heart of our design of the CHOICE program.

Our objective is to build on and strengthen patients' personal physician relationships --- and to provide a meaningful choice --- not just a potential --- for referral and specialty care. A choice that provides an opportunity to choose outstanding, recognized specialists, surgeons and hospitals ahead of time --- before they are needed.

SO WHAT NOW IS CHOICE ABOUT?

CHOICE is a two level program ---

Two levels to correspond with the two levels of medical care I've been discussing.

There's a program of personal care and a program of referral specialty and associated hospital services.

The personal care program not only allows people --- but in fact it requires people --- to choose their own physician for primary care. Employees and families will be free to choose any licensed physician for personal medical services --- so primary care choices resemble traditional health insurance plans.

The CHOICE program emphasizes primary care, as do prepaid group practice HMOs. It will provide payments toward personal physician services including office visits, and it will feature some first-dollar payments intended for a conservative program of preventive services. But unlike traditional insurance, these payments will only be made to the particular personal physician designated by the enrollee.

For those enrollees who do not already have valued primary care physician relationships, the CHOICE program will suggest consideration of a select group of primary care physicians who are interested in such CHOICE patients and have established a relationship with CHOICE for that purpose.

If non-emergency medical services beyond the primary care level are needed, enrollees in CHOICE will receive those services through referral

physicians and surgeons and hospitals which the enrollees have selected and who have established reputations and are recognized in their community for excellence.

Assuring all enrollees access to such physicians and hospitals is accomplished by contractually and administratively linking specific physicians and hospitals to the CHOICE program. Then an enrollee can specify at the time of enrollment a particular set of referral physicians and hospitals along with his own choice of personal physician.

Thus, CHOICE extends patients' freedom of choice beyond what they have at present by providing them an opportunity to select physicians and hospitals they might not otherwise have access to through their own doctors!

FINANCIAL CONSIDERATIONS

The distinction between personal physician services and specialty/referral care is very convenient from a financial point of view:

> Personal physician services amount to relatively small dollars. Whereas specialty referral, surgical and associated hospital care is where the big dollars are!

Because the importance of the distinction between personal physician services and referral care is not yet widely recognized as important, data regarding the cost split is not readily available.

But looking at this slide we can see the preponderance of expenses which are usually paid by health benefits plans are on referral care. Most hospital care is associated with non-emergency referral care. And the distribution of our payments for physician services under group insurance indicate that at least two-thirds or more of those payments are for referral physician services and services associated with referral care as well.

Consequently something of the order of three-fourths of present claim costs are associated with referral and specialty care.

CHOICE VS. TRADITIONAL INSURANCE AND HMO'S

Let's examine how patients personal physicians and referral care relate to each other and the system. It's illuminating to contrast the CHOICE program with traditional insurance and closed panel HMOs.

Schematically we'll consider the three approaches beginning with traditional insurance.

This diagram represents patients' use of personal physicians and referral specialists and hospitals.

Traditional insurance here is used as a generic term which includes plans written by companies like ours, and those provided by Blue Cross/Blue Shield and under employer self-administered plans.

Traditional insurance is terrific in that it allows patients to go to the personal physician of their choosing. That's very important because the subjective quality of the relationship is very important to a patient's sense of well-being. Different patients need different personal physicians, so that's partly why there is a high level of satisfaction with traditional insurance. Notice the small dollar sign associated with the different personal physicians.

Notice, however, that those personal physicians refer patients to different specialists and hospitals --- and that those specialists and hospitals range from cost-effective to wasteful --- and occasionally worse. And notice the large dollar signs on specialists and hospitals.

In contrast to the reasons for different patients choosing different personal physicians --- almost always good by definition --- some of the

reasons the personal physicians have for choosing some referral physicians and hospitals are not so good.

Within specified limits, traditional insurance mechanisms pay for services regardless of who provides service. As a result, the premiums charged for traditional insurance mechanisms are a weighted average of whatever combination of cost-effective, wasteful and mostly in-between specialists and hospitals are chosen.

In passing, I'd observe that a Foundation IPA Model which encompasses a large number of a community's physicians and hospitals would act in this context like traditional insurance --- the only exception is that we can expect it to cut out what is beyond wasteful and hope it puts a slight squeeze on the system overall.

Now look at the prepaid group practice style HMO.

In sharp contrast to traditional insurance forms, the Kaiser style HMO offers the patient a very limited number of personal physicians because the patient is limited to those employed through the plan.

However, in a successful closed panel HMO, specialty and referral services are provided through specialists and hospitals chosen from near the more cost effective end of the spectrum.

So while the freedom of choice under traditional insurance is attractive, it permits the choice of wasteful or even incompetent physicians along with outstanding ones. The Kaiser style HMO does better here, because it controls the flow of patients to specialists, surgeons and hospitals --- but it accomplishes this control at very high cost --- the cost of sacrificing patient freedom of choice which means the cost is diminished market appeal.

In contrast to both traditional insurance and the Kaiser-style HMO, CHOICE combines the best features of the Kaiser style HMO with the best features of traditional insurance. CHOICE will produce cost containment precisely <u>because it expands meaningful freedom of choice and assures access to physicians and hospitals with outstanding reputations</u>.

<u>COST CONTAINMENT IN CHOICE</u>

How will CHOICE produce cost containment? The answer is certainly not through one magic pill or potion.

CHOICE focuses comprehensively on the entire complex of behaviors that produce health care costs.

CHOICE has substantial effects on physician behavior, hosptial behavior, and system behavior. Physician behavior with respect to cost has a great deal to do with which physicians have the decision making power to spend the bulk of the program's financial resources.

CHOICE will work with referral physicians who don't do unnecessary tests and surgery. They don't need to order every test and procedure possible because they know their fields well enough to select the right ones. --- Because, they are already busy and so already have good incomes --- and the professional satisfaction that comes from caring for patients who really need them --- they have little reason for unneeded surgeries or hospitalization. What is at least as important is that these physicians have non-economic reasons for their behavior as well. The kind of physicians who will be referral physicians in CHOICE are particulary concerned and distressed about exposing patients to added risks of procedures whose value is doubtful.

That, along with geniune concern for patients, is what excellence in care us about!

CHOICE is a comprehensive approach --- and so has important features for the economic determinists as well: CHOICE reverses the perverse incentives that are a side effect of all traditional insurance mechanisms. By this I mean that in the traditional system --- physicians who practice wasteful medicine are rewarded by more income. Similarly, hospitals that encourage wasteful physicians derive more income, whereas responsible physicians and hospitals may lose revenue.

In the CHOICE program the opposite is true --- cost-effective clinical decision making --- and good hospital utilization review programs, for example translate to lower program costs --- which will bring more patients who really need care --- and will then mean more revenue to the contracting physicians and hospitals. This, coupled with the strengthened primary care physician role and relationships with its emphasis on preventive services, makes CHOICE a program designed for cost-effectiveness.

Pending Illinois regulatory approvals, CHOICE will be available to employees and their families through Chicago employers within the next six months. The nation's first CHOICE program in the Chicago area will provide an opportunity to select any personal physician and to receive referral and specialty care through private practice physicians on the staff of Evanston Hospital in the northern suburbs of Chicago.

The physicians and the hospital exemplify the standards of excellence and the personal concern for patients that will be characteristic of all physicians and hospitals who join with Aetna to provide for the referral and specialty care in the program.

I'm going to turn the microphone over to Bernard J. Lachner now, who is president and Chief Executive Officer of Evanston Hospital. He will share his perspectives and the perspectives of the professional staff members at Evanston Hospital.

Thank you.

Questions from Senator Durenberger

2. If a uniform payment system is put into place for all payers, on what basis would you compete with the Blues or with other commercials?

Answer

The insurance premium on which carriers compete is broken down into basically two components. One is the claims experience which is based on the price of the services covered, and the other is the expected volume of services delivered in the care and treatment of the patient. Both of these factors are controlled by the provider, and together they represent more than 90% of the average group medical and hospital expense premium. The balance of the premium, namely, the retention, involves the expenses of the carrier for acquisition, administration, taxes, and a net operating margin.

With a uniform payment system in place, competition would be based primarily on differences in "demand" for care or the volume side of the claims expense, and differences in the retention (the expense controlled directly by the carrier). Under such circumstances, the demand can be affected by differences in coverage (e.g., deductibles, co-insurance, and utilization review). The retention is affected by the services provided by the carrier and differences in acquisition and other administrative expenses.

3. Outside of fixing a rate for all payers, which would seem to discourage competition, what value is there to State rate-setting?

Answer

It reverses the current incentives to increase revenues through unjustified utilization and encourages hospitals to reduce utilization as the most effective method of improving their operating margins.

It is an equitable system in that only cost-justified differentials are recognized between patients.

It is designed for "cost containment" for all patients not "cost predictability" for some at the expense of others.

Questions from Senator Baucus

1. You stated that State regulation of health insurance is effective. This may be much more true now than it was a few years ago, before medigap. Are there any remaining areas where you believe improvement is needed?

Answer

The ERISA preemption provision, Section 514(c), has created serious problems for state regulation, through no fault of the states.

By operation of the preemption provision, non-insured plans, particularly uninsured multiple employer trusts, have been able to avoid state regulation, with its accompanying financial tax and other regulatory requirements. In some well publicized cases, these plans have become insolvent. The states have been able to become involved with these plans only after great difficulty and after considerable damage has been done.

Another problem raised by the ERISA preemption provision is the inability of insurers to successfully implement plans to guarantee the availability of health insurance to uninsurable individuals through a state pooling system. Through operation of the preemption provision, self-insured plans cannot be made subject to state laws requiring participation in the pools and leaves insurers with an ever decreasing base caused by these legal barriers. This again is not a fault of state regulation, but one of operation of federal law which, ironically, is to protect recipients of employee welfare benefits.

ERISA preemption has also resulted in an inequity of competition among financing mechanisms by providing self-insured plans with an immunity from state mandatory benefit laws. These state laws, even though mostly enacted with good intention, have disrupted insurer attempts to provide employers with sound and competitive plans. Should an employer wish to provide his employees with different benefit structures, the insurer has no choice but to remain with the state mandates. Uninsured plans have no such problem under the ERISA preemption.

It is our belief that amendments to the ERISA preemption provision, as outlined in our statement to the Committee on September 16, 1982, are essential, promoting sound competition in health care financing among all financing mechanisms. These aberrations can be corrected in the public interest and result in much-needed assistance to the states in their continued effectiveness of regulation.

Questions from Senator Baucus

2. Much has been made of the advantage that Blue Cross enjoys as a result of its so-called hospital discount. How do you account for the success private insurers have had in marketing their insurance?

Answer

The Blue Cross discount varies widely, and in most areas of the United States it is either minimal or non-existent. Where the discount is large (e.g., in excess of 6%), it is a barrier to competition between carriers. Where it is minimal, the carriers have effectively been able to compete with the Blue Cross plan primarily with respect to differences in retentions (i.e., the amount controlled by the carrier directly) because of greater flexibility in contract design, more effective administration, and better service.

Where the discount is substantial the differences in retention are so modest that they are offset by the size of the discount. Thus, true competition is impossible and results in market domination by the carrier which has the largest discount. This is true of the current Blue Cross operation in Massachusetts, Michigan, New York, and Pennsylvania, as well as a few other states.

3. In your testimony you refer to the problem of a single insurer not having enough patients in any one hospital to negotiate a favorable payment rate as many Blue Cross plans do. What is the size of the payment differential that generally occurs?

Answer

Please see the attached Hospital Relations Bulletin, "Blue Cross Hospital Payment Differentials," which is submitted for the record.

HEALTH INSURANCE ASSOCIATION OF AMERICA

Report on Consumer & Professional Relations...

HOSPITAL RELATIONS

#7-82 - August 6, 1982

RE: BLUE CROSS HOSPITAL PAYMENT DIFFERENTIALS

INTRODUCTION

This release is a third in a series on hospital-payment differentials as an increasingly significant problem which, in the short term, threatens to produce intensified adverse health-insurance experience with longer-term potential for undermining the viability of private health insurance itself. Please refer to the first release, #2-81, dated February 12, 1981, for additional background information on the general subject of differentials. The second release, #6-81, dated August 26, 1981, identified the growing government hospital-payment shortfalls under *Medicare* and *Medicaid* as major driving forces shifting to private-sector patients a disproportionate financial burden for the payment of hospital services. This phenomenon has been labeled as *Hospital Cost Shifting* and is reflected in the differentials between the higher rates paid by private patients compared to *Medicare* and *Medicaid* payments for the same services.

However, not all private-sector payors and patients bear this cost-shift burden fairly. In particular, *Blue Cross Plans* in many areas of the country pay hospitals significantly less for services provided to their subscribers than the charges paid by insurers and self-paying patients, even though the services rendered may be identical. As a result, the insurance industry should expect intensified adverse experience arising not only from *Medicare* and *Medicaid* differentials, but also *Blue Cross* differentials which are continuing to escalate. The purpose of this release is to examine *Blue Cross* hospital-payment differentials in order to properly understand their impact.

BLUE CROSS HOSPITAL PAYMENT DIFFERENTIALS

The payment agreement between a *Blue Cross Plan* and individual hospitals sets the framework and ground rules for any subsequent differentials. In general, each plan usually offers the same type of agreement to each hospital in its area. Thus, *Blue Cross Plans*, for purposes of this discussion, can be separated by the type of hospital-payment agreements with which they have become identified, namely, charge-paying and non-charge paying *Blue Cross Plans*.

CHARGE-PAYING BLUE CROSS PLANS

Approximately 55% of the 67 *Blue Cross Plans* operating in the United States, representing approximately 43% of total *Blue Cross Plan* hospital payments nationwide, pay for their subscribers' hospital services on the basis of charges, as do other private-sector patients. Due to historical development factors, these plans are generally located outside the Northeast and the eastern portion of the Midwest. As indicated on *CHART I (see page 8)*, many plans pay 100% of charges and are thus shown as having a "0" differential, while others pay a percentage less than charges as indicated.

Please note that the indicated differentials in *CHART I* are generally uniform between all hospitals in the plan area and maintain a year-to-year fixed percentage relationship to the full charges paid by other private-sector patients. In other words, the differential does not change, regardless of the increase in hospital charges.[1] (These differentials

[1] *All charge-paying plans have some type of requirements relating to hospital-charge increases. Such requirements may vary from merely advance notice in some plans to a formal review process*

in others. The plans in Arkansas, Delaware, Florida, Indiana, Kansas, Kentucky, Ohio(Cincinnati) and Wisconsin have established more formal mechanisms including review boards for hospital charge increases. With the exception of Wisconsin, these review boards ultimately are responsible to the Blue Cross Board of Trustees. The Wisconsin Board consists of appointees by Blue Cross, the Hospital Association and the Governor.

---

must not be confused with the non-charge related differentials identified in the next section and displayed in *CHART II* [*see Page 10*].)

Consequently, in *Blue Cross* charge-paying-plan areas, all private-sector patients share the responsibility for paying for not only the hospital-cost increases due to inflation, but also the growing cost-shift burden generated by government-payment cutbacks under the *Medicare* and *Medicaid* programs. From the insurance industry's viewpoint, these charge-paying *Blue Cross Plans*, regardless of whether or not they pay hospitals 100% of charges or some fixed percentage less than full charges, have maintained a stable relationship with all-other-sector patient payments.

However, this picture is beginning to change rapidly as plans in these historically "safe" marketing areas begin to negotiate increased differentials to help offset their own adverse experience generated by hospital-cost inflation and the mounting cost-shift burden from the *Medicare* and *Medicaid* programs. Indeed, such activities represent a general movement among charge-paying plans fostered by the staff of the *Blue Cross* and *Blue Shield Associations* to aggressively implement the *Blue Cross* hospital-payment agreement as a cost-containment vehicle. The following developments are cited as examples of the trend:

- The *Northern California Blue Cross Plan* has approached its member hospitals with a request for a 5% differential;
- The *Wisconsin Blue Cross Plan* has initiated discussions with some 32 of its largest hospitals for the purpose of establishing a 4% to 5% differential;
- The *Kentucky Blue Cross Plan* is moving toward a negotiated payment rate with a 3% differential;
- The *Texas Blue Cross Plan* is seeking to limit hospital price hikes to 10%;
- The *Cincinnati Blue Cross Plan* has negotiated differentials with at least five of its member hospitals.

No doubt, hospitals will remain generally cool to the idea of giving differentials to *Blue Cross* where none existed previously. This will be especially true as hospitals shift costs to their private patients to recover increasing *Medicare* and *Medicaid* payment shortfalls. Granting differentials to *Blue Cross* will, to a greater or lesser extent, restrict hospitals' ability to recover the cost-shift burden from *Blue Cross*.

However, other factors may argue for a growth in differential activity:

- The continued interest of the *Blue Cross* and *Blue Shield Associations* to maximize the leverage of the reimbursement agreement to reduce adverse experience and improve the *Blue Cross* competitive position.
- Insurance department pressure to stabilize the growing number of financially-weak plans by eliminating or curtailing open-ended charge-payment systems, in order to alleviate the painful process of approving rate increases at a level otherwise required in the absence of modifying the hospital-payment agreement;
- The general tendency of hospitals, in current *Blue Cross* charge-paying plan areas, to maintain the ability to set charges at their own desired level regardless of the specific fixed *Blue Cross* discount tied to those charges;
- Competition among hospitals for patients where declining utilization presents a revenue problem.

Consequently, even in the areas where *Blue Cross Plans* have paid on the same basis as private insurers, the competitive environment is beginning to change. *Blue Cross Plans* will more aggressively utilize the leverage of their hospital-payment agreements to curtail adverse experience which, in turn, may produce increased payment differentials and a competitive disadvantage for other private-sector payors.

NON-CHARGE PAYING BLUE CROSS PLANS

Approximately 45% of the 67 *Blue Cross Plans* operating in the United States, representing approximately 57% of total *Blue Cross Plan* hospital payments nationally, reimburse hospitals on a basis other than billed charges. The differentials enjoyed by these plans are substantially different, both in origin and impact, from the differentials existing in charge-paying *Blue Cross Plans*. The level of differential for these plans indicated in *CHART II* are by no means uniform throughout the plan area and differ markedly between hospitals, as indicated by the wide range in many instances where data are available. More important, the differentials have no fixed stable relationship to hospital charges at all. Indeed, these differentials have been increasing steadily, due primarily to the fact that non-charge *Blue Cross* payments are generally insulated from the *Medicare* and *Medicaid* cost-shift burden which falls exclusively on charge-paying private-sector payments.

Historically, these types of differentials arise because certain hospital financial requirements are either partially or totally disallowed by the *Blue Cross* reimbursement contract. Typical financial elements excluded from the payment rate are: a proportionate share of the cost of care incurred by patients who do not pay their bills (bad debts and charity); equity capital accumulation for replacement, growth and development; research and certain education costs, to name the major items. Some plan contracts are more or less generous than others, depending on the scope of the definition of allowable costs and the absence or presence of a "plus factor" which is paid to partially compensate for the otherwise unrecognized costs. The size of the differential, which varies by hospital, depends on the dollar amount of the financial elements not recognized and the proportion of the hospital patients who pay charges, since it is the charge-paying patients who will be surcharged in order to make up for the *Blue Cross* disallowances. The greater the proportion of charge-paying patients using the hospital, the lower the differential, because disallowances will be spread among a larger population.

Clearly, these types of reimbursement systems, by their very definition, pay less than charges. The differentials enjoyed by *Blue Cross Plans* in these areas appeared to be a relatively stable quantity, at least until the mid-1970s. However, many factors affecting the more recent hospital economic environment have caused these differentials to escalate markedly:

- Unacceptably high rates of average hospital-cost inflation which has led several plans to place limits on reimbursement increases. For instance, the *Michigan Blue Cross Plan* has developed a prospective payment program which permits *Blue Cross* payments to increase at levels lower than overall hospital inflation.

- Increased cost-shifting to private patients by deepening cutbacks in *Medicare* and *Medicaid* payments accentuated by: rising hospital bad debts caused by *Medicaid* eligibility reductions; the growing proportion of *Medicare* hospital utilization due to the aging of the population; and federal government charity-care requirements.

- Record hospital "profit" margins generated as a hedge against an uncertain future.[1]

---

[1] *In 1975, aggregate "profit" or operating margins for community hospitals nationwide, based on the balance of total revenue less total expense, was $286 million or .7% of total revenue. In 1980, this had increased to $2.9 billion and 3.6% of total revenue.*

SOURCE: American Hospital Association Annual Statistics

Non-charge paying *Blue Cross Plans* are insulated from the full effect of these factors. Thus, the majority of the increasing financial burden falls on charge-paying patients only, thereby driving the differential between *Blue Cross* payment and charges to record levels.

COST JUSTIFIED DIFFERENTIALS

The insurance industry supports the principle that all patients should pay for hospital services on the same basis, regardless of third-party sponsorship (or lack of it). Any differentials established should be based solely on actual cost differences generated by the patient or the third-party payor acting on the patient's behalf. Generally, this position has remained academic because there have been few real opportunities to challenge the cost justification of *Blue Cross* differentials with any meaningful expection of correcting an inequitable situation.

Yet, the insurance industry has experienced notable successes in reversing substantial *Blue Cross* differentials in the states of Maryland and New Jersey. In 1974 *Maryland Blue Cross* was required to relinquish its approximate 15% non-charge based differential in return for an interim 4% differential as a fixed percentage of charges by a decision of the *Maryland Health Services Cost Review Commission* (MHSCRC). In 1980 the *New Jersey Blue Cross* differential of approximately 25% (also non-charge based) was reduced substantially and is currently 6.18% of charges for hospitals subject to the *New Jersey Hospital Rate Setting Program*.

The remarkable improvement in these inequitable *Blue Cross* differential situations has occurred as a direct result of implementing legislation in both states establishing a hospital prospective payment system requiring:

1. A uniform definition of hospital financial requirements as the basis for rates to be paid by all payors; and,

2. Cost justification of payor differentials.

Under these systems, *Blue Cross* is not allowed to continue categorically avoiding responsibility for any valid financial element of a hospital's budget such as uncompensated care, equity capital accumulation, research and education costs, identified previously. In addition, *Blue Cross* must accept the same rate of increase, year-to-year, as all other payors. Significantly, it is only these types of programs which have been able to extend this same basis of payment to *Medicare* and *Medicaid*, thereby correcting not only the *Blue Cross* differential, but also the *Medicare* and *Medicaid* payment differentials, as well. The success of these two programs argues convincingly that correction of the differential problem for all payors requires a system that addresses the cost-containment problem across the board for all payors.

Blue Cross is not likely to give up differentials in states where it has negotiated agreements with hospitals that provide at least a modicum of influence over its own payment increases, unless an alternative could be implemented which would be at least as effective in restraining payment increases. Similarly, the *Medicare* and *Medicaid* programs will not relinquish their ability to make unilateral cutbacks in payment unless participation in some alternative system promises cost containment for the government. Moreover, because the non-charge based *Blue Cross Plan* differentials are largely a reflection of insulation from the cost-shift burden, *Blue Cross* will fiercely resist equity with other private payors, unless equity with *Medicare* and *Medicaid* is also achieved.

To date, only Maryland and New Jersey have implemented systems with the ability to set overall hospital rates prospectively in a manner and at a rate applicable to all patients. By reducing the rate of increase in total hospital revenue, the program is able to generate sufficient savings to offset the acceptance by *Blue Cross, Medicare* and *Medicaid* of the previously unrecognized financial requirements.

Confidence in the Maryland and New Jersey systems to generate these results has been well placed. *Maryland Blue Cross*, for two consecutive years (1978 and 1979), was required to make refund payments in excess of $15 million to its subscribers because the projected 13% rate far exceeded the 7% actual increase in experience. Moreover, this was accomplished despite the previously referenced dramatic reduction in the *Blue Cross* differential. From the period, 1977 to 1980, *Medicare* and *Medicaid* saved $52.5 million (4.9%) and $33.9 million (7.08%), respectively, according to a calculation accepted by the federal government. Overall, the Maryland system has demonstrated accumulated savings of approximately 19.5% or $282 million in the period from 1975 to 1981.[1] Although, to date, the New Jersey system has recorded the experience of only 26 hospitals during the first year of program implementation, the results in that state parallel those in Maryland. According to the first annual report of the *New Jersey Hospital Rate Setting Commission*, increases in revenues and expenses in 1980 over 1979 are significantly below the national average.

At the same time, these programs should not be viewed by the insurance industry as totally and instantly resolving the differential issue. Rather, their advantage is that they provide the industry with an opportunity for the first time to participate in the determination of differentials. At the very least, this process has served to explode many of the myths advanced by *Blue Cross Plans* regarding the cost savings of *Blue Cross* practices in comparison to those of private insurers.

The *Maryland Health Services Cost Review Commission* (MHSCRC) produced some preliminary results in its study completed in late 1981 which, though still subject to audit, show clearly that there are very little actual cost differences between *Blue Cross* and private insurers. Indeed, even the statistics submitted by *Blue Cross* consultants in the debate on the *Harford Memorial Hospital* (Maryland) differential, as well as the *Blue Cross* application for a statewide differential submitted to the *Illinois Health Finance Authority* (an agency similar to those established in Maryland and New Jersey)[2], reinforced this conclusion.

BLUE CROSS AND PRIVATE INSURANCE HOSPITAL PAYMENT DIFFERENTIAL (%)

CATEGORY	*MHSCRC STATEWIDE DIFFERENTIAL PRICING STUDY (1/82)*	*BLUE CROSS SUBMISSION IN HARFORD MEMORIAL HOSPITAL (11/81)*	*BLUE CROSS SUBMISSION ILLINOIS STATEWIDE DIFFERENTIAL (8/79)*
Incurred Bad Debt	.93	.94	.61
Administrative Costs	.48[3]	.47[4]	.045[5]

The result relative to incurred bad debt should be especially satisfying to the insurance industry because *Blue Cross Plans* have generally argued that the wide variations in insurance program self-responsible amounts create hospital bad debts. Indeed, these statistics indicate that hospitals have been successful in collecting self-responsible amounts without causing any significant administrative cost increase. Consequently, the substantial dif-

---

[1] *Maryland Health Services Cost Review Commission, "Disclosure of Hospital Financial and Statistical Data," February 3, 1982.*

[2] *The Illinois General Assembly failed to extend the Illinois Health Finance Authority's enabling legislation beyond its October 1, 1982 sunset date. As a result, the proceeding on the Blue Cross differential application will not be concluded.*

[3] *This statistic, in addition to the administrative cost areas, encompasses differences in nursing costs and other patient services.*

[4] *Includes accounting, admitting, billing, collection, medical record, nursing and social service costs.*

[5] *Includes only admitting, billing, collection and medical record costs.*

ferentials currently enjoyed by *Blue Cross Plans* in many areas can, in no way, be justified on the basis of a cost relationship.

Moreover, the HIAA has argued that differences in actual incurred bad debt should not be used as a basis for a differential because to do so would be an encouragement for totally comprehensive coverage and a discouragement for the co-payment and deductible features aimed at bringing about overall cost and utilization reductions.

Because the traditional arguments based on cost differences in incurred bad debt and administrative cost areas provide practically no basis for any significant differential, *Blue Cross Plans* in various localities have argued the justification of their differentials on a different basis, namely, "averted bad debt." Indeed, this basis constitutes the major portion of the total 5.07% requested in Harford Memorial and the 5.0% requested in Illinois. The amount of "averted bad debt" differential *Blue Cross* will argue for under the *Maryland Differential Pricing Study* is yet to be determined and will be the major focus of the MHSCRC hearings expected in late 1982.

Blue Cross reasons that its underwriting practices make coverage available to high-risk groups and individuals which would otherwise not be available through private-insurance programs. According to *Blue Cross*, these enrollees would incur increased amounts of bad debt through less comprehensive and more expensive private health-insurance coverage if *Blue Cross* coverage were not available. *Blue Cross* then proceeds to calculate the amount of this "averted bad debt" which it then credits to itself as a differential amount. The insurance industry has maintained the position that "averted bad debt" is not a legitimate basis for a cost-justified differential. The HIAA maintains that in Maryland, New Jersey[1] and Illinois:

- *Blue Cross* has provided no evidence that it provides unique coverage which could not be provided by insurers operating under circumstances similar to those enjoyed by *Blue Cross*; and,
- The methodology variously employed by *Blue Cross* to place a value on its "unique" practices is deficient in design and rests on assumptions that cannot be substantiated.

Regardless of the outcome of this debate, the insurance industry has been provided the opportunity to act as a participant in determination of the *Blue Cross* differential. In all other states, the insurance industry, at best, is merely an observer of hospital/*Blue Cross* payment discussions and a passive recipient of their impact.

In the absence of any prospect of expanding such programs to a significant number of additional states, HIAA's efforts have focused on supporting legislation requiring all private-sector patients to fairly shoulder their responsibility for hospital financing, including the cost-shift burden from *Medicare* and *Medicaid*. Under such legislation, any agreement between a hospital and a third-party payor providing for differentials which are not cost justified and not made available to all payors whose practices produce similar cost savings would constitute an unlawful act. The insurance industry continues to aggressively pursue this strategy in Alabama, Ohio, and Pennsylvania.

CONCLUSION

Growing hospital differentials between government payment and private-sector-patient payments constitute the major obstacle to both cost containment and payment equity. In those areas where *Blue Cross* has successfully insulated itself from the major impact

---

[1] *The New Jersey Hospital Rate Setting Commission has granted Blue Cross an interim differential of 6.18% consisting of the following components: 1.76% for incurred bad-debt differences; .89% for Patient Account Cost differences; and 3.53% reflecting Blue Cross total subsidy to community-rated groups from experience-rated groups. This last element was granted in lieu of a larger differential requested by Blue Cross on the basis of "averted bad debt" which is still under study. Reconsideration of this issue by the Commission is currently underway.*

of hospital cost-shifting due to *Medicare* and *Medicaid* cutbacks, it is a particular problem for private insurance and other non-*Blue Cross* sponsored patients. Indeed, as those cutbacks continue to deepen, *Blue Cross*, as well as *Medicare* and *Medicaid* payments, as a percentage of charges, will continue to decline even more rapidly.

Yet, hospital-payment differentials are not so much a problem in themselves, as they are a symptom of a problem which is more fundamental - the fragmented hospital-payment system which continues to operate with no agreement between hospitals, government and private-sector payors on a single definition of hospital-financial requirements and a permissible rate of increase in those requirements year to year. Some of the other symptoms of this fundamental problem are:

A. Incentives for hospitals to increase cost and utilization of services in order to maximize revenue and improve operating margins;

B. Financial instability for some hospitals, not due to their inefficiency or quality-of-care deficiencies, but as an ironic reward for rendering needed community service by treating a substantial number of poor, near-poor and elderly patients;

C. Denial of access to care for the elderly and the poor as hospitals claim they cannot afford to treat such patients and maintain the fiscal integrity of their institutions;

D. Elimination of competition between private-sector payors as the ability to compete has less to do with efficiency and service differences and more to do with the ability to obtain and maintain non-cost justified hospital-payment differentials; and,

E. Severe limitation, due to the *Medicare* and *Medicaid* cost-shifting, of the cost-containment potential of private-sector initiatives, such as utilization review, co-payment and deductible features, and promotion of out-of-hospital benefits as an alternative to more costly care.

All of these symptoms are interrelated with the differential problem. Consequently, any solution of the differential issue must also take into account the more fundamental problem reflected by these symptoms.

Traditionally, the HIAA has attempted to deal with these issues on the state level. However, it has become painfully clear that after years of effort and few (if significant) successes, it is next to impossible to deal on a state-by-state basis with what is clearly a national problem.

This conclusion is reflected in the recent (January 9, 1982) *HIAA Health Care Payment Reform Package*. Among the key features in that proposal is national legislation establishing temporary, short-term, state-by-state limits on permissible hospital revenue increases applicable to the rates paid by all payors. The objective of that provision is to bring hospital costs under some interim control, stem the increase in the differentials due to the cost-shifting burden, and provide time for a Presidential Commission to propose innovative approaches to long-term health-care-payment reform to be implemented by Congress and the Administration. If these recommendations are to be effective, ultimately, they must address inequitable hospital-payment differentials as an all-pervasive symptom of the fundamental problems in the current hospital-financing system.

Any questions regarding this bulletin should be directed to: Mr. Thomas O'Hare, Director, Health Care Management Programs, Health Insurance Association of America, 332 S. Michigan Avenue, Chicago, Illinois 60604, 312/322-0832.

DISTRIBUTION: *Council Relations Officers/ Chief Recipients-Group & Individual/ Committee on Consumer & Professional Relations/ Health Care Management Committee/ State Council Chairpersons/ Staff I & II*

BLUE CROSS PLAN HOSPITAL PAYMENT DIFFERENTIALS

C H A R T I

CHARGE-PAYING BLUE CROSS PLANS

By Location	Differential Percent Below Charges[a]	Percent of Distribution of Persons Under Age 65 With Hospital Expense Coverage By State and Type of Insurer[b]		
		BLUE CROSS	*INSURANCE COMPANIES*	*OTHER*
AZ Phoenix	0	20%	72%	8%
AR Little Rock	0	34	53	13
CA Oakland[c]	0	18	53	29
CO Denver	Note[d]	25	55	20
DE Wilmington	0	62	36	2
FL Jacksonville	0	19	78	3
GA Atlanta	0	25	70	5
Columbus	0			
ID Boise	0	52	37	11
IL Rockford	0[e]	23	65	12
IN Indianapolis	0	37	58	5
KS Topeka	Note[f]	40	51	9
KY Louisville	0[g]	47	41	12
LA Baton Rouge	0	24	71	5
MD Towson	4.0[h]	46	44	10
MN St. Paul	0	30	62	8
MT Great Falls	0	42	49	9

(NOTE: *Please refer to NOTES TO CHARTS I & II, following Chart II, Page 12.*)

NOTE: Above figures applicable as of 7/1/82.

CHARGE-PAYING BLUE CROSS PLANS (CON'T)

By Location	Differential Percent Below Charges	Percent of Distribution of Persons Under Age 65 With Hospital Expense Coverage By State and Type of Insurer		
		BLUE CROSS	*INSURANCE COMPANIES*	*OTHER*
NE		30	61	9
Omaha	2.0			
NH		53	45	2
Concord[i]	2.0			
NJ		59	32	9
Newark	6.18[j]			
NM		18	54	28
Albuquerque	0			
NC		37	60	3
Durham	0			
ND		67	30	3
Fargo	0			
OH		39	46	15
Cincinnati*	0			
Columbus	3.0			
Lima	3.0			
OK		26	65	9
Tulsa	0			
OR		45	40	15
Portland	0			
SC		38	60	2
Columbia	0			
TN		37	56	7
Chattanooga	2			
Memphis	3			
TX		27	69	4
Dallas	0			
UT		32	56	12
Salt Lake City	0			
WA		45	36	19
Seattle	0			
WV		22	42	36
Charleston	3.0			
Parkersburg	5.0			
Wheeling	0			
WI		47	43	10
Milwaukee	0			
WY		31	57	12
Cheyenne	0			

NOTE: Above figures applicable as of 7/1/82.

BLUE CROSS PLAN HOSPITAL PAYMENT DIFFERENTIALS

CHART II

NON-CHARGE PAYING BLUE CROSS PLANS

By Location	Differential Percent Below Charges[a]			Percent of Distribution of Persons Under Age 65 With Hospital Expense Coverage By State and Type of Insurer[b]		
	Low	Avg.	High	*BLUE CROSS*	*INSURANCE COMPANIES*	*OTHER*
AL						
Birmingham	0	10.0	20.0	36%	52%	12%
CA						
Los Angelesc	.01	1.3	10.0	18	53	29
CT						
North Haven	(14.5)[m]	2.6	11.1	42	53	5
DC						
Washington	*UA	6.0	UA	66	19	15
IL						
Chicago[o]	0	5.0	20.0	23	65	12
IA						
Des Moines	0	3.0	20.0	41	50	9
Sioux City[n]	0	8.0	19.0			
ME						
Portland	0	14.0	16.0	58	40	2
MA						
Boston	0	UA	35.0	55	36	9
MI						
Detroit	UA	15.0	UA	49	44	7
MS						
Jackson	UA	3.1	UA	29	65	6
MO						
Kansas City	See Note [p]			25	66	9
St. Louis	" " [q]					
NY						
New York	UA	32	UA	55	25	20
Albany	See Note [r]					
Buffalo	" " "					
Rochester	" " "					
Syracuse	" " "					
Utica	" " "					
Watertown	" " "					

*NOTE: *"UA" is an abbreviation indicating that the question in the AHA survey response was left unanswered. It should not be understood as indicating that no differential is applicable.*

NOTE: Above figures applicable as of 7/1/82.

NON-CHARGE PAYING BLUE CROSS PLANS (CON'T)

By Location	Differential Percent Below Charges			Percent of Distribution of Persons Under Age 65 With Hospital Expense Coverage By State and Type of Insurer		
	Low	Avg.	High	*BLUE CROSS*	*INSURANCE COMPANIES*	*OTHER*
OH				39%	46%	15%
Canton	UA	UA	UA			
Cleveland	"	"	"			
Toledo	"	"	"			
Youngstown	0	7.0	20.0			
PA				47	31	22
Allentown	UA	20.0	UA			
Harrisburg	"	20.0	"			
Philadelphia	"	20.0	"			
Pittsburgh	"	20.0	"			
Wilkes-Barre	"	20.0	"			
RI				76	21	3
Providence	2.0	12.0	24.0			
VA				45	49	6
Richmond	UA	UA	UA			
Roanoke	0	8.0	23.0			

NOTE: Above figures applicable as of 7/1/82.

NOTES TO CHARTS I & II

[a] Unless otherwide indicated, the differential percent below charges in each plan area is taken from "Hospital-Blue Cross Contract Provisions, July 1981," published by the *American Hospital Association*, Division of Health Financing Policy, Office of Public Policy Analysis, February 1982, Catalog #073200. Copies of this 86-page report, which reviews Hospital-Blue Cross contracts in detail may be purchased for $8.75 for non-members and $7.00 for members by writing to:

Order Processing Department
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

[b] The 1980 statistics are derived from *Health Insurance Association of America, Blue Cross/Blue Shield Associations, U.S. Department of Health and Human Services,* and *U.S. Bureau of Census*. Statistics apply on aggregate statewide basis only. Consequently, these statistics may not reflect the specific market shares applicable to a specific *Blue Cross Plan* in the states with multiple plans.

[c] The *Oakland Plan* covers the northern half of the State of Nevada, while the *Los Angeles Plan* covers the southern half of that state, which has no local *Blue Cross Plan*. However, both plans are in the process of merging in order to form a single *California Blue Cross Plan*.

[d] Information obtained from the *Colorado Hospital Association* staff indicates that *Blue Cross* differentials range from 0% to 5%. With a few exceptions, hospitals grant *Blue Cross* at least a 2% prompt-payment differential. In addition, a class-of-payor differential is granted to *Blue Cross*, depending on the level of aggregate annual *Blue Cross* payments to an individual hospital, as follows:

--	Over $2 million	- 3%
--	Over $1 to $2 million	- 2%
--	$500,000 to $1 million	- 1%
--	Under $500,000	- 0%

[e] The *Rockford Blue Cross Plan* merged with the *Chicago Blue Cross Plan* in 1982. However, the *Rockford Blue Cross Hospital Payment Contract*, which involves no differentials, will remain in force for the immediate future.

[f] Information from the *Kansas Hospital Association* staff indicates that there are three types of *Blue Cross* payment systems operative in the state. Approximately 135 of the state's community hospitals are paid 100% of charges under a relatively recent *Blue Cross* rate-review program. Six hospitals are under a *Blue Cross Budget Review System* whereby the plan currently has no differential, but maintains the option of disallowing hospital cost elements it believes unreasonable. A third option applicable to five hospitals is a "fair payment" program which is based on allocation to *Blue Cross* of only costs which it incurs. This last option has the greatest opportunity for a differential, although no more than three hospitals are granted a 3% prompt-payment discount under this system.

[g] Conversations with State Hospital Association staff indicate that several hospitals, most commonly proprietary institutions, apply charge increases to non-*Blue Cross* patients immediately, but wait for approval through the *Blue Cross* rate-review process before applying such increases to *Blue Cross* patient rates.

[h] An additional 2% differential is granted to *Blue Cross* for prompt payment which is also available to all patients who remit their hospital bills upon discharge. A 1% differential is available for payment within 30 days.

[i] In addition, the plan also covers Vermont and offers to Vermont hospitals a cost plus 3% reimbursement agreement in addition to the prospective charge-based negotiated rate.

[j] A prompt-payment differential is also available to all payors, amounting to 5% for payment on or before day of discharge (or earlier billing) and 4% for payment within 15 days, then grading down to 0% for payment after 105 days.

[k] The Canton, Lima and Youngstown, Ohio plans merged with the Cincinnati plan in 1975. However, each plan area maintains a separate hospital reimbursement contract.

[m] This statistic indicates that the plan has paid 14.5% above billed charges in at least one hospital, as reported in the AHA survey.

[n] Plan also covers State of South Dakota.

[p] Plan pays hospitals on the basis of a prospective analysis of budgets and rates. The percentage of charges paid varies to the extent that costs or charges are disallowed in the prospective analysis. State Hospital Association staff indicates that, ordinarily, 20% to 25% of the hospitals in the area would be granting *Blue Cross* some differential below charges. However, this situation is further complicated by the fact that all hospitals in the plan area have been granting *Blue Cross* a 3% differential because of the plan's low-planned reserves. This situtation will continue until the plan achieves 60-days operating expenses in reserves. Because the current reserve level is only 3 to 4 days, Hospital Association staff does not anticipate any change in the current differential situation in the foreseeable future.

[q] Charges are paid with a net-income limitation of 4%. Hospital Association staff estimates that this produces an aggregate differential of 3% to 4%.

[r] The AHA survey results indicate a single, average differential for all Upstate New York plans at 26%. No indication of the range is listed.

Questions from Senator Baucus

4. Blue Cross has argued that it is entitled to a discount because hospitals receive certain indirect benefits from Blue Cross. For example, Blue Cross has argued that it sells policies to high-risk groups at premium rates they can afford by pricing the policies below cost. Blue Cross argues that this reduces hospitals' bad debts. Do you believe that payment differentials might be justified where a plan provides this or some other special indirect economic benefit to hospitals?

Answer

The insurance industry believes that hospital payment differentials should be limited to the economic cost differences experienced by hospitals in the provision of services to differing patient classes. This would include prompt payment, admitting, billing, credit and collection cost differences.

However, Blue Cross claims such differentials must go beyond differences in hospital cost to include differences in: 1) lower bad debt alleged to be produced by any Blue Cross service contracts and 2) bad debts avoided by the provision of coverage to alleged disavantaged population frequently at rates below costs. Both of these reasons are inappropriate.

Relative to the first point, the question is whether there is any substantial difference between the bad debts incurred by privately insured patients and those with Blue Cross services benefit coverage, and if so, should this be allowed as a differential. Studies to date indicate that there are only minimal differences between Blue Cross and private insurance bad debts which suggest hospitals are effectively able to correct self-responsible portions of private insurance to the extent that they exist. For example, the Maryland Differential Pricing Study completed in late 1981 indicates that the difference in incurred bad debt levels between Blue Cross and privately insured patients is approximately .9 of 1%, while a study done by Blue Cross in Illinois indicates that the amount of approximately .6 of 1%. Even with the minimal differences, no differential should be granted, because to do so would merely foster full service benefit programs and create a disincentive for maintaining a self-responsible portion in the payment of hospital services which could serve to reduce cost and utilization as indicated in the recent Rand Study "Interim Results of a Study of Cost Sharing and Its Impact on Utilization of Health Care Study Services" (New England Journal of Medicine, December 17, 1981).

Consideration of the second point raises three questions: a) Does Blue Cross really provide unique coverage? b) What is its value; and, c) If properly quantified, should the determined value be used as a basis of a hospital payment differential.

New Jersey Blue Cross has been granted a payment differential based on the allegation that its community rated subscribers constitute a "Second Medicaid program" which makes health insurance coverage available to the poor, near-poor and those in poor health. After granting that differential, the Commission required that a study of Blue Cross subscribers be conducted to identify if, in fact, Blue Cross was providing coverage to a disadvantaged group. The study, completed by the Eagleton Institute, which is a research organization housed at Rutgers University, showed that the population covered by Blue Cross is not poor, not economically disadvantaged and, for the most part, considers itself to be in relatively good health.

Assuming for the moment that some group has been identified as being covered uniquely by Blue Cross, what should be used to measure the value of that practice? It should not be the amount of money Blue Cross loses on that line of business because to do so would merely incorporate any inefficiences in administration or poor underwriting practices. At most, the value of this practice cannot exceed the excess morbidity or benefit paid beyond that which would be considered standard.

Regardless of how such unique practices, if they do exist, are valued, their quatifications should not be used as a hospital payment differential. Blue Cross Plans are generally established as non-profit hospital prepayment service corporations under special enabling statutes which envision certain responsibilities and privileges. Chief among the privileges is the exemption from taxation, including premium, property and income taxes. To allow a differential for a unique activity is to expect similar behavior from organizations which are constituted differently, namely Blue Cross and private insurance companies and should not be expected to necessarily act in similar fashion. By the same token, Blue Cross should not be receiving a differential in hospital payment rates in addition to the exemption from taxation which more than offsets the alleged value of the unique practice. To do so would constitute a double subsidy to Blue Cross which would restrict the insurance industry's competitive marketing of non-group insurance including the provision of insurance to high-risk population. Commercial insurers also sell to high-risk individuals and groups. There is price competition in this market as well. Why should one competitor be allowed to price its product "below cost" and then get a financial reward which will be made up directly from higher costs to other competitors? That in itself gives not one but two artificial competitive advantages for which we see no social or economic value.

Senator DURENBERGER. At this point, I am going to recess for approximately 5 minutes before we go to the next panel.

Mr. MOOREFIELD. Mr. Chairman, we thank you very much for this opportunity.

[Whereupon, at 10:40 a.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. The hearing will come to order. Our next witness will be Mr. Bernard Tresnowski, president, Blue Cross & Blue Shield Association, Chicago, Ill. Barney, come on up. I didn't, unfortunately, have the benefit of your prepared statement when I flew out to Minnesota for the primary and had some reading time. You have heard the drift of some of my questions. Feel free to take whatever time you need to deliver your statement.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION, CHICAGO, ILL.

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. I am Bernard Tresnowski, president of Blue Cross & Blue Shield Association. I have asked a couple of members of my staff to sit to my left here. Immediately to my left is Mr. Larry Morris who is senior vice president of professional and provider affairs; and to his left is Mr. Bob Snyder who is director of our payment and utilization programs. You can relax. They are not going to say anything unless I ask them to respond to a question.

They are particularly expert on some of the individual plan situations. And under the assumption that you might want to ask a specific question about that then they are the experts that can do that.

Senator DURENBERGER. Thank you for inviting them.

Mr. TRESNOWSKI. I will take advantage of your offer not to read my statement with the understanding that it will be introduced into the record.

Senator DURENBERGER. It will be made a part of the record.

Mr. TRESNOWSKI. I do appreciate your taking the time to read it because we think it is an important statement in the interest of what this committee's objectives are.

Obviously, this Congress faces some very severe budget problems and difficult policy issues as it seeks the most cost-effective way to pay for health care services. I would quickly add to that the fact that the Blue Cross and Blue Shield plans are faced with many of the same kinds of problems in dealing with the increasing health care cost problem in the United States.

In my prepared statement I noted that there were five major points that I wanted to convey to the committee. The first was that hospital payment methods should be designed to contain costs, but they should also generate levels of payment adequate to assure the availability of needed services—a fundamental principle, we think.

Second, we also believe that there is no single best payment method that exists, given the general variations in community needs and resources that exist in this great land of ours.

Third, regardless of the payment method, the results in our opinion depend on effective design and implementation. In our judg-

ment and based on our experience, these are as important as the method itself.

And, fourth, we believe deeply that coordinated actions to influence utilization in the supply of health resources are an important element in cost containment, along with the payment system.

And, finally, the design and implementation of successful cost containment programs need to be sensitive to the differences among communities, and the factors in those communities that give rise to unnecessary expenditures for health care.

In my prepared testimony I outlined our approach to effective payment, and cost containment programs that fit local circumstances and markets. I also provided examples of some plan programs that have produced good results. In addition, calling on our experience both as medicare contractors and as private payers, I offered some assessments of alternative directions that may be considered for the medicare program per se, which I realize is a major interest to this committee.

I think, Mr. Chairman, you know about Blue Cross and Blue Shield plans. We serve 80 million Americans in our private markets. We serve another 20 million Americans through our government contracts. You also know that by design, our organization is structured to relate to local health care delivery and competitive circumstances. This structure that is the Blue Cross/Blue Shield organization brings to our role as medicare intermediaries and carriers the ability to adapt a single national program to the wide variations and local community characteristics.

Indeed, it was our basic structure that was attractive to the Federal Government at the time that the medicare program was enacted. The ability of a large and experienced organization to take a program of the size of medicare and implement it at the community level.

Our experiences both in terms of our private markets and our government markets has shown us that when you look at the payment systems, they need to be built upon some very specific objectives. And in my written statement, I laid those out. And I won't go into those in detail except to say that predictability is important, fair and equitable payment is, access to care is, the quality of the health care system is, cost effective management is, as well as the efficiency of the system and the feasibility of the system, the responsiveness of the system to individual, hospital, and community needs, and, obviously, the communitywide involvement in the definition and design of the system.

It's our opinion that achieving those objectives requires that Blue Cross and Blue Shield plans be prudent and responsible purchasers of care for their subscribers. Just as any responsible purchaser seeks fair prices for goods and service through a process of negotiation, thus Blue Cross and Blue Shield plans have used negotiation as the basis of payment programs—the outcome generally taking the form of contracts between our member plans and the providers.

As a prudent purchaser of care for our subscribers, we seek recognition in our payment negotiations for our business and our underwriting practices that, in fact, lower hospital costs by limiting revenue losses caused by bad debts, carrying charges, and other factors. These practices include prompt or advanced payments that

improve provider cash flow, comprehensive benefits, continuity of coverage through conversion privileges, and coverage of high risk populations and individuals.

Since these practices reduce hospital operational costs, it would be irresponsible for us, as a prudent carrier—a prudent purchaser on behalf of our subscribers—to fail to negotiate a reasonable evaluation of these business and underwriting practices in our hospital payment arrangements.

Clearly to the extent that some carriers pay slowly, provides sparse coverage, fails to cover poor risks, are inattentive to questionable utilization or ineffective in other ways, the cost of providing care to their customers will be higher than it needs to be. The differentials that result from our negotiations have been labeled "cost shifting" by those who oppose recognition of the work of prudent business practices.

To the contrary, the business practices that earn a price differential avoid cost shifting by covering the actual cost incurred by the carrier's subscribers.

While there are no easy or standard solutions to the problems of increasing hospital costs, negotiated reimbursement methods which require hospitals to operate within specified financial limits can and do have an effect on costs. Most Blue Cross plan payment methods are based on this principle, and its effective implementation. As noted in my written testimony, Blue Cross plans are payment methods, that while they vary in overall design, detail and administration, are classified into general categories—cost based and charge based. And within either of these categories payments can be paid prospectively or retrospectively.

And as I indicated, it isn't so much the particular approach you use but the design of the system and how it is implemented. In some States, as you know, where Blue Cross plans are subjected to mandated State rate regulations, the plans reimbursement methods and the amount they pay are determined by the State's review body.

However, we firmly believe that nongovernmental approaches offer the greatest potential for restraining the rate of increase in hospital costs. In my written testimony I have described five plan payment programs which demonstrate the basis for this belief. Three are planwide programs and two are experimental, limited area programs. I am not going into those in detail. You can ask questions. Rhode Island's maxi-cap program established in 1974 is a prospective cost based system which uses a budget review and negotiation process to establish payment rates for the Blue Cross plan and the State medicaid program.

In Michigan, the prospective reimbursement system is a program wherein a committee composed of major involved interests set a percentage increase target or screen which applies to hospitals' expenses. A program similar to the Michigan one was recently implemented by the Massachusett's Blue Cross plan. Under this program, a maximum allowable cost or the acronym MAC is determined for each hospital. This is the maximum amount the hospital can spend and be guaranteed proportional reimbursement from the Blue Cross plan during the year.

Under an experimental program in operation in Rochester, N.Y., the Blue Cross plan and 17 participating area hospitals jointly determined an overall limit of the hospitals' combined annual net patient revenue. And within that overall limit, they distribute those revenues among the individual hospitals based on a process of negotiation.

Another experimental hospital payment program that we are testing at the moment is in two plans—North Dakota and in Massachusetts. This program involves a capitation payment method, which pays a hospital prospectively a fixed amount for each covered Blue Cross plan subscriber.

In my written testimony I make the very important point that even the best payment program, however well implemented, cannot constrain hospital costs by itself. Cost is a function not only of the price but of the utilization and the intensity of service. A payment program to be fully effective must be augmented by a comprehensive program of cost containment to influence all of those factors. And in our testimony, we went into some detail on that. I simply, at this point, refer to the fact that the five components of a cost containment program are utilization review, medical necessity programs, benefit design, health planning, and alternative delivery systems.

I would make one other point. In combining payments in cost containment programs it means payers have got to be prepared to invest in administrative areas such as these programs to realize much larger savings in benefit payouts. This is especially noteworthy in the shortsightedness of current medicare budget policy that doesn't recognize the opportunity in benefit savings from the relatively smaller investment in administrative costs. And we were particularly pleased to see the Senate Finance Committee paid attention to that at this last round.

Again, as noted in my written testimony, after looking at the medicare current payment program against our principals, it is my conclusion that while improvements are necessary and possible, medicare has been successful in doing what it was designed to do. And in our testimony we offer some suggestions on how that program might be improved in its current mode.

However, we do offer some payment techniques with which medicare might experiment. These ideas relate directly to hospital payment, but clearly there are other possibilities involving incentives for physicians or incentives for beneficiaries.

Earlier we pointed out what some Blue Cross plans are doing in payment. We believe the system in place in Rhode Island, for example, is transferable to the medicare program. The capitation program we are testing could also be used for medicare.

Let me just identify a couple of others very briefly. One experimental approach which we have brainstormed on might be an alternative payment program for perhaps 200 hospitals throughout the country in which medicare and medicaid are a significant part of the hospitals' case load, and which cumulatively represent a good portion of medicare's costs.

Now you could develop a voluntary program to provide a more flexible payment approach for medicare designed to deal with issues such as charity care, clinic operations or teaching costs. And

to participate in such a program, of course, the hospital would have to be prepared to disclose budget information and be subject themselves to negotiate a utilization of payment levels.

Another possibility is that of selectively contracting with hospitals that meet established cost and quality standards of the medicare program. Such a program would have to be sensitively designed, of course, to insure that hospitals are provided with enough funding to protect the goal of access and quality. It would be necessary to recognize that there are certain services which are both unique and costly, and which only selected institutions can provide.

Another payment approach that can be tested is an extension of the current target rate concept, which was just recently included in the medicare reimbursement arrangement. That is to make the individual provider target rate the actual fixed payment rate. This change would heighten the incentive by increasing the potential for reward as well as loss to the provider.

The final suggestion is that you consider creating an opportunity for hospitals voluntarily to group together and work toward a collectively target payment level, similar to the type of program we have been experimenting with in Rochester, N.Y. Under this, individual institutions could be above or below the ceiling as long as the whole cluster met the goal of the target for that group of hospitals.

Let me conclude by reiterating two points within which everything I said here or in my written testimony needs to be considered. And they are that medicare, like most financing systems, has multiple objectives. And these objectives must be balanced against the goal of cost containment. And those are the difficult questions that need to be weighed when considering this matter.

Also, a critical ingredient in any payment or cost containment approach is careful implementation. That actual cost containment will depend on this as much as the ideas themselves.

Thank you, Mr. Chairman, for the opportunity to appear today. And we would welcome questions you may have.

Senator DURENBERGER. Thank you very much for your testimony.

Blue Cross serves 80 million Americans?

Mr. TRESNOWSKI. Yes.

Senator DURENBERGER. And the commercial insurers cover 20 million?

Mr. TRESNOWSKI. No; 20 million is government programs so that adding the private market and the government market it is roughly 100 million. We like to say that we touch the lives of 100 million Americans.

Senator DURENBERGER. Undoubtedly you do. Within the 80, how many are medicare aged? In other words, I want to find out what your experience is with the same kind of population that we are dealing with. And what is the nature of that experience?

Mr. TRESNOWSKI. Well, there are 9 million medicare eligible beneficiaries that are covered under our complementary coverage programs. And they would be included in the 80 million.

Senator DURENBERGER. That will include the people in the Federal employee health benefit plan?

Mr. TRESNOWSKI. Yes; it would.

Senator DURENBERGER. I think I heard you suggest that prospective reimbursement under medicare would be an improvement. And in 5 months, we may have prospective reimbursement. But it isn't necessarily the answer to all the problems of medicare, including accessibility, quality, and cost containment. Is that a correct interpretation of your statement?

Mr. TRESNOWSKI. If it wasn't explicit, let me make it clear. I don't know that anybody is sitting over in the Health Care Finance Administration with a magic bullet to solve the hospital payment arrangement under the medicare program. A lot of very, very good minds have been put to the subject of medicare reimbursement over a long period of time.

And as we said in our statement, we really shouldn't scrap the system we have now. The devil you know versus the devil you don't. That system has served the program very well. We think that the changes that were recently made, which provides some upper limits, provides for the first time an incentive in the target rate approach, needs to be played out a bit and worked through.

If you are going to make any changes—and the reason we suggested what we did in our statement is you ought to take a couple of ideas and experiment with them around the country. It could be disastrous to make one fell swoop change in the reimbursement system in a program as large and as comprehensive and as complex as the medicare program is.

The recent waiver in Massachusetts, the medicare program for that payment system, I think, is a good example. That waiver was granted under the experimental authority that the Secretary now has under the statute. And it will be worthwhile to evaluate that in that context. And if that makes sense, then it offers the basis on which to take that experiment and incorporate it in the existing payment system.

But, as I say, I don't know anybody sitting over there that has got a magic answer to it. And I would frankly be surprised if in 5 months, Mr. Chairman, they come up with a magic solution for you.

Senator DURENBERGER. Behind the move from retrospective to prospective payment, there is not only a feeling of disaffection for retrospective but also a movement in the direction of capitation. That is evident by the fact that we incorporated an HMO voucher proposal into the tax bill.

In your opinion, is this movement toward prospective payment and capitation a good way to go? Do you feel that we should not try to do it overnight and should just test the water as we move in that direction, or do you feel that based on the tremendous amount of experience your organization has had that this is an impractical way for us to head with medicare and medicaid?

Mr. TRESNOWSKI. The trend of the times today is away from retrospective cost-based reimbursement. The trend of the times today is away from Federal and State regulation around very prescriptive ways to pay for care. The trend of the times today is around negotiations, the HMO notion in terms of negotiating with physician groups or hospital groups to represent a fair price to the marketplace for those services. The notion of preferred provider organiza-

tions is another trend of the times so that you sit down and negotiate a price that a buyer is willing to pay for those services.

The law that was enacted in California is another example of that. All of that leads me to conclude—and not just me, but our organization to conclude—that capitation is a critical component of that. In other words, you sit down with a physician group or a hospital group and identify a given population and pay for that population on a capitation basis.

What is needed most importantly is to change the incentives in the system—to reverse them. And to turn them inward into the system. And a capitation payment allows that to happen.

You have to be very careful, though, that when you do that you have carefully designed the system so it doesn't have the opposite effect. And I suppose that's the basis of my word of caution. That in implementing it, that it be done slowly and cautiously and carefully over time.

Senator DURENBERGER. OK. And I appreciate those comments. I'm bothered when you say "trend of the times." Implicit in that is that 10 years from now there will be another trend—or 15 or 20 years from now. In talking about capitation in particular, I feel the significance of the trend is more long range. In other words, it is a trend to put more of the decisionmaking with regard to health and sick care in the hands of individuals.

Mr. TRESNOWSKI. Yes.

Senator DURENBERGER. That trend forms the basis of my approach to health issues as chairman of this subcommittee. I believe that we must have the individual playing a much larger choice in his or her health care.

But how do you facilitate those choices, and how do you make those choices realistic. And in cases where others have to make choices on people's behalf, such as those of you who design and sell benefits, how do you maximize access, quality, and cost containment?

One of the elements is information. Information helps us in negotiation and it helps us in making personal choices.

What kinds of information are important to those of you who are providing health plans for Americans? What kind of additional information would be helpful to you in negotiating on behalf of those people for more efficient, more cost effective health care? In that same context, can you comment on the AAPCC? And please be as specific as possible about what kind of data and information would be helpful.

Mr. TRESNOWSKI. I would like to have Larry Morris comment on this if he knows something else. But let me say that I am not aware of any particular problems in terms of access to information to improve the quality of the negotiating process. In other words, I don't see any particular barriers to it. In the medicare program, as you know, there are a very comprehensive set of cost finding schedules and cost report information.

In our negotiations, of course, depending on how it is done, there is detailed budget data supplied by the institution. So I don't think there are any particular barriers to it. I think the problem, if there is one, is that we lack a good data base in terms of an understanding of health patterns and their relationship to cost. And that's not

somebody hiding information. It's just that we haven't put our full imagination to the process of developing data bases that would assist us to do that.

Larry, did you want to add anything?

Mr. MORRIS. I think, Mr. Chairman, that I agree. The problem is not so much access to data as improving the analysis of the data and the putting of it to practical use. We have a good bit to learn about how to interpret what we now know. There are now coming into being some improved systems for doing that. There has been a good bit of research done in the last few years about how levels of care can be judged, and the conclusions drawn about that.

This is also a significant question that is being addressed in different ways in a lot of places simultaneously about how best accounts and other community interests can be pulled into the issue of how can the health care system be effective; how can congruent objectives be put into place. But I don't really think the problem is so much barriers.

Senator DURENBERGER. Well, when I asked the commercial insurers the question about the AAPCC, their answer was that the big problem with it would be the cost shift. According to your testimony you either deny the existence of cost shift or you characterize it some other way.

Is there a problem with a cost shift by any definition that would affect our coming up with an accurate formula for the AAPCC?

Mr. TRESNOWSKI. Well, is there a problem in cost shift? I think that, yes, there are cost shifts. But the cost shifts are defined, I think, quite differently than perhaps was represented here.

For example, let's take medicare. The assertion was made that medicare represents a $6 billion cost shift. And I don't believe that. I just don't think that is true. If you look at the medicare law, the medicare law was never written from its very inception to include elements of cost that are included in the definition that derives $6 billion. So I think that's a considerable overstatement.

On the other hand, if you look at some of the policies that have developed in the medicare program, there are some policies that have, in fact, caused medicare to be a bit inconsistent. For example, the dropping of the nursing differential and picking up a specific focus on malpractice costs. I mean the two principles are inconsistent. It's not a question of whether you drop one or the other but you ought to drop both to be consistent across. And to the extent that you are inconsistent, then you have disallowed a cost and that could be added up and turned into cost shifting.

But I would suggest, Mr. Chairman, that if you added all that up, you would get a conservatively lesser number than was included here.

The real problem of cost shifting is not associated with what's covered costs in a payment arrangement. The real problem of cost shifting is in the benefit structure and the eligibility because to the extent that the benefits are not comprehensive, to the extent that they create bad debts, to the extent that those things accumulate, they fall heaviest on those carriers that have the most comprehensive coverages. And that is where cost shifting occurs; not in terms of what the covered costs are.

Senator DURENBERGER. Since you fall in that category, let me ask you another question about the art and the process of price negotiation. On what basis do you begin negotiations? Is it strictly an historical price or is there also an element of cost? Describe for us the process of negotiation that Blue Cross is generally involved in.

Mr. TRESNOWSKI. OK. I'm going to ask Bob Snyder to comment on that. He deals with those negotiations more directly than I do.

Let me just make the initial observation that the negotiation process, as you well understand, is quite diverse across the system. It depends on the resources in the community; it depends on the personalities in the community; it depends on what the objectives of the negotiation are. For example, in the State of Massachusetts our representatives, our plan people, there have described marathon sessions in negotiation around some very small points. But there are some basic principles engaged in it. And I would like for Bob to comment on what those are. Bob.

Mr. SNYDER. I think the negotiation process takes place perhaps at three levels. First, the negotiation of the basic payment system. And the elements that would be covered under the payment system. That kind of negotiation takes place less frequently because once a basic design of the system is in place, it isn't modified annually.

The second level of negotiation then takes place in terms of what happens annually or maybe even less periodically with respect to the level of payment or the level of cost.

And then a third level of negotiation may be over individual hospital problems or provider problems that may arise in some interim period. And that could just be sporadic. And the Blue Cross plan has frequently looked to help the hospital solve a particular problem, and negotiations will take place around that kind of a problem.

Senator DURENBERGER. Do you negotiate from a different base for non-profit versus for-profit? For example, the issue of the cost of capital. Would one of you address that?

Mr. SNYDER. Generally, the elements of payment for proprietary and not for profit will not vary in a specific plan payment mechanism. Some plans do provide a return on equity for proprietary in their payment system. Other plans do not. And it varies around the country depending on how the specific negotiation and payment system developed.

Senator DURENBERGER. There's no one general rule about this?

Mr. SYNDER. No.

Senator DURENBERGER. On a community-by-community basis, how much of your leverage in negotiations depends on marketshare? I think of Des Moines where you have a huge marketshare. What part does that large volume play in negotiating, and what should we learn from this about our own position?

Mr. TRESNOWSKI. Actually the most important thing to keep in mind in terms of marketshare is that the larger share you have, the more responsibility you have to the community. And, therefore, the more intense you are with regard to the negotiation process.

Second, I would say obviously that the more marketshare you have, the more opportunity you have to sit down with providers and sort out evaluation of these business and underwriting prac-

tices and make determinations of what is to be paid and what is not to be paid. But I would quickly add, Mr. Chairman, that we have a number of plans around the country. Even though we cover 80 million Americans in our private business, that marketshare varies. There are parts of the country—States—where we enjoy only 5 to 6 to 7 percent marketshare. And even in those situations, our planners do go out and sit down with the providers, and negotiate. We just think the principle of negotiation is valuable regardless of the marketshare. Clearly, the marketshare gives you greater opportunity. It places greater responsibility on you. But the principle of negotiation is there notwithstanding the size of your market.

Senator DURENBERGER. In your statement you appear to dismiss cost sharing as a mechanism for cost containment. What is the function of deductibles and coinsurance? And what has been your experience generally with consumer cost sharing?

Mr. TRESNOWSKI. Well, I don't know that we spoke to it specifically, but let me speak to it now. Cost sharing—its primary objective in our opinion is to reduce the premium cost. And that it does very nicely. Second, the question of what impact it has on the consumers' behavior is very much up in the air. And contrary to what a lot of people might think, we have had very much of an open mind on that question. We have watched very carefully the results of the Rand study which seemed to indicate that deductibles and copays do impact on the use of service.

The Rand study held back on its subsequent findings, which have not been published yet, on just exactly how that falls on the population. Does it fall on those segments of the population that can least afford to have it fall on in terms of access to care? So that remains an open question in our mind.

And third, I would say to you that we are not stuck in the mud on the matter of cost sharing as a matter of basic philosophy. Today, we have a broad product line. We will make available to the public products which include cost sharing and deductibles and copays. The interesting part of that, of course, is that the American public, in a competitive environment, still opts substantially for comprehensive coverage.

And the last point I would make is that under those circumstances because the subscriber is out of the transactions, we feel a very special responsibility to represent him vis-a-vis the delivery system, which we do.

Senator DURENBERGER. You say it is still an open question with regard to the effectiveness of cost sharing. Is it still an open question as to the effectiveness of cost sharing at the front end? In other words, at the premium level versus the utilization level, which is copayments, deductibles, and so forth. Is that still open?

Mr. TRESNOWSKI. As I say, there's no question that it affects the premium. It does indeed. It makes a dramatic difference.

Senator DURENBERGER. Tell me a little bit about health planning as it relates to what we are talking about. How do you feel about health planning as a necessary component of cost containment?

Mr. TRESNOWSKI. Let's try not to be ideological about it; let's be very practical. I try to be practical by saying that in the statement we have pointed out that a cost containment program is an interrelationship of several important strategies. A payment strategy is a

critical one. Utilization review strategy is a critical one. But I would say to you that you could have an effective payment system with a lot of incentives to reduce costs and to impact on utilization. You could have an effective utilization program. But if you leave in place capacity or you promote the opportunity for increased capacity that is not necessary, then you have got a problem. And that's where health planning comes in.

Now one can argue about what is the proper vehicle for health planning. The debate between whether it should be highly regulated under Government auspices, certificate of need legislation, et cetera, or should it be under voluntary initiative, and so on.

Blue Cross has had a long and, I think, respectable history in that respect. Planning in this country began in communities where they were supported largely by Blue Cross plans. As one looks back over time, distinguished areas were Pittsburgh, Cleveland, Detroit, and Rochester, N.Y., where effective planning took place at the community level. What you do is you bring the people of interest together in that community and you begin to make decisions about the proper distribution of resources.

That, really, is the objective that needs to be served. I think it would be tragic if, at this state in our development in the health delivery system, if we were to just dismiss planning as an unimportant strategy. It's a critical strategy that needs to be employed.

We have supported certificate of need legislation because there needs to be a point in the process of planning where there is a "yes" or "no" decision. And we think that those laws have served that objective. But planning is a critical part of it.

Senator DURENBERGER. Under the current setup, the closest we get to people in the medicare program is through the paperwork that is processed at a regional level. As I understand it, Blue Cross is a large number of mainly State associations, hooked together in a national association.

Do you feel there might be some advantages to medicare if it started to look a little bit more like Blue Cross? Also, has Blue Cross thought about the value of becoming more of a national program with local or State implementation rather than a widely diversified group of State associations? Can you talk to us about that?

Mr. TRESNOWSKI. Sure. One of the great debates in the industry in this country—it's part of the folklore, I suppose—is the balance between centralization and decentralization. And clearly, we have that debate ad nauseam in our organization, given some of the tensions that develop over that issue.

I think that like any other issue of that kind you need a proper balance between centralization and decentralization. We think that there is considerable value to local community identification and understanding community needs. And, thus, we have supported plans in that regard. There are certain unifying principles, though, that need to be applied under a decentralized arrangement. And that's the role that we have played through the association.

And the medicare program per se—we take a great deal of pride in the fact that we have been involved in that program and have brought to it, as I said in my statement, "The ability to relate a massive program to the community level and to be sensitive to it."

And the transactions that play out in that program are very complex. And we think we brought an important equation to that relationship.

We think that that structure could be exploited more than it is. We have argued that for a long, long time. Even in the area of the payment arrangement. And the Secretary is now beginning to take advantage of that, and the Massachusett's waiver is a good example of that. And as in my testimony, I said that there are other opportunities such as the Rhode Island system and so on. So we think there is some opportunity to use that structure more than it has been used.

Senator DURENBERGER. What is your experience, if any, with preferred provider plans?

Mr. TRESNOWSKI. I'm going to let Larry comment on that. He's been closer to it. But let me just make the observation that the preferred—we were talking a moment ago about current trends. The current notion of a preferred provider organization amuses me in a sense because what we have now done is recreated Blue Cross like it used to be. Many years ago, Blue Cross had participating hospital requirements. And we went out and negotiated. And only dealt with certain institutions that we felt met quality standards and the cost standards and so on. And legislation was adopted in many of the States to require us to contract with any licensed institution and the so-called freedom of choice laws and that sort of thing. Now we have come full cycle again, and we are now talking about preferred provider organizations, which is just another term, in my judgment, for what Blue Cross and Blue Shield stood for for many years. The law in California just puts a cap-stone on that 180 degree turn. But that's just sort of a commercial for the fact that there is nothing new under the Sun.

But in terms of what we are currently doing about it, Larry, if you would comment on that.

Mr. MORRIS. Mr. Chairman, I haven't got very much to add. The basis of this system has been contacts with hospitals and physicians and other providers of care. The preferred provider organization introduces a selective contracting, which as a matter of practical market fact is probably going to develop most rapidly on a local business basis. Therefore, our role has been to follow very closely the experiences of the individual funds, which to date has been more in terms of debate, negotiation, brokering than actual experience with the program. It is really quite a new concept despite the fact that it has been widely broadcast very quickly.

We have an internal working group charged with doing that and addressing some of the legal question; some of the market questions; some of the provider relation questions that are implicit in it. But to be perfectly honest, there is very little concrete experience at this point.

Senator DURENBERGER. I'm looking at page 20 of your testimony under benefit design. I'm wondering if you feel the provider should play any role at all in the decision to have the patient share in the cost. Right now, the physicians clearly have an option to do so under medicare by not taking assignment. I am wondering what your feeling is about whether the hospitals should also be allowed to play that kind of a role.

Mr. TRESNOWSKI. Well, obviously, the hospital plays an extremely important role in benefit design because you can't as a carrier sit there and design a set of benefits that the delivery system isn't prepared to deliver. In terms of cost sharing per se, I think, Mr. Chairman, you are aware of the hospitals' increasing attention to cost sharing as a strategy to impact demand for care. Hospitals and doctors, I suppose, have been justifiably concerned about being placed in the position of rationing care in the United States. And they don't welcome that. And they would rather use some other vehicle to accomplish the same purpose—something that impacts demand for care and brings the subscriber back into the transaction.

So I think that in terms of hospitals' approach to that is that they would be supportive. On the other hand I would say that—again, thinking about how you go around in circles on some of these things—that if you employ strategies such as cost sharing, and it depends on the level and the amount, of course, then you get into the questions of access of care. And you also begin to get into questions of revenue streams for institutions. And then people change their minds in terms of the efficacy of those strategies.

So I think, No. 1, yes, they are receptive to it. No. 2, it depends on how they are constructed and implemented. And, No. 3, you would have to watch it over time to see what kind of impact it does have on access and revenue sources.

Senator DURENBERGER. The last question is about what experience you may have had with diagnostic groupings.

Mr. TRESNOWSKI. Diagnostic groupings. We've had very little experience with that in terms of a payment system. New Jersey is the only experience, and that record is yet to be written.

I would caution with diagnostic groupings in this sense. That the diagnostic groupings that are used today—mostly the Yale University ones—were developed as a management tool, and as a utilization review tool. And they have been taken and employed in a payment setting. And it has caused some problems, at least based on the early experience in New Jersey.

But I don't know that we have a definitive answer for you on that. It needs to be looked at more carefully than it has. And I think we need some more experience with that.

Senator DURENBERGER. Well, thank you very much for your testimony.

Mr. TRESNOWSKI. You are welcome.

[The prepared statement of Bernard R. Tresnowski and the answers to questions from Senators Durenberger and Baucus follow:]

Prepared Statement of Bernard R. Tresnowski, Blue Cross & Blue Shield Association

Mr. Chairman and members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. I appreciate this opportunity to share with you some of our experience in developing and implementing hospital payment and cost containment programs. Like the federal government, Blue Cross and Blue Shield Plans must deal with the problem of increasing health care costs. We understand that this Congress faces severe budget problems and difficult policy issues as it seeks the most cost-effective ways to pay for health care services.

In my testimony, I will comment on five major points:

- First, hospital payment methods should be designed to constrain costs but still generate levels of payment adequate to assure the availability of needed services.

- Second, no single best payment method exists, given the regional variations in community needs and resources.

- Third, regardless of the payment method, results depend on effective design and implementation; indeed, these are as important as the method itself.

- Fourth, coordinated actions to influence utilization and the supply of health resources also are key elements in cost containment.

- Fifth, the design and implementation of successful cost containment programs must be sensitive to differences among communities and the factors in them that give rise to unnecessary expenditures for health care.

In my testimony, I will outline our approach to effective payment and cost containment programs that fit local circumstances and markets. I will also provide examples of some Plan programs that have produced good results. In addition, calling on our experience both as Medicare contractors and as private payors, I will offer some assessments of alternative directions that may be considered for the Medicare program. While public and private organizations differ in important ways, our extensive nationwide experience in health care financing has relevance to this Committee.

The Blue Cross and Blue Shield organization has several distinguishing characteristics. The 104 Blue Cross and Blue Shield Plans are community-based financing organizations. Each Plan has a public board that governs its business activities, including contractual relations with providers and also with individuals and employer groups that reflect the level of health care the people in a community are willing and able to buy.

Blue Cross and Blue Shield Plans serve more than 80 million Americans in the private health benefits market and another 20 million as contractors for Medicare and other government programs. By design, the Plans are structured to relate to local health care delivery and competitive circumstances. This structure brings to our role as Medicare intermediaries and carriers the ability to adapt a single national program to wide variations in local community characteristics.

Payment Objectives and Processes

Blue Cross and Blue Shield Plans' effective provider payment practices are a basic element in developing successful products in the highly competitive market for group health insurance. Over the years, we have assessed alternative payment methods. Repeatedly, the same basic conclusions have emerged. They confirm the importance of:

* sound objectives for a payment system;
* careful implementation of the chosen system;
* complementary programs to control utilization, quality and institutional capacity; and
* sensitivity to local problems and opportunities.

We have concluded that any sound payment system must build from specific objectives. These include:

* predictability of payment amount, method and timing for all participants;
* fair, equitable payment for service provided our subscribers;
* subscriber access to medically necessary care delivered at appropriate levels and at reasonable cost;
* maintenance of a quality health care system;
* cost-effective management of health care resources, supported by involvement of providers in both the positive and negative financial consequences of their actions;
* administrative economy and feasibility;
* responsiveness to individual hospital and community needs, including recognition of community resource capabilities and limitations; and,
* community-wide involvement in assessing and controlling health care capacity.

Achieving these objectives requires Plans to be prudent and responsible purchasers of care for their subscribers. Even though the market for health care services differs in significant ways from classical competitive markets, prudent business practices can be applied to hospital payment.

A responsible purchaser seeks fair prices for goods and services through a process of negotiation. In a negotiation process, neither party unilaterally sets prices, nor does any outside party. Negotiating parties usually have conflicting interests and objectives, but the negotiation process is a strong and proven mechanism for balancing interests and devising acceptable compromises.

For Blue Cross and Blue Shield Plans, the outcome of negotiations generally takes the form of contracts between Plans and providers. It is important to note that the arrangements we negotiate have to be acceptable to those who buy our product. We must maintain a balance in access, cost and quality of care. Although the Plan has the leverage of a large purchaser with unique business practices, the hospital has the leverage of our accounts' expectations of access to care for their employees. In other words, we operate in a competitive environment where our customers, unlike Medicare beneficiaries, can turn to another carrier if they are dissatisfied with our results.

The negotiation process attempts to balance the responsibility of a carrier to pay only a fair price for services received by subscribers or beneficiaries against a hospital's responsibility to obtain fair payment for these services.

We seek to base payment on the reasonable cost of providing care to our subscribers and to negotiate what is reasonable with respect to such elements as a return on equity for the hospital. Further, as a prudent carrier, we seek recognition--in payment negotiations--for our business and underwriting practices that lower hospital costs by limiting revenue losses caused by bad debts, carrying charges and other factors. These practices include prompt or advance payment that improves provider cash flow, plus comprehensive benefits, continuity of coverage through conversion privileges, and coverage of high risk populations and individuals. By high risk, I mean, for example, individuals not in groups, those in very small organizations, and those with existing health problems. Our coverage of these people minimizes debt collection problems and reduces the charity care load for hospitals.

Since these practices reduce hospital operational costs, it would be irresponsible for a prudent carrier to fail to negotiate a reasonable valuation of these business and underwriting practices in its hospital payment arrangements. By the same token, it would be impossible for a carrier to maintain such practices without such recognition of their value. For example, our payment practices help us to underwrite the high risk individuals who are avoided by most other carriers.

The negotiation process highlights other aspects of the cost equation. These include the cost of bad debts from other insurers' customers, who may be responsible for a significant portion of their hospital bills; unnecessary or questionable use of services by these patients; and capital expenditures or other investments not required for the care of a prudent carrier's subscribers.

Clearly, different carriers bring different strengths to health care financing. To the extent that some carriers pay slowly, provide sparse coverage, fail to cover poor risks, are inattentive to questionable utilization or are ineffective in other ways, the costs of providing care to their customers will be higher than it needs to be. It is no more unusual for hospital prices to vary among payers than it is for interest rates or other contract prices to differ among businesses with differing financial characteristics. There should be a price differential between a payer that accepts hospital charges and a payer that effectively negotiates hospital payment that is based on the actual cost of serving subscribers or beneficiaries.

Put another way, negotiations between a hospital and a carrier with sound business and underwriting practices--and dedicated to prudent purchase of services on behalf of its subscribers--should result in prices that differ from those the hospital expects other less effective and efficient carriers to pay.

The resulting differential has been labeled "cost-shifting" by those who oppose recognition of the worth of prudent business practices. To the contrary, the business practices that earn a price differential avoid cost-shifting by covering the actual costs incurred by the carrier's subscribers. Cost-shifting can and does occur when some payers do not pay the reasonable cost of services rendered, when they provide poor or inadequate coverage, when they delay payment, or take other steps that create bad debt, increase revenue losses, or contribute to inefficient health care delivery. Were all payers to act in this manner, hospital costs and charges would be even higher than they are today.

Blue Cross Plan Hospital Payment Methods

While there are no easy or standard solutions to the problem of increasing hospital costs, negotiated reimbursement methods which require hospitals to operate within specified financial limits can--and do--have an effect on costs. Most Blue Cross Plan payment methods are based on this principle and its effective implementation.

In general, Blue Cross Plans have payment methods that--while they vary in overall design, detail and administration--can be classified in two categories: cost-based and charge-based. Within either of these categories, payment may be made prospectively or retrospectively.

Cost-Based Payment

Eighteen cost-based Plans pay on a retrospective basis. This means that the level of reimbursable cost is determined after the hospital's fiscal year, according to negotiated predetermined guidelines that define allowable costs. Interim payments are made during the year prior to the final settlement.

Four cost-based Blue Cross Plans pay on a prospective cost basis. For these Plans, the level of reimbursable costs is determined prior to the hospital's fiscal year through negotiation and/or budget review. If the volume of service exceeds prospectively agreed upon limits or if cost increases beyond the hospital's control occur, retroactive adjustment may be made.

Charge-Based Payment

Twenty-four Plans pay on the basis of charges which are negotiated between the Plan and the hospital. In some cases, the negotiation process focuses on charges for specific services; in other cases, it focuses on limitations on certain financial elements such as the hospital's operating margin. In the majority of these Plans, hospital charges are reviewed and approved prospectively, usually for the coming fiscal year.

Thirteen Plans pay on the basis of a schedule of charges established by each hospital.

In states where Blue Cross Plans are subject to mandated state rate regulation, the Plans' reimbursement methods and the amounts they pay are determined by the state rate review body. This occurs in Maryland, Minnesota, New Jersey and New York.

State rate review, which often is equated with prospective payment, has been offered by some as the solution to the problem of increasing health care costs. While some studies of state rate review suggest positive results, they do not provide sufficiently complete or reliable evidence to support a policy of requiring or encouraging such programs. In any case, state rate review is an approach distinguished not by its elements of prospective payment so much as by its shift from private to governmental decision-making. With that shift comes all the difficulties of trying to use regulation to control complex economic behavior.

We firmly believe that non-governmental approaches offer the greatest potential for restraining the rate of increase in hospital costs. A brief review of five Plan payment programs will help demonstrate the basis for this belief. Three are Plan-wide programs and two are experimental, limited area programs.

The oldest of the three Plan-wide programs is Rhode Island's "Maxi-Cap," established in 1974. This program is a prospective cost-based system which uses a budget review and negotiation process to establish payment rates for the Blue Cross Plan and State Medicaid program.

The system basically involves two steps. First, the Blue Cross Plan, State Budget Office and hospitals voluntarily negotiate a percentage limit or ceiling on the total annual increase in hospital operating costs for the entire state. Second, each individual hospital's budget is reviewed by the Plan and State Budget Office with a final budget negotiated among the three parties. When individual budget negotiations are completed, the totals are compared with the pre-set limit. The Maxi-Cap cannot normally be exceeded, although there is a contingency provision for unforeseen and unpredictable expenses. The goal of Rhode Island's Maxi-Cap program is to maintain a ceiling on the state's total expenses while providing the flexibility to recognize any individual hospital's special needs.

The Michigan Plan's Prospective Reimbursement System is another innovative state-wide payment program. Under this program, a committee composed of major involved interests sets a percentage increase target or screen which applies to hospitals' expenses. Hospitals whose budget increases are equal to or below the screen generally have their budgets accepted without further review. Hospitals whose budgeted increases are above the screen may elect to undergo a review in order to justify and win acceptance of their higher spending levels. Budget reviews are required, regardless of the size of projected increases, for hospitals that are overbedded, have low occupancies, or have overspent the limits in two preceding years.

Based on the budget review process, a percentage increase is approved for a hospital above or at the screen percentage. The approved percentage increase forms the payment constraint for the upcoming year. At this point, the Plan's share of the hospital's total approved budget is determined. The Plan also provides, as part of its payment system, incentive payments to hospitals whose actual allowable costs are below their approved budgets. The incentive payment is equal to the Plan's share of half the difference between the actual costs and the approved budgeted costs. Hospital expenses in excess of the approved budget are not reimbursed by the Plan. The objective of the Michigan Plan's prospective reimbursement system is to introduce prospective limits which put hospitals at risk by penalizing overspending and rewarding those that are within pre-set financial targets.

A program that is similar to the Michigan Plan's recently has been implemented by the Massachusetts Blue Cross Plan. Under this program, a maximum allowable cost or "MAC" is determined for each hospital. This is the maximum amount the hospital can spend and be guaranteed proportional reimbursement from the Blue Cross Plan during the year. If the hospital spends in excess of its maximum, the Plan is not committed to make up the difference. On the other hand, if the hospital succeeds in keeping its costs below its "MAC," it may keep the Blue Cross Plan's portion of the savings. The program includes incentives and disincentives designed to control patient and service volume. In areas of service where the Plan wishes to encourage volume decreases, such as inpatient ancillary services,

payments for volume increases beyond a specified level are set below the marginal cost of an additional unit of volume. On the other hand, in areas where the Plan wishes to encourage volume increases, such as outpatient surgery, payment for the additional unit of volume may be set at a level higher than the actual marginal cost. Thus, these disincentives and incentives--combined with the maximum allowable cost concept--introduce both risk and reward for the hospitals. The Massachusetts Legislature recently accepted the MAC system as the model for a proposed state-wide payment system for which it is seeking a Medicare waiver.

An experimental program in operation in Rochester, New York involves the Rochester Blue Cross Plan and nine area hospitals. Payments by the Plan, Medicaid and Medicare are covered under the program. The Rochester Hospital Experimental Payment (HEP) program is similar to Rhode Island's "Maxi-Cap" program. Under the Rochester program, the Blue Cross Plan and the participating hospitals jointly determine an overall limit on the nine hospitals' combined annual net patient revenue. Two percent is added to each year's overall limit as a contingency fund for unexpected volume increases and incremental costs associated with approved capital projects. For each individual hospital, a limit is then placed on the amount of revenue the hospital may receive from services to patients. If a hospital's total net patient revenue from all sources exceeds its allowable limit at the end of the year, the excess revenue must be paid into the contingency fund.

Another experimental hospital payment program is being tested by the Blue Cross Plans of North Dakota and Massachusetts. This program involves a capitation payment method which pays a hospital a prospectively determined, fixed amount for each covered Blue Cross Plan subscriber. In return, the hospital assumes responsibility for providing or paying for any covered hospital services its covered subscribers may need. Under these programs, the Blue Cross Plan--on a monthly basis--pays each participating hospital the agreed-upon capitation payment for every Plan subscriber affiliated with that institution. As long as the subscriber goes to his or her affiliated hospital, no further flow of funds occurs. However, if a subscriber uses another hospital, the Blue Cross Plan will pay that hospital on the traditional unit-of-service basis, and the amount of that payment will be deducted from the affiliated hospital's pool of funds. At the end of each of the first two years of the experiment, each participating hospital's total capitation revenue will be compared with the expenses it incurred in serving its capitated population. If revenues exceed expenses, the hospital will retain a portion of the difference. During the first two years, hospitals will not be at risk for expenses in excess of revenues; however, in subsequent years, it is expected that they will be liable for such expenses. The capitation method is based on the concept that prospectively determined per capita payment creates a better economic environment for hospitals and provides opportunities for them and their medical staffs to identify and act in ways to provide health care more effectively and efficiently.

The payment programs just described are diverse in structure, methodology and operating environment. However, based on our experience with various payment methods, some conclusions can be drawn from them.

First, no particular method has proven to be better than others in all circumstances. The appropriateness and effectiveness of a particular payment method depends largely on factors such as the key characteristics of the area's hospital industry and its community. There is considerable variation in such factors across the nation. In Massachusetts, for example, the hospital industry is characterized by a high concentration of large teaching hospitals in the Boston area and a relatively rural area at the other end of the state. This diversity requires a flexible system with emphasis on individual hospital expenditures. In Rochester, New York, there is a tradition of active involvement in the health care system by the business community. The compactness of Rhode Island lends itself to management of the health system on a state-wide basis. The small number of hospitals in North Dakota facilitates communication and experimentation. Other areas have other special characteristics. The point is that the payment systems which have been worked out in these areas tend to reflect and accommodate those characteristics.

The variety of these approaches demonstrates that the effectiveness of a payment system does not depend on whether the system is prospective or retrospective. For example, Michigan's prospective system includes a retrospective adjustment for volume increases beyond a predetermined level, while most Blue Cross Plans which pay retrospectively first set guidelines for allowed cost elements.

Two elements of a payment system which help determine its effectiveness are its specific design and its implementation. As noted previously, the Blue Cross Plan payment programs that have been described are very diverse in their structures and methodologies. In the Massachusetts Maximum Allowable Cost system, for example, the focus of the incentive structure is on influencing particular utilization patterns, such as the volume of inpatient days and ancillary services in individual hospitals. In the capitation experiment in North Dakota and Massachusetts, the incentives are directed primarily toward influencing hospitals to effectively manage resources, direct care to appropriate settings, and still provide services that satisfy patients.

Although these programs are diverse, they all have a few key elements in common. First, these programs all involve a voluntary negotiation process: all the participating parties mutually agree upon a price which represents a fair payment for the services the hospital provides to the payer's subscribers. Second, these programs attempt to constrain a hospital's total spending by focusing not just on the payment per unit but also on the hospital's total expenses and revenues.

The translation of these concepts into reality hinges on the implementation process. Implementation imposes a variety of requirements:

-- A management staff skilled in negotiation, schooled in payment objectives and with the latitude and authority to make decisions.

-- A knowledge of community health needs and resources.

-- Relationships with customers and providers to permit evaluation and accommodations of the needs of each.

-- Careful evaluation in advance of the consequences of decisions and appropriate provision for dealing with them.

-- Ongoing evaluation of the payment process and willingness and ability to adjust it as circumstances require.

It is most important, however, to understand that even the best payment program, however well implemented, cannot constrain hospital costs by itself. Cost is a function not only of price but of utilization and intensity of service. A payment program, to be fully effective, must be augmented by a comprehensive program of cost containment to influence all three factors. Let me explain this linkage in terms of our experience.

Cost Containment

An integral part of the Blue Cross and Blue Shield organization's cost containment efforts is the Association's standard of membership that requires Plans to have operational programs to control costs. This standard recognizes that individual cost containment programs need to be sensitive to local circumstances for much the same reasons that Plan payment programs must be similarly responsive.

We are aware that many causes of cost escalation arise from significant environmental circumstances. These include inflation in the general economy, an aging population and technological and clinical innovation which create powerful forces for increased utilization. Nevertheless, the dramatic increases in health care costs in recent years and the resultant pressure on our premiums and reserves make it clear that we need to be more effective in controlling costs. Therefore, we have initiated a major reassessment of our cost containment strategy. The objective is to determine what approaches suit today's circumstances.

Based on our experience, there are five cost containment strategies with incentives for appropriate use and intensity of services that reinforce constraints in the payment method. They are:

- o utilization review;
- o medical necessity;
- o benefit design;
- o health planning; and
- o alternative delivery systems.

Utilization Review

The last few years have seen important innovations in the design and use of methods for monitoring and controlling utilization of health care services. Better data, more informative analysis, increased sophistication in developing and applying standards, selective use of positive and negative financial incentives--all these factors convince us that utilization review programs will continue to be important cost containment tools.

Precise estimates of the effects of utilization review programs often are difficult to ascertain. However, a study done for us by researchers from Johns Hopkins University has concluded that Blue Cross Plan utilization review programs were factors in the steady decline during the 1970's in Blue Cross Plan inpatient utilization rates. On the Medicare side, the Health Care Financing Administration has estimated that for every one dollar spent by intermediaries on medical review, the government saves nearly three. HCFA estimated that carrier Part B medical reviews saved an average of five dollars for every one dollar spent. A recent survey of several Blue Cross and Blue Shield Plans found average savings of over four dollars for every one spent on hospital reviews and an average of more than seven dollars saved for every one spent on physician reviews. The application of improved UR tools has promise for even better results in the future.

Good results are especially likely if a UR program is matched to a specific payment program. For example, a program that uses admissions as the unit of payment would appropriately be backed up by utilization review that helps discourage inappropriate admissions. Programs for pre-certifying admissions also build on strong UR efforts, as do benefit designs promoting greater substitution of outpatient for inpatient care.

Given the enormous pressure on Congress to obtain short-term budget savings, this Committee is to be commended for resisting some very strong pressure to end Medicare utilization review. Last month's budget conference

was encouraging in its direction that the Secretary of Health and Human Services improve and monitor medical review by Medicare contractors. However, the amounts budgeted for contractors are not adequate to maintain, much less improve, truly effective audit and review functions. Medicare benefit payouts already are increasing and will continue to do so unless the current budget policy is reversed to achieve savings in the relatively large benefit payments rather than in the relatively small administrative expenditures. It is our experience that the provider community can be enlisted in responsible efforts to constrain cost while maintaining the quality of care.

Medical Necessity Program

Some of you may be familiar with the 1980 report by the Government Accounting Office that assesses the Blue Cross and Blue Shield organization's Medical Necessity Program. This program is a cooperative effort of our organization and the medical community to control costs and to improve quality by reducing the use of outdated, ineffective or inappropriate diagnostic or therapeutic procedures. First year findings from the initial stage of the program indicated a 26% drop in targeted surgical procedures and an 84% drop in listed laboratory procedures. One small Blue Cross Plan estimated $7 million in savings is available within its state just from not paying for routine admission tests without explicit physician orders. Based on findings such as these, the GAO has recommended that health insurance programs for federal employees adopt the approach taken in the Blue Cross and Blue Shield organization's Medical Necessity Program.

The base of the Medical Necessity Program is an ongoing Blue Cross and Blue Shield Plan medical policy process that evaluates major and minor changes in clinical practice and medical technology. The role of this process in establishing guidelines for payment based on the best available professional medical opinion and solid business judgments about the conditions of payment is critical to our ability to reconcile the objectives of cost containment and access to good quality care. The point here is that a good price for an unneeded or ineffective service is a hollow bargain. Providers are becoming increasingly aware of this, and one of our objectives is to encourage and to support them in addressing the issue.

Benefit Design

Benefit design is another important element of any comprehensive program to influence service use and control costs. Cost sharing is frequently described as cost containing. While it unquestionably does lower the expenditure for premiums, we are not convinced that transferring part of the outlay from group purchasers of care to individual patients can really contain total costs.

One major prospective reimbursement proposal would allow hospitals to surcharge Medicare beneficiaries beyond coinsurance and deductible amounts. This approach may allow hospitals to evade the cost control intent of the prospective payment method by obtaining extra revenue from the patient surcharges. The point, again, is that payment methods cannot be viewed apart from the incentive and financing features built into the benefit structure.

A more promising benefit strategy is to design benefit packages to shift hospital care to appropriate lower cost settings. Changes in clinical practice and new technologies are enabling more and more complicated procedures to be performed on an outpatient basis. Utilization review programs reinforce the trend. And with the availability of more and better ambulatory care capacity, consumers are learning to appreciate the economy and convenience of such care.

Health Planning

However, it is important to point out that reducing inpatient hospital use does not necessarily lead to major short-term savings in a straightforward way. This is because inpatient facilities continue to generate a substantial amount of fixed cost regardless of occupancy. The need for careful analysis of the real needs of the individual institution continues. To realize the potential savings from reducing and shifting utilization, unneeded hospital capacity must be phased out and inappropriate new investments avoided. When appropriate, investments in cost-effective alternative sites of care should be encouraged.

The recent Congressional Budget Office study demonstrates that the impact of health planning is difficult to document. However, we have some evidence to suggest that it does produce results. The Johns Hopkins study cited earlier found that Blue Cross Plan health planning activity helps lower Blue Cross Plan and community-wide hospital admission rates.

These findings are consistent with the proposition that the supply of health care resources is an important influence on the utilization of health services. Thus, health planning is another component in a total cost containment program that controls volume of service as well as unit price.

As I testified before the House Ways and Means Subcommittee on Health and Environment this past April, we believe that traditional cost containment, as just described, can contain health care costs when intelligently and energetically implemented. In addition, we believe that alternative financing and delivery systems have much to offer in some communities. They can be a laboratory for new cost containment tools that can be applied to traditional care arrangements. Equally important, they can be used to educate physicians about cost-effective care.

Alternate Delivery Systems

Alternate delivery systems such as HMOs are essentially a variant of the negotiated payment approaches described earlier. Payers negotiate special risk sharing arrangements with groups of providers with the objective of limiting benefit payouts while maintaining access to quality health care for members.

The involvement of Blue Cross and Blue Shield Plans in alternate delivery system is substantial. There are 54 Blue Cross and Blue Shield Plan HMOs with more than one million members. Plans sell various services to another 23 HMOs that have nearly 600,000 members. As you know, HMO failure rates have been high, which is not remarkable for new and complex

businesses. Ours have fared considerably better than average, reinforcing the fundamental importance of effective implementation.

Another alternate delivery system concept of very recent interest is the so-called "preferred provider organization" or PPO. Put quite simply, a PPO is a small group of hospitals and physicians who agree to a negotiated payment arrangement that is generally below usual hospital and physician charges. Subscribers in a PPO would usually be free to select non-PPO providers for their care, but would have to pay more to do so. Although there are not many such PPO's, it is clear that among the key elements in their success is the ability to negotiate advantageous payment and other arrangements with health care providers.

Alternative Directions for Medicare

At this point, I would like to comment on Medicare's performance as measured against a reasonable set of payment system objectives, bringing to bear Blue Cross organization experience with payment and related cost containment activities.

Medicare Payment Objectives

First, there is little debate that the Medicare payment system has assured beneficiaries good financial and geographic access to health care. Also, providers have been paid promptly and predictably for the obligations that Medicare has assumed. Finally, Medicare pays full, reasonable cost of those services for which it has assumed responsibility. It covers reasonable expenses for all direct patient care plus bad debts resulting from beneficiary deductibles and coinsurance.

Clearly, the development of acceptable expense definitions produces differences of interpretation and judgment. Reasonable people may differ about whether Medicare should pay certain additional costs if it is really to meet the objectives of the law. For example, if the community is to have a supply of trained physicians, then it is arguable that Medicare should help pay for educating those physicians. However, such issues involve a relatively small part of the total cost of delivering services.

There are areas in which we believe Medicare could be improved; one is the administration of the program. While the contractors' costs of administering the Medicare program approximate only 2 percent of the total cost of the program, there are substantial hidden administrative costs associated with Medicare requirements for hospitals and other providers. Congress appears to be recognizing this, for instance, by authorizing elimination of the so-called "lesser of charges or costs" provision--a complicated and costly provision to implement. Administrative costs are an area of continuing concern for any payment system and therefore must be continually reviewed.

Next, we should examine how Medicare's payment system promotes the effective management of health care resources. A basic question is whether it offers providers incentives to achieve desirable results. Medicare's emphasis on financial reporting and the associated allocation of expenses has dramatically improved hospital financial reporting and accountability.

Better financial information has affected not only how care is paid for but also how care is delivered. For example, this information is useful in indicating how home health, hospice and other ambulatory services can best be joined to the hospital system. With improved financial information, hospitals are able to make better decisions on the most cost effective way to deliver care and the financial feasibility of providing certain types of care. Further, while there is disagreement about the mechanics, Medicare's move to limit allowable costs under Section 223 has contributed to making providers aware of the need to manage their hospitals within the available resources. However, Medicare has failed, in general, to provide positive financial incentives for improved management.

Another major objective of a payment system is responsiveness to individual hospital and community needs. Here Medicare, as a national program, often has lacked the flexibility and capacity that is inherent in Blue Cross Plan approaches. Since this nation is not homogeneous, either in its delivery structure or the needs of Medicare beneficiaries, this is a serious concern. We think that some change and greater flexibility may be possible, even within the scope of a nationwide program. I will have more to say about this in a minute.

Finally, and in a sense this is the crux of the question before you today, there remains the issue of how the payment system promotes the delivery of good quality care at the lowest cost. Medicare clearly has provided a financial basis for the provision of quality care.

However, the payment system and benefit structure have not necessarily provided the incentives for doing so at the lowest cost. For example, the Secretary now has authority to eliminate the three-day hospitalization required before an individual can be admitted to a skilled nursing facility. This three-day stay may encourage inappropriate admissions and payment for a higher level of care than is necessary. The payment system is only part of the problem here; coverage is the other part. Such approaches as payment for "swing beds" that can be used for either short term or long term care could have contributed earlier to the solution of this problem. And a more fundamental problem is worth noting again. If a hospital saves a dollar through prudent management--such as with a swing bed program--and its only reward is to lose that dollar, this is hardly a positive incentive for efficiency and economy.

It is clear that the Medicare payment system has been relatively successful in doing the job it was designed for--paying the reasonable cost of care for its beneficiaries. Moreover, the program has many of the elements necessary to achieve its cost objectives. This argues that the program does not need immediate, radical change but that there should be much more experimentation and legislative adjustment to rectify its shortcomings. These should focus on the introduction of more positive incentives for efficiency and on the development of more flexible and locally oriented approaches to payment. One way of doing this would be to provide stronger encouragement and legislative direction to the Secretary of HHS to enter into experimental arrangements. Experimentation may very well show that Medicare should have more than one payment program, as Blue Cross and Blue Shield Plan experience has demonstrated.

Selected Areas for Medicare Experimentation

Let me offer some payment techniques with which Medicare might experiment. These ideas relate directly to hospital payment, but clearly there are other possibilities involving incentives for physicians and beneficiaries. Earlier we pointed out what some Blue Cross Plans are doing in payment. We believe the system in place in Rhode Island, for example, is transferrable to the Medicare program. The capitation payment program we are testing could also be used by Medicare. However, I want to offer some additional suggestions in payment approaches, many of which incorporate some features of the programs just described.

One experimental approach might be an alternate payment program for certain hospitals with special characteristics. There are a number of hospitals, perhaps 200 throughout the country, in which Medicare and Medicaid are a significant part of the hospital's caseload and which, cumulatively, represent a good portion of Medicare's costs. These hospitals are faced with many problems that are uniquely related to the communities they serve. Some are the sole sources of care for their service areas. A voluntary program could be established to provide a more flexible payment approach for Medicare, designed to deal with issues such as charity care, clinic operations and teaching costs. To participate in such a program, hospitals would have to be prepared to disclose total budget information and to subject themselves to negotiated utilization and payment levels to control total costs in the institutions and to reflect special community needs. This kind of flexible and community-sensitive approach could serve multiple objectives for the government, the institutions and their communities. It would, at the same time, enable the present payment system to continue to operate in hospitals for which it is more appropriate. Intermediaries could play an important role in helping to design and implement these types of experiments.

Another possibility is that of selectively contracting with hospitals that meet established cost and quality standards of the Medicare program. Such a program would have to be sensitively designed to ensure that hospitals are provided with enough funding to protect the goals of access and good quality care. It would be necessary to recognize that there are certain

services which are both unique and costly and which only selected institutions can provide. Some allowance would have to be made to ensure continued availability of those services. In sum, the selection of hospitals under such an approach would have to be carefully determined. The position of teaching hospitals, inner city hospitals and other special institutions would need thoughtful attention. Not only cost but quality and access objectives have to be part of the contracting criteria.

A final suggestion is that you consider creating an opportunity for hospitals voluntarily to group together and work toward a collective target payment level. Individual institutions could be above or below the ceiling as long as the whole cluster met the goal. Under this concept, a major criticism of federal programs could be dealt with. Specifically, different hospitals have different needs at different times. By allowing hospitals to cluster together to meet an objective, Medicare could recognize that fact and the need for flexibility for individual hospitals to achieve goals over a long period of time. It could encourage them to think as community systems, serving in a more cooperative way. More sharing of services and expertise and less duplication could be an important outcome. This sort of experiment would allow Medicare to take advantage of such innovations as those in Rhode Island and Rochester. The geographic basis should be flexible. A statewide approach might be less feasible than clusters based on medical service areas.

Objectives and Implementation

Let me conclude my comments by making a few points that I think are relevant to all of these experimental approaches and which I have tried to emphasize throughout my testimony. In the first place, Medicare, like most financing systems, has multiple objectives. Some have to do with cost; others deal with less tangible factors such as access and quality. I have suggested some ideas that could contain cost. However, the effect of any initiative must be judged on the basis of its effect on each important objective. I believe that the thoughts I have offered, if carefully implemented, could maintain and perhaps improve the Medicare program's effectiveness in several significant areas. A second point is that none of these approaches will, merely by enactment, establish effective incentives for efficiency, quality of access. Implementation is as important as concept, and Congressional and Executive oversight ought to be attentive to the execution as well as the design of experimental changes.

I thank you for the opportunity to appear before you today and welcome the opportunity to respond to your questions.

BLUE CROSS AND BLUE SHIELD ASSOCIATION RESPONSE FOR
SENATE COMMITTEE ON FINANCE, HEALTH SUBCOMMITTEE

Questions from Senator Durenberger

Durenberger 1. What circumstances lead your Plans to choose one method of payment over another?

Response: There are many reasons why a particular payment method may be used in a given Plan area. However, it is not so much a matter of selecting a method as it is of evaluating and refining the elements to be paid and the processes through which the level of Plan payment is determined. Most payment systems have evolved locally, and changes in those systems have been negotiated incrementally. These systems are not easily categorized, but have elements of prospectivity and retrospectivity as well as cost and charge-based payment. Cost-based payment arrangements developed as an alternative to the historic practice of paying a uniform fixed per diem rate to all hospitals in a community. This evolution to payment of cost was regarded as an improvement over uniform rates. As other specific problems were identified, the definitions of cost elements to be covered changed.

As time passed, some Plans changed from a retrospective cost system which may or may not have exercised control over payments, to a system of controlled charges through which the Plan was able to obtain a degree of control over the amounts it would pay. In the process, the definition of allowable elements often changed. As one parallel example, Medicare, when granting waivers in certain states (e.g. Maryland), has agreed to change from a cost basis to a charge basis in which its definition of allowable elements expands. This trade-off is made because of the potential for controlling the level of payment.

In sum, it is a combination of factors or series of events which result in the use of a payment system that the Plan believes, when combined with its other programs, can best serve its purpose in the community. In recent years payment systems have been carefully developed by Plans as they recognize the need to consider the variety of factors that affect the total amounts they pay. Nevertheless, because it is a negotiating process, and because there are conflicting goals, the resulting payment system is frequently a balance between what the Plan and the hospital consider to be optimal.

Durenberger 2. Of all the systems you have in use, is there one in particular that gives you a competitive advantage through realizing lower costs resulting in lower premiums?

Response: No. All of the payment systems currently used by Blue Cross Plans are available to others, including our competitors. It is important to understand, however, that direct comparisons between the costs of care for Blue Cross Plan and commercial insurance subscribers are not easily made, because of differences in business practices, comprehensiveness of coverage and other factors affecting both costs and premiums.

Durenberger 3. For those 24 Plans which negotiate charges, what consideration is given to the costs on which those charges are based? If cost is not involved, what basis is used to establish the highest acceptable vs. lower possible charges for the Plan's negotiator?

Response: Plans that negotiate charges use a variety of means of considering the acceptability of charges. Most of those Plans have defined the financial requirements for which the hospitals can set charges that the Plans will pay. Although there may be some variations among Plans' definitions of financial requirements, all include direct operating and overhead expenses, including depreciation. Other elements dealt with in the definitions include bad debts and charity care; level of operating margin; and payment for capital requirements. Any or all of these elements, within their basic definition, may be limited as to what is allowable.

Two basic approaches are then followed in assessing the acceptability of the level of financial requirement. One is a review process in which, similar to cost-based prospective budget systems, Plans receive financial, statistical and budget data for review in order to determine whether the hospital's requested budget level is justified.

A second approach is to compare the charges for services representing the major share of hospital revenue with those of other similar hospitals in the area. If the charges for a particular service are out of line, additional justification may be requested and the negotiation process continues until a resolution is reached.

Durenberger 4. In addition to payment per unit arrangements, you indicate that total expense or revenue constraints are also a part of the negotiated reimbursement systems now in use. Do you believe overall expense or revenue is a necessary element for cost containment and, if so, why?

Response: To be maximally effective, a program to control health care cost must, in its design and implementation, be concerned with total health care costs, not merely price per unit of care. Total

Durenberger Response: cont'd.

health care spending is a function not only of price but of utilization and intensity of service. A good price for an unneeded or needlessly elaborate service is no bargain. Therefore, hospital payment policies need to be supplemented by programs concerned with appropriate service use. Programs that Blue Cross and Blue Shield Plans have found effective include: utilization review; medical necessity; benefit design; health planning; and alternative delivery systems. The need for these elements to be related to each other in a comprehensive cost containment program is not always adequately appreciated.

The effectiveness of the above programs is not guaranteed merely by their adoption. Each program needs to be designed and implemented to take into account the focus of other cost containment programs and the characteristics of the community (e.g., over- or undersupply of hospital and physician resources, population density, employment patterns). For example, if the hospital payment program is based on admissions as the payment unit, then the utilization review program would probably be most effective if it discouraged inappropriate hospital admissions and encouraged the substitution of less costly forms of care. The point here is that no single cost containment program or set of programs will fit all community circumstances.

Questions from Senator Baucus

Baucus 1. You stated that you have concluded that any sound payment system should have communitywide involvement in assessing and controlling health care capacity. However, a community might want the benefits of "excessive" hospital capacity because they know that the costs will be borne largely by Blue Cross and private insurance beneficiaries who live in other parts of the state or of the country. Has this been a problem in your experience?

Response: Blue Cross and Blue Shield Plans in many parts of the country have felt the costs of excess hospital capacity in their communities. In addition to supporting community health planning and capital investment control programs, a number of Plans have sought, through negotiation, financial aid and other means, to encourage the elimination or conversion of unneeded hospital facilities and services. This involvement has taught us a great deal about how difficult it is to reduce excess capacity--people may lose jobs, physicians may lose places to practice, patients may be inconvenienced, and communities lose an important symbol.

Although the economic and other benefits of keeping excess capacity may be relatively clear to communities, it is true that the costs are not particularly visible since they are relatively small and are submerged in health service charges and insurance premiums. Nevertheless, communities do pay a substantial portion of the cost of their excess capacity. They bear the burden either through individual payment of hospital charges or through insurance pre-

Baucus Response: cont'd.

miums. Most private insurance is group insurance that is rated on the basis of the group's experience, that is, its history of employee heatlh care expense. Since most employees get health care where they live, this means that their companies' insurance costs reflect lbcal hospital costs, including those associated with excess capacity. The concern of many community cost coalitions with health planning reflects the business participants' health understanding of these economics.

In contrast, public insurance programs disperse the costs of excess capacity through the tax system so that taxpayers in other areas help support communities with excess capacity. This suggests that government does need to be concerned about excess capacity at the community level, and that the continuation of some federal and state support for community health planning and certificate of need programs is responsible public policy.

Baucus

2. What factor(s) differentiate those Plans which are able to negotiate discounts and those that are not?

Response:

Our records indicate that relatively few Plans actually negotiate discounts--that is a payment rate which is expressed as hospital determined charges less a stated percent. The majority of Plans that pay less than such "billed charges" do so because they have negotiated payment rates specific to the Blue Cross Plan. These rates can be derived from cost-based retrospective or prospective budget review formulas, or can result from direct budget negotiations over charge levels that Plans will accept for services provided to their subscribers. Hospitals independently decide to charge other patients at a rate different from the rate negotiated by the Blue Cross Plan. Three factors influence the extent to which the level of Plan payment will differ from that of other payers. First, is the history of payment arrangements in the community. In those areas where the early payment arrangements were based on a per diem charge, cost-based Blue Cross payment arrangements seemed to evolve. In other areas, Blue Cross Plans paid charges based on discrete services for reasons unique to those environments.

Second, while high market share is sometimes an advantage in the negotiation process, Blue Cross Plans, regardless of their market shares, have strong negotiation positions due to a number of their business practices (e.g., prompt payment, comprehensive coverage, more liberal underwriting practices, community service, etc.) and their local orientation.

A third factor is the hospital community's recognition that: 1) negotiations can be a positive influence for providing cost effective care in the community; and 2) hospitals incur different costs for different payor populations. This recognition is important since Plans must ensure that their subscribers have appropri-

Baucus Response: cont'd.

ate access to health care services and therefore need to negotiate a payment arrangement successfully with an appropriate number of hospitals in a community.

As noted earlier, however, from the hospital point of view, and from the community point of view, "the discount" does not tell the entire story. The important factor is the percent of the hospital bill that is actually paid or the percentage of premium revenue paid out in health care benefits. Blue Cross Plans have consistently outranked other payers in both these categories.

Baucus 3. What is the basis for Blue Cross' nonprofit tax status and do you feel it gives you a competitive advantage?

Response: Most Plans originated in an era when nonprofit status was the dominant institutional form in health care delivery and when few if any other organizations were interested in underwriting health care benefits. The mission of the Plans was to establish a community-based financing mechanism to pay for hospital and physician care for middle and lower income groups. Section 501 (c)4 status was, and remains, appropriate to the Plans' policies and practices regarding open enrollment, non-cancellation for health reasons, and the provision of a protective system for the entire community.

Nonprofit status has its advantages and disadvantages. In today's health care system, many organizations have found the advantages of for-profit organization to be substantial, and this form is much more significant today than 30 years ago. However, since the assumption is often made, wrongly, that nonprofit status means freedom from premium taxes and a concomitant competitive advantage, some attention to this particular issue is warranted.

First, with respect to the application of premium taxes, many Blue Cross and Blue Shield Plans do pay state premium taxes or payments in lieu of taxes. Moreover, the effective premium tax rate for commercial companies is rarely the assessed rate. Typically, tax credits for maintaining a home office or other premises in the state, for investing in local securities and for similar activities, plus deductions against federal corporate taxes and other factors, significantly reduce and sometimes eliminate the premium tax burden for commercial insurers.

Moreover, as a function of their nonprofit social welfare purpose and organization, Blue Cross and Blue Shield Plans generally experience a level of state regulation not applicable to their competitors. In many states, Plans suffer a serious cost disadvantage from strict state regulation, particularly regulation of their premium rates. Plans' contracts and rates may require approval by the state and are often the subject of public hearings.

Baucus Response: cont'd.

State regulation varies from state to state, but in general Blue Cross and Blue Shield Plan operations tend to be much more heavily scrutinized than those of commercial insurers. This scrutiny may cover (in addition to rates) contract forms, kinds of benefits, provider reimbursement, cost containment activities and financial condition. In addition, Plans are regularly subject to thorough investigations and examinations which often lead to published reports. This regulation unquestionably imposes economic costs on Plans, although the exact level of costs is difficult to determine.

Baucus

4. Your written testimony describes the diversity of payment formulas in Blue Cross and some of the reasons for the differences. Have you assessed the relative effectiveness of the different payment approaches in containing hospital cost?

Response:

As we testified, the factors that affect the level of hospital cost and its rate of change in a local community encompass a wide range including hospital capacity, community demographics, nature and scope of services available in a community, local wage rates and other price factors that all make effective comparative evaluation of payment programs difficult. Researchers looking at the effectiveness of state hospital rate regulation have found that the major problems of separating the impact of these factors from that of the regulatory process similarly makes evaluation of the latter difficult and obscures the result.

In our testimony we cited several payment programs which we believe are desirable because of their design. Moreover, in the three Plans with some experience with these programs, results are encouraging. The Rochester, Rhode Island and Michigan Plans had lower rates of increase in hospital benefit payments both per inpatient day and per admission than the average for all Plans in 1981. On a state-wide basis, Rhode Island rates of increase in total and per capita hospital expenditures were less than the U.S. average consistently over the past several years. For hospitals in the Rochester program, the increase in total expenditures were 9.1% and 10.1% for 1980 and 1981 respectively--both considerably below the national average. Michigan's rate of increase in per capita expenditures in 1980 was lower than the U.S. average, and its rate of increase in total hospital expenditures was less than the U.S. average in both 1979 and 1980.

Since the Massachusetts Plan's MAC program, and the capitation payment experiments in North Dakota and Massachusetts were just recently implemented, no results are available. However, we believe that because they have the same structural elements as the other three--that is, they all focus on total hospital costs

Baucus Response: cont'd.

or revenues and contain incentives for particular cost efficient behavior--they too hold the potential for restraining hospital costs.

However, there are other Plans, whose payment programs we did not cite as having the same elements, which have, nevertheless, experienced lower than average rates of increase in benefit payments. This reinforces our belief that a variety of factors affect the level and rate of change in hospital costs, and that definitive statements of a particular payment program's effectiveness cannot be made at this time. This is why we emphasized experimentation with new programs in Medicare and urged that the adoption of any new payment program for Medicare follow a deliberate and careful process of testing.

Baucus

5. Have you measured the impact that any of the medical review programs have on hospital utilization or hospital expenditures?

Response:

Measuring the impact of medical review and similar programs on utilization and cost is a difficult undertaking since unintended consequences or side effects may be difficult to detect and since effects may not be immediate. However, we have undertaken several studies of review program effects.

For example, with respect to the Medicare program specifically, a recent survey of several Blue Cross and Blue Shield Plans reported an average four-to-one ratio of savings to costs for hospital reviews and seven-to-one for physician reviews.

A study of the Federal Employee Program indicated that from 1975 through 1978, the number of paid claims for the surgical and diagnostic procedures listed as "not generally useful" by the Blue Cross and Blue Shield Association in the first phase of its Medical Necessity Program declined 26% and 84% respectively.

With respect to the routine admission testing phase of the Medical Necessity Program, a 1981 survey indicated that over 3,000 hospitals in the United States have eliminated or reduced their requirements for routine admission testing as a result of Plan implementation of the policy.

Furthermore, the Oregon Blue Cross Plan has calculated the laboratory costs per diagnosis in the year before and the year after the announcement of its routine admission testing policy. Extrapolating from the Plan's sample, nearly $8 million can be saved annually in Oregon if the policy is fully and effectively implemented.

More generally, in a study done for us at Johns Hopkins University, researchers concluded that Blue Cross Plan utilization review programs were factors in the steady decline in Blue Cross Plan inpatient admission rates during the 1970's.

Senator DURENBERGER. You have been very helpful.

If I can take a 3-minute break before we get to our final panel. They are: Roger Birnbaum, Group Health and president of Rutgers community health plan; David Pockell, regional manager, Kaiser-Georgetown community health plan; and Thomas O. Pyle, Group Health Association of America.

You are welcome to come up and array yourselves. And I will be right back.

[Whereupon, at 11:38 a.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. The hearing will come to order. It is difficult being in three places at one time, and I apologize to those of you who might be inconvenienced by that fact.

Our third panel has already been introduced. And you may proceed in any order. If you don't have a predesigned order, we will go with Roger first.

STATEMENT OF ROGER W. BIRNBAUM, TREASURER, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND PRESIDENT, RUTGERS COMMUNITY HEALTH PLAN, NEW BRUNSWICK, N.J.

Mr. BIRNBAUM. Thank you, Mr. Chairman. My name is Roger Birnbaum, treasurer of the Group Health Association of America, and president of the Rutgers Community Health Plan.

The Group Health Association of America represents over 100 prepaid group practice health plans, a majority of the group and staff model HMO's in the Nation. Our member plans serve approximately 8 million enrollees, 80 percent of the total national HMO enrollment. The Rutgers Community Health Plan is a 6-year-old group practice HMO serving 43,000 enrollees in central New Jersey.

GHAA welcomes the opportunity to testify before the Senate Finance Subcommittee on Health on the subject of prospective reimbursement. Let me state at the outset that HMO's are no stranger to prospective reimbursement. Payment for health services provided by HMO's has always been on a predetermined, prospective basis. But our prospective payment is systemwide; not related to specific procedures or to specific hospital stays. And this has been a major contributing factor to the HMO track record in providing quality, cost-effective health services to their enrolled members.

In fact, this subcommittee recognized the potential offered by HMO's in this respect by recommending that the law be amended to authorize prospective reimbursement under risk-sharing medicare contracts with HMO's at a rate equal to 95 percent of the average cost of providing health services to medicare beneficiaries in the fee-for-service sector, a proposal that has now been passed by the Congress and signed into law by the President.

We deeply share your interest in providing incentives for additional medicare recipients to enroll in HMO's and believe that the new statutory authority will go far in achieving that objective.

We also support additional initiatives contained in the Tax Equity and Fiscal Responsibility Act of 1982 to reward efficient providers of care by developing prospective reimbursement propos-

als to pay hospitals and other institutional providers under medicare. We do have concerns, however, that unless the unique structure of HMO's is recognized and unless HMO's are permitted to maintain their traditional incentive-based design, these proposals could seriously undermine the HMO's ability to achieve their demonstrated cost efficiencies.

Current interest in prospective reimbursement for hospitals is borne out of a recognition that there is a disincentive in the traditional cost-reimbursement-oriented health care system to contain hospital lengths of stay and to provide services in a more cost-effective manner. HMO's, in contrast, are integrated systems that provide as well as pay for a comprehensive range of services. And because their prospectively determined per capita payments cover a broad spectrum of care—ranging from ambulatory services to inpatient hospitalization—they have an incentive to reduce inappropriate hospitalization. Moreover, because the HMO's prospective payment is population-based and covers a virtually complete range of services, their incentives result in controlling admissions as well as lengths of stay. This is in contrast to the per case method of reimbursing hospitals, which may well serve to contain length of stay—the jury is out, as was noted earlier—but, if anything, can provide an incentive to increase admissions.

I would like to comment briefly on the New Jersey experience with respect to DRG's. New Jersey has nine HMO's with a combined enrollment of over 160,000 members. And we have now had 2 to 3 years experience under New Jersey's per case reimbursement system. New Jersey's diagnosis-related group reimbursement system provides that all payers or classes of payers reimburse a hospital on the basis of that hospital's approved rate for each of some 467 different diagnosis-related groups. Payment rates do not vary by lengths of stay as long as the stays fall within designated so-called "trim points." The law provides that payment differentials may be granted to payers, and I quote: "for quantifiable economic benefits rendered to the institution or to the health care delivery system as a whole." But the State's rate setting commission has provided few guidelines for translating the legislative intent of recognizing systemwide benefits offered by a payer, for example HMO's, into preferential reimbursement rates, and has taken a generally conservative approach in considering any deviations from the standard uniform rates.

The outcome of applying DRG reimbursement practices to New Jersey HMO's has been extremely negative. The bottom line so far of the New Jersey HMO experience has been, in fact, an increase in their hospital costs attributable just to the DRG program in the range of 20 to 30 percent, an increase of cost, of course, that we are forced to pass along to the enrolled members of the plan.

But I think even more significant from the standpoint of the committee's interest is that per case reimbursement, which, of course, is based on the average length of stay, neutralizes and even reverses the traditional HMO incentive to reduce length of stay. Why should the HMO, in short, encourage hospital stays that are below the average for a specific diagnosis if it must pay on the basis of the average? More significant yet, per case reimbursement will not only increase costs to the HMO, to their competitive disad-

vantage, but can also increase cost to the health care system overall.

I would just like to read you one sentence from a management letter written to the Rutgers Community Health Plan by our auditors, Touche-Ross, in which they said as follows: "[Under DRG] if pre- or posthospitalization services are currently being provided at the health center, and it is anticipated that a patient will not fall outside the trim points, the plan may want to have such services performed in the hospital rather than the health center, thus resulting in a shifting of costs to the hospital."

Now Touche-Ross was fulfilling their responsibilities in indicating what was appropriate to our HMO as their client in maximizing our cost containment potential, but clearly, their advice would lead to a shift in services to more costly hospital facilities, counter to the objective of cost containing efforts in the health care system overall.

New Jersey's new State health commissioner has recognized that the inequities to HMO's in the DRG system were unintended and has recently proposed to HCFA that certain payers, particularly individual payers and HMO's, be exempt under the medicare and medicaid waivers granted by HCFA for the New Jersey DRG program.

I would like to comment just briefly on HMO hospital reimbursement practices. HMO's, in a competitive market, have been free to negotiate directly with hospitals in ways that serve to maximize their potential cost effectiveness and encourage innovative delivery and reimbursement arrangements.

Most basically, HMO's can and do shop for hospital services on the basis of price, consistent, of course, with their quality standards. In negotiating with hospitals, HMO's can take advantage of the volume of predictable business they bring to the institution, prompt payment terms, and reductions in bad debts resulting from comprehensiveness of coverage (for example, the hospitals have no payments to collect from HMO subscribers because they don't have copayment and deductible provisions). The benefit of progressive HMO efforts to reduce stays and contain costs also are areas within which the HMO can negotiate.

Those HMO's that do not own their own hospitals—that is, those that must negotiate with independent institutions—employ various methods to reimburse the hospitals with which they affiliate depending in part upon the factors that I have noted. And I will just indicate what some of them are. Some HMO's do pay itemized charges, but in many instances they are able to negotiate discounts from those charges. More typically, HMO's have paid an all-inclusive per diem rate, which is a more predictable rate for the HMO. Some HMO's have contracted with hospitals to pay for a given number of beds, whether or not those are utilized. And this gives the hospitals as well as the HMO assurance of predictable revenues and cost.

Still other HMO's reimburse hospitals on a capitation basis, again offering advantages to both institutions and giving the hospitals incentives to contain costs so that they will operate within the limits of that per capita payment.

But regardless of the specific contractual arrangement, HMO's and hospitals cooperate in efforts to share services and optimize the utilization of resources. And some of the specifics of those approaches are also noted in the testimony.

I would just like to summarize by saying that HMO's remain a singular model of innovation and reform in an otherwise cost-reimbursement-oriented health care system. In an industry notably lacking the benefits of a competitive market, with disincentives for consumers, payors, or providers to be concerned about cost effectiveness, HMO's and hospitals have employed considerable creativity in developing financing and delivery arrangements that can benefit the respective institutions, their patients, and the health care system overall.

In developing new cost containment initiatives it is imperative that the design of one such measure does not result in the subversion of another. In the case of the HMO, reliance on its global prospective financing base, which has worked so well, should take precedence over efforts to tamper with any of its individual parts. Limiting the HMO's ability to negotiate directly with hospitals would greatly undermine the HMO's integrated financing and delivery structure and, I think even more important, choke off any future innovative delivery and reimbursement arrangements that can flow out of this negotiating process.

In examining necessary reforms to improve the cost effectiveness of the traditional fee for service sector, we urge that HMO's retain the management flexibility to negotiate directly with hospitals in ways that take maximum advantage of their existing incentives to reduce hospital utilization and contain costs.

Mr. Chairman, I appreciate the opportunity to share our experiences with you this morning. And I would now defer to my colleagues to present their remarks. And then we would be pleased to answer any questions that you may have.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Roger W. Birnbaum and answers to questions submitted by Senators Durenberger and Baucus follow:]

PREPARED STATEMENT OF ROGER W. BIRNBAUM, TREASURER, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND PRESIDENT, RUTGERS COMMUNITY HEALTH PLAN

SUMMARY

- HMOs contribute to cost containment in the health care system overall through their efficient health care utilization patterns resulting in reduction in the use of costly inpatient services, and prospective hospital reimbursement proposals should take advantage of the existing incentives for cost effective HMO/ hospital relationships.

- The HMO's prospective payment system produces incentives to control admissions as well as length-of-stays, while per case hospital reimbursement creates incentives which can help contain length-of-stay but potentially increase admissions.

- By hampering HMO negotiations with hospitals, the New Jersey DRG system has increased HMO hospital costs from 20% - 30% over the past 2-3 years and created incentives counter to traditional HMO practices of providing pre- or post- hospitalization services in their own ambulatory facilities.

- HMOs have developed a variety of mutually beneficial relationships with hospitals, and prospective hospital reimbursement systems should permit HMOs to retain the management flexibility to negotiate such relationships.

Mr. Chairman and members of the Subcommittee, I am Roger Birnbaum, Treasurer of Group Health Association of America (GHAA) and President of the Rutgers Community Health Plan. Group Health Association of America represents over 100 prepaid group practice health plans, a majority of the group and staff model health maintenance organizations (HMOs) in the nation. Our member plans serve approximately 8 million enrollees, 80% of the total national HMO enrollment. The Rutgers Community Health Plan is a six-year old group practice HMO serving 43,000 enrollees in Central New Jersey.

GHAA welcomes the opportunity to testify before the Senate Finance Subcommittee on Health on the subject of prospective reimbursement. Payment for health services provided by HMOs has always been on a predetermined, prospective basis, a major contributing factor to the HMOs' track record in providing quality, cost-effective health services to their enrolled members. This Subcommittee recognized the potential offered by HMOs in this respect by recommending that the law be amended to authorize prospective reimbursement under risk-sharing Medicare contracts with HMOs at a rate equal to 95 percent of the average cost of providing services to Medicare beneficiaries in the fee-for-service sector (i.e., the adjusted average per capita cost, or AAPCC), a proposal that has now been passed by the Congress and signed into law by the President.

We share your interest in providing incentives for additional Medicare recipients to enroll in HMOs and believe that the new statutory authority will go far in achieving that objective.

We also support additional initiatives contained in the Tax Equity and Fiscal Responsibility Act of 1982 to reward efficient providers of care by developing prospective reimbursement proposals to pay hospitals and other institutional providers under Medicare. We do have concern, however, that unless the unique structure of HMOs is recognized and unless HMOs are permitted to maintain their traditional incentive-based design, these proposals could seriously undermine the HMOs' ability to achieve their demonstrated cost-efficiencies.

Current interest in prospective reimbursement for hospitals is borne out of a recognition that there is a disincentive in the traditional cost-reimbursement-oriented health care system to contain hospital lengths-of-stay and to provide services in a more cost-effective manner. HMOs, in contrast, are integrated systems that provide as well as pay for a comprehensive range of services. Because their prospectively determined per-capita payments cover a broad spectrum of care -- ambulatory services as well as inpatient hospitalization -- they have an incentive to reduce inappropriate hospitalization. Moreover, because the HMOs' prospective payment is population-based and covers a virtually complete range of services, their incentives result in controlling admissions as well as length-of-stays. This is in contrast to the per case method of reimbursing hospitals which may help contain length-of stay but, if anything, can provide an incentive to increase admissions.

New Jersey Experience

New Jersey's nine HMOs, with a combined enrollment of over 160,000 members, have now had 2-3 years of experience under New Jersey's per case reimbursement system. New Jersey's DRG (Diagnosis Related Group) reimbursement system provides that all payors or classes of payors reimburse a hospital on the basis of that hospital's approved rate for each of some 467 different diagnosis related groups. Payment rates do not vary by length-of-stay as long as the stays fall within designated "trim points." The law provides that payment differentials may be granted to payors "for quantifiable economic benefits rendered to the institution or to the health care delivery system as a whole," but the State's Rate Setting Commission has provided few guidelines for translating the legislative intent of recognizing system-wide benefits offered by a payor (e.g., HMOs) into preferential reimbursement rates and has taken a generally conservative approach in considering deviations from the standard of uniform rates.

Applying DRG reimbursement practices to New Jersey's HMOs has had extremely negative consequences for these alternative health care systems. The bottom-line of the New Jersey HMO experience to date has been an increase in their hospital costs attributable to the DRG program in the range of 20-30%.

More significant, per case reimbursement, based on average length of stay, neutralizes and even reverses the traditional HMO incentive to reduce length of stay. In short, why should

the HMO encourage hospital stays that are below average for a specific diagnosis if it must pay on the basis of the average? Per case reimbursement will not only increase costs to the HMO, to their competitive disadvantage, but to the health care system overall as well. This was perhaps best expressed by the following recommendation made by the Rutgers Community Health Plan's auditors, Touche Ross & Company, in a recent management letter:

> "(Under DRG) if pre- or post-hospitalization services are currently being provided at the Health Center, and it is anticipated that a patient will not fall outside the trim points, the Plan may want to have such services performed in the hospital rather than the Health Center, thus resulting in a shifting of costs to the hospital."

While the Touche Ross recommendations are clearly appropriate to an HMO attempting to maximize its immediate cost-containment potential, their advice would lead to a shift in services to more costly hospital facilities, clearly counter to the objective of containing costs in the health care system overall.

New Jersey's new State Health Commissioner has recognized the unintended inequities in the DRG system, and has recently proposed to HCFA (the Health Care Financing Administration of Health and Human Services) that individual (i.e., non-group) payors and HMOs be made exempt under Medicare and Medicaid waivers granted for the New Jersey DRG program.

HMO Hospital Reimbursement Practices

HMOs, as model delivery systems in a competitive market, have been free to negotiate directly with hospitals in ways

that serve to maximize their potential cost-effectiveness and encourage innovative delivery and reimbursement arrangements.

In negotiating with hospitals, HMOs can take advantage of the volume of predictible business they can bring to the institution; prompt payment terms; reductions in bad debts resulting from comprehensiveness of coverage (i.e., no payments to collect from the patient) and guarantee of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs such as pre-admission diagnostic testing and early discharge programs.

HMOs (those that do not own their own hospitals) employ various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically they pay a more predictable and cost-based all-inclusive per diem rate; some HMOs contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed "occupancy" in consideration for a preferred rate; still other HMOs reimburse hospitals on a capitation basis, providing greater predictibility of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMOs and hospitals cooperate in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agree-

ments to accept the HMOs' pre-admission testing, utilization review and early discharge programs; and sharing of costly diagnostic and treatment services.

In summary, HMOs remain a singular model of innovation and reform in an otherwise cost-reimbursement-oriented health care system. In an industry notably lacking the benefits of a competitive market, with disincentives for consumers, payors or providers to be concerned about cost-effectiveness, HMOs and hospitals have employed considerable creativity in developing financing and delivery arrangements that can benefit the respective institutions, their patients and the health care system overall.

In developing new cost-containment initiatives it is imperative that the design of one such measure does not result in the subversion of another. In the case of the HMO, reliance on its underlying global prospective financing base which has worked so well should take precedence over efforts to tamper with any of its individual parts. Limiting the HMOs' ability to negotiate directly with hospitals would greatly undermine the HMOs' integrated financing and delivery structure and choke off future innovative delivery and reimbursement arrangements.

In examining necessary reforms to improve the cost-effectiveness of the traditional fee-for-service sector, we urge that HMOs retain the management flexibility to negotiate directly with hospitals in ways that take maximum advantage of their existing incentives to reduce hospital utilization and contain costs.

Mr. Chairman and members of the Subcommittee, we appreciate the opportunity to share our experience and views with you this morning. I would be pleased to answer any questions.

11-627 0 - 83 - 10

group Health association of america, inc.

October 7, 1982

Mr. Robert E. Lighthizer
Chief Counsel
Senate Finance Committee
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lighthizer:

Enclosed are the responses to the questions forwarded to me by Senators David Durenberger and Max Baucus in connection with the hearing before the Subcommittee on Health on September 16, 1982, at which our panel of witnesses testified.

Please contact me if any further information is needed.

Sincerely,

Candace Keller
Legislative Counsel

CK/va
Enclosures

Group Health Association of America

1. You suggested that prospectively established rates are an efficient method of reimbursement, insuring efficient use of services. On what basis (costs, etc.) do you establish your rates?

HMO rates are established by projecting costs and revenues and taking into consideration the market impact. A tolerable level of rate increase is established by assessing the market. Revenues are then projected by forecasting membership growth and calculating the premium income for the coming year based upon present year rates. Anticipated costs are estimated. Any shortfall between the revenue projection and cost estimate must be generated through increased premiums. The least predictable costs are hospital utilization and referrals to physicians outside of the HMO. Where the projected premium increase is not at a competitive level, increased efficiency is sought in these areas. The bottom line of the overall program, then, provides the discipline which produces increased efficiency in health care delivery at competitive rates. Fee-for-service providers are not so constrained and therefore do not engage in this process.

2. What value do you see in a prospective versus a retrospective system of reimbursement?

If the question concerns the value of prospective budgeting for HMOs, the primary value is that HMOs must operate within the limits of a predetermined revenue base and must, therefore, have systems to assure the cost effective delivery of high quality care. Retrospective budgeting (based on a fee-for-service system) does not provide this incentive to contain costs.

If the question concerns the value of prospective budgeting for hospitals from the perspective of HMO negotiations, the central point is that competition can be used as a lever in hospital negotiations only if a prospective system of reimbursement is used. This is the case where per diem, per capita or per unit rates are used. The volume of services which an HMO may purchase must be estimated; such prospective rates provide a much greater degree of predictability in costs. Negotiations in this context permit HMOs to maximize bargaining power with the hospitals in their service areas based upon such factors as the HMO's ability to negotiate on behalf of blocks of patients and/or for blocks of beds, the hospitals' occupancy rates, et al.

3. How often do you have open enrollment? How is this influenced by your price negotiations with institutions?

Open enrollment is conducted annually for new members of existing groups. In other respects, HMOs also follow customary industry standards. The frequency of open enrollment periods is not influenced by hospital price negotiations but rather by statutory requirements and the usual practice in the marketplace.

4. The Blues place a strong emphasis on the art and process of price negotiation. On what basis do you begin your negotiations? Historical prices? Cost? Is it generally related to the institution's own past behavior or of the industry on average?

Each negotiation is an individual situation affected by all factors upon which the bargaining positions of the parties depend. Historical prices, the institution's own past behavior and prices charged by other institutions are all relevant. In many states, HMOs cannot get access to hospital cost data. However, where such data is available, it is valuable and is used in negotiations. In any negotiation, the parties use their size and strength to arrive at the most advantageous agreement possible.

5. If cost is not involved, what basis is used to establish the highest acceptable vs. the lowest possible charges for your negotiator?

Where hospitals of equivalent quality are competing with one another for business, a wide variety of factors might prompt a hospital to alter its charges to an HMO and might be kept in mind by the HMO negotiator. Comparisons among hospitals must recognize that the institutions may be building their charges on different unit bases. Where an all inclusive per diem rate is used, it is usually cost-based, and cost might also be a factor in bargaining, if cost data is available. However, while cost may be a factor, it will not be the controlling factor, since the character of the marketplace, the relative positions of the parties, the service or services bargained for and their relationship to the hospital's bottom line and a host of other elements will have a strong impact on the negotiation. No bargaining occurs unless more than one hospital of acceptable quality is involved, and when this occurs, all parties bargain with their overall best interests in mind.

6. Do you negotiate lower prices with non-profit facilities or is a return on equity allowed for all your providers?

Bargaining occurs to arrive at the best possible price irrespective of the non-profit or for-profit status of the hospital. The status of the hospital has no impact upon negotiations.

7. Do non-profit vs. for-profit, rural vs. urban, or teaching vs. non-teaching providers pose any particular difficulties in negotiating payments? What are they?

Rural and non-teaching hospitals generally have a lower cost structure than urban and teaching hospitals respectively. These and other differences do not produce any particular difficulties in the conduct of negotiations, and it is the competitive situation or lack of it which will be the source of any problems. Again, there is no distinction between non-profit and for-profit hospitals based upon their tax status.

8. Do you feel any reimbursement in which Medicare negotiates prices independent of the rest of the industry adversely affects the HMO industry?

To the extent that such a separate system of negotiation results in an underpayment by Medicare (a payment set at less than cost) which hospitals recoup through higher charges to other payors, HMOs are disadvantaged in the same way as other private sector payors.

This is the extent of the impact upon HMOs which are reimbursed by Medicare on a cost-basis. Under cost-based contracts with HMOs, Medicare continues to reimburse hospitals directly or will do so at the HMO's election.

However, there may be special implications for HMOs which elect risk-based Medicare contracts. Where payment to the HMO is based upon 95% of the cost of providing care in the non-HMO sector, reductions in Medicare reimbursement rates which do not reflect increased efficiency in the delivery of services will in time reduce the prospective payment to a level against which the HMO cannot compete. The HMO's rate reflects the delivery of high quality health care in a cost effective manner. Where efficiencies cannot be achieved in this context, HMOs cannot compete with cost reductions.

Under a DRG-based system, since the norms used are not based upon HMO performance, the Medicare rates upon which the prospective HMO payment is based may be arbitrarily high or low vis-a-vis the HMO's enrolled population and will increase the HMO's difficulty in determining in advance whether it can compete under the rate. To the extent that even the DRG rates are consistently lower than the HMO can negotiate independently and to the extent that they reduce the prospective HMO payment in a manner that cannot be matched through increased efficiency, the HMO's inability to compete is again at issue. Under a DRG-based system for Medicare, the prospectively reimbursed HMO's bargaining position with hospitals with respect to services provided to its Medicare population is likely to be quite unpredictable and may constitute a significant disincentive for HMOs to elect risk-based contracts.

9. How would you suggest we avoid harming HMOs when we create a prospective payment system?

HMO negotiations with hospitals reflect the exercise of bargaining power which grows from their structure as prepaid comprehensive health care delivery systems and reflects their internal incentives to provide services in a cost effective manner. The unique character of these negotiations produces the kind of cost effective responses which legislators and policymakers are seeking therefore, prospective hospital payment systems should avoid disruption of HMOs current freedom to negotiate favorable rates. In an all payor prospective payment system, such as one based upon DRGs, inclusion of HMOs creates a disincentive to maximize HMO efficiencies. When a DRG-based or similar system is applied to Medicare alone, it is Medicare which will pay the DRG rate despite an average length of stay for HMO patients which is consistently lower than average or the performance of tests in the HMO's outpatient facilities which are ordinarily performed in an inpatient setting by fee-for-service providers. Special problems are posed by risk-based HMO contracts with Medicare, and these require further study. One response is that HMOs should not be required to participate in such a system, since their bargaining already reflects the incentives the new system is designed to create. We are willing to work with the Subcommittee on seeking other solutions which preserve the benefits of HMO negotiating flexibility.

STATEMENT OF DAVID POCKELL, REGIONAL MANAGER, KAISER-GEORGETOWN COMMUNITY HEALTH PLAN, INC., WASHINGTON, D.C.

Mr. POCKELL. Mr. Chairman, my name is David Pockell, and I am vice president of Kaiser Foundation Health Plan, and vice president and regional manager of Kaiser-Georgetown Community Health Plan. By way of further introduction, I should tell you that I have functioned for some 10 years of my career as a hospital administrator, and see this issue from a variety of perspectives.

I won't describe the Kaiser Foundation health plan to you. I am sure you are familiar with it. Except that I will indicate that the vast majority of our health plan members in our larger regions are served by hospitals owned and operated by Kaiser Foundation Hospitals. The exceptions are the smaller regions in Colorado, Texas, Connecticut, and here at Kaiser-Georgetown.

Today, I would first like to address my remarks to the hospital reimbursement experience of Kaiser-Georgetown Community Health Plan, a health maintenance organization which does not own or operate its own hospital. I will next briefly describe some problems with existing prospective payment systems.

The Kaiser-Georgetown Community Health Plan is a federally qualified HMO, which provides and arranges for health care services on a prepaid basis to approximately 75,000 voluntarily enrolled members. Uniquely, it functions in three legal jurisdictions: The District of Columbia, the State of Maryland, and the commonwealth of Virginia.

Ambulatory services are provided at five medical facilities operated by Kaiser-Georgetown that are located throughout the metropolitan Washington, D.C. area. A sixth facility will open in Maryland in November.

Since the program does not own or operate its own hospitals, it arranges inpatient care for members at hospitals in the community.

In two of the three jurisdictions in which we function, Virginia and the District of Columbia, we are free to negotiate rates with individual hospitals with no legal constraints. There is a considerable amount of give-and-take in those negotiations. We have found that we have received some special consideration in rates and are now beginning to achieve considerably better experience. This is in part, we believe, because our growth has been considerable in this area, and because hospitals recognize the value of dealing with an organization that can provide them with a sizable patient population.

We believe also that our willingness to openly discuss the issue of cost while negotiating with hospitals—not to pretend that it's not an important issue in the relationship between health care organizations—assists us in strengthening our economic position with the hospitals.

However, in Maryland where hospital rates are controlled by the State's health services cost review commission, Kaiser-Georgetown has had no success in negotiating any sort of special provision. I should add that Maryland does not have a system of DRG's similar

to the one that Mr. Birnbaum mentioned in New Jersey. We are very grateful for that.

However, the system, although it appears to have the effect of controlling hospital costs, does have an inadvertently negative effect on our organization's ability to accomplish open negotiations with the hospitals about rates. With limited exceptions, hospitals are not allowed to recoup revenue losses that would result from such discounts.

The commission is empowered to grant hospital discounts under very special circumstances, but few third party payors can qualify. The commission requires any third party payor that wants to obtain a discount from a hospital to hold an open enrollment period of 30 days without any medical screening. To ameliorate this requirement, third party payors are allowed to exclude coverage for preexisting conditions for up to 1 year. They are also permitted to impose other limits on coverage, such as deductibles and other barriers to the provision of services, to protect them from high enrollments of people who might be high utilizers and who might join those plans during the open season.

The situation with the HMO, as you know, does not allow for nor do I believe that HMO's philosophically agree with those kinds of barriers. So the open enrollment period would expose HMO's to a tremendous risk of adverse selection and make the economic value of the discount that would be permitted under those circumstances very questionable.

As of this time, only a few organizations have taken advantage of the discounts and most of those have been indemnity or service benefit carriers that could put the barriers in the way of utilization.

We believe that were we able to freely negotiate with hospitals in suburban Maryland, the fact that we have a considerable amount of patient load and the fact that we will probably spend somewhere between $3 and $4 million in one hospital would certainly demonstrate to a hospital that there might be some reason that they would be willing to perform in a businesslike manner to attract our patient load, all other things being equal.

Very simply put, were it not for the current reimbursement system in Maryland, we would achieve substantial savings due to our purchasing power. In our case, the system artificially—and I believe unintentionally—thwarts the full realization of the benefits of the marketplace. I also believe that that negotiation process has benefits for the hospital, and when it recognizes the benefits and the give and take of negotiation, it is willing, under most circumstances, to come up with some economic reward.

My colleague, Mr. Birnbaum, already has done an excellent job of describing potential negative consequences for HMO's of a mandated prospective hospital payment system based on DRG's.

I want to add emphasis to his observation. The purchase of discrete hospital services on a per admission, per diem, or per service basis, regardless of the intent, can create incentives for unnecessary admissions, extending lengths of stay or provision of unnecessary services. This can occur whether the payments are made prospectively or retrospectively. On the other hand, when payment is made for a comprehensive set of services, including inpatient hospi-

tal service and ambulatory services, on a prospective capitation basis these incentives are eliminated. The leading example of this method of payment is the health maintenance organization. Its method of payment and benefits provide incentives for the most appropriate use of resources.

The HMO medicare payment legislation recently enacted by Congress represents the best way for medicare to purchase services for its beneficiaries. By prospectively paying HMO's for medicare part A and part B services on a capitation basis, incentives are created to use resources efficiently and, in the case of hospital use, to admit only when medically necessary and appropriate.

As the Congress considers prospective hospital payment proposals, it will have to choose from a large number of options. Some of the options and the way they are applied may have an adverse impact on HMO's. Such an impact should be avoided if at all possible. We offer to provide you and your subcommittee with our advice on the options presented, and the potential impact on HMO's and HMO hospitals.

[The prepared statement of David G. Pockell follows:]

PREPARED STATEMENT OF DAVID G. POCKELL, VICE PRESIDENT AND REGIONAL MANAGER, KAISER-GEORGETOWN COMMUNITY HEALTH PLAN, INC.

SUMMARY OF TESTIMONY
PRESENTED BY KAISER FOUNDATION HEALTH PLAN, INC.
SEPTEMBER 16, 1982

- The Kaiser-Georgetown Community Health Plan is a federally qualified Health Maintenance Organization (HMO) which provides and arranges for health care services on a prepaid basis to approximately 75,000 voluntarily enrolled members in the District of Columbia, Maryland and Virginia. Since the Program does not own or operate its own hospitals, it arranges inpatient care for members at hospitals in the community.

- In two of the three jurisdictions we serve, Virginia and the District of Columbia, Kaiser-Georgetown is free to negotiate rates with individual hospitals. During the past year, the Program had limited success in negotiating discounts because the inpatient volume we were able to project was insufficient to induce hospitals to give significant discounts.

- In Maryland, where hospital rates are controlled by the state's Health Services Cost Review Commission, federally qualified HMOs are not able to avail themselves of hospital discounts enjoyed by indemnity insurers, Cross-Blue Shield, Medicare, and Medicaid. This places federally qualified HMOs at a competitive disadvantage.

- Any mandated prospective hospital payment system based on Diagnostic Related Groups (DRGs) may have negative consequences for HMOs that must purchase hospital services, and could neutralize their cost-effectiveness.

- When payment is made for a comprehensive set of services, including inpatient hospital services and ambulatory services, on a prospective capitation basis, the incentive to use resources unnecessarily is eliminated. The leading example of this method of payment is the Health Maintenance Organization. Its method of payment and its benefits provide incentives for the most appropriate use of resources.

- As Congress considers prospective hospital payment proposals, it will have to choose from a large number of options. Some of the options and the way they are to be applied may have an adverse impact on HMOs. Such an impact should be avoided if at all possible. We offer to provide you and your subcommittee with our advice on the options presented and their potential impact on HMOs and HMO hospitals.

- The HMO Medicare payment legislation recently enacted by Congress embodies the kind of payment system that maximizes efficient use of resources. It is the best way for Medicare to purchase services for its beneficiaries. Kaiser Foundation Health Plan believes improvement of the Adjusted Average Per Capita Cost (AAPCC) accuracy is an extremely important undertaking, and we urge the Department of Health and Human Services to dedicate appropriate resources to insure the task is completed as soon as possible.

Statement of

Kaiser Foundation Health Plan, Inc.
Before the Subcommittee on Health
of the Committee on Finance,
U. S. Senate

September 16, 1982

Mr. Chairman and Members of the Committee: I am David G. Pockell, Vice President of Kaiser Foundation Health Plan, and Vice President and Regional Manager of Kaiser-Georgetown Community Health Plan.

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and eight independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. The Program is an economically self-sustaining, organized health care delivery system that provides health services on a prepaid, direct-service basis to over four million members in California, Connecticut, Colorado, the District of Columbia, Hawaii, Maryland, Ohio, Oregon, Texas, Virginia, and Washington. Kaiser-Permanente members receive services through 30 hospitals, 75 outpatient facilities, more than 4,200 full-time physicians and over 37,000 employees.

Today I will first address my remarks to the hospital reimbursement experience of the Kaiser-Georgetown Community Health Plan, a health maintenance organization (HMO) which does not own or operate its own hospitals. I will next briefly describe some problems with existing prospective payment systems and conclude with brief comments on the HMO Medicare payment legislation

recently enacted by Congress.

The Kaiser-Georgetown Community Health Plan is a federally qualified HMO which provides and arranges for health care services on a prepaid basis to approximately 75,000 voluntarily enrolled members in the District of Columbia, Maryland and Virginia. Ambulatory services are provided at five medical facilities located throughout the metropolitan Washington, D.C. area. A sixth facility will open in Maryland in November. Since the Program does not own or operate its own hospitals, it arranges inpatient care for members at hospitals in the community.

In two of the three jurisdictions we serve, Virginia and the District of Columbia, Kaiser-Georgetown is free to negotiate rates with individual hospitals. During the past year, the Program had limited success in negotiating discounts because the inpatient volume we were able to project was insufficient to induce hospitals to give significant discounts. Recently we have experienced an improvement in our bargaining position as our Health Plan membership has grown. Also, we believe our willingness to discuss cost openly in our negotiations with hospitals has strengthened our position.

In Maryland, where hospital rates are controlled by the state's Health Services Cost Review Commission, Kaiser-Georgetown has had no success in negotiating discounts. With limited exceptions, hospitals are not allowed to recoup revenue losses that would result from such discounts. The Commission is empowered

to grant hospital discounts under circumstances which permit few third party payors to qualify. The Commission requires third party payors to conduct an annual open enrollment period of thirty days without medical screening. To ameliorate this requirement, third party payors are allowed to exclude coverage for pre-existing conditions for up to a year. In addition, they are permitted to impose a thirty-day limit on coverage for inpatient admissions, and may impose coinsurance provisions up to 20 percent of covered charges. Further, third party payors may require patients to pay certain deductibles. Because federally qualified HMOs are precluded by law from utilizing most of these protective measures, the potential adverse selection resulting from an annual open season without such protection would far outweigh the advantages of any discount obtained.

Only a few indemnity insurers, Blue Cross-Blue Shield, Medicare and Medicaid have been able to obtain discounts. This places federally qualified HMOs at a competitive disadvantage. In addition, since this reimbursement system precludes mutually advantageous relationships between HMOs and hospitals, significant savings are lost. For example, this year Kaiser-Georgetown will reimburse hospitals $3-4 million for patient care services in Maryland. Were we able to negotiate a discount, our need to increase members' rates would be reduced.

To put it simply, were it not for the current reimbursement system in Maryland, we could achieve substantial savings using our

purchasing power. In our case, the system artificially thwarts the full realization of the benefits of the marketplace.

My colleague Mr. Birnbaum already has done an excellent job of describing potential negative consequences for HMOs of mandated prospective hospital payment systems based on DRGs. I want to add emphasis to his observations. The purchase of discrete hospital services on a per admission, per diem, or per service basis, can create incentives for unnecessary admissions, extended lengths of stay, or provision of unnecessary services. This can occur whether the payments are made prospectively, or retrospectively. On the other hand, when payment is made for a comprehensive set of services, including inpatient hospital services and ambulatory services, on a prospective capitation basis, these incentives are eliminated. The leading example of this method of payment is the health maintenance organization. Its method of payment and its benefits provide incentives for the most appropriate use of resources.

The HMO Medicare payment legislation recently enacted by Congress represents the best way for Medicare to purchase services for its beneficiaries. By prospectively paying HMOs for Medicare Part A and Part B services on a capitation basis, incentives are created to use resources efficiently, and in the case of hospital use, to admit only when medically necessary and appropriate.

As the Congress considers prospective hospital payment proposals, it will have to choose from a large number of options.

Some of the options and the way they are to be applied may have an adverse impact on HMOs. Such an impact should be avoided if at all possible. We offer to provide you and your subcommittee with our advice on the options presented and their potential impact on HMOs and HMO hospitals.

Since the HMO Medicare payment legislation contains most of the features necessary to encourage HMO participation in Medicare, I will conclude my remarks with comments on two issues germane to the legislation.

First, the legislation mandates improvement of the methodology for calculating the Adjusted Average Per Capita Cost (AAPCC), to insure its accuracy. Kaiser Foundation Health Plan believes this is an extremely important undertaking, and we urge the Department of Health and Human Services to dedicate appropriate resources to the task so that it can be completed as soon as possible. We have already dedicated considerable resources to this task. A representative of our Program is serving on the task force convened by the Health Care Financing Administration (HCFA) to improve the AAPCC. In addition, Kaiser Foundation Health Plan has submitted a proposal for a HCFA demonstration, which, among other things, would test improvements to the AAPCC Calculation.

Finally, I would like to bring to your attention an omission in the legislation. The new law denies HMOs that have contracted to provide Medicare services on a risk basis, the opportunity to avail themselves of the Medicare hospital discount enjoyed by HMOs

with cost-based contracts. Currently, an HMO with a cost-based Medicare contract has two reimbursement options. It may elect to have HCFA pay hospitals directly for hospital services used by patients of the HMO, in which case the amount is deducted from the monthly payment to the HMO. Or it may accept a full monthly payment from HCFA for all services provided, and have the freedom to negotiate more favorable rates with individual hospitals.

An HMO with a risk-based contract, on the other hand, does not have the option of having HCFA pay hospitals directly. It must accept a total monthly payment from HCFA, and then attempt to negotiate rates with hospitals which may often be higher than those paid by Medicare. It is very important, especially for HMOs like Kaiser-Georgetown that do not own or operate their own hospitals, to have this option. Without the option, risk-based HMOs are at a competitive disadvantage.

Mr. Chairman, I appreciate this opportunity to share these observations with you. I would be happy to answer any questions.

STATEMENT OF THOMAS O. PYLE, VICE PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND PRESIDENT, HARVARD COMMUNITY HEALTH PLAN, BOSTON, MASS.

Senator DURENBERGER. Mr. Pyle.

Mr. PYLE. My name is Tom Pyle. I am president and chief executive of the Harvard Community Health Plan, as well as vice president of Group Health Association of America.

The Harvard plan, a staff model HMO, serves nearly 130,000 members in greater Boston, most of them not from Harvard University. We enroll employees from over 1,700 employer groups. About 90 percent of our enrollment comes from that source. About 8 percent of our members are nongroup members. In addition, we enroll medicaid recipients; about 2 percent of our members are in that category. We also have a small program for the working poor subsidized by our other members.

We have our own hospital for approximately 25 percent of our hospitalizations, the simpler stuff, and we make significant use of seven other hospitals, six of which are Harvard teaching hospitals, for the remainder of the hospital care.

Our arrangements with these hospitals span charges, cost reimbursement, negotiated fixed price per day, capitation, and per episode payment. In one case, we make a capacity guarantee to the hospital. In several cases, we have more than one arrangement with a given hospital.

I think that pattern of reimbursement reflects our belief that the current pattern of pure cost reimbursement is one of the major sources of soaring hospital expenditures. We have a system in which you get paid what you spend in essence. Although many preliminary steps have been taken to correct this, I would submit that the playing field is currently underwater to pick up the analogy of earlier statements.

It seems to me there are three ways to consider achieving hospital cost reduction. One way would be a Government sponsored regional hospital system that would plan, coordinate, and operate hospitals to assure effective interinstitutional management. Such a solution would be very difficult to implement since it would involve leveling some of the current players and would involve the taking of private property.

The problem with the second way, increased regulation, is that it is usually ineffective in controlling behavior in complex environments where there are a large number of variables and it's very hard to anticipate all the ways they might interact. I think this can be illustrated by two things. One is if you think about the chaos that can be caused by a work-to-the-rule strike. If you would like a simpler kind of situation, just think about trying to get an unwilling teenager to do his or her homework by setting down a set of rules. It generally doesn't work; they don't want to do it.

Senator DURENBERGER. It sure helps. [Laughter.]

Mr. PYLE. The third possibility is to create a reimbursement system with financial incentives for a hospital to change its spending patterns. I have tried to divide this concept of incentive into two types: Bargained incentives and formula incentives.

Bargained incentives occur simply when two parties make an agreement in a buyer-seller type of relationship. In this kind of relationship the buyer has the incentive to make sure that the seller lives up to what the seller promised. Unfortunately, there are not many payors for hospital services who are really buyers in the traditional sense.

Insurance companies, almost by the very nature of what they do, are prevented from dealing aggressively on hospital bills because everytime they deal aggressively, they are taking away what they were guaranteeing to their customer. Withholding or reducing payment would obligate the customer, the insured, to pay the bill. Even the self-paying patient doesn't represent a normal buyer because the physician makes the decisions about what services are going to be utilized.

I think the great advantage of the HMO is that it integrates the paying and doctoring functions, and so we really are buyers. As has been noted, we have this capacity to move business around, if you will, blocks of beds that are being used, from one hospital to another. In this way we can stimulate people to accept bargained incentives. I think we are the only payers in the health care industry at the moment that can do that. As such, we not only have a part in serving our own members, but we can influence the hospital system and create the kind of economic behavior we would all like to see.

There has been a lot of talk this morning about cost shifting. I have a slightly different view of it. Narrowly defined, the way it

has been, cost shifting goes on all over our economy. That's the way the economy works. People bargain for a variety of things.

When I talk about what an HMO does, I am assuming that when we push on price, ultimately, the hospital has to push on costs or they will go bankrupt unless all of the other players in the game want to be entirely passive. We are doing that kind of pushing by moving business around or threatening to move business around, and I think that our pushing ultimately—not necessarily over the short term—leads to efficient capacity utilization in decisions by the hospital system. This is above and beyond and should not be confused with the HMO savings created by using less days in the hospital or by reducing the number of admissions. I think we play a role in pressing the hospitals into being efficient, and I don't think they will be efficient if they aren't pressed in that way.

This has been objected to because it really corrupts the level playing field concept. I would suggest that if you go out and try to buy health insurance or life insurance, it is very hard to find a level playing field. There are not regulated rates in those fields.

Because there are no true buyers other than HMO's, formula incentives, however, do have to be used in this field. These are not as effective as bargained incentives. They really constitute regulations. But they are the best thing that we have at the moment.

I think that in developing these it should not be done like a cookbook. A mandate to reduce expenditures expressed in broad terms would be more effective than some highly specific formula which very often becomes quite disfunctional over time. The Government ought to have full discretion to develop and modify the rules as needed.

While this flexibility and exercise of judgment can present extreme administrative difficulties, I think that rigid rules almost always guarantee perverse results.

Massachusetts recently enacted legislation intended to move away from cost reimbursement to a methodology based on incentives. This legislation began as an initiative of the Business Round Table responding to increases in the health care costs and in the premiums of the policies that they provide for their employees. As they moved into this field and took a very strong legislative initiative, they were rapidly joined by the traditional health players, the hospitals, the insurers, and so on—a group that I sometimes call the spirits of Christmas past in this field.

Compromise legislation was fashioned, and I think it is probably pretty good legislation although it is very hard to understand. Unfortunately, HMO's were excluded from the legislative process. I don't think this is surprising since we are not part of the establishment in this field, and you have heard other indications of that kind of exclusion here today. As a result, the legislation as it came out seems to prevent HMO's from using their bargaining powers to negotiate reimbursement arrangements with hospitals on some basis other than the payment of full charges. Specifically, there is one provision in the legislation which says that any company authorized to sell accident and health insurance under chapter so-and-so, which is a nonprofit hospital corporation or health maintenance organization, may apply to the rate setting commission for a

reduction in the charges it would otherwise be required to pay under sections 53 to 57, inclusive.

It then says later that if the commission finds that the applicant has implemented an activity or program resulting in quantifiable savings to hospitals, they can get the discount. What that says is that we ought to be managing their businesses rather than our own because they are the ones that ought to produce the savings beyond what we produce ourselves.

This legislation, which isn't entirely clear—and there are different interpretations of it—was interpreted by the president of the Massachusetts Hospital Association in a letter to all hospitals in the State in which he wrote:

> All HMO's must be able to defend in objective terms any discount from charges they get from hospitals. This seems like a protection for our hospitals because it will prevent situations like those now occurring in Minneapolis-St. Paul, southern California and other areas where HMO's are leveraging discounts out of the hospitals.

God forbid they should spread to the East.

Fortunately, with the help of the Department of Health and Human Services—and this started with the Director of the HMO program and moved up to the Assistant Secretary for Health Planning, and finally to the Secretary—when the waiver was granted, there was a condition on it that this legislation could not disadvantage HMO's. That was extremely important. I feel that we are in a much better position today, but that perhaps won't be possible in other legislation that gets passed. I think this is a real danger to HMO's, and ultimately, to the whole system.

It now appears that the Massachusetts' law will be amended to fix this, and I think that in other respects the experiment is probably quite promising. I hope that this kind of disincentive can be kept out of legislation elsewhere in the country.

Returning for just a moment to this cost-shifting argument, I think that the cost shifting argument may be quite real with statutory discounts. That's very different from a discount that arises from the interaction between a willing buyer and a willing seller, and I don't think the hospitals really need to be protected from it.

Regarding the incentive system itself that might accompany future legislation, I caution you to keep it simple if at all possible. The Massachusetts legislation is so complex it is hard to understand, and we have had a good deal of trouble finding anyone who could really explain it to us. I am told by the hospital people that without resorting to computer modeling, which they are now actively engaged in, it will be difficult for a hospital to figure out what operational changes will be needed to keep it fiscally sound. It will be even more difficult to predict whether the changes will be those intended or a totally different set.

Whatever system is ultimately chosen, it should encourage experimentation and variation, and should continue to preserve the ability of the participants to do what I call hondling. This bargaining is terribly important because it does produce new variations which may ultimately permit the creation of other buyers or buyer surrogates who can do the same kind of job that HMO's are able to do at the present time. I think the preferred provider concept may be one example of that.

While HMO's have a unique position at the present time, we represent a minority market segment. I think we can stimulate the hospitals, but I don't think that we can be a controlling force in changing their behavior. We need company in doing this.

I thank you for the opportunity to share my thoughts with you.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Thomas O. Pyle follows:]

TESTIMONY OF THOMAS O. PYLE
PRESIDENT, HARVARD COMMUNITY HEALTH PLAN, INC.
BEFORE THE HEALTH SUBCOMMITTEE OF THE FINANCE COMMITTEE
OF THE UNITED STATES SENATE

September 16, 1982
Washington, D.C.

SUMMARY

- HMOs are the only class of hospital payor with the present capacity to bargain effectively with hospitals.

- The new reimbursement system should not damage HMOs' capacity to bargain with hospitals and to act as catalysts in changing hospital behavior.

- The new system should be simple and should provide regulators with broad goals rather than rules carved in stone.

Mr. Chairman and members of the Subcommittee:

My name is Thomas O. Pyle and I am the President of the Harvard Community Health Plan, Inc., a staff model HMO serving nearly 130,000 members in greater Boston. The Harvard Plan enrolls employees from over 1,700 employer groups and has enrolled a large non-group population. In addition, we enroll Medicaid recipients and subsidize a program for the working poor.

I am also Vice President of the Group Health Association of America. I am pleased to appear before you today to share with you briefly some of my thoughts concerning prospective reimbursement of hospitals.

We all know that the current pattern of cost reimbursement is one of the causes of soaring hospital expenditures. To reduce hospital costs, or at least to moderate the rate of increase, this method of reimbursement will have to be replaced. The question is no longer whether but when and with what.

There are three ways to consider achieving hospital-cost reduction: One way is to establish a government-operated, regional hospital system that would plan, coordinate, and operate hospitals to assure effective inter-institutional management. Such a solution would be very difficult to implement.

A second way is through increased regulation. The problem with regulation is that it is usually ineffective in controlling behavior in complex environments, i.e., where there are a large number of variables and it is impossible to anticipate all the ways they might interact.

A third possibility is to create a reimbursement system with financial incentives for a hospital to change its spending patterns. There are really two kinds of incentives: bargained incentives and formula incentives.

Bargained incentives play out in a dynamic way between two parties in a buyer-seller relationship. The buyer, with one set of incentives, is half of this relationship, bargaining to get what he wants and measuring performance against expectations. Unfortunately, while there are many payors for hospital services, there are few buyers in the traditional sense. Insurance companies pay hospital bills, but their obligation to the individuals they insure prevents them from dealing aggressively on hospital bills. Withholding payment would obligate their customer to pay the bill. Even the self-paying patient does not represent a normal buyer. The physician rather than the self-paying patient determines what services will be ordered.

The HMO integrates the paying and doctoring functions. It is a buyer. Through its capacity to move business (blocks of patients) from one hospital to another, an HMO can stimulate hospitals into accepting bargained incentives. It is probably the only payor in the health care industry that can. As such, HMOs have a part to play beyond serving their own members -- influencing the hospital system and creating the kind of economic behavior we would all like to see.

Because there are no true buyers other than HMOs, formulae incentives must be used for other payors. These are not as effective as bargained incentives. They really constitute regulation, but they are the best thing we have at the moment. The regulatory authority that controls these incentives should not be given a cookbook. A mandate to reduce expenditures expressed in terms of broad goals would be more effective. The authority should have full discretion to develop and modify the rules as needed. While this can present difficulties, rigid rules almost guarantee perverse results.

Massachusetts very recently enacted legislation intended to move away from cost reimbursement to a methodology based on incentives. This legislation was enacted with the cooperation of a coalition where business joined forces with Blue Cross, insurers and the hospitals to fashion a

compromise. There was no analysis of the effect of this legislation on HMOs, nor any attempt to use the natural incentives within an HMO to best advantage in fashioning the bill. In fact, the legislation seems to prevent HMOs from using their bargaining power to negotiate reimbursement arrangements with hospitals on some basis other than the payment of full charges. What the Massachusetts law provides in the way of incentives through complex formulae and calculations, HMOs can provide quite naturally across the bargaining table with a hospital. At least one of the parties to these negotiations thought this legislation would benefit hospitals at the expense of HMOs (and their members). The President of the Massachusetts Hospital Association, in a letter to all the hospitals in the state, wrote: "All HMOs must be able to defend in objective terms any 'discount' from charges they get from hospitals. This seems like a protection for our hospitals because it will prevent situations like those now occurring in Minneapolis/St. Paul, Southern California and other areas where the HMOs are levering discounts out of hospitals."

Fortunately, with the intervention of the Department of Health and Human Services, it appears that the Massachusetts law will be amended to assure that HMOs attain the independent right to contract with hospitals in innovative ways. I hope the Medicare incentive system you're considering will be kept free of the disincentives that were almost established in Massachusetts.

Regarding the incentive system itself, I caution you to keep it simple if at all possible. The biggest drawback of the Massachusetts law is its complexity. Without resorting to computer modeling, it will be difficult for a hospital to figure out what operational changes will be needed to keep it fiscally sound; it will be even more difficult to predict whether the changes will be those intended or a totally different set.

Whatever system is ultimately chosen, it should allow experimentation and variation. Perhaps some of these variations will lead to the creation of other buyers or buyer surrogates. HMOs are likely to represent a minority market segment for a long time. As such, they can be a catalyst but not a controlling force, and need company in dealing with hospitals on a give-and-take, willing buyer/willing seller basis.

Thank you for this opportunity to share my thoughts with you this morning. I am, of course, happy to answer any questions.

Senator DURENBERGER. Mr. Birnbaum, in your testimony where you are talking about the negotiating process you mentioned prompt payment terms, which was the only thing that the commercial insurers felt provided them with any negotiating leverage. But you also talked about volume, and you talked about reduction in bad debts, the guarantee of eligibility, preadmission diagnostic testing, early discharge programs, and a variety of other things.

In your opinion, is that kind of leverage available to those in the system other than the HMO's?

Mr. BIRNBAUM. I think not in the current system because the HMO, uniquely can direct patients to an institution. We control the paying mechanism as well as the provider mechanism to them. When we sit with a hospital, we sit really as a spokesperson for our physicians as well as exercising the leverage that we have as administrators.

Just because of the way the traditional system is structured, there is more of an arm's length relationship between your typical third party payer and the provider, with the exception of the preferred provider arrangements which are now generating increasing interest. I think most third party payers simply don't have that linkage that enables them to sit across the table with a hospital administrator and talk about the kinds of volume and the case mix and other cooperative arrangements. We have one of our hospitals, for example, administering a laboratory for us. And I think there can be arrangements back and forth that as payer providers we can uniquely develop with participating institutions.

Senator DURENBERGER. Mr. Pockell, I wonder if you would take this a step further and talk to us about your experiences in the D.C. area—you have been here approximately 2 years, I guess--and how you use this leverage in the negotiating process. Also, who else in the area uses such leverage? There is some competition.

Mr. POCKELL. Yes. There are three other group practice HMO's in the area. One of them is linked rather closely to a university hospital and I would suspect has less leverage in dealing with it, although I don't really know. The other is in a similar situation to ours.

It's really very interesting. We can sit down with a hospital administrator in Virginia, and we can say to him, we have a population here of 35,000 people. We know what their characteristics are. We can reasonably project what their utilization of services is going to be, and we have some idea of how that population is going to grow over the next few years. That population is relatively dispersed around nothern Virginia, around Fairfax and Arlington Counties and would probably end up in a variety of hospitals were they in the fee-for-service system. They would go where their doctor happened to practice or, in some rare instances where the patient would prefer to go, but generally where the doctor prefers to care for the patient.

We can go into an administrator and say, "We notice that your occupancy of your hospital"—and this is one of the few pieces of data that's readily available—"is lower than optimal. You have a good hospital. We would consider concentrating this 35,000 population in your hospital. All their hospitalization that was controllable, other than the kinds of things that are really of emergency

nature that have to be taken to the nearest hospital, could be done here, but that's a big step for us to take. What do you think you might want to do to encourage us to do that?"

When the hospital administrator looks at this, he knows that he has a lot of fixed costs in operating this hospital, and he knows that the marginal cost associated with taking care of the additional population is going to be lower than the average cost. If it weren't, he probably wouldn't be interested in talking to us, but it almost always will be unless the hospital is running a very, very high occupancy rate.

He also knows, especially if a person in the Washington area is a Federal employee—and I know that you are very interested in the Federal employees' health benefit plan—that the person may be one of the many, many people who are subject to increasing deductibles and coinsurance payments. Many, many people are switching to lower option coverage, which increases the probability of having the patient in the hospital pay a portion of his care out of pocket, which vastly increases the hospitals' exposure to bad debt or at least to extension of payments over a longer period of time.

He also knows that his other patient population is subject to a lot of forces that he can't control well. The physicians could be attracted to another hospital by provision of certain conveniences for those physicians, or several doctors could retire and move their offices. He just can't control that very well. So it's very attractive for that administrator to deal with us, and he may. He may just do it in certain services. He may say, well, the occupancy level in this service is high; and this level is low; and there is an economic incentive to me to have you bring the pediatrics care here, but not the internal medicine, so I will only give you a special deal for the pediatrics care.

There is haggling, as Mr. Pyle mentioned. There is haggling back and forth about those economic issues. There are service tradeoffs that may be provided in order to get the business, too. It's not merely an economic tradeoff. He might provide us, for instance, with a space to run an after hour urgent care center, which is of some interest to nonhospital based HMO's.

What I have described to you, in fact, is what has occurred in Virginia with us very recently. We look at Maryland, which is a very similar place in many respects, with one exception. There are several hospitals in really close competition with each other for patients, and some of them are doing better than others. They have higher occupancy rates. There are some hospitals there who would just love to be able to attract certain kinds of activity into those hospitals, and would certainly be willing to pay something for that. They would be willing to pay something because they would gain something. I don't think that there is any mistake about it—the hospitals are going to act in their overall best interests.

Those best interests are not only consonant with ours, but our negotiations with hospitals could very well result in an overall lower average cost for the care of that hospital's patients. The result could be to hold down hospital rates or contribute to the generation of capital to replace facilities or a whole variety of things.

The system in Maryland makes it nearly impossible for the hospitals to do that. This means, if we want to talk about crossover payments, that we are sharing in the bad debt payments for all those folks in the FEHBP that have switched to low option. We are paying for some aspects of inefficiency that exist in those hospitals that we might be able to alleviate. That equation works both ways.

Senator DURENBERGER. OK. Let me take it another step. And maybe one of you can speak to the situation. At some point in time I would think that if this sort of negotiating process is successful in bringing business to certain kinds of hospitals that other hospitals may recognize it as an opportunity for them. Does some kind of bidding among hospitals develop in any of the communities in which HMO negotiations are going on?

Mr. PYLE. I can answer that it has already begun in Boston. If it is beginning in Boston, it will probably begin anywhere. I mean that our hospitals are actively and aggressively seeking business. We are getting very gentle overtures about the possibility of transferring certain services and things like that.

Senator DURENBERGER. What is your population?

Mr. PYLE. We have almost 130,000 members. The total population is 2.7 million in the Greater Boston area so we are small.

Senator DURENBERGER. Is anybody else in the Boston area in a position to negotiate and to provide some of the benefits of negotiation that we have talked about here this morning?

Mr. PYLE. There are a bunch of HMO's getting started, and I think some will be able to do that soon. But I don't think that anyone is able to very effectively do that at the moment with the exception of the Blue Cross controlled HMO's who ought to be able to do that because they can, I think, deal as a group if they want to.

Senator DURENBERGER. You made some reference to the process by which the Business Roundtable approach became an arrangement in which the present major payers found it in their interest to get involved. Another trend of the times is the employer coalition. And I take it that if that were carried to its ultimate that employer coalition might also be in a position to negotiate with certain hospitals for preferred rates. Is there some evidence that that is going on in the country?

Mr. PYLE. I hear a lot of people talking about it. I don't know if it is really going on.

Senator DURENBERGER. Does anyone else have any evidence?

Mr. BIRNBAUM. Well, I think there have been some limited areas where perhaps a single employer may be dominant in the community and, therefore, would be able to exert that kind of leverage. Other than that, I think it has been very difficult for employers dealing through an intermediary, like a third party, to really provide the kind of direct across the table bargaining that we have discussed here this morning.

Senator DURENBERGER. Can somebody explain to me the differences between HMO's owning hospitals versus contracting?

Mr. POCKELL. I can try. In the situation in which I worked at Kaiser in southern California for a number of years, almost all our hospitalization occurred in our own facilities although we did occasionally send things of a special nature outside. We were known to

put out requests for proposals to the community and have them respond if they wanted to provide us with cardiac catheterization services or open heart surgery and stimulate competition by doing that.

In our own hospitals, our ability to forecast not only our membership but the utilization of that membership is fairly sophisticated so we are able to plan and operate our hospitals on what is, in essence, a prospectively set budget that is a portion of the dollar that we charge for health care to our health plan members and groups.

We don't, then, bother to calculate charges for individual services. In essence, we budget the hospitals on something like a capitation basis only it's much more refined than that. We assume that it is going to cost a specific amount to operate that hospital for the patient population in a year, and that's their budget. They are held accountable to meet that budget so that there is no reimbursement system on a per case basis or a per patient day basis or on a per service basis. Instead, it's sort of amalgamated into an overall cost for that population.

It's very hard to translate that into the situation of a community hospital. However, in Maryland when the hospitals go before that rate review commission, they attempt to analyze what their costs are going to be and then they try to translate that cost into a rate. But the uncertainties that the hospital is dealing with for most of its patient load are greater than the uncertainties that exist in a hospital that is primarily or almost universally operating on behalf of an HMO. They are really in two different economic worlds. Of course, the incentive for non-HMO hospitals is still to increase patient days, the more patient days they have, the more money flows into the hospital on the fee-for-service world, except when they are working on per case reimbursement system. In our hospitals that was not the case. The budget for our hospital was sort of set in advance, and there were no incentives to pack the rooms with patients.

Senator DURENBERGER. It seems to me that given the differences in the testimony here today that some of those incentives are basically endemic to the way certain other payers are organized. Kaiser seems to me to be as an institution uniquely situated with regard to hospital care. And I am curious to know what else we might be able to learn from an organization that has operated both as a negotiator and a direct provider of hospital care. It might be helpful to us in structuring the system for prospective reimbursement.

Mr. POCKELL. One thing I might add, then, is that one of the questions that we were asked most frequently when we moved into town was when are you going to build your hospital? Or where are you going to build it? Or how big is it going to be? Because they know that Kaiser is typically a hospital-based program.

The issue of whether we ought to build a hospital or in the larger regions whether they should expand within their own geographical area by cloning the existing system and building hospitals is, today, an economic decision to some degree. I am able to respond to those people by saying that if you don't give us any reason to build a hospital, then we may never build it. If you deal

with us fairly and give us the recognition for the kind of a buyer that we are, then we could get very large—the size of our other regions that do have hospitals—and still never have any need to go ahead and build our own facility.

Mr. BIRNBAUM. I think it would be worth noting a characteristic that the hospital-based and nonhospital-based HMO's share in common. And that is we are all paid for our services in the same way. That is, we receive a total premium encompassing hospital and ambulatory services so the revenue coming in is not biased relative to the type of procedures or the volume of hospitalization that we provide. And as a result, our hospitalization utilization rates are amazingly similar, independent of the particular model. This leads to a situation where if you look at the total expense allocation of an HMO, for example, we spend on the average about a third of our total health care budget on hospitalization, give or take, depending upon the plan. I think that is generally about inverse to the proportion of the budget that a typical health insurer would allocate to the hospital sector.

And so our bias is very much in the direction of nonhospital alternatives as opposed to the usual mechanism that would be biased toward hospitals whether we own our own hospitals or whether we don't.

Senator DURENBERGER. It would be helpful to have one or more of you react to the DRG problem and why it seems to be your advice that we stay away from that particular approach as we move toward prospective reimbursement.

Mr. BIRNBAUM. Are you suggesting that this be followed up with written comment? I'm sorry. I missed your——

Senator DURENBERGER. No.

Mr. BIRNBAUM. Why DRG's should be avoided?

Senator DURENBERGER. Right.

Mr. BIRNBAUM. Let me respond only in terms of the problems we see with respect to DRG as it applies to HMO's because I think I would concur with the gentleman testifying earlier that we have not had enough experience to know how DRG's are going to impact on the system overall. It's just too new; although I would note that I think there is significant danger in the DRG mechanism focusing too sharply on that stay, and as a result, putting institutions in a situation where they are likely to make it up on admissions. I don't see that DRG really is in a position to make much of an impact on admission rates. And hospitals, as all institutions, are concerned about their own economic survival, are likely to look for ways to continue to recover their fixed costs and to avoid making the hard decisions that we all have to make in our own organizations to reduce costs.

With regard to DRG as it applies to HMO's, I think the principal problem is one of really taking away from HMO's what has been our traditional incentive to control length of stay. It's very difficult for me, under DRG, to sit with our medical group and begin exerting the kind of pressure that's a classic HMO phenomenon of the administrators and the physicians sitting together—exerting pressure to really monitor length of stay closely.

Indeed, the extent to which we now have mechanisms to shorten length of stay is really cost ineffective under DRG. Why should we

incur the cost of providing diagnostic services in our health center when we are going to be paying for them again in any case in the hospital because we are paying that flat DRG rate.

The most dramatic example of where we have been hurt with DRG is in obstetrical services, which constitute about 11 percent of our admissions. We have an average length of stay of 2.9 days for normal spontaneous deliveries. The State averages something in the order of about 4.2 days. We are paying, in effect, on the basis of that statewide average. And this is true of other diagnoses as well. The physicians tend, with increasing experience under DRG, to let the patient stay in the hospital until they get to the upper range of the so-called trim points because there simply is no economic advantage to do otherwise. And there are similar situations in the area of discharge planning relative to discharging early and providing for perhaps some physical therapy after hospitalization. Again, why not do it in the hospital if we are going to be paying for that stay anyway.

So these are some of the perverse impacts. Now the DRG legislation does provide for some vague promise of reconciliation downstream. But downstream reconciliation or whatever one might want to call it is just too remote and too indirect an incentive mechanism to influence behavior. And I can't tell our physicians that in the next world if everybody continues to behave and control the system that we may in some as yet to be defined way be rewarded and be able to get some preferential treatment. It has got to be direct, immediate, the kind of thing where, as you have heard described, we can sit with administrators and say, OK, this is what we can do. You can offer us this; we can offer you that; this makes good sense and you have made a sound business decision and we have made a sound business decision.

DRG interposes a regulatory mechanism that simply negates the ability to conduct that kind of process.

Senator DURENBERGER. Is there something inherently wrong in DRG as opposed to other bases for determining payment? Is it not possible to use that as the base?

Mr. BIRNBAUM. Well, as I noted in the testimony, there are provisions in the New Jersey statute that contemplate mechanisms to provide payer differentials for so-called quantifiable economic benefits. But the process in really achieving these is so cumbersome, the length of time, the hearings, the responses from other third party carriers, from the public advocates office, et cetera, is such that by the time the process has taken its course the immediacy and the dynamic of the process has been fairly well lost.

It just has not proven to be effective. I think there is also inherent in any rate setting mechanism a great reluctance to provide one class of payers with something that is going to be unique to that class of payers. You know, we all come in pleading special circumstances. And there has been a very conservative environment where a rate setting commission—and I think this is not unique to New Jersey—really will be reluctant to grant favorable treatment because they are going to then be confronted with other payers coming in claiming inequity and special treatment. And they are going to want theirs. And then the neatness of the standardized approach begins to disintegrate.

We have seen and we were somewhat comforted earlier on with the reassuring rhetoric about, yes, show us benefits to the health care system and show us benefits to the institution. But as a practical matter, I think regulatory agencies find great difficulty in converting some of these benefits to discounts and then being able to defend not making similar opportunities available to other payers.

Mr. PYLE. I think that DRG is a beautiful illustration of the need for flexibility. It is something that has given Roger and the other HMO's in New Jersey a good deal of trouble. On the other hand, we use what are essentially DRG arrangements with two hospitals for noncomplex maternity. However, we negotiated the length of stay in advance, as well as what the dollars were on that DRG; so they are HMO specific, and they work very well. We have an incentive arrangement with the hospital whereby if there is a reduction in the length of stay that is substantial, we share in that. It is working beautifully. We have just renewed the contract, I think, for the fourth year, and we are all very happy with it. But it's a flexibile, give-and-take, entered into relationship, not an arrangement that is imposed.

A DRG system or almost any system one can think of, no matter how good it is, instituted as an overall rigid system is going to end up disadvantaging some significant section of this industry.

Mr. BIRNBAUM. There has been one variation of DRG which might be worth looking at. The DRG as it is now being administered in New Jersey is based on average length of stay, which really reduces the whole concept to one of the lowest common denominator or at least somewhere along the middle. It has been proposed—and it might be interesting to look at—that DRG payment be based on the most efficient payer so that in the example that I indicated where a class of payers has a normal spontaneous delivery length of stay of 2.9 days, that the rate be based on the 2.9 days rather than the 4.2 days. And then let's set that as the target rather than creating a target that essentially accepts the status quo as being optimal because it certainly isn't. That's the reason that we are trying to address this systemwide problem to begin with.

Senator DURENBERGER. Thank you all very much for your testimony. We appreciate everyone's participation in the hearing. And it will all be very helpful, I am sure. The hearing is adjourned.

[Whereupon, at 12:45 p.m., the hearing was adjourned.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION
Two Skyline Place, Suite 400 • 5203 Leesburg Pike
Falls Church, Virginia 22041 • Phone: 703/820-4700

Statement on Behalf of the
American Mental Health Counselors Association
a Division of the
American Personnel and Guidance Association

on

Systems Used by Private Third-Party Payers To Reimburse Hospital and Other Providers

by

William J. Weikel, Ph.D., CCMHC
President
American Mental Health Counselors Association

Before The

U.S. Senate Finance Committee
Subcommittee on Health
Senator David F. Durenberger, Chairman
September 17, 1982

I am pleased to offer a statement for the record on behalf of the American Personnel and Guidance Association (APGA), and the American Mental Health Counselors Association (AMHCA). AMHCA, with almost 6200 members, is currently the third largest and fastest growing division of the 40,000 member American Personnel and Guidance Association.

WHO ARE MENTAL HEALTH COUNSELORS?

Mental health counselors typically possess a master's degree or doctorate degree in mental health counseling, community counseling, or community mental health counseling, from a variety of academic departments, including education, and psychology. Certified Clinical Mental Health Counselors include those persons who typically have a two years master's degree or higher and at least two years of supervised clinical counseling experience. Many members of the American Mental Health Counselors Association are licensed by those states that now provide licensure for mental health counselors, or certified by the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) and listed in the register of NACCMHC. The certification process is a competency based program requiring the master's degree or higher and is based on recommendations of the Commission for Health Certifying Agencies. It also involves a comprehensive examination. The American Mental Health Counselors Association advocates voluntary certification for its members and licensure for those in states offering it for professional counselors.

WHERE DO MENTAL HEALTH COUNSELORS WORK?

Several surveys have indicated that the majority of AMHCA members are employed in community mental health counseling centers. Other work settings include private practice, college counseling centers, private mental health agencies,

and other psychological/mental health and university facilities, including teachers. Approximately 20% of the members of AMHCA are also engaged in full or part-time private practices. Another study showed that, excluding student members, 70% of current AMHCA members hold a master's degree, 26% hold a doctorate degree, and 4%, the educational specialist degree. Mental health counselors work hand in hand with the other core providers, psychiatrists, psychologists, clinical social workers, and psychiatric nurses, and according to estimates provide up to 50% of direct services to clients.

MENTAL HEALTH COUNSELORS ARE COST-EFFICIENT

The following data is excerpted from the most exhaustive manpower study of mental health personnel across the United States, performed by NIMH. While the data is extremely detailed, only those items clearly contrasting numbers and types of mental health professionals will be shown for the sake of brevity as well as for the need for awareness of the magnitude of the participation of the "other mental health professional," i.e., not referring to psychiatrists, psychiatric social workers, and psychiatric nurses.

A. Federally Funded Community Mental Health Centers (CMHCs)

	Number	Percent
Mental Health Professions (MA or above)	9,714	30
Psychiatrists	3,908	12
Psychologists (MA or above)	5,257	16
Social Workers (MSW or above)	6,691	21
Registered Nurses (AA and above)	6,524	21
Total	32,094	100%

B. The NIMH data provides detailed information for:

1. Free standing psychiatric clinics (outpatient);
2. Veteran's Administration Hospitals (inpatient);
3. Nonfederal general hospitals (outpatient);
4. State and County mental hospitals;
5. Day/Night treatment centers;
6. Private Psychiatric hospitals;
7. Veteran's Administration Clinics (outpatient).

A cursory examination of the data will show that the largest professional treatment staff in a variety of clinical settings (both outpatient and inpatient) are basically mental health counselors. The highest percentage of these counselors are found in community mental health centers, private psychiatric settings, and veteran's administrations hospitals. The overwhelming numbers of mental health counselors and clinical mental health counselors in all of these clinical settings attests to their worth as a part of the clinical team. Although not recognized as "core providers", it is evident of their impact on the mental health system. The problem lies in the fact that these mental health counselors, while providing the majority of direct clinical services, do not receive recognition by third party payees. By forcing mental health counselors to look to other mental health professionals to "sign-off" for their work, we are adding an increased cost to the provision of mental health services in our country.

Recent data (1978) indicated that two thirds of the members of the American Mental Health Counselors Association reported salaries from $11,000 to $23,000 with a mean of $17,000. Almost 70% of this same sample report their major job duty as "counseling". Another (1981) study showed that 70% of mental health counselors in private practice employed a sliding scale fee system -- that is, fees based on income. The average fee was $35 for an individual session and $23 for a group session. A comparison of this recent salary and fee data to that for the other core providers clearly indicates the cost efficience of mental health counselors.

Mental health counselors are providing quality cost-efficient services; it is time that their contribution to the mental health care system in the United States receives full recognition by the federal government. Historically, the other non-physician core-providers have struggled for the recognition that we now seek. While we fight these internal battles, the taxpaying public continues to

suffer, especially in rural areas, by not getting the mental health care they need and/or by paying exorbitant prices for mental health services. The time has come (just as it had for the other mental health disciplines) for mental health counselors to be recognized by mandate, for the depth and variety of essential mental health services they provide to thousands of clients each year.

SUMMARY

Mental health counselors are active and well organized and function throughout the country in cities and towns of all sizes. In many underserved communities, both rural and urban, we are often the only service providers for individual and group counseling services. We provide intervention and preventative mental health care. Yet, for the most part, mental health counselors are forced to serve under the supervision of the other "core providers". The fact that mental health counselors cannot practice independently and qualify for third party payments has more to do with the politics of "turfism" than the issue of competence. Our cost-effectiveness in mental health services in this era of the new federalism and fiscal restraint, provides strong justification for the recognition of mental health counselors as legitimate fifth core service providers. In the current supervisory arrangement for reimbursement by medicare/medicaid funds, and so forth, there is an administrative chain of command for reimbursements that costs extra tax dollars: for example, currently, the freedom of choice of patients is severely limited -- they must always use the core mental health specialists, even if the public expenditure is going to be more than if the mental health counselor were another "recognized" mental health specialist. This decreases competition and is inflationary for federal, state, and local governments who are trying to provide mental health services to the taxpayer.

If mental health counselors were reimbursed directly for their services (without the need for supervision or "middlemen"), the savings of time and tax dollars could be better spent on additional services to those truly needing mental health care.

The time is right, we can no longer afford to allow only an elite few to provide the vital services needed by so many thousands of our citizens. Day after day, mental health counselors are on the job, providing direct services to those in need. We must recognize the contribution they are making to the mental health care system in the United States, we must recognize the effectiveness of their services and the cost-effectiveness of this delivery system.

I urge you, for the good of the millions of people in need of mental health services in our country, to recommend that mental health counselors receive full recognition as core providers, and as bona-fide practitioners receive third-party payments.

Hearing on
Hospital Reimbursement Systems Used by
Private Third Party Payers

SEPTEMBER 16, 1982

"REIMBURSEMENT BY DRG: POLICY OR PERVERSION"

by

James Studnicki, Sc.D.
Associate Professor
Department of Health Services Administration
School of Hygiene and Public Health
The Johns Hopkins University

ABSTRACT

Using techniques derived from the proprietary model, 22 selected diagnoses are analyzed to determine their relative "profitability" within a hypothetical hospital. Various diagnoses range from the highly profitable to those which actually produce a deficit. Therefore, regulation by DRG provides hospitals with a financial incentive for adjusting their product mix (i.e., diagnostic mix) in order to improve profitability. These incentives are viewed as distortions in the medical care process caused by the nature of poorly conceived regulation.

Critics of the U.S. hospital industry have continually suggested that hospitals are not effectively managed. Underlying much of this criticism and the more recent discussions concerning the need for competition among hospitals is the assumption that hospital managers lack the incentives for effective management that are inherent in the for-profit, commercial enterprise. It must be a source of some dismay for hospital administrators who have been around long enough to hear the once taboo idea of proprietary motivation in the provision of hospital services being promoted as the latest regulatory panacea In fact, the varying regulatory approaches to the problem of escalating hospital costs reflect a certain ambivalence toward the role of the hospital in American society, with the regulated-to-the-hilt public utility model at the one extreme and the completely deregulated neighborhood hospital supermarket at the other. In today's economic and political environment, it is essential that we look beyond the rhetoric and the buzz words to anticipate, as best we can, the implications of any new government or industry sponsored policy initiatives. This paper deals with some of the possible implications of reimbursement by DRG. However, its major conclusion - that even subtle changes in the dynamics of the hospital can produce unanticipated results - applies to all forms of public policy intervention, whatever the ultimate source.

THE PROPRIETARY MODEL

Hospital executives always seem to suffer in comparison with their counterparts from the proprietary, commercial sector. It seems appropriate at this point to restate the basic, micro-economic elements which are often referred to as the "discipline" of the proprietary model and also to review the somewhat different set of influences which have shaped the U.S. hospital industry. Perhaps the most elemental illustration of the proprietary model is the profit-volume graph, also referred to as the break-even chart for reasons which will become clear (Figure 1). The profit-volume graph is a diagram showing the expected relationship between cost and revenue at various production volumes for each product. Basic to the proprietary model is the idea that there are different kinds of costs in any production process. Briefly stated, they are:

a) fixed costs - A cost which remains constant over a particular period of time and relevant range of production activity. The fixed cost per unit becomes progressively smaller as the volume of production increases. These costs do no vary at all with the volume of production and are independent of the level of activity within a time period. Rent for production facilities, property taxes, supervisory salaries and heating and lighting bills often behave as fixed or non-variable costs.

b) variable costs - A cost which fluctuates in total in direct proportion to production increases and decreases. The variable cost per unit remains constant within the relative range of production activity. Director labor and direct material costs

vary with production increases and are, therefore, usually considered as variable costs.

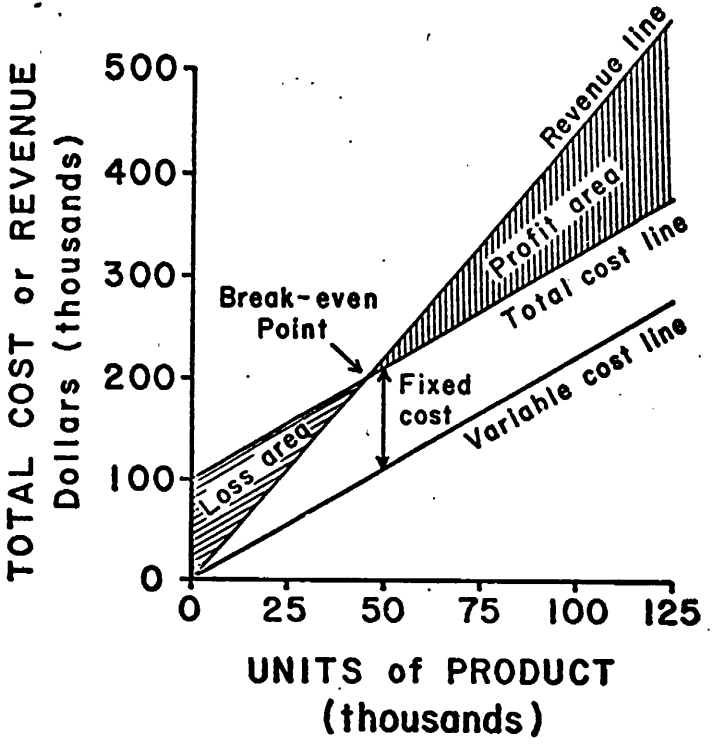
c) semi-variable costs - A cost that changes with production activity but not proportionately. Semi-variable costs have both a fixed and variable cost element. For example, a certain minimum amount of maintenance is necessary for most equipment, regardless of the volume of activity for which it is used. Basic maintenance represents a fixed cost. In addition, maintenance costs will increase with increased use of the equipment although not in direct proportion to it. Theoretically, most costs have both a fixed and variable component and would be considered semi-variable. However, for practical cost accounting purposes, most costs are considered to be either fixed or variable. In fact, financial managers have developed a number of methods for breaking down semi-variable costs into their fixed and variable component.

insert Figure 1 →

The profit-volume graph shows the cost-volume-profit relationship of the proprietary company. Note the break-even point which represents the volume of units sold at which total sales revenue and the total costs are equal. To the left of the break-even point is the loss area, where the total cost line exceeds the total revenue line. In the loss area, the combination of fixed and variable costs are greater than revenues, even though the gap narrows as the fixed cost per additional unit decreases with increasing volume. To the right of the break-even point, revenues have exceeded costs and the gap increases with increasing production volume.

These revenue-cost-volume relationships suggest that the

FIGURE 1 - PROFIT VOLUME GRAPH



useful way of studying the profit factors of the business is to consider not the profit per unit (which is different at every volume), but rather the non-variable costs and the marginal income, which is the difference between the selling price and the marginal cost. When viewed in this way, the much romanticized role of the proprietary executive is really rather simple. There are four ways, and only four, in which the profit of the business can be increased:

1. increase production volume
2. increase selling price per unit
3. decrease variable costs per unit, and
4. decrease fixed costs

In this context, the "discipline" of the marketplace refers to the fact that every profit maximizing strategy can have other unintended consequences. For example, reduced production costs intended to increase profit per unit may also decrease total profit if those production changes impact negatively on total sales. Selling price increases resulting in buyer substitution of comparable lower priced units from other manufacturers can trigger additional price hikes as the company tries to recover, through pricing increases, a profit picture which has deteriorated because of decreased sales volume. One of the big-3 automobile manufacturers experienced this paradox of proprietary dynamics recently as its unpopular large automobiles were experiencing dramatic price increases while at the same time sales of those cares plummeted! The point here is

that the proprietary company must search for the optimum balance of production costs and volume consistent with the highest possible (or acceptable) profit. Decisions concerning which products or services are to be marketed, and in what numbers, depend upon accurate and detailed information about the costs of production. Proprietary motivation does, therefore, inject an undeniable pressure on management to determine the resource absorbtion characteristics and profitability potential for each of its various product mixes.

THE NEGOTIATED SURPLUS

Until very recently, the proprietary model has not had a great deal of relevance for the American hospital. As late as 1940, only about 9% of the population was covered by some form of health insurance.[1] Prior to that time, high unemployment and a faltering economy had left many persons unable to finance their hospital care. Hospital occupancy had dwindled and many were forced to close. Administrators searched for a way to provide continuing and stabilized incomes for the hospitals. With the 1930's came the development of the Blue Cross plans and, subsequently, the commercial companies became aware that the cost of medical care could be insured in a manner consistent with the principles of sound underwriting. Public demand for such coverage increased and the period of greatest expansion in enrollment was during and following World War II in the mid-1940's.[2] By the late 1950's and early 1960's, awareness developed concerning those segments of the

U.S. population who had meager health insurance coverage or none at all.[3] The poor and the aged were groups of particular interest in this regard and various piecemeal efforts eventually resulted in the landmark Medicare and Medicaid legislation.

The growth of insurance has resulted in the addition of the "Third Party" now imposed between the patient and the hospital. Dollars do not flow directly from the patient to the hospital for services rendered. Instead, various third parties collect dollars from citizens and their employers and redistribute those dollars to hospitals on the basis of varying contractual arrangements. While these contractual arrangements tend to differ in terms of the benefit levels and eligibility requirements, they typically involve the payments for hospital services based on the cost of providing those services. We can refer to this period as the era of the negotiated surplus. A surplus is typically involved because the third party payers are generally receptive to the idea that revenues should exceed costs in order to allow for some capital growth or expansion of services. Even today, ther is some discussion concerning which of the various associated costs (e.g., research, education, depreciation) should be allowable under reimbursement formulae.

In the context of the proprietary model, however, the negotiated surplus suffers from a fatal flaw. If a hospital is reimbursed for whatever it spends to provide services, plus a negotiated surplus beyond that level, the basic financial incentive will be to maximize costs. For hospital executives in the era of the negotiated

surplus, the "philosophy of abundance" (i.e., more is better) was also good management. In particular, the increase in the intensity of services, or the average per diem volume of diagnostic and therapeutic services, was encouraged because additions to direct patient care costs were not usually contested by third parties. The discipline imposed upon the proprietary manager by the marketplace consequences (sales) of his cost/volume decisions is largely absent from the hospital environment. The consumer (patient) typically exercises very little influence on the decision to purchase hospital services on his behalf. The professional values of the admitting physicians promote the idea of maximizing treatment and this is generally consistent with the needs of the hospital as a financial entity to maximize revenues. Hospital managers, therefore, developed a very rational approach to survival in the era of negotiated surplus. They simply emphasized the revenue side of the proprietary equation, increasing volume (utilization) and increasing the selling price (costs plus the reimbursable surplus). There was still room for efficiency, of course. Those hospitals that could minimize costs could experience marginal increases in the revenue surplus per unit of service. Clearly, however, social and professional status accrued to those institutions that were larger and more complex, and those influences put the premium on managing revenue maximization, not cost minimization.

The past decade, especially the last 3 years, has been characterized by an increasing realization that the methods of financing hospital care were contributing to dramatic rises in medical care costs.

In particular, the cost-plus method of payments has been singled out as a special culprit. Various governmental initiatives can be viewed, from another perspective, as a means for imposing some of the discipline of the proprietary model onto the hospital industry. Those intiatives, however, may themselves have some unintended consequences!

The DRG is a culmination of a number of efforts which have as their ultimate objective the more precise description of various kinds of hospital "products." Each manufactured commodity or service absorbs resources (materials, energy, labor) during its production and, as we have seen, those resources consumed are reflected in the costs of production. DRG reimbursement clearly promotes increased cost consciousness. The misleading simplicity of the use of a homogeneous "patient day" in management and planning will be eliminated. Episodes of illness will display varying cost and revenue patterns. It will be easier to describe departures from clinically appropriate care in monetary terms. Theoretically, such a system may also provide incentives for reducing the costs of providing service since the hospital is allowed to share in any surplus by "splitting the difference" with the third party payer. The thrust of such regulation is to work at the margin of per unit costs for each DRG, allowing hospitals to keep a portion of the difference between the negotiated rate per DRG and their actual costs (if their costs are lower) but also denying reimbursement for costs exceeding the negotiated rate.

DIFFERENTIAL PROFITABILITY OF THE DIAGNOSTIC RELATED GROUP (DRG)

The idea of regulating hospitals by DRG reimbursement rates, however, has its own serious conceptual flaw: some DRG's are quite simply more profitable than others. Certainly, hospitals may attempt to reduce fixed or variable costs within any DRG in order to qualify for their "bonus." Such behavior would stimulate hospital efficiency - at least until all the "fat" was removed from the cost profile of each DRG. But there is another strategy for the hospital to follow, and that is to change the "product mix" by substituting more profitable DRG's for less profitable ones. This means of income maximizing behavior would be one of the unintended consequences of regulation by DRG, a kind of iatrogenic regulatory effect.

How can the differential profitability of the diagnoses be demonstrated? Table 1 illustrates the nature of the relationships among length of stay (LOS), average ancillary charges (AAC), average routine charges (ARC), average total charges (ATC) and a measure of service intensity (AAC/LOS) for 22 selected diagnoses. While this table represents the average experience of 40 hospitals, note that for any single hospital, each diagnostic group varies along two major dimensions: LOS and AAC/LOS. The state of the art of medicine and the physiologic rationale involved in the diagnostic and therapeutic decisions of the physician define an expected LOS and an expected service intensity (AAC/LOS). From another perspective, however, these clinical parameters also establish certain relationships between the costs of treating the patient and the amount of revenue

generated for the hospital by each diagnostic group.

In order to illustrate the profitability of various diagnoses, the following assumptions are made about the nature of the relationship of the charges profiled in Table 1 and costs for a hypothetical hospital:

1. average routine costs are 75% of average routine charges (ARC)
2. average ancillary costs are 50% of average ancillary charges (AAC)
3. there is a fixed cost per admission of $500.

These three assumptions are consistent with the literature on hospital costing and reflect the consensus that the proportion of fixed to total costs ranges from 30% to 80%.[4-5] The important point here is that the ratio of costs to charges within any single hospital can be calculated with some precision. Therefore, while these relationships will differ from hospital to hospital, the relative profitability of any diagnostic group within any single hospital can be measured.

Insert Table 1 →

From Table 1, we see that diagnosis 250.0 (Diabetes) has an AAC of $629, ATC of $1758, a LOS of 9.4 days and an AAC/LOS of $67. We will depart from the table of actual charges and use an ARC figure which was calculated for a hypothetical single hospital with an average routine cost per day of $88, or an ARC of $1103 ($117.33 × 9.4 and rounded to the nearest dollar) for diagnosis 250.0. As mentioned previously, Table 1 represents the average experience of 40 hospitals, therefore, the ARC vary to some degree from diagnosis to diagnosis. For any single hospital, however, ARC

Table 1 - Actual Average Charge Components for 22 Selected Diagnoses*

Diagnostic group	Length of Stay (LOS)	Average Ancillary Charges (AAC)	Average Ancillary Charges divided by Length of Stay (AAC/LOS)	Average Total Charges (ATC)	Average Routine Charges (ARC)
650.0	3.27	720	220	1094	384
413.9	8.18	874	107	2055	1174
414.0	9.35	1621	173	3014	1393
411.8	9.74	924	95	2324	1400
626.2	4.12	659	160	1137	478
626.8	3.14	559	178	937	378
697.7	6.83	1399	205	2235	836
474.0	1.88	403	214	649	246
474.1	1.73	408	236	652	244
474.9	1.80	366	203	598	232
550.9	4.84	625	129	1200	575
722.[illegible]	10.92	833	76	2104	1276
V25.2	2.72	560	206	890	329
218.9	7.61	1123	148	2065	908
410.9	13.80	1269	92	3463	2195
250.0	9.40	629	67	1758	1129
618.1	8.10	995	123	1952	957
574.1	10.08	1254	124	2421	1167
470.0	3.02	620	205	1006	386
592.0	6.94	876	126	1718	843
592.1	5.24	606	116	1192	586
540.0	5.51	736	134	1394	603

* Source: Maryland Blue Cross, Inc.

per diagnosis will be quite similar, differing only with the variation of the use of special care units (ICU,CCU) by diagnosis. The following calculations also assume that ancillary charges and costs are incurred on a daily basis equal to AAC ÷ LOS; that is, ancillary services are distributed equally with respect to each day of hospital stay. Of course, ancillary services utilization will actually differ from diagnosis to diagnosis but would be expected to follow a "decay" pattern with more ancillary services provided in the first few days after admission and fewer ancillary services provided in the days prior to discharge.[6] We will also assume for purposes of the following calcuations that the fixed cost of $500 is incurred on the first day of hospitalization.

Based upon what we know to be relationships between the various components of hospital charges for diagnosis 250.0 and the various assumptions we have made about the relationships between costs and charges within our hypothetical hospital, we can describe the dynamics of charging, costing and LOS in financial terms. Figure 3 is an illustration of these relationships - a profitability analysis of diagnosis 250.0.

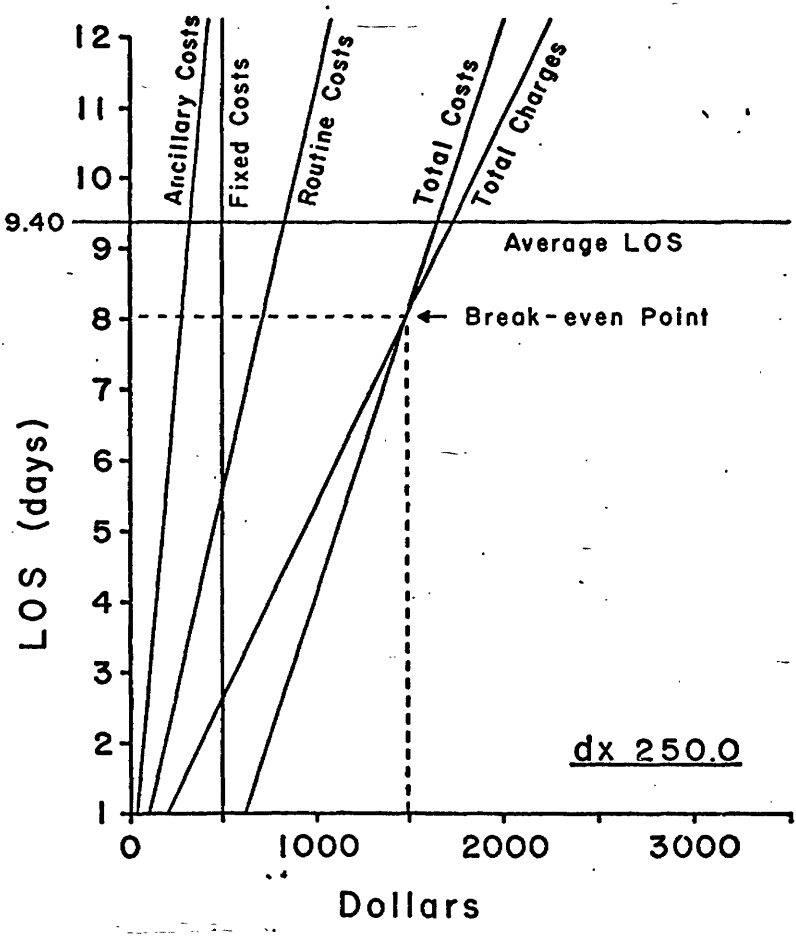
At the end of the first day, our hypothetical patient has incurred total costs of $622; a $500 fixed cost assigned to the first day of hospitalization, $34 in ancillary costs (50% of AAC÷LOS and rounded to the nearest dollar), and $88 in routine costs (75% of ARC÷LOS and rounded to the nearest dollar). The hospital would receive a total of $194 in charges for that first day; $67 for

AAC÷LOS plus $117 for ARC÷LOS. For each additional day of stay, charges will exceed costs by $62. This measure of marginal income (MI) represents the daily difference between combined routine and ancillary costs and charges. From a financial perspective, marginal income within a single hospital varies directly by diagnosis primarily as a function of service intensity, or ancillary costs per day. It is possible, therefore, to calculate a break-even point (BEP) defined in both LOS days and total costs/charges dollars for each diagnosis. At this break-even point, costs and charges are equal. For diagnosis 250.0, the break-even point comes at 8.1 days of stay. Since the average LOS for this diagnosis 9.4 days, we will assume this to be the upper limit for the hospital's utilization experience. Therefore, the profitability potential (PP) for each admission in diagnosis 250.0 at our hypothetical hospital is 1.3 days (BEP-ALOS) × $62 (marginal income) and rounded to the nearest dollar, or $81. The profit potential per day (PPPD), or PP÷LOS, is $8.62. (Figure 2 illustrates the cost and charge dynamics, the BEP, the average LOS and the profitability potential for diagnosis 250.0)

Insert Figure 2 →

In order to demonstrate the wide variability in profit potential represented by different diagnostic groups, note the different pattern of costs and charges represented by diagnosis 414.0 (Isch. H.D.) with an almost identical LOS (9.35 days) to that of diagnosis 250.0. The service intensity for 414.0 is high for a diagnosis with a relatively long LOS. The marginal income is $115 per day. The BEP is 4.3 days, the PP is $581 and the PPPD is

FIGURE 2 - PROFITABILITY GRAPH FOR Dx. 250.0



$61.13. (Figure 3 illustrates the cost and charge dynamics, the BEP, the average LOS and the profitability potential for diagnosis 414.0)

nsert figure 3 →

Table 2 is a summary of these various relationships for our 22 selected diagnoses calculated under the assumptions related to a hypothetical hospital. Note that a number of the diagnoses have BEP's which are longer than the average LOS. In this context, those diagnoses would be considered as units of service generating a deficit. Note that, in the example, deficit diagnoses tend to exhibit high intensity and relatively high marginal incomes but also short average LOS. Highly profitable diagnoses tend to be characterized by a LOS of 7 days or more and a moderately high marginal income. Short stay admissions tend to have another financial disadvantage since there is a greater likelihood that rapid turnover admissions will result in a higher frequency of empty beds attributed to discharge/admission coordination.

nsert Table 2 →

Hospital reimbursement mechanisms based upon average charges for diagnostic group, therefore, will provide financial incentives for hospitals to:

1. favor highly profitable diagnoses to less profitable ones;
2. especially in periods of low occupancy, prefer an empty bed to a deficit producing bed-day;
3. extend, whenever possible, the LOS for diagnoses with high marginal incomes; and
4. especially in periods of high occupancy, reduce the LOS for diagnoses with low marginal incomes.

FIGURE 3 - PROFITABILITY GRAPH FOR Dx. 414.0

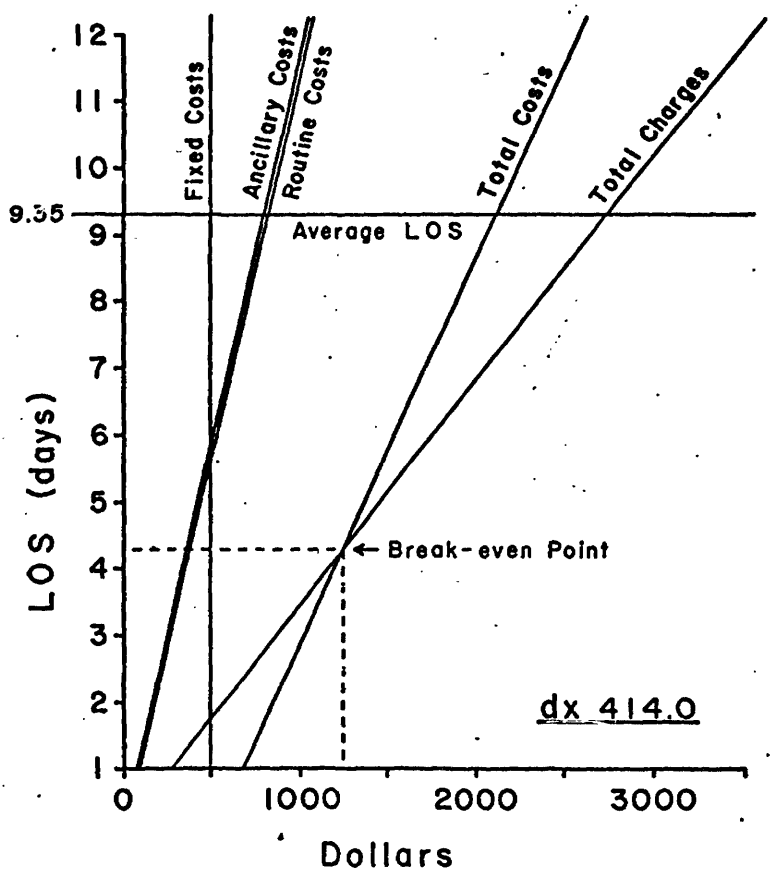


Table 2 - For 22 Selected Diagnoses, Average LOS, Break-Even Points, Marginal Incomes, Total and Per Diem Profitability Potential

Diagnosis	(days) Av.LOS	(days) BEP	($) Marginal income (MI)	($) Profitability Potential (PP)	($) Profitability Potential Per Day (PPPD)
650.0	3.27	3.6	139	(47)*	(12.77)
413.9	8.18	6.1	82	171	20.90
414.0	9.35	4.3	115	581	62.14
411.8	9.74	6.6	76	239	24.54
626.2	4.12	4.6	109	(52)	(12.62)
626.8	3.14	4.2	118	(125)	(39.81)
697.7	6.83	3.8	130	390	57.10
474.0	1.88	3.7	136	(247)	(131.38)
474.1	1.73	3.4	147	(245)	(141.62)
474.9	1.80	3.8	131	(262)	(145.55)
550.9	4.84	5.3	94	(47)	(9.71)
722.1	10.92	7.5	67	229	20.97
V25.2	2.72	3.8	132	(145)	(53.31)
218.9	7.61	4.9	103	279	36.66
410.9	13.80	6.7	75	532	38.55
250.0	9.40	8.1	62	81	8.62
618.1	8.10	5.5	91	237	29.26
574.1	10.08	5.5	91	417	41.37
470.0	3.02	3.8	132	(103)	(34.10)
592.0	6.94	5.4	92	142	20.46
592.1	5.24	5.7	87	(40)	(7.63)
540.9	5.51	5.2	96	30	5.44

* () show a deficit

Such a set of income maximizing strategies would, of course, represent the best traditions of proprietary managerial discipline!

CONCLUSION

The era of the negotiated surplus in the hospital industry was a reflection of the assumption that each dollar spent on medical care was a dollar well spent. Clearly, those days of innocence and naiveté have been replaced by a legitimate concern about accelerating costs and the need to monitor the efficiency with which hospitals render services. Recent efforts at regulation, however, have revealed serious limitations in the ability to mediate the often inconsistent pressures placed upon the hospital by its dual identity. On the one hand, the hospital must serve the needs of its various constituencies; that is, the patients it treats; the students it trains, the researchers who use it as a laboratory and the employees who depend upon its existence. From this point of view, the hospital serves a number of social, professional and scientific objectives. On the other hand, the hospital is also very much an economic entity seeking to increase its financial stability and improve its ability to survive a changing financial environment.

Recent regulation has failed to recognize this dual nature of the hospital organization, encouraging instead the simple idea that efforts to control the financial environment of the hospital would have little or no effect on its ability to achieve its various objectives. This simplistic notion of hospital regulation is patently absurd, of course, but nonetheless seductive to those politicians

and officials who seek to measure the "success" of such regulation by merely tracing the gross patterns of state and national hospital expenditures over time.

This analysis has demonstrated the potential of a regulatory device for providing financial incentives for distorting the legitimate practice of medical art and science. Such potential distortions can be avoided by recognizing that clinical and financial considerations are interdependent, and that attempts to influence changes in one area will be invariably accompanied by changes in the other. Such interdependence ought not to be a source of regret, but rather should be viewed as an objective fact of organizational life. Hospitals are sacred places where modern miracles occur and where the state of the art and science of medicine is advanced. Hospitals are also crass economic entities where millions of dollars are exchanged for services rendered. There is yet a great deal to be learned about the interface of these two natures of hospital operations. Many of the important questions of quality assurance and cost containment hinge on our ability to understand the delicate balance of clinical and financial influence on the medical care process. Regulation based upon the simplistic notion that the discipline of proprietary management can be transferred directly to medical care without thoughtful modification is merely a hoax.

REFERENCES

1. Anderson and Feldman: Family Medical Costs and Insurance- A National Survey. New York, McGraw-Hill Book Co., Inc, 1956

2. Gregg, DW (editor): Life and Health Insurance Handbook. Homewood Illinois, Richard D. Irwin, Inc., 1959

3. Cohen WJ: Health Insurance and Government. Paper presented at meeting of American Risk and Insurance Association, December 29, 1961. Later published in Journal of Insurance.

4. Restuccia JD, Murphy DV: Estimating Hospital Costs by Diagnosis Group. Inquiry 17:155-164, Summer 1980, page 161

5. Lave JR, Lave LB, Silverman LP: Hospital Cost Estimation Controlling for Case-Mix. Applied Economics 4:165, 1972.

6. Phillip PJ, Hai A: Hospital Costs - An Investigation of Causality. In the Nature of Hospital Costs: Three Studies. Hospital Research and Educational Trust, Chicago, 1976, p. 135

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO • NEW YORK • WASHINGTON

LEGAL DEPARTMENT
Joe W. Peel, *General Counsel*

Chicago Office
332 South Michigan Avenue
Chicago, Illinois 60604
(312) 322-0800

August 4, 1981

No. 1-81

TO: HOLDERS OF THE HIAA DIGEST OF LAWS AND REGULATIONS

SUBJECT: LEGISLATIVE AND REGULATORY REFERENCE CHARTS RELATING TO HEALTH INSURANCE

In July 1980 you received charts on individual state requirements for mandatory benefits, mandatory availability, and other related matters. An update of those charts is attached. In addition, a new chart on miscellaneous mandated benefits is included. Please discard the previous charts and replace them in your binder with the following:

Alcoholism
Allied Practitioners
Claims Settlement Practices
Continuation and Conversion
Discrimination
Drug Addiction
Group Replacement and Discontinuance
Handicapped Children
Home Health Care
Loss Ratio Requirements
Maternity and Complications of Pregnancy
Mental Illness
Newborn Children
Social Security Offsets
Surgical Centers
Uniform Claim Forms
Miscellaneous Mandated Benefits

These charts are intended to augment the Digest material in a readily usable form. You will want to check the citations in order to have a complete understanding of the details of the requirements.

The charts were compiled by staff for quick reference purposes, and every effort has been made to assure the accuracy of the information. There may be some inaccuracies due to rapid changes which have taken place in the Legislatures and Insurance Departments. When you refer to them, we will appreciate it if you will call to our attention any errors or omissions. We will plan to send out updated copies from time to time in order to keep them as accurate as possible.

Cordially,

Joe W. Peel

JWP:jq
Attachment

	Citation	Effective Date	Comments
Alabama	§27-20A-(1) et seq.	7/19/79	Grp., blanket, franchise, nonprofit indemnity, grp.-type self-insurance and HMO Ks must offer elective alcoholism benefit. Minimum benefits include minimum of 30 days inpatient treatment or its equivalent per calendar year. Equivalency computed to equate 2 days treatment in short-term residential alcoholism treatment facility or 3 sessions of outpatient treatment by M. D. or alcoholism treatment facility to 1 day inpatient treatment.
Alaska			
Arizona	20-841 20-934 20-1057 20-1376 20-1406	1/1/80	If K provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in general hospital or psychiatric special hospital. Applies to Ks delivered on or after 1/1/80 and to existing grp. policies thereafter on renewal, anniversary date or expiration of collective bargaining agreement.
Arkansas			
California	§10123.6	1/1/79	Grp. medical expense insurers must offer alcoholism coverage as may be agreed upon between insurer & policyholder. The availability of such coverage must be communicated to all grp. & prospective grp. policyholders. Same requirement for health care service & hospital service plans.
Colorado	§10-8-301	1/1/76	Grp. must offer 45 days inpatient and $500 outpatient; coinsurance up to 50%. Each day of confinement shall reduce days covered under policy for illness & for minimum mental illness coverage.
Connecticut	38-262b PA77-237 (Laws '77)	5/10/74 10/1/77	Grp. hospital or med. expense Ks must include same coverage for hospital confinement as for any other disease; minimum of 45 days in "treatment facilities". Grp. Ks must be offered providing outpatient benefits.
Delaware			
Florida	§627.669	1/1/80	Grp. health insurers shall make available, if req. by policyholder, specified level of benefits for necessary care and treatment of alcoholics -- optional coverage.

	Citation	Effective Date	Comments
Florida (Cont'd)			Policyholder may select alternate levels of benefits & grp. must have at least 25 eligible employees, 75% of which must enroll. Basic benefit defined as intensive treatment program for treatment of alcoholism with minimum lifetime benefit of $2,000, allowable maximum of 44 outpatient visits, and outpatient visit benefits not to exceed $25. Does not apply to ind'l, short-term travel, accident only, limited or specified disease, ind'l conversion or policies issued to persons eligible for Medicare.
Georgia			
Hawaii			
Idaho			
Illinois	§367(10)	10/1/73	Grp. policy with in-hospital coverage for sicknesses cannot exclude treatment of alcoholism from such coverage. Does not apply to a policy covering specified sicknesses only.
Indiana			
Iowa			
Kansas	KSA 40-2, 105	7/1/78	Unless refused in writing, grp. insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility & outpatient benefits limited to not less than 100% of first $100 & 80% of next $500 in any year.
Kentucky	304.32.158 304.38.197 304.18.130; .140; .160	1/1/79 7/15/80	Grp. Ks providing major med. or outpatient benefits must offer option to purchase minimum benefits for alcoholism emergency detoxification, residential or outpatient treatment. Treatment in acute care hospitals licensed by state and accredited by hospital commission shall be treated by all health care carriers as any other disease covered in Ks. Also applies to grp. Ks issued by nonprofit hospital, medical-surgical or health service corporations or HMOs.

	Citation	Effective Date	Comments
Louisiana	T. 22, §215.5	7/1/75	Grp., blanket & franchise policies must offer coverage - no benefits defined.
Maine			
Maryland	48A,§490F	7/1/81	Grp. expense incurred Ks & nonprofit health service plans, must provide minimum benefits for alcoholism treatment in calendar/policy year; to include 7 days emergency care, 30 days in type C or D facility; 30 days outpatient group major medical policies providing hospital/ medical care must provide benefits equal to at least 1/2 those required. Overall benefits may be limited to 120 days or visits combined in covered person's lifetime and maximum outpatient benefit in calendar or benefit period may be limited to $1,000.
Massachusetts	C. 175 §110(H)	1/1/76	Blanket & grp. Ks must provide as minimum benefits: a) inpatient hospitalization benefits of 30 days in any calendar year; b) outpatient benefits of a maximum of $500 over a 12-month benefit period.
Michigan	500.3425	1/1/82	Ind'l & grp. expense incurred policies shall provide coverage for intermediate & outpatient care for substance abuse. Minimum of $1,500 in benefits per individual per year with minimum adjusted annually with increase or decrease in CPI for preceding year. If premium would be increased 3% or more because of coverage, insured may decline.
	500.3609	1/1/82	Grp. policies shall offer inpatient benefits for substance abuse as shall be agreed upon between insurer & policyholder & shall provide coverage for intermediate & outpatient care as required by 500.3425. Also applies to Blues.
Minnesota	§62A.149	4/6/78	Every grp. policy & grp. nonprofit health service contract, upon issuance or renewal, shall provide for payment of benefits for treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident covered thereunder on same basis as coverage for other benefits when treatment rendered in a licensed hospital, licensed residential treatment program pursuant to diagnosis or recommendation by M.D., nonresidential treatment program approved or licensed by state. Inpatient coverage to provide minimum of 20% total

	Citation	Effective Date	Comments
Minnesota (Cont'd)			patient days, not less than 28 days per 12-month benefit period; outpatient coverage to provide minimum of 130 hours treatment per benefit period. Same coverage required for individual policies subject to insured refusal in writing.
Mississippi	83-9-27 83-9-29 83-9-30	1/1/75	Grp. Ks must provide benefits on same basis as other illness up to $1,000 per year.
Missouri	§376.779	12/31/80	Ind'l, grp., health service corp., & self-insured plans providing hospital treatment shall provide coverage for treatment of alcoholism on same basis as other illness, except may be limited to 30 days in any benefit period. All policies shall offer benefits for alcoholism, chemical dependency & drug addiction which cover (1) residential treatment, (2) non-residential treatment. Benefits may be limited to 80% of reasonable charges to maximum of $2,000 per benefit period. Insured may reject, or elect coverage for (1) or (2) or both.
Montana	33-22-701	10/29/79 1/1/82	Insurers & health service corps' hospital & medical expense policies must make available benefits for care & treatment of mental illness, alcoholism & drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1,000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime policy limit whichever is less. Does not apply to blanket, short term travel, accident only, limited or specified disease, ind'l conversion or Medicare supplement Ks.
Nebraska	L. 646 (Laws '80)		Grp. hospital service & HMO Ks which do not provide basic coverage of 30 days inpatient treatment in 1 year period with 2 such periods in policy lifetime & 60 outpatient visits in policy lifetime must so inform applicants & insureds. Must offer some coverage if specifically requested at terms & conditions agreed upon between insurer & insured, but may provide different or lesser benefits.
Nevada	689A.030(9) & 689A.046 689B.030(9) & 689B.036 HIAA IDB Nev.1-75 695B.180 695C.170	7/1/79	Ind'l, grp. health, HMO & hospital & medical service Ks must provide optional coverage for alcoholism which includes: (a) if provide inpatient benefits--not less than 5 days room & board; (b) if provide inpatient benefits in health care facility--minimum of 30 days with maximum benefit of $1,000; (c) if provide major medical--outpatient treatment in health care facility for at least 52 visits with maximum benefit

	Citation	Effective Date	Comments
Nevada (Cont'd)			benefit of $800 provided treatment commences within 7 days after completion of inpatient treatment. Law unclear as to whether minimum benefits are annual. Also requires provision of "two such episodes" of treatment plus an add'l 60 days outpatient coverage.
New Hampshire			
New Jersey	17B:26-2.1 17B:27-46	6/2/77	Ind'l & grp. must provide for inpatient & outpatient in licensed hospital, detoxification facility or state approved facility same as any other sickness.
New Mexico			
New York			
North Carolina			
North Dakota	26-39-01 Dept.Bul. No. 30	7/1/75	Requires 70 days inpatient; 140 days outpatient; blanket, franchise & grp. policies over 50 lives & which cover 70% or more of grp.
Ohio	3923.29	1/1/79	Grp. medical expense Ks, other than accident only or specified disease, must provide benefits for alcoholism on outpatient, inpatient or intermediate primary care basis equal to $500 in any 12-month period. Applies to Ks issued or renewed after 1/1/79 & for period ending 4 years thereafter.
Oklahoma			
Oregon	743.412 & 743.557	10/4/77	Grp. Ks must provide, & ind'l Ks must provide at request of applicant, coverage not less than $3,000 in any 24-consecutive month period. Type of facility may be limited. Applies to renewal or extension of existing Ks.
Pennsylvania			
Rhode Island	27-38-1	1980 10/1/80	All expense incurred policies shall provide; inpatient--detoxification benefits not to exceed 7 days per occurrence, with no more than 3 such occurrences per year; rehabilitation services for 30 days in any 12-month period. Outpatient--30 hours for each ind'l under treatment & 20 hours for remaining family members in any 12-month

	Citation	Effective Date	Comments
Rhode Island (Cont'd)			period. Lifetime benefit of 90 days for rehabilitative services. (Note: Also see HIAA IDB Rhode Island 1-81 for Dept. guidelines).
South Carolina			
South Dakota	58-17-30.5 58-18-7.1 58-38-11.1 & .2 58-40 58-41	7/1/79	Any insurer providing coverage on expense incurred basis must offer, in writing, in policies issued or renewed after 7/1/79, coverage for inpatient treatment of alcoholism in licensed hospitals & residential primary treatment facilities approved by state, carrying out program pursuant to diagnosis & recommendation of M.D. Grp. offer to include inpatient therapy & treatment in approved inpatient alcoholism treatment facility. Grp. benefit level on same basis as other benefits but need not exceed 30 days care in any 6-month period & care per recipient need not exceed 90 days during life of K. Does not apply to grp. accident only, limited or specified disease policies.
Tennessee	56-7-1003 1004	7/1/74 7/1/80	Unless specifically excluded, ind'l, franchise, blanket or grp. Ks must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Jt. Com. of Accreditation of Hospitals or facility owned or operated by state which is especially intended for diagnosis, care & treatment of psychiatric, mental or nervous disorders. Grp. hospital, medical or major medical Ks shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year & deductibles & coinsurance not less favorable than illness generally. Benefits shall be part of policy unless policyholder rejects in writing. If K provides inpatient benefits, shall include community mental health centers with inpatient care facilities.
Texas			
Utah	H. 257 (Laws '81) §31-2012	5/12/81	Grp. policies shall contain optional rider which provides coverage for alcoholism treatment or detoxification in licensed facilities or accredited inpatient hospitals.

	Citation	Effective Date	Comments
Vermont			
Virginia	38.1-348.7 38-1-348.8	7/1/79 7/1/78	Ind'l & grp. policies shall include benefits for drug & alcohol rehabilitation & treatment in the 30-day period of coverage of inpatient care specified for mental, emotional or nervous disorders. Level of coverage for benefits for drug & alcohol rehabilitation only may be different provided such benefits cover reasonable cost for necessary services & may be limited to 90 days active inpatient treatment in covered person's lifetime. Grp. Ks shall offer as option alcoholism or drug treatment benefits same as illness with minimum benefits 45 days in alcoholism or drug treatment facility or intermediate facility, 45 sessions of outpatient ind'l, grp. or family counseling.
Washington	48.21.160 48.21.170 48.21.180 48.21.190	7/1/74	Grp. policies must provide alcoholism coverage in licensed treatment centers. Benefits not defined.
West Virginia			
Wisconsin	632.89	9/1/74	Grp. Ks must include up to 30 days inpatient; outpatient up to $500.
Wyoming			

	Citation	Effective Date	Comments
Alabama	§27-1-10	11/1/75	Chiropractor; right of insured to select practitioner of healing arts
	§27-1-11	10/19/75	Dentists; dental hygienists
	§27-1-15	8/23/76	Podiatrists
	§27-19-39	10/1/67	Optometrists in policies covering visual service.
Alaska	21.89.040	5/26/76	Optometrists
Arizona	§20-1376	1968	Podiatrist, optometrist or physician & surgeon skilled in eye care, dentists
	§20-1406		
	§20-841	1977	
Arkansas	§66-3212	2/3/71	Chiropractors; osteopaths
	§66-3212.2	7/19/71	Optometrist
	§66-3212.4	7/9/75	Podiatrist
	§66-3212.6	7/9/75	Psychologist
	§66-3212(12)	5/17/81	Dentists
		7/20/79*	*Includes out-of-state grp. Ks
California	§10176	1959-69 1/1/79*	Chiropractors, dentists, podiatrists, dispensing opticians, psychologists, optometrists, occupational therapists*, speech pathologists & audiologists (optional)*
	§10127.5	1/1/77	Clinical social worker, orthomolecular
		1/1/80	medicine (optional)--group only
	§10176, §10177, §11512.8	1/1/81	Marriage, family & child counselors upon referral of physician or surgeon
Colorado	§10-8-103(3a)	1975	Osteopaths, chiropractors, podiatrists, dentists, psychologists, optometrists
Connecticut	75-117	10/1/75	Optometrists
	§38-174h	10/1/75	Dentists included in definition of physician
	§38-174d	10/1/75	Psychologists - group medical expense only
	§38-174d(e)		Social worker with master's degree if under supervision of psychiatrist & rendered in child guidance clinic
Delaware	T. 24§516	6/27/78	Podiatrists
	§717	10/11/63	Chiropractors
	§2101	5/1/63	Optometrists
District of Columbia	Act 1-86	10/7/75	Optometrists, Psychologists
Florida	§627.419	10/1/74	Dentists included in definition of physician Podiatrists; optometrists; osteopaths; chiropractor (optional)
Georgia	C.964/ (Laws 76)	7/1/76	Optometrists
	§56-3016	1974	Dentists
	§56-3110	1974	Psychologists
	§56-3111	1975	Podiatrists

	Citation	Effective Date	Comments
Georgia (Cont'd)	§56-2445 §56-2445.1 §56-3611	7/1/80	Applied Psychologists, chiropractors
Hawaii	§431-450 §431-499	1967 1974	Optometrists Dentists
Idaho	Ch. 21 §41-2103	1967	Podiatrists, optometrists
Illinois	364 370b 370c 364.1	8/5/69 9/19/69 7/1/77 1/1/80	Dentists Osteopaths, chiropractors Psychologists Optometrists if optometric services covered in K
Indiana	Ch. 6 §27-8-6-1	2/15/74	Dentists, podiatrists, osteopaths, chiropractors, optometrists
Iowa	H. 2537 (Laws 80) §514D.5(4)(e)	7/1/80	Chiropractors - if services not covered, outline of coverage must so state
Kansas	40-2,100 40-2,101 40-2,104	7/1/73 7/1/73 7/1/74	Optometrists, dentists, podiatrists Chiropractors Psychologists
Kentucky	§304.17.305 §304.17.315 §304.17-305 §304.18-095 §304.32-157	1972 1976 7/15/80	Optometrists, osteopaths Dentists Chiropractors make available & offer
Louisiana	§22.662 §22-664 §22-213.1 §22-665 §22-668 §22-213.2	1972 1972 1974 1974 1975 1977	Podiatrists Optometrists Dentists Psychologists Chiropractors Social worker supervised by M.D. (optional in group only)
Maine	24-A, 2744 24-A, 2437 24-A, 2840	7/1/75 (ind) 10/1/75 (grp) 10/1/75 1/1/80	Psychologists--does not require coverage of psychologist by any plan, but if there is coverage, insured can choose any psychologist or physician Dentist included in definition of physician Chiropractor--grp. policies shall offer to grps. of 50 or more members
Maryland	Art. 48A 470A, 477F 489 490 490-1/2 490A 490A-1 354N, 470M, 477R, 490A-2 354S, 470-O 477T 354L, 470K, 477-O	 1974 7/1/79 7/1/79 7/1/80 7/1/77	Optometrists Chiropractor Podiatrist Podiatrist, Dentist Psychologist Health care provider (not defined) Nurse midwife Nurse practitioner--must offer Social worker

	Citation	Effective Date	Comments
Massachusetts	175§110(1)	9/4/75	Podiatrists--grp. & blanket policies
	175§108B	7/11/75	Dentist included in def. of physician
	175§110(F)		Optometrists
	175§47B	1/1/76	Psychologist, psychotherapist--in outpatient mental illness coverage
Michigan	§500.2243	7/23/65	Optometrists (grp. only)
	§500.3475	11/15/68	Chiropractor, podiatrist, consulting psychologist
Minnesota	§62A.03	8/1/74	Osteopath, optometrist, chiropractor (ind.)
	§62A.043	8/1/76	Dentists, podiatrists
	§62A.15	8/1/73;76	Chiropractors, optometrists (grp.)
	§62A.152	8/1/75	Consulting psychologist; psychiatrist (grp.)
Mississippi	§83-41-203	1966	Optometrists
	§83-41-209	7/1/74	Dentists
	§83-41-211	7/1/74	Psychologists
	§83-41-213	7/1/79	Nurse practitioners
	H. 393 (Laws '80)	4/24/80	Chiropractors
Missouri	§375.936(11)(b)		Surgeon, optometrist, chiropractor, dentist, pharmacist, pharmacy, podiatrist--unfair discrimination to limit freedom of choice
	§376.381(3)	1980	Psychologists--in policies offering mental illness outpatient benefits, unless rejected by policyholder
ontana	§33-22-111	1971 10/1/81	Osteopaths, chiropractors, podiatrists, optometrists, clinical psychologists, pharmacists, dentists
Nebraska	44-513	8/24/75	Osteopaths, chiropractors, podiatrists, dentists, optometrists, psychologists
	44-513.01	7/12/74	Psychologists
Nevada	Ch.689A.380	1975	Osteopaths, chiropractors, podiatrists, dentists, optometrists, those who practice Oriental medicine
		7/1/79	Psychologists
New Hampshire	§415:5(A)(8)	8/23/69	Osteopaths, chiropractors, podiatrists, optometrists
	§415:18VI		
	§415:18-a	6/4/76	Psychiatrists, psychologists, licensed pastoral counselor (grp.)
	§415:5(A)(9)	1975	Dentists
New Jersey	17B:26-2c, e & f	6/5/75	Optometrists, psychologists, chiropractors
	17B:27-50	12/23/73	Psychologists
	17B:27-51	1971	Optometrists
	17B:51.1	6/5/75	Chiropractors
	17B:26-44.1 & 17B:27-51.8	7/19/79	Dentists
New Mexico	§59-18-19	6/15/73 *12/31/77 7/1/79	Chiropractors, dentists, osteopaths optometrists, podiatrists, psychologists* nurse midwives
New York	164-7-a,b, c,d,j		Optometrists, podiatrists, dentists, psychiatrists or psychologists in policies covering mental, nervous or emotional disorders, physical therapists in outpatient coverage (ind.)

ALLIED PRACTITIONERS
7-81

	Citation	Effective Date	Comments
New York (Cont'd)	§221.5 §162 & 253	1/1/78	Optometrists (grp.) Social workers in grp. policies covering mental disorders
North Carolina	§58-260 §58-259.2	1965;69; 73;77 1973	Chiropractors, podiatrists, dentists optometrists, psychologists Registered nurses
North Dakota	§26-03.39.1 Ch.26-03.1 - 04.1 Ch. 26-27	7/1/79	Prohibition against inhibiting free choice of physician Availability, at option of insured, coverage for chiropractic services (grp.)
Ohio	§3923.23 §3923.231 §3923.232	7/1/80*	Osteopaths, optometrists, chiropractors, podiatrists Psychologists Dentists *also applies to out-of-state group policies if "subject to jurisdiction of this state"
Oklahoma	Title 36 §3634 §4404B §6051 §6055		Podiatrists; psychologists Psychologists Optometrists Right of insured to select practitioner of healing arts
Oregon	Title 56 §743.123 §743.117 Initiative 5 §743.052 §743.124	1/1/76 9/13/67 7/1/80 1971 1979	Psychologists Optometrists Denturists in Ks covering dental health Dentists for surgical services if policy covers such service Nurse practitioners
Pennsylvania	C.5 Art.IX§1 (40PS§1511) Act 16 (Laws '78) P.A. 72 C.5 Art.IX§2 (40PS§2102)	8/12/71 June '78 6/22/78	Osteopaths, dentists, chiropractors, podiatrists Psychologists in Ks providing reimbursement for psychologically necessary services Physical therapists Optometrists
Rhode Island	§27-18-25 Act 16 (Laws '78)	1968 6/18/78	Persons licensed under Chs. 30, 36, 37 in Title 5 - General Laws Psychologists
South Carolina	38-35-90 38-35-445	5/72 3/21/80 1/22/80	Podiatrists Oral surgeons Chiropractors--shall offer as option
South Dakota	§58-17-53 §58-17-54 §58-17-54 §53-38-2	1966 1970 7/1/80	Optometrists Osteopaths, dentists, optometrists, chiropractors, podiatrists Physician's assistants, nurse practitioners, midwives
Tennessee	56-7-108 56-7-1002	1974 1974	Optometrists, clinical psychologists Dentists (ind.)

	Citation	Effective Date	Comments
Texas	Article 3.70-2B		Osteopaths, chiropractors, podiatrists, dentists, optometrists
	21.35A	8/29/77	Psychologist services--grp.
	21.52	8/29/77 8/27/79	Podiatrists, chiropractors, dentists, optometrists
Utah	§31-20-3	1968	Optometrists (grp.)
	§31-27-24	5/24/75	Psychologists, dentists, optometrists, podiatrists, chiropractors, social workers or other practitioner of healing arts
	Bul. 79-3	5/8/79	Nurse midwives
Vermont			
Virginia	38.1-347.1	1968 1973 1979	Chiropractors, optometrists, opticians, psychologists, podiatrists, chiropodists; clinical social workers--must offer coverage
	38.1-348.5	1968	Dentists
Washington	48.20.390	1963	Podiatrists
	48.20.410	1965	Optometrists
	48.20.411	1973	Registered nurses
	48.20.412	1971	Chiropractors
	48.20.414	1971	Psychologists
	48.20.416	1974	Dentists
West Virginia	§33-6-30	7/12/73	Chiropractors, dentists, podiatrists, optometrists
Wisconsin	§628.33	6/16/74	Chiropractors
	§632.887	6/30/76	Health care professional--may not refuse payment unless K clearly excludes services of such practitioner
Wyoming	26-25-101	1971	Reimbursement not denied if covered services rendered by person licensed to treat the illness or disability or perform the service
	26-13-109(c)	1971	Dentists

The following states have legislated or regulated claim settlement practices:

Alabama	Sec. 27-12-24	Missouri	Sec. 375.936(10) Reg. 190-10.060
Alaska	Sec. 21.36.125	Montana	Sec. 33-18-201
Arizona	-	Nebraska	Sec. 44-1525(9) Rule 20
Arkansas	Sec. 66-3005(9)	Nevada	Sec. 686A.310
California	Sec. 790.03		Reg. M-9
Colorado	Sec. 10-3-1104(h)	New Hampshire	Sec. 417:4.XV Reg. M-10
Connecticut	Ch. 676, Sec. 38-61(6)	New Jersey	Sec. 17:29B-4(9)
Delaware	18 Sec. 2304(16) Reg. 26		Sec. 17B:30-13.1
		New Mexico	Sec. 59-11-13(I)
District of Columbia	-	New York	Sec. 40-d Reg. 64, Part 216
Florida	Sec. 626.9541(9)	North Carolina	Sec. 58-54.4(11) 4NCAC.0319
Georgia	-	North Dakota	Sec. 26-06-08 & Sec. 26-30-04.9
Hawaii	Sec. 431-647	Ohio	Rule 3901-1-07
Idaho	Ch. 13, Sec. 41-1329	Oklahoma	§4505
Illinois	Sec. 154.6 (Sec. 766.6) Rule 9.19	Oregon	Sec. 746.230
Indiana	-	Pennsylvania	Ch. 5, Sec. 5(10) Reg. Ch. 146, Subch. A
Iowa	Sec. 507B.4(9)	Rhode Island	-
Kansas	Sec. 40-2404(9) Reg. 40-1-34	South Carolina	Rule 69-19 Reg. R2-75
Kentucky	304.3-200(b)	South Dakota	-
Louisiana	22:657	Tennessee	-
Maine	24-A §2825	Texas	Art. 21.21-2 Order No. 27085
Maryland	-	Utah	-
Massachusetts	Ch. 176D Sec. 3(9)	Vermont	T. 8, Sec. 4724(9) Reg. 79-2
Michigan	500.2006 & 500.2026		
Minnesota	72A.20(12)		
Mississippi	-		

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona			
Arkansas	§66-3712 - 3715 Reg. 19	7/20/79	Continuation of coverage for 120 days after termination if employee requests in writing within 7 days of termination, unless policy provides otherwise. Dependent spouse ineligible for continuation due to change in marital status eligible to convert to ind'l policies subject to conditions of grp. policy dealing with conversion privileges. Includes Blues.
California	10126 11512.6 10116 T. 10 §2560.3(t)	1/1/76 1961 1/1/75	Employee grp. hospital, medical & surgical policies which provide for conversion on termination of employment shall also provide conversion to spouse on termination of marriage or death of employee. Applies to renewals. Includes Blues. Requires continuation of grp. coverage during labor disputes. Insurer may not refuse to continue coverage on spouse or ex-spouse while continuing coverage for other spouse following separation or dissolution of married couple previously covered under family or household K.
Colorado	10-8-116(3)	1/1/76	Based on NAIC Model Conversion Bill without the rate & loss ratio limitations.
Connecticut	38-374(b) 38-262d	6/9/76	Grp. hospital, medical & surgical must provide election for 39 weeks continuation to any covered person upon termination for any reason. Requires 31-day notice to elect continuation & payment of premium.
Delaware			
Florida	§627.6675 §627.646	1/1/79	Similar to NAIC model bill, except contains no rate or loss ratio restrictions, applicable to both grp. & ind'l. Conversion from ind'l policy. Includes Blues.

	Citation	Effective Date	Comments
Georgia	56-3004.1 56-3102.1	7/1/80	Ind'l/grp. policies may not terminate coverage to spouse of insured solely as result of marital break.
Hawaii			
Idaho	41-2213	7/1/78	Extension of benefits for dismemberment loss.
Illinois	73-356d	10/1/75	Ind'l & grp. Ks may not provide for termination of coverage for dependent spouse upon termination of marriage except by valid divorce decree. Ks must provide conversion right to such terminated spouse.
	73-367e(A)(8)	9/17/71	On death of insured, grp. health coverage for dependents continues for 90 days. Effective 10/1/77. Includes Blues.
	73-367e	2/1/76	Grp. conversion based on NAIC model bill without rate & loss ratio limitations. Includes Blues.
Indiana			
Iowa	509.3.4	8/15/75	Grp. Ks must provide conversion to "benefits similar" to those of the grp. K.
Kansas	KSA 40-2209 40-1802 40-1905	7/1/78	Substantially NAIC model bill with provision of 6-month continuation of existing grp. coverage. Premium for converted policy issued pursuant to period of continued coverage shall be expected to produce anticipated loss ratio of not less than 80%. If grp. policy terminated & not replaced, converted policies may be issued at self-sustaining rates not unreasonable in relation to coverage. Employee or member not entitled to continuation or conversion under grp. policy if termination of coverage occurred because employee/member is or could be covered by Medicare or any other insured or noninsured grp. hospital, medical, surgical plan. If grp. policy not replaced after termination of policy, conversion may be issued in lieu of right to continue grp. coverage at option of either employee or insurer.
	40-2209(D)	1980	

	Citation	Effective Date	Comments
Kentucky	304.18-110 304.32-151 & 152	1/1/75 7/15/80	Grp. policies to provide continuation of coverage for earliest of a) 9 months after grp. coverage would otherwise terminate, b) failure to pay premium, c) date policy terminated & not replaced within 31 days. Conversion shall be made available following period of continuation to employee or any covered spouse and dependents upon death or divorce of employee. Conversion coverage to provide substantially similar benefits as original policy, including option to continue maternity coverage if provided under grp. policy.
Louisiana			
Maine			
Maryland	477K 354T 477N 354K	1/1/78 7/1/79 7/1/77	Grp. conversion required to coverages as may be required by Commissioner. Applies to grp. hospital, surgical or major medical expense incurred policies other than specific disease or accidental injuries only. Continuation of grp. coverage may be required for period not to exceed 6 months. Spouse conversion privilege at term. of marriage or death of insured, if policy provides insured conversion rights. Includes Blues.
Massachusetts	Ch. 175 §110g 176A§8D 176B§6A Ch. 175 §110d	10/2/76 1/1/68	Grp. Ks on contributory basis must provide continuation of coverage to employee, spouse & dependents for 39 weeks upon involuntary layoff or death. Grp. Ks must provide 31 days continuation upon leaving the grp.
Michigan			
Minnesota	62A.146 62A.148	8/1/73 8/1/73	Grp. Ks must continue coverage upon death of employee for 1 year for covered survivors. No employer or insurer may terminate grp. coverage or restrict participation as to covered employee solely because of absence due to total disability.

	Citation	Effective Date	Comments
Minnesota (Cont'd)	62A.17 subd. 1-5	8/1/73	No employer providing coverage for employees & dependents shall terminate, suspend or otherwise restrict participation in or receipt of benefits under such policy or plan to a covered survivor within 1 year of the covered employee's death. Such survivor is required to pay full cost of such extended coverage. Terminated employee eligible to continue coverage for 6 months or until reemployed & eligible for grp. policy, whichever is shorter. Includes Blues.
	62A.17 subd. 6	6/3/77	Grp. policies must provide right of conversion to a comprehensive qualified plan as to "covered" survivors of a deceased covered employee at the end of the 1 year continuation period (see 62A.17, subd. 1-5 above). Includes Blues.
	62E.16	8/1/77	Grp. insurers, self-insurers & HMOs must include right to convert to individual qualified plan without addition of underwriting restrictions, if individual leaves group or group coverage is canceled or terminated without replacement.
	62A.21 62C.146	7/20/77	Grp. & ind'l policies may not provide for termination of coverage for dependent spouse upon break in marital relationship except by valid divorce decree. Ks must provide conversion right to terminated spouse most nearly similar to but not greater than terminated coverage. Includes Blues.
Mississippi			
Missouri	Reg. 190-14.100	2/1/76	Grp. Ks must offer conversion privilege to surviving spouse & covered dependents on death of insured.
Montana	S. 129 (Laws '81)	7/1/81	Persons covered by grp. disability Ks issued or renewed after 10/1/81 may, for period of 1 year with consent of employer or trustees, continue coverage after reducing regular work schedule to less than minimum time required for membership in grp. Grp. Ks issued or renewed after 10/1/81 shall provide conversion benefit on termination of employment or employer's discontinuance

	Citation	Effective Date	Comments
Montana (Cont'd)			of business, with conversion policy to be, at option of insured, on any of the forms then customarily issued to ind'l policyholders & with premium at insurer's then customary rate applicable to coverage under ind'l policy. Converted policy may not exclude as preexisting condition any condition covered by grp. K. Conversion available to spouse & covered dependents on death of insured or on cessation of being qualified family member. Includes Blues.
	S. 314 (Laws '81)	120 days after 10/1/81	Similar to HIAA model for continuation or conversion of ind'l Ks for spouse & dependent children in event of death, divorce, separation or annulment from insured. Includes Blues.
Nebraska	§44-1633 Bul.CB-52	9/30/78 4/18/80	Employer & employee trust grp. policies shall provide continuation when coverage terminated for other than employee misconduct. Coverage on monthly renewal basis until earliest of 6 months following termination, eligibility for other grp. coverage or Medicare, nonpayment of premium, date employee exercises conversion right, if any, or date grp. K terminates.
	§44-1636	7/19/80	Employer & employer trust grp. policies on death of employee shall provide that covered surviving spouse & dependents shall be entitled to continue such coverage subject to provisions of grp. policy.
Nevada	C.689B.120, et seq. C.695B.251 & 252, et seq.	1/1/80	Grp. Ks must provide conversion privilege to employees covered for at least 3 months on termination for reasons other than termination of grp. K itself or failure of policyholder or employee to pay premium. Employee must make written request & pay first premium within 31 days of termination. Carrier must make available at least 3 types of conversion policies but may elect to continue grp. coverage for period not to exceed 3 months if conversion offered on termination of continued coverage. Includes Blues.
New Hampshire	415:18VII	9/22/75	Grp. conversion based on N.Y. conversion law but with richer benefits & other variations.

	Citation	Effective Date	Comments
New Jersey	17B:26-2	9/19/80	Insurer shall make available to former spouse benefits at least equal to basic benefits issued to acceptable new non-grp. applicants of same age & family status.
	17B:27-30 17:48-6.1 17:48A-7.1		Grp. Ks shall continue coverage for dependents for at least 180 days on death of insured with payment of appropriate premium. Includes Blues.
New Mexico			
New York	§162	1959	Conversion privilege
	§253	1/1/76	Amends benefits of old law
	162.5c 164.B(3)	1/1/80	Grp. conversion Ks must contain required maternity benefits & must be same or substantially same as those provided in policy specifically approved as ind'l conversion policy by Superintendent.
North Carolina			
North Dakota			
Ohio	3923.122	1/1/76 1/1/81	Grp. Ks must provide conversion for persons covered one year, including spouse & dependent children on death of insured, on divorce, annulment or legal separation, & for children reaching terminal age. Need not be provided when comparable coverage exists. No minimum level of benefits required. No rate limitations.
	3923.32	1/1/81	Ind'l Ks providing hospital, surgical & medical expense or hospital indemnity benefits must provide continuation for spouse on death of insured, on divorce, annulment, dissolution of marriage or legal separation. Spouse has option to include covered dependent children for whom spouse has responsibility for care & support. Not applicable for covered family member eligible for Medicare or other similar federal or state program.
Oklahoma	4509	1/1/76	Continuation must be provided for termination of coverage for at least 30 days. Termination as to persons covered for at least 6 months shall not prejudice a claim incurred prior to termination, & in such case, benefits shall continue for 3 months of basic & for 6 months of major medical coverage. Includes Blues.

	Citation	Effective Date	Comments
Oregon	743.525	1967	Grp. expense incurred policies may provide continuation of benefit provisions, or any part or parts thereof, for family members or dependents after death of insured.
	743.529	7/1/77	Grp. hospital or medical policies shall continue benefits for insured who is hospitalized on date of termination of policy if terminated policy is immediately replaced by another insurer's grp. health insurance policy. Obligation continues until hospital confinement ends or hospital benefits are exhausted, whichever is earlier.
	743.527	10/3/79	Grp. medical expense Ks where entire or partial premium paid by employer under a collectively bargained agreement will continue coverage, upon timely payment of premium, if cessation of work by insured employee due to strike or lockout. Includes Blue
Pennsylvania	Ch. 2 §621.2(d)	1/5/77	Similar to NAIC model but without rate or loss ratio restrictions. Ind'l policies containing conversion privilege--no person shall lose conversion due to change in marital status. Conversion policy must approximate original coverage. Includes Blues.
	31 PAC C.145.4(c)	10/26/77	
Rhode Island	Reg.XXIII Part VIII §2 27-19.1-1	10/4/79	Similar to NAIC model but without rate or loss ratio restrictions.
South Carolina	§38-35-946	1/1/79 9/1/79	HIAA model grp. continuation and conversion bill in substance. Also gives employee alternate right to continue in effect prior grp. coverage "for the fractional policy month remaining at termination plus 1 add'l policy month." Upon termination of continuance feature, employee has right to conversion privilege. Includes Blues.
South Dakota	Chs. 58-17 58-37 58-38 58-40 58-41	7/1/79	Requires accident or health policies covering hospital or medical expenses of insured & spouse to provide that on eligibility of one spouse for Medicare or Social Security disability benefits, the other is entitled, without evidence of insurability, to an ind'l policy, upon application within 60 days & payment of premium. Conversion policy

	Citation	Effective Date	Comments
			shall provide coverage then being issued by insurer most nearly similar to existing coverage. Insurer may continue existing policy at appropriate premium. Includes Blues.
South Dakota (Cont'd)	S. 200 (Laws '80) Ch. 58-17 58-37 58-381 58-40 58-41	7/1/80	Spouse conversion upon divorce to ind'l policy most similar to existing coverage; allows continuation of coverage under existing policy. Includes Blues.
Tennessee	56-7-1501	1/1/81	Grp. expense incurred policies shall provide continuation of coverage for fractional policy month remaining at termination plus 3 add'l policy months for terminated employee having been continuously insured for at least 3 months prior to termination. Premium payment must be made in advance to employer of full grp. premium. Employee entitled to conversion to one of three types of ind'l policies meeting basic requirements. Insurer may elect to continue rather than convert coverage. Conversion available to surviving spouse & dependents on death of insured or when cease to be qualified family member under grp. policy. Applies to grp. policies delivered or issued on or after eff. date & to policies in effect on 1/1/81 as of first anniv. date after 1/2/81.
Texas	Art. 3.51-7	8/29/77	Grp. Ks must provide continuation of coverage during labor dispute as to contributory collective bargained plans.
	Art. 3.51-6(f)	6/7/79	Grp. A&H policy covering dependents may provide for continuation of coverage for such dependents after death of insured for period not exceeding 180 days, subject to any other policy provisions relating to termination of dependents' coverage. Grp. hospital, medical or surgical expense policies including Blue Cross, that provide for conversion to ind'l policies by insured on termination of membership or employment in grp. shall provide conversion privilege to spouse of insured on death of

	Citation	Effective Date	Comments
Texas (Cont'd)	Art. 3.51-6 Sec. 3A	8/27/79	insured, divorce from insured, or termination of insured's membership or employment with grp. for any reason, including retirement. If conversion privilege available to insured on retirement or termination provides for coverage of spouse, insurer not required to issue separate conversion policy to spouse. Applies to policies delivered or issued on or after 1/1/80.
Utah	§31-20-11 thru 19 Bul. 79-2	5/13/79	Similar to NAIC model, except rating section which allows premiums applicable to the age, class of the person and coverage, but without using health conditions in determining a class. Excepts grp. policies which provide catastrophic, aggregate stop loss, specified stop loss, and policies with a deductible of $500 or more (sic). Includes Blues & HMOs.
	Bul. 80-1	5/13/79	Dept. interprets as requiring grp. conversion policies to cover pregnancy commencing during grp. coverage; need not contain pregnancy benefits per se.
Vermont			
Virginia	§38.1 - 348.11	1/1/80	NAIC model without rate or loss ratio restrictions. 90 day continuation.
Washington	§48.21.075 48.44 48.46	9/8/75	Grp. disability Ks must provide continuation for up to 6 months when coverage is terminated due to strike; thereafter, if coverage is no longer available, must provide conversion coverage. Level of benefits not prescribed, rates not restricted. Includes Blues & HMOs. Ind'l Ks--spouse and/or dependents continuation of coverage on termination of marriage or death of insured.
	Ch. 48.20 48.21 48.44 48.46	6/14/80	Grp., blanket, service plan or HMO--conversion for insured & dependents on termination of employment. Conversion for spouse & dependents on termination of marriage or death of insured.
West Virginia	33-16-3	7/14/77	Grp. Ks must provide continuation at same premium rate for 18 months during involuntary layoff.
	33-16A	6/8/78	Conversion: NAIC model--Blues.

	Citation	Effective Date	Comments
Wisconsin	632.897	5/14/80	Grp.--shall continue or convert to ind'l policy with similar benefits coverage for former spouse on divorce or annulment; grp. member who terminates for reason other than misconduct; spouse or dependent on death of insured. Ind'l--may not terminate coverage for spouse solely because of break in marital relation except on divorce or annulment; must offer conversion policy; coverage shall continue until 30 days after notice of right to convert is sent. Grp./ind'l--may not deny eligibility for coverage of dependent solely because child does not reside with insured or solely because child is dependent on a former spouse rather than insured.
Wyoming	26-25-104 26-23-101	7/1/81	NAIC, without rating provisions; also applies to certificates issued in state. Includes prepaid plans.

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	Rule 4-14-209	6/77	Sex & marital status - NAIC model reg.
	Rule 4-14-213	1/78	No unfair discrimination on basis of blindness, partial blindness or physical disability.
	§20-448.B	7/31/80	No unfair discrimination on basis of hemophilia.
	§41-1461, et seq.		Employers of 15 or more--prohibition of discrimination because of age of those 40-69.
Arkansas	66-3005(11)(a)	1975	Unfair trade practice to refuse or limit coverage solely because of race, color, creed, sex.
	Rule 19	2/1/76	No unfair discrimination because of sex, marital status.
	Rule 28	1/1/81	No unfair discrimination because of physical or mental impairment, blindness or partial blindness. (Note: also applies to grp. out-of-state Ks).
California	10123.1	1/1/77	Physical condition--grp. policies must include handicapped persons but need not cover handicapped condition.
	T.10.§2560	1/1/76	Sex, marital status, sexual orientation.
	10123.3	1/1/78	Insurer shall not discriminate against insured by reason of insured possessing
	10143		Tay sachs, sickle cell or thalassemia traits or X-ray linked hemophilia.
	10140		Race, color, religion, national origin or ancestry.
	A. Z402 (Laws '80)		No unfair discrimination because of
	10144	1/1/81	physical or mental impairment.
	11512.18		
	10119.7	1/1/81	May not exclude, reduce or limit solely
	11512.18		because of exposure to DES.
Colorado	10-3-1104	7/1/74 7/1/78	Sex, marital status: Unfair trade practice to use as basis of classification of risk unless actuarially justified or for purpose of identifying family units. Unfair discrimination on basis of blindness, partial blindness or specific physical disability.
Connecticut	31-126	10/1/73	Unfair labor practice to terminate woman's employment or deny sick pay benefits because of pregnancy.
	PA 75-346	10/1/75	Expands definition of "physically disabled".

	Citation	Effective Date	Comments
Connecticut (Cont'd)	PA 78-350	1/1/79	Eliminates mandatory retirement in private sector.
	38-61(12)	10/1/79	Blindness
		10/1/80	Physical disability & mental retardation--unfair trade practice to discriminate unless based on sound actuarial principles or actual or reasonably anticipated experience.
Delaware	T. 18§2315	3/25/74	Age--may not deny coverage to persons over age 65; may not deny availability of same coverage as provided for those under age 65. Medicare benefits may be offset.
	T.18§2316	2/10/78	Prohibits discrimination in ind'l accident & sickness insurance against blind & deaf.
Florida	626.9541(24)		Refusal to insure or continue--(a) race, color, creed, marital status, sex, national origin; (b) residence, age, lawful occupation unless reasonable relation to risk exists; (c) failure to place collateral business with insurer; (d) refusal of coverage by another insurer if such refusal occurs with such frequency as to indicate general business practice.
	626.9705	10/1/79	Severe disability, including spinal cord disease/injury resulting in permanent & total disability; amputation of extremity which requires prostheses; permanent visual acuity of 20/200 or worse; neuro-sensory deafness--cannot refuse but need not cover handicap already sustained.
	627.644 & 627.6575	7/1/77	Mental or physical handicap--refusal or unfairly discriminatory rates--need not cover handicap already sustained.
	626.9554 627.9706&07	7/1/78	Sickle cell trait--refusal or discriminatory rates.
	Rule C. 4-43.01	1/1/78	Sex, marital status.
	S. 688	7/1/78	Age discrimination & retirement.
	S. 668 (Laws '78)		Employee retirement on basis of age to extent permitted by Federal Age Discrimination in Employment Act.
Georgia			
Hawaii	Rule Ch. 11	2/1/79	Virtually identical to NAIC model reg. on blindness.
Idaho			

	Citation	Effective Date	Comments
Illinois	Rule 26.04	1/1/76	Unfair discrimination based on sex, sexual preference or marital status.
	356F	1/1/80	DES--may not cancel or deny or contain exceptions or exclusions solely because mother of insured has taken DES.
	364	1/1/81	Handicaps or disabilities--may not unfairly discriminate.
	S. 1377 (Laws ' 80)		Employers--may not unfairly discriminate because of race, color, religion, national origin, ancestry, age (between 40-70 years), sex, marital status, handicap (physical or mental unrelated to ability) or unfavorable military discharge.
Indiana			
Iowa	Rule 507B	3/26/80 4/13/76	NAIC model - unfair discrimination - physical or mental impairment. Unfair discrimination on basis of sex & marital status.
Kansas	Reg.40-1-31	2/15/77	Unfair discrimination on basis of sex or marital status.
	40-2,109	7/1/80	Mental or physical handicaps--unfair discrimination.
Kentucky	304.12-085		Sex, race, religion--may not deny issuance or renewal; rates may be justified through valid actuarial tables.
Louisiana			
Maine	24.A §2159-A		Blindness--cannot be basis for refusal of coverage (nor can deafness or developmental disability as of 10/24/77).
	§2741	10/1/75	Where ind'l Ks already provide maternity coverage, it must be provided regardless
	§2450 §2832	1979	of marital or dependency status. Same maternity rule for grp. Ks.
Maryland	470P, 477C	7/1/80	DES--may not deny or cancel solely because insured exposed to DES.
	48A 223(b)(2), (3) & (4)	7/1/79 7/1/80	May not differentiate rates on basis of sex, blindness or physical handicap or disability or genetic trait, including sickle cell, thalassimia-minor, hemoglobin C, Tay Sachs or other genetic trait harmless in itself unless actuarial justification made.
	234A(a) & (b)		May not cancel or refuse for any reason based wholly or in part on race, color, creed, sex, religion, national origin, place of residence, blindness or physical handicap or disability.

	Citation	Effective Date	Comments
Massachusetts	C.175§24A	7/31/74	Sex--cannot be basis for denial or limitation of coverage.
	C.175§108A	10/10/74	Blindness or deafness--cannot be basis for denial of coverage--ind'l policies
Michigan	§2027	4/1/77	Unfair methods of competition & unfair acts or practices--race, color, creed, marital status, residence, age, handicap, lawful occupation, sex or national origin, location of risk or denial of insurance by another insurer.
Minnesota	72A.20	8/1/75	Disability--cannot be basis for denial of coverage or rate differential except where justified by actuarial, experience or other data.
Mississippi	Reg. LA&H 79-1	2/28/79	Blindness or partial blindness--no unfair discrimination.
Missouri	Reg.4CSR 190-13.170	8/11/78	Blindness, partial blindness & physical disability; rate differentials permitted if affect expected risk of loss.
Montana	Reg. 6.6.1201		NAIC model regulation on blindness & partial blindness.
	Reg. 6.61202-1203	2/1/79	Sex & marital status.
Nebraska	Rule 35	10/1/77	NAIC model Regulation on Discrimination on Basis of Blindness or Partial Blindness.
	Rule 28	10/1/77	Sex & marital status.
Nevada	Reg. M7	1/1/77	Sex, marital status--NAIC model sex discrimination regulation.
New Hampshire			
New Jersey	Reg.11:1-4.2	9/1/75	Sex, marital status.
	Reg.11:4-20.1&.2		NAIC model--blindness, partial blindness, physical or mental impairments.
New Mexico			
New York	Reg. 62	12/1/72	Sex, marital status--may not be basis for discrimination in coverage--rate differentials must be justified.
	Reg. 75	7/1/75	Complications of pregnancy covered as
	§40-2	9/1/75	illness.
	§174-b	8/7/78	Exposure to DES no basis for denial, cancellation, or refusal to renew.
North Carolina	58-251.7	7/1/75	Disability--sickle cell or hemoglobin count--cannot be basis for denial of coverage or higher rates.
	Ins.Dept. Notice	4/8/77	
	C. 894 (Laws '77)	1/1/78	Physical handicap or mental retardation not basis for refusal.

	Citation	Effective Date	Comments
North Carolina (Cont'd)	4NCAC.0317	1977	Sex, marital status--unfair discrimination to restrict, exclude, modify or reduce coverage.
	12NCAC.0304		Sex--may not discriminate in any manner on application.
	§58-251.5	1973	Physically handicapped or mentally retarded children--if policy provides coverage for minor children, may not deny or charge higher rates; may exclude benefits for expense solely attributable to handicap or retardation.
North Dakota	H. 1360 (Laws '79)	7/1/79	Employers may not discriminate in employment practices, including compensation, privileges & conditions, because of race, color, religion, sex or national origin.
	§26-30-04(11) S. 2162 (Laws '81)	7/1/75	Race, color, creed, sex, national origin--unfair practice to refuse to insure. Visual acuity.
Ohio	3999.16	7/23/76	Handicap--cannot be basis of discriminatory standards or rates; reasonable classifications permitted.
	3901.21(L)	8/31/76	Sex & marital status--unfair discrimination.
	H. 230 (Laws '79)	11/13/79	Employers of 4 or more state residents may not discriminate because of age in employment, inc. employer insurance plans; "age" defined as at least 40 but less than 70 years old.
Oklahoma			
Oregon	793.037(2)	10/5/73	Sex, marital status--may not be basis for different coverages. Same coverages required for children of unmarried dependents.
	743.037	1/1/75	
	Reg. IC 61	1/1/75	Unfair discrimination--sex & marital status
	746.015	10/3/79	Physical handicap, including blindness, deafness, hearing or speaking impairment, or loss or partial loss of function of one or more of upper or lower extremities, cannot be basis of discrimination unless based on sound actuarial principles or related to actual or reasonably anticipated experience.
	743.125	1/1/80	Policy may not be denied or canceled solely because insured's mother was exposed to DES.

	Citation	Effective Date	Comments
Pennsylvania	C.5§5(a)(7) (40PS§1171.5)		Age, sex, marital status, occupation, race, religion, residence, nationality, ethnic grp., family size--cannot be basis for unfair discrimination among individuals of same class as to eligibility amounts of coverage or premium rate.
	31PAC C.145	10/26/77	Sex, marital status--unfair discrimination.
Rhode Island			
South Carolina	37.474.1	6/29/76	Physical condition--prohibits denial of coverage based on eligibility for state vocational rehabilitation.
	Reg. 69-32	7/5/79	NAIC Model Regulation on Blindness & partial blindness.
South Dakota	58-33-19	7/1/79	Prohibits denial or modification of terms or type of coverage on basis of sex or marital status; allows permitted rate differentials.
Tennessee	Rule 0780-1-34	4/12/76	Sex or marital status--NAIC Model Sex Discrimination Regulation.
Texas	Bd. orders 32447, 32050	12/1/78	Substantially same as NAIC Model Sex Discrimination Regulation.
Utah	§13-7-1	5/7/73	Sex--cannot be basis of any discrimination.
	Reg. 78-2	9/5/78	Blindness or partial blindness--unfair discrimination unless based on sound actuarial principles or experience.
	80-14	10/1/80	Sex, marital status--reasonable & consistently applied class rating differentials allowed.
	80-17	10/1/80	Unfair discrimination--physical or mental impairment (similar to NAIC Model)
Vermont	T.8§4724(7)(B)	1/1/76	Sex or marital status cannot be basis of discrimination against applicant or insured except rates may be based on relevant actuarial data or actual cost experience.
	Reg. 78-2	9/4/78	Blindness or partial blindness, unfair discrimination unless based on sound actuarial principles or experience.
	Bul. 49	3/1/80	Marital status in provision of maternity benefits.
Virginia	38.1-52.7(3)	1979 1980	Blindness, partial blindness, mental or physical impairment--unfair discrimination unless based on sound actuarial principles or experience.

	Citation	Effective Date	Comments
Washington	48.30.300 (Ins. Code)	1976	Sex, marital status, sensory, mental or physical handicap--may not be basis for denial, cancellation or refusal to renew. Fair discrimination allowed when bona fide statistical differences in risk or exposure substantiated.
	49.60.178 (Human Rights Act)	6/7/79	Sex, marital status, race, creed, color, national origin, or sensory, mental or physical handicap--may not be basis for cancellation, denial or refusal to issue.
	48.18.298	7/1/73	Change in physical or mental condition or health--may not refuse to renew; may, with approval of commissioner, discharge obligation by obtaining compatible coverage for insured with another insurer.
West Virginia			
Wisconsin	111.32(5)	5/27/76	Discrimination in employment.
	Rule 6.55	6/1/76	Unfair sex discrimination.
	§628.34(3)(b)	1/1/81	Physical & mental impairment--unfair discrimination unless based on actuarial principles or experience.
	Rule 6.67	1/1/80	
Wyoming			

DRUG ADDICTION
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	20-841 20-934 20-1057 20-1376 20-1406	1/1/80	If K provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in general hospital or psychiatric special hospital. Applies to Ks delivered on or after 1/1/80 and to existing grp. policies thereafter on renewal, anniversary date or expiration of collective bargaining agreement.
Arkansas			
California			
Colorado			
Connecticut	38-174i	7/1/75	Ind'l & grp. hospital or medical expense policies must provide at least 30 days inpatient & up to $500 outpatient for accidental ingestion of a controlled drug.
Delaware			
Florida			
Georgia			
Hawaii			
Idaho			
Illinois			
Indiana			

	Citation	Effective Date	Comments
Iowa			
Kansas	KSA 40-2, 105	7/1/78	Unless refused in writing, grp. insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility & outpatient benefits limited to not less than 100% of first $100 & 80% of next $500 in any year.
Kentucky			
Louisiana	T. 22, §215.5	9/7/79	Grp., blanket or franchise policy include as option, to be exercised by policyholder, benefits for treatment of drug abuse prescribed by physical in any hospital or other public or private facility licensed in state. No specific level of benefits required. Policies in force 9/7/79 shall conform to provisions on or before next renewal date.
Maine			
Maryland	Title 48A, §354M §477Q §477S	7/1/79	Insurer must offer drug abuse treatment coverage to grp. policyholders where new or extended Ks cover 25 or more lives. Coverage to include 21 days inpatient treatment in licensed facility. Major medical policies' coverage of outpatient treatment to extent of 80% of cost but not required to exceed $1,000 in any 12 month period.
Massachusetts			
Michigan	500.3425	1/1/82	Ind'l & grp. expense incurred policies shall provide coverage for intermediate and outpatient care for substance abuse. Minimum of $1500 in benefits per individual per year with minimum adjusted annually with increase or decrease in CPI for preceding year. If premium would be increased 3% or more because of this coverage, insured may decline coverage.

	Citation	Effective Date	Comments
Michigan (Cont'd)	500.3609	7/1/74 *1/1/82	Grp. policies shall offer inpatient benefits for substance abuse as shall be agreed upon between insurer and policyholder and *shall provide coverage for intermediate and outpatient care as required by 500.3425. Also applies to Blues.
Minnesota	§62A.149	4/6/78	Every grp. policy & grp. nonprofit health service contract, upon issuance or renewal, shall provide for payment of benefits for treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident covered thereunder on same basis as coverage for other benefits when treatment rendered in a licensed hospital, licensed residential treatment program pursuant to diagnosis or recommendation by M.D., nonresidential treatment program approved or licensed by state. Same coverage required for ind'l policies subject to insured refusal in writing.
Mississippi			
Missouri	§376.779	12/31/80	All policies shall offer benefits for alcoholism, chemical dependency and drug addiction which cover (1) residential treatment, (2) nonresidential treatment. Benefits may be limited to 80% of reasonable charges to maximum of $2000 per benefit period. Insured may reject, or elect coverage for (1) or (2) or both.
Montana	33-22-701	10/29/79 1/1/82	Insurers & health service corps., hospital & medical exp. policies must make available benefits for care & treatment of mental illness, alcoholism and drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime policy limit whichever is less. Does not apply to blanket, short-term travel, accident only, limited or specified disease, ind'l conversion or Medicare supplement Ks.
Nebraska			
Nevada	689A.030(9) & 689A.047 689B.030(9) & 689B.037 HIAA IDB Nev. 1-75	7/1/75	Ind'l & grp. Ks must offer up to 10 days inpatient in hospital and up to 30 days in other than hospital to maximum of $1000; outpatient up to 180 days, not to exceed $800.

	Citation	Effective Date	Comments
New Hampshire			
New Jersey			
New Mexico			
New York			
North Carolina			
North Dakota	26-39-01 Dept.Bul.30	7/1/75	Requires 70 days inpatient; 140 days outpatient -- grp., blanket & franchise Ks of 50 lives & which cover 70% or more of grp.
Ohio			
Oklahoma			
Oregon			
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota			
Tennessee	56-7-1003 1004	7/1/74	Unless specifically excluded, ind'l, franchise, blanket or grp. Ks must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Jt. Com. of Accreditation of Hospitals or facility owned or operated by state which is especially intended for diagnosis, care & treatment of psychiatric, mental or nervous disorders.

	Citation	Effective Date	Comments
Tennessee (Cont'd)		7/1/80	Grp. hospital, medical or major medical Ks shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year & deductibles & coinsurance not less favorable than illness generally. Benefits shall be part of policy unless policyholder rejects in writing. If K provides inpatient benefits, shall include community mental health centers with inpatient care facilities.
Texas			
Utah			
Vermont			
Virginia	38.1 - 348.7	7/1/79	Ind'l & grp. policies shall include benefits for drug & alcohol rehabilitation & treatment in the 30-day period of coverage of inpatient care specified for mental, emotional or nervous disorders. Level of coverage for benefits for drug & alcohol rehabilitation only may be different provided such benefits cover reasonable cost for necessary services & may be limited to 90 days active inpatient treatment in covered person's lifetime.
	38.1 - 348.8	7/1/78	Grp. Ks shall offer as option alcoholism or drug treatment benefits same as illness with minimum benefits 45 days in alcoholism or drug treatment facility or intermediate facility, 45 sessions of outpatient ind'l, grp. or family counseling.
Washington			
West Virginia			
Wisconsin	§632.89	9/1/74	Grp. Ks must include at least 30 days inpatient; outpatient up to $500 per year.
Wyoming			

GROUP REPLACEMENT
AND DISCONTINUANCE
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	Rule R4-14-210		NAIC Model
Arkansas			
California	Art. 1.5 §10128 §10128.4	5/18/77	All grp. disability policies shall contain a reasonable extension of benefits upon discontinuance of policy for employees totally disabled while insured & still totally disabled at date of discontinuance. Carriers providing replacement coverage with respect to medical expense benefits within period of 60 days of discontinuance of prior policy must immediately cover all employees & dependents validly covered under previous policy.
	Labor Code §2806	1/1/80	Employers shall notify employees in writing at least 15 days in advance of discontinuance, nonrenewal or cancellation. If coverage provided by third party, failure of employer to give notice shall not require third party to continue coverage beyond point it would otherwise terminate. Does not apply to plans subject to ERISA.
Colorado			
Connecticut			
Delaware			
Florida	§627.6651 §627.667	10/1/75	NAIC Model Group Replacement & Discontinuance Regulation provisions.
Georgia	Act 1194, (Laws '78) (S. 474)	1/1/79	Requires accident & sickness coverage of dependent children until age 25 if child is student.

	Citation	Effective Date	Comments
Georgia (Cont'd)	Act 1420, (Laws '78) (S. 530)	7/1/78	Limits exclusions for preexisting illness for period in excess of 12 months.
Hawaii			
Idaho	41-2211	7/1/75	Similar to NAIC Model
Illinois			
Indiana			
Iowa			
Kansas	40-2209(D)	7/1/80	Policies terminated for any reason and not replaced shall continue coverage for 6 months and then issue conversion policy under specific conditions. At option of employee or insurer, conversion policy may be issued in lieu of right to continue grp. coverage.
Kentucky			
Louisiana	§215.6	9/9/77	Grp. & blanket Ks of 10 or more lives, the succeeding carrier must provide the lesser of the new plan benefits without preexisting limitations, or the benefits of the prior plan. Grp. & blanket Ks of 50 or more lives, the succeeding carrier shall give credit for any deductibles or waiting periods satisfied under prior carrier's plan.
Maine			
Maryland			
Massachusetts			

	Citation	Effective Date	Comments
Michigan			
Minnesota	60A.082 Rule 4MCAR §1.9251,et seq.	8/1/80 6/22/81	Insured shall not be denied benefits solely because of change in insurer writing coverage. Substantial deviation from NAIC model.
Mississippi			
Missouri			
Montana			
Nebraska			
Nevada			
New Hampshire	Reg. 19§V	1/1/77	NAIC model except for notice provisions (NAIC §5) and extension of benefits (NAIC §6).
New Jersey			
New Mexico	Rule 11-3-1 to 11-3-10	3/1/73	NAIC Model Regulation
New York			
North Carolina			
North Dakota	Dept. Bul. 10	11/16/71	All eligible persons covered under present carrier plan must be included, regardless of health condition, under plan of succeeding carrier.
Ohio			
Oklahoma			
Oregon			
Pennsylvania			

	Citation	Effective Date	Comments
Rhode Island	R.I. Reg. XXIII, Part IX H. 5690 (Laws '79)	10/9/78 5/5/79	Provides minimum standards in those cases where grp. replacement & discontinuance is required. Grp. policies may not be cancelled unless grp. contract holder receives written notice of cancellation by certified or registered mail at least 30 days prior to cancellation date.
South Carolina			
South Dakota			
Tennessee	56-7-114	1976	Authority to Commissioner to establish rules & regulations.
Texas			
Utah			
Vermont			
Virginia			
Washington			
West Virginia			
Wisconsin	Reg. 6.51	1/1/73	Substantially NAIC Model Group Replacement & Discontinuance Regulation.
Wyoming			

ALL REFERENCE ARE TO HIAA MODEL BILL

HANDICAPPED CHILDREN
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	20-1342.01 20-1407 20-826	8-27-77	Model bill. Applies to policies delivered or issued for delivery more than 120 days after effective date.
Arkansas	66-3632.1 & 66-3702	7-9-75	Substantially model bill, ind'l and group policies
California	10277 10278 10118	1971	Model bill
Colorado			
Connecticut	38-174(e)	1971	Model bill
Delaware			
Florida	627.6055 627.6615	10-29-70	Model bill, except excludes Blues.
Georgia	56-2440	1972	Model bill, except handicap to be determined by State Department of Education.
Hawaii	431-451 & 452 431-551 & 552 433-20 & 21	5-8-68	Model bill; includes life insurance.
Idaho	§41-2139 §41-3436	1972	Substantially model bill
Illinois	356(b) 367(b)	1969	Not model bill, defective notice provisions
Indiana	27-8-5-2(8) 27-8-5-10(4)	1973	Substantially model bill
Iowa			
Kansas			

ALL REFERENCES ARE TO HIAA MODEL BILL

	Citation	Effective Date	Comments
Kentucky	304.17-310	6-13-68	Model bill, except does not apply to group contracts
Louisiana	§215:2	8-1-74	Substantially model bill
Maine			
Maryland	48A354(a-1) 438 471(7)	7-1-77	Substantially model bill - No 31-day notice
Massachusetts	Ch. 175 §108.2(a)(3)	1965	Substantially model bill
Michigan	§500.2264	1966	Model bill, except applies to individual contracts only
Minnesota	62A.14	5-16-69	Model bill
Mississippi	83-41-205 Ind. 83-41-207 Grp.	1972	Model bill with adult premium rates
Missouri	376.776	10-13-67	Substantially model bill, except applies to individual policies only
Montana	33-22-304 33-20-506 33-30-1003&1004	1971	Model bill
Nebraska	44-761(4) 44-710.01(3)	2-19-76	Substantially model bill
Nevada	689A.045 689B.035	11-1-73	Model bill, except does not apply to Blues
New Hampshire	§415.5(A) (3-a), §415.18V	1969	Not model bill. Contains language relating to replacements, conversions & estates.
New Jersey	17B:26-2(b) 17B:27-30	1971	Substantially model bill
New Mexico	59-18-20 59-19-49	1969	Model bill
New York	221.5 164.2(3)	1966	Model bill; expanded to include children with developmental disabilities.

ALL REFERENCES ARE TO HIAA MODEL BILL

	Citation	Effective Date	Comments
New York (Cont'd)	164.2.B(3)	9-1-76 1-1-78	Individual policies covering dependents shall include any other unmarried child incapable of self-sustaining employment, regardless of age, because of mental or physical handicap
North Carolina	58-251.3	7-1-73	Model bill
North Dakota			
Ohio	§3923.24	1-1-72	Substantially model bill
Oklahoma			
Oregon			
Pennsylvania	617(A)(9) 621.2(6)	1-1-68	Substantially model bill, except does not include Blues
Rhode Island	Reg. XXIII Part VII §5(A)(7)	10/9/78	Substantially model bill
South Carolina	38-35-450 38-35-950	4-23-70	Model bill
South Dakota	58-17-30.1	1969	Model bill, not Blues
Tennessee	56-7-1005	5-7-68 Ind. 5-7-69 Grp.	Model bill
Texas	Art. 3.70-2(c)	1971	Substantially model bill
Utah	§31-20-2 Reg. 80-12 §7.A,8	4-4-74	Model bill; does not apply to Blues
Vermont	Title 8 §4090	4-7-76	Substantially model bill
Virginia	38.1-348.1 32-195.20.1	7-1-74	Substantially model bill

ALL REFERENCES ARE TO HIAA MODEL BILL

	Citation	Effective Date	Comments
Washington	48.20.420 48.21.150 48.44.200 48.44.210	6-11-69 9-21-77	Model bill, not Blues. Substitutes term "developmental disability" for "mental retardation".
West Virginia	Reg. 33-28 Series XIII §4.02(H)	4/1/75	Essentially model bill
Wisconsin	§632.88	1972	Model bill, except does not apply to group policies or Blues
Wyoming	26-24-101 26-24-102	1971	Model bill

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	20-826 20-1342 20-1402	5-12-71	All Ks must provide benefits for services rendered by home health care agency for surgical, diagnostic & other services performed outside a hospital if covered when performed in hospital
Arkansas			
California	10123.10	1-1-79	Grp. medical expense insurance policies, self-insured employee welfare benefit plans & hospital & medical service plans must make available benefits for home health services by licensed home health care agencies when (a) continued hospitalization would have been required; (b) plan is established & approved by physician within 14 days of end of inpatient confinement; (c) home health care commences within 14 days of end of inpatient confinement. May limit visits, but not less than 100 in any calendar year or continuous 12-month period. Benefits may be subject to annual deductible of not more than $50 & may be subject to coinsurance of not less than 80% of reasonable charges.
Colorado			
Connecticut	38-174k 38-174l	10-1-78	Individual & grp. K must provide benefits for home health care services if continued hospitalization would otherwise have been required if home health care were not provided except in the case of a terminally ill person. May limit visits to 80 per year; $50 deductible; 25% coinsurance.
Delaware			
Florida			
Georgia			
Hawaii			

	Citation	Effective Date	Comments
Idaho			
Illinois			
Indiana			
Iowa			
Kansas			
Kentucky	304.17.313	1/1/81	Ind'l, grp., blanket, HMO expense incurred Ks & nonprofit hospital, medical-surgical, dental & health service corporations offering hospital, medical or surgical expense benefits shall make available & offer coverage for home health care. Coverage may limit visits to 60 per year. Medicare beneficiaries eligible for coverage of those home health services not paid by Medicare and not exceeding maximum policy liability.
Louisiana			
Maine	24-A, §2745 §2837	10/24/77 3/31/78	Ind'l, grp. or blanket policies providing coverage for inpatient hospital care shall make available that coverage for home health services.
Maryland	48A. §470J	7/1/77 *7/1/79	Must make known to insured upon request of availability of home health care *(applies to health insurance policies providing coverage for inpatient hospital care on expense incurred basis).
Massachusetts			
Michigan			
Minnesota			
Mississippi			

	Citation	Effective Date	Comments
Missouri			
Montana	S. 49 (Laws '81)	10/1/81	Grp. insurers & health service corps. shall make available benefits for home health care. Applicant may select any level of benefits offered. Does not apply to blanket, short term travel, accident only, limited, specified disease, ind'l conversion or Medicare supplement Ks.
Nebraska			
Nevada	689A.030.8 689B.030(4)	7/1/75	Ind'l & grp. Ks must provide benefits for services on same basis as would be covered when rendered in or by hospitals, health care facilities, child care facilities, grp. care facilities & skilled nursing facility or hospitals.
New Hampshire			
New Jersey	17B:26-40, et seq 17B:27-51.3, et seq	11/23/77	Ind'l & grp. policies must allow 60 home care visits in any calendar year if policy covers inpatient hospital care.
New Mexico	59-18-23 & 59-19-52	1/1/78	Ind'l & grp. hospital or major medical expense policies issued after eff. date shall make available option of home health care coverage which includes at least 100 home visits per insured per year & medical supplies, drugs, medicines & laboratory services to extent benefit would have been provided on inpatient basis.
New York	§162;§164 Reg. 81 (NYCRR 69) 164-7-f	7/1/76 1/1/78 4/1/76	Mandates home health care coverage in all Ks. Apparently retroactive & extraterritorial in application. Mandates availability in policies supplementing Medicare. Ind'l Ks providing inpatient benefits shall offer coverage for home health care.
North Carolina			
North Dakota			

	Citation	Effective Date	Comments
Ohio			
Oklahoma			
Oregon			
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota			
Tennessee			
Texas			
Utah			
Vermont	T. 8§4096	10/1/76	Must offer coverage of at least 40 visits per year; 9-month waiting period may be required for maternity & childbirth coverage.
Virginia			
Washington			
West Virginia	§33-28-5a	1/1/81	Ind'l hospital or major medical policies shall offer home health care coverage of at least 100 home visits per policy year; 4 hours of home health care services considered one visit.

	Citation	Effective Date	Comments
Wisconsin	§632.78(3)	8/1/78	Policies providing coverage for inpatient hospital care shall provide coverage for home care. Maximum weekly benefit need not exceed usual & customary weekly cost for care in skilled nursing facility. If insured has two or more policies, home care coverage required under only one. Policy may limit number of visits but not less than 40 in any 12-month period.
	§632.78(3)(h)		Medicare supplement policies shall make available coverage for supplemental home care visits beyond those provided by Medicare sufficient to produce an aggregate coverage of 365 home care visits per policy year.
Wyoming			

LOSS RATIO REQUIREMENTS AND REASONABLENESS IN RELATION TO PREMIUM 7-81

NOTE: For purposes of this chart, it is assumed that health insurance premium rates or rate classifications and/or manuals must be filed in all states. While there may be an absence of clear statutory authority in a few states (particularly as to group), in practice, forms usually are not approved unless the rates, classifications and/or manuals also are filed. It is not the function of this chart to list the various requirements among the states for premium rate justification other than the indicated reasonableness of premium and specific loss ratio requirements indicated. Many states are likely to request various kinds of support for rate filings, including actuarial memoranda and other subjective requirements. When looking at original rate filings or subsequent rate increases, generally these criteria are not specified in the statutes.

State	Rate Review Criteria	Loss Ratio Requirements
Alabama	-	-
Alaska	-	-
Arizona	Ind'l (including franchise) -- disapproval if benefits not reasonable in relation to premium. §20-1342.02	-
Arkansas	Ind'l A&H--reasonableness in relation to premium. §66-3210 (5)	-
California	Ind'l hospital, medical, surgical--withdrawal of approval if benefits not reasonable in relation to premium. §10293 (a)	50%-ind'l hospital, medical, surgical policies 35%-such policies with annual premiums per person of $7.50 or less 55%-medicare supplement Adm. Code T. 10 §2222.10, et seq
Colorado	Loss ratio under medicare supplement policies not less than that prescribed by Commissioner. §10-8-102.5 Nonprofit hospital and health service corps.--not excessive or inadequate (filing required with basic rating formula). §10-16-125	60%-medicare supplement Rule 78-1
Connecticut	A&S--rates not excessive or inadequate; approval of rates. §38-165 Health insurance for elderly--reasonable in relation to premium. §38-174 (c)	NAIC guide for filing and approval of A&H contracts. Medicare Supplements - 65% Ind'l, 70% Grp Bul. 28
Delaware	Ind'l--reasonable in relation to premium. 18 §2713 (4) Grp & blanket & health service corps--not excessive or inadequate. 18 §2503	Filing of anticipated loss ratios required. Bul. 71-15, amd. 10/15/71

LOSS RATIO REQUIREMENTS AND REASONABLENESS IN RELATION TO PREMIUM 7-81

State	Rate Review Criteria	Loss Ratio Requirements
District of Columbia	-	-
Florida	A&S--reasonable in relation to premium. §627.411 (5)	50% to 65% benchmarks considered reasonable. FLA IDB 563A Supplemental Guidelines (1973)
Georgia	-	-
Hawaii	-	-
Idaho	-	-
Illinois	-	-
Indiana	Reasonable in relation to premium. §27-8-5-1	Informally follows NAIC benchmarks.
Iowa	Grp A&H--not excessive or inadequate; 50% deemed reasonable. §509.17	Commissioner authorized to establish loss ratios for all ind'l health policies. 514D 7/1/80
Kansas	Ind'l A&H--reasonable in relation to premium. §40.2215	Based on NAIC 1979 Loss Ratio Guidelines without Medicare Supplement. Reg. 40-4-1, amd 5/1/81
Kentucky	Ind'l health--reasonable in relation to premium. §304.14-130	-
Louisiana	-	-
Maine	Ind'l--reasonable in relation to premium. 24-A §2414	-
Maryland	Health insurance--reasonable in relation to premium. 48A §376 (b) (6)	-
Massachusetts	Reasonable in relation to premium. C. 175, §108, subsec. 8A	Ind'l policies - hospital, medical expense: 60%-optionally renewable; 55%-conditionally or guaranteed renewable; 50%-guaranteed rate. Loss of income: 60%-optionally renewable; 55%-conditionally renewable; 50%-guaranteed renewable; 45%-guaranteed rate. NOTE: 5% less on above if average annual premium less than $200. Specified perils/short-term non-renewable/ accident only: 45%. Policies issued to those aged 65 or older: 65% 211 CMR 47.09(4)

LOSS RATIO REQUIREMENTS AND REASONABLENESS IN RELATION TO PREMIUM 7-81

State	Rate Review Criteria	Loss Ratio Requirements
Michigan	Ind'l & family expense--reasonable in relation to premium. §500.2242 (2)	65%-rated by age 60%-collectively renewable or optionally renewable 55%-guaranteed renewable non-can or guaranteed renewable or ind'l accident 55%-all other insurance Not applicable to credit health or policies of less than $7.50 annual premium. MICH Rule 500.801 - .806
Minnesota	A&S--reasonable in relation to premium. Commissioner shall establish schedule of minimum anticipated loss ratios which, with exception of ind'l disability or income protection, shall not be less than 50% after first year policy in force. §62A.02	-
Mississippi	-	-
Missouri	-	-
Montana	-	-
Nebraska	A&S--reasonable in relation to premium. §44-710	-
Nevada	Ind'l--reasonable in relation to premium. §687B.130	-
New Hampshire	A&H--reasonable in relation to premium. §415:2	40%-short-term ind'l accident only, nonrenewable 45%-all other ind'l accident only 45%-non-can ind'l disability income 50%-all other ind'l A&H 60%-franchise, except if number lives covered 25 or less (excluding dependents)-55% 55%-franchise accident only NH Reg. No. 4, revised 10/76
New Jersey	Ind'l--reasonable in relation to premium. §17B-26-2	Dept. may require 75% anticipated loss ratio on grp. conversions.
New Mexico	Ind'l--reasonable in relation to premium. §59-18-2	-

LOSS RATIO REQUIREMENTS AND REASONABLENESS IN RELATION TO PREMIUM 7-81

State	Rate Review Criteria	Loss Ratio Requirements
New York	NAIC reasonableness in relation to benefits. §141 (withdrawal), §154 (disapproval)	All loss ratios 50% except: 45%-short-term non-can trip 45%-accident only 40%-short-term nonrenewable accident only 60%-rated by age, over age 60 60%-franchise 60%-medicare supplement benchmark NY Adm. Code C. III, §52.45, Reg. 62
North Carolina	Ind'l--reasonable in relation to premium. §58-254.7	-
North Dakota	-	-
Ohio	Ind'l--reasonable in relation to premium. §3923.021	-
Oklahoma	-	-
Oregon	Ind'l and fraternal benefit health and ind'l health care service contractors-reasonable in relation to premium. §743.009(6)	-
Pennsylvania	Formal approval of rates by Commissioner. Ch. 2 §616	Individual A&H: (a) new filings- 45%-industrial 50%-all other (b) rate revisions- 50%-industrial 60%-all other PA. Adm. Reg. §89.83
Rhode Island	Health Benefits Plans-disapproval if unreasonable in relation to prem. Reg.XXIII, Part XI, §3	-
South Carolina	Ind'l accident, health or A&H-disapproval or withdrawal if not reasonable in relation to premium. §38-35-410	-
South Dakota	-	-
Tennessee	A&S-must be reasonable in relation to premium based on such reasonable regulations as Commissioner may promulgate. Experience rated grp rates need not be filed but must be maintained by insurer and made available for review on request of Commissioner. §56-26-102	NAIC 1979 model guidelines in substance with certain modifications. Includes Medicare Supplement loss ratio of 60% individual; 75% group. REG 0780-1-20, eff. 1/1/81

LOSS RATIO REQUIREMENTS AND REASONABLENESS IN RELATION TO PREMIUM 7-81

State	Rate Review Criteria	Loss Ratio Requirements
Texas	Ind'l--Board may withdraw approval if benefits not reasonable in relation to premium. ART. 3.42(b) & (g)(1)	-
Utah	A&S--withdrawal of approval or suspension of further sale if benefits unreasonable in relation to premium. Doesn't apply to conversions issued pursuant to contractual conversion privilege under grp or ind'l A&S when K contains provisions inconsistent with requirements of Act or any regulation issued pursuant to it or to franchise policy issued to employees or members being added to such plans in existence. §31-44-4 (H.B. 187, Laws 79)	NAIC 1979 model guidelines for filing rates for individual A&S insurance forms. Includes Medicare Supplement--60%. REG 80-20, eff. 9/1/80.
Vermont	Just, reasonable and adequate. §4656 (b)	Loss Ratios based on NAIC 1979 model guidelines for filing rates for ind'l A&S insurance forms. Includes Medicare Supplement--60% ind'l. REG 80-1§7.A.15, eff. 7/1/80.
Virginia	Ind'l--Commissioner may disapprove or withdraw approval if finds that benefits are or are likely to be unreasonable in relation to premium. §36.1-362.8	-
Washington	Any form of disability (A&S)--reasonable in relation to premium. §48.18.110 (2)	Medicare Supplement: 60% ind'l; 75% Baucus grp. H. 297 (Laws '81) - 1/1/82
West Virginia	Reasonable in relation to premium. §33-6-9 (e)	-
Wisconsin	Ind'l--not excessive or inadequate. §625.11	Informally follows 50% benchmark.
Wyoming	Reasonable in relation to premium. §26-15-113	Generally, Dept. considers ratios of about 65% acceptable.
Puerto Rico	A&S--fair in relation to premium. T. 26 §1112 (7)	-

NOTE: Reference to the NAIC benchmarks are to the 1956 general benchmark of 50% if total annual or single A & S premium is over $10.

NOTE: NAIC 1979 Loss Ratio Guidelines are 60% OR; 55% CR/GR; 50% guaranteed rate; 60% eligible for Medicare by reason of age; 45% specified accident/short-term nonrenewable/accident only. Includes criteria to be filed with forms to justify anticipated loss ratios and the various kinds of data and other consideration that may be taken into account.

MATERNITY AND
COMPLICATIONS OF PREGNANCY
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	Rule R4-14-209	6/13/77	Complications of pregnancy benefits same as illness. Cannot deny maternity benefits to insured or prospective insureds purchasing ind'l K when offered in family Ks. Applies to all Ks delivered or issued for delivery instate; to all existing grp. Ks which are amended.
Arkansas	Reg. 19	2/1/76	Complications of pregnancy benefits same as illness. May not apply arbitrary waiting periods to exclude coverage for premature birth when normal maternity included in K. Applies to renewals & grp. Ks as amended, including out-of-state grp. Ks.
California	§10119.5 §10121 T.10 §2560.3(e)	7/1/76 7/1/76 1/1/76	Involuntary complications of pregnancy coverage must be offered in all Ks. Cannot refuse to offer maternity benefits under individual Ks when offered under family Ks.
	Labor Code 1420.35	1/1/79	Employer must treat pregnancy, childbirth & related medical conditions as any other temporary disability but need not extend disability leave past six weeks for normal pregnancy.
	Hlth& Safety Cd. 1367.7 Ins. Code 10123.9 11512.16	1/1/80	Grp. policies offering maternity coverage shall offer coverage for prenatal diagnosis of genetic disorders of fetus by diagnostic procedures in cases of high risk pregnancies. Terms & conditions to be agreed upon between insurer & grp. policyholder.
Colorado	10-8-122 10-16-137 10-16-138 10-17-131	1/1/76	Complications of pregnancy benefits same as illness. Same maternity coverage & benefits shall be offered to unmarried women as offered married women. Applies to all Ks issued after eff. date & grp. Ks on renewal or reinstatement after eff. date.
Connecticut	§38-371§1(q)	1976	Pregnancy & resulting childbirth or miscarriage as "disease or injury" in state comprehensive health care law.
	Title 31 Ch. 557 §31-126	10/1/73	Unfair labor practice to terminate employment or to deny sick pay benefits on the basis of pregnancy.

	Citation	Effective Date	Comments
Delaware			
Florida	Rule C. 4-43.01(c) Rule C. 4-43.01(f)		Cannot deny maternity benefits in ind'l K when comparable family coverage offers maternity benefits. Complications of pregnancy same as illness.
Georgia	56-2443	7/1/77	Complications of pregnancy coverage required in all grp. major medical policies which cover maternity benefits. Applies to grp. Ks issued for delivery, amended or renewed after 1/1/78.
Hawaii			
Idaho	§§41-2140, 41-2210, 41-3438, 41-3932, & 41-4023 Reg. 31 Reg. 7	1/1/77 1/1/77 3/1/62	Involuntary complications of pregnancy - coverage must be offered in policies which provide maternity coverage, except ind'l noncancellable or guaranteed renewable Ks issued or delivered before 1/1/77. (Includes ind'l, grp., medical expense & disability income.)
Illinois	Rule 26.04	7/1/76	Complications of pregnancy benefits same as illness. Cannot restrict availability of maternity coverages or benefits based upon marital status. Cannot deny maternity coverages to an ind'l who has not purchased dependent or family coverage when maternity coverages are otherwise available. Applies to all Ks, endorsements or riders issued on or after 7/1/76.
Indiana			
Iowa	Rule 510-15.50-15.54 (507B)	4/13/76	Complications of pregnancy benefits same as illness. Cannot deny available maternity coverage to unmarried female if same policy is available to married females. Applies to all Ks delivered or issued for delivery in this state on or after 4/13/76 & to all existing grp. Ks which are amended or renewed on or after 4/13/76.
Kansas	Reg. 40-1-31 Bulletin 1977-3	2/15/77	Complications of pregnancy benefits same as illness. Cannot deny coverages for maternity benefits to single insureds when such benefits are provided to covered spouses.

MATERNITY AND
COMPLICATIONS OF PREGNANCY
7-81

	Citation	Effective Date	Comments
Kentucky	H. 299 (Laws '78)		Elective abortions only by optional rider & additional premium.
Louisiana			
Maine	24A-§2832	1975	Cannot deny maternity benefits to unmarried women policyholders & minor dependents of policyholders with dependent or family coverage when married policyholders & wives of policyholders are provided with maternity coverage. Applies to all grp. & blanket insurance written or renewed after the eff. date of this act & shall include but not be limited to all types & forms of grp. insurance issued by ind'l companies or corporations.
	§2741	1/1/76	Applies to all policies & plans issued or renewed after the effective date.
Maryland	Article 48A §354F, G&H §470H&I §477I&J	 1975 1975 1975 7/1/77	Maternity benefits coverage to be offered to the same extent as hospitalization benefit provided for any covered illness, regardless of marital status. Applies to temporary disability insurance policies, nonprofit health service plans, individual or family basis policy forms & grp. or blanket health insurance policies. Does not require any insurer to provide benefits for pregnancy or childbirth in any policy.
	S. 775	7/1/77	Requires employers to treat pregnancy, childbirth as a disability for purposes of temporary disability plans. Can be limited to 6 weeks.
	4701, 477J	1975	Maternity benefits offered without regard to marital status.
	477P	1977	Grp./blanket insurers shall offer benefits for temporary disability caused by pregnancy or childbirth same as other covered disabilities except normal pregnancy disabilities may be limited to 6 weeks.
Massachusetts	§201 §202 Civil Rights Act		Employer shall not segregate, classify or otherwise discriminate against a person on basis of sex with respect to term, condition of employment including a benefit plan or system.

MATERNITY AND
COMPLICATIONS OF PREGNANCY
7-81

	Citation	Effective Date	Comments
Michigan	§2027	4/1/77	Unfair methods of competition & unfair act or practices--race, color, creed, marital status, residence, age, handicap or lawful occupation.
Minnesota	§62A.041	6/4/71	Same coverage for maternity benefits shall be provided to unmarried women & minor female dependents as is provided to married women including wives of employees choosing dependent family coverage. Applies to ind'l policies & to grp. policies & to grp. policies of accident & health insurance issued or renewed after 6/4/71.
	Ch. 363 Minn. Human Rights Act	6/3/77	Unfair employment practice for employer or labor to treat women affected by pregnancy, childbirth or disabilities related to pregnancy differently under fringe benefit programs.
Mississippi			
Missouri			
Montana			
Nebraska			
Nevada	Reg. M-7 5.3 & 5.6	1/1/77	Complications of pregnancy to be treated same as illness. Cannot deny maternity coverage to unmarried female insured or prospective insured purchasing an ind'l contract when comparable coverage is available to a married female insured or prospective insured. Applies to all Ks delivered or issued for delivery in this state by any insurer on or after 1/1/77.
	689B.032	7/1/77	Grp. or blanket policy may not exclude complications of pregnancy. Defines term.
New Hampshire			

MATERNITY AND
COMPLICATIONS OF PREGNANCY
7-81

	Citation	Effective Date	Comments
New Jersey	Circular Letters 75-2& 76-2 Admin.Code 11:1-4.3	9/1/76	Maternity coverage must be made available to single, divorced, separated and widowed women on same basis as offered to married women. Complications of pregnancy--same as illness.
New Mexico			
New York	162a, 164a	1976	Complications of pregnancy same as illness. Normal maternity coverage may be limited to 4 days hospital confinement. Note application of PL 95-555.
	Ch. 843 (Laws '76)	1/1/77	Mandates maternity coverage same as any other sickness in all grp. & ind'l Ks, except guaranteed renewable.
	162.5c	1/1/80	Grp. conversion Ks must contain required maternity benefits & must be same or substantially same as those provided in policy specifically approved as ind'l conversion policy by Supt.
North Carolina	Rule 11 NCAC 4.0107	1977	Similar to the NAIC Model Sex Discrimination regulation. Coverage for complications.
North Dakota	S. 2385 (Laws '79)	7/1/79	Prohibits insurance coverage of abortions except by optional rider for which additional premium must be paid & except where abortion necessary to save life of mother.
Ohio	Ch. 3901 3901.21(O)	8/31/76	If maternity benefits included, must be available to any ind'l covered by the policy in connection with family coverage.
Oklahoma			
Oregon	Ch. 731 743.037 IC-61	1973 1/1/75	Must provide same benefits for maternity to unmarried women as provided to married women, including the wives of insured persons choosing family coverage.
	§659.010 to 659.110	10/4/77	Women affected by pregnancy, childbirth or related medical conditions shall be treated the same for all employment related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected.
Pennsylvania	31 PA Cons. Stat. Ch. 145	1977	Substantially similar to NAIC Model Sex Discrimination Regulation.

MATERNITY AND
COMPLICATIONS OF PREGNANCY
7-81

	Citation	Effective Date	Comments
Rhode Island	R.I. Reg. XXIII	10/9/78	Provides that insurance K may exclude coverage for pregnancy "except for complications of pregnancy."
South Carolina			
South Dakota			
Tennessee	Ch. 0780-1-34.04	5/19/76	Complications of pregnancy benefits same as illness. Maternity benefits, if provided, cannot discriminate on basis of marital status. Applies to Ks issued 1/1/77; grp. blanket & franchise amended or renewed 6/1/76; K forms filed for approval 6/1/76.
Texas	Bd. Order 31704	12/1/78	Complications of pregnancy benefits same as illness. Exceptions or exclusions permitted for normal pregnancy & childbirth. Certain minimum benefits prescribed for maternity coverage if policy provides such coverage. Applies to ind'l basic hospital, medical & surgical expense policies, hospital indemnity, major medical expense & disability income policies.
Utah			
Vermont	Bul. 49 Bul. 54 Rev	3/1/80 4/22/81	Marital status in provision of maternity benefits requires coverage of complications of pregnancy. State employment act construed to require pregnancy coverage in employer grp. plans.
Virginia	38.1-348.9 38.1-348.13	7/1/78 7/1/81	Grp. hospital or major medical policies shall provide option for obstetrical services same as physical illness generally. Ks providing benefits for accidents shall include, same as for other covered accidents or accidental injury, benefits for pregnancy following rape which was reported to police within 7 days following occurrence. Time period extended to 180 days in case of rape or incest of female under age 13.
Washington	WAC 284-50-320(6)(c)	3/1/77	Ind'l--may not exclude complications of pregnancy. Does not include disability income protection policies.
West Virginia			
Wisconsin	Rules Ins. 6.55	6/1/76	Complications of pregnancy benefits same as illness. Applies to all Ks issued after 6/1/76 & grp. Ks issued prior thereto upon renewal or amendment.
Wyoming			

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	20-841 20-934 20-1057 20-1376 20-1406	1-1-80	If K provides coverage for alcoholism, drug abuse or psychiatric services, reimbursement shall be made whether covered service rendered in gen'l hospital or psychiatric special hospital. Applies to Ks delivered on or after 1/1/80 and to existing grp policies thereafter on renewal, anniversary date or expiration of collective bargaining agreement.
Arkansas	§66-3212 (11)	120 days after 7-20-79	Indl & grp policies providing payment of any health care services provided by hospitals or related facilities shall cover on equal basis services provided by licensed outpatient psychiatric center. Also applies to out-of-state grp Ks.
California	§10125	1-1-74	Group, hospital, medical & surgical - must offer to policyholder such benefits as may be agreed on
Colorado	10-8-116	1-1-76	Grp. hospital & medical expense Ks must include as to basic policies 45 days inpatient & 90 days "partial" on a "2 for 1 day" basis; as to major medical Ks, same as basic with up to 50% coinsurance (also see Alcoholism).
Connecticut	§38-174d	5-28-75	All grp. Ks must provide up to 60 days inpatient; major medical Ks shall provide benefits (outpatient) after the applicable deductible, at a 50% rate during any calendar year, up to $1,000.
Delaware			
Florida	§627.668		Grp., HMOs & hospital/medical service plan corps. shall offer benefits same as other illness except: inpatient may be limited to 30 days per benefit year, any excess need not be same as other illness; if offering outpatient benefits, coinsurance may not exceed 50%, maximum yearly benefit may be limited to $500 for consultations & dollar amounts need not be same as applied to physical illness generally.

	Citation	Effective Date	Comments
Georgia	56-3110 56-3016 56-2447 (S. 105 - Laws '80)	7/1/70 10/1/81	Policies providing hospital care which do not cover mental illness must contain statement in bold face type to this effect on policy & any identification card. Major medical Ks issued, delivered or renewed after 1/1/82 must make available to insured, covered spouse & dependents treatment of mental disorders same as other physical illness. Need not cover outpatient treatment for more than 40 visits per policy year.
Hawaii			
Idaho			
Illinois	370c	7-1-77	Grp. Ks must offer benefits with annual max. at least lesser of $10,000 or 25% of lifetime policy max. & coinsurance of 50% or less.
Indiana			
Iowa			
Kansas	KSA 40-2, 105	7-1-78	Unless refused in writing, grp. insurers must provide coverage for treatment of alcoholism, drug abuse or nervous or mental conditions for no less than 30 days per year in licensed hospital or facility & outpatient benefits limited to not less than 100% of first $100 & 80% of next $500 in any year.
Kentucky			
Louisiana	Title 22 §213.2	7-1-75	Grp., blanket & franchise Ks must offer benefits same as other illness; no waiting periods in excess of 12 months; services include psychologist and clinical social workers when in consultation with physician.
Maine	§2838	3/28/80	Grp. & blanket policies covering hospital care shall make available coverage of outpatient mental health services by community mental health centers.
Maryland	354J & 477M	1/1/77	Grp. & nonprofit health service Ks must offer option of providing benefits for cost of psychiatric care through partial hospitalization.

	Citation	Effective Date	Comments
Massachusetts	175§47B	6/1/76	Ind'l, grp. & blanket, employee welfare benefit plans must include 60 days inpatient in mental hospital; general hospit ' same benefits as for other illness; outpatient up to $500 over 12-month period.
Michigan			
Minnesota	§62A.152	8/1/75	Grp. Ks providing mental illness benefits must provide 90% of first $600 outpatient expense by hospital, community mental health center or approved mental health clinic.
	62A.151	7/1/75	Grp. policies, HMOs & health service plans shall include benefits, on same basis as other benefits, for treatment of emotionally handicapped children in residential treatment facility licensed by commissioner of public welfare.
Mississippi			
Missouri	§376.381	8/13/80	Insurers, health service corps, HMOs shall offer coverage of psychiatric services for recognized mental illness as follows: (1) if providing inpatient benefits, same as other illness; may be limited to 30 days in benefit period, (2) if providing outpatient benefits, treatment in psychiatric residential treatment center on inpatient or outpatient basis when prescribed by physician specializing in treatment of mental illness. Not less than 50% reasonable charges to maximum of $1500 in benefit period. Shall also offer 50% reasonable charge for 20 psychotherapy services rendered by physician specializing in treatment of mental illness or psychologist unless rejected by policyholder. Frequency of sessions may be limited but benefit shall be available for at least one session in any seven consecutive days.
Montana	33-22-701	1/1/82	Insurers & health service corps, hospital & medical expense policies must make available benefits for care & treatment of mental illness, alcoholism & drug addiction on same basis as other benefits, except inpatient benefits may be limited to 30 days per year; outpatient to $1,000 per benefit period; and maximum lifetime benefits to $10,000 or 25% of lifetime policy limit whichever is less. Does not apply to blanket, short-term travel, accident only, limited or specified disease, ind'l conversion or Medicare Supplement Ks.

	Citation	Effective Date	Comments
Nebraska			
Nevada			
New Hampshire	RSA 415:18-a	as amended 6-4-76	Minimum grp. benefits: 1) for basic hospital expense policies same benefits as for any other illness; 2) for basic medical expense policies same benefits as for physicians for other illnesses - outpatient same as any other illness, except may be limited to 15 hours treatment over 12 months; 3) for major medical, deductible & coinsurance at least same as for any other illness with 12 month maximum of not less than $3,000 per covered individual.
New Jersey			
New Mexico			
New York	Ch. 894 §162	1-1-78	Must make available on request 1) inpatient - not less than 30 days per calendar year 2) outpatient may be limited to $700 per calendar year.
North Carolina			
North Dakota	26-39-01 Dept. Bul. No. 30	7-1-75	Must provide 70 days inpatient, 140 days outpatient for grp., blanket & franchise over 50 lives & who cover 70% or more of grp.
Ohio	3923.28	1-1-79	Grp. medical expense Ks. other than accident only or specified disease that provide benefits for mental or emotional disorders shall provide benefits on outpatient basis equal to $500 in any calendar year or 12-month period. Applies to new & renewed policies after 1/1/79 & for period ending 4 years thereafter.
Oklahoma			
Oregon	743.558	10-5-73	Grp. Ks must offer benefits for at least 30 days inpatient; major medical outpatient at 50% coinsurance up to $500 per year.
Pennsylvania			
Rhode Island			

	Citation	Effective Date	Comments
South Carolina			
South Dakota			
Tennessee	56-7-1003 1004	7/1/74	Unless specifically excluded, ind'l, franchise, blanket or grp. Ks must provide benefits for psychiatric disorders, mental or nervous conditions, alcoholism, drug dependence or medical complications of mental illness or mental retardation. Benefits not defined but must be provided for services rendered in health facility licensed in state as hospital accredited by Jt. Com. of Accreditation of Hospitals or facility owned or operated by state which is especially intended for diagnosis, care & treatment of psychiatric, mental or nervous disorders.
		7/1/80	Grp. hospital, medical or major medical Ks shall make available outpatient benefits in community mental health centers which shall include minimum of 30 outpatient visits per year & deductibles & coinsurance not less favorable than illness generally. Benefits shall be part of policy unless policyholder rejects in writing. If K provides inpatient benefits, shall include community mental health centers with inpatient care facilities.
Texas			
Utah			
Vermont	T. 8 §4089	10-1-76	Grp Ks must provide option of "45 day equivalents of active case" per policy or calendar year; outpatient at 100% for first 5 visits, 80% thereafter, up to $500 per policy or calendar year.
Virginia	38.1-348.7	11-1-77	Indl & grp Ks must provide same benefits as for other illness, up to 30 days treatment per yr. Grp Ks must offer outpatient same as other benefits but may limit to $1,000 per benefit period at 50% coinsurance.

	Citation	Effective Date	Comments
Washington			
West Virginia	33-15-4a 33-16-3a	7-4-77	Indl & grp Ks shall provide, unless rejected by policyholder, at least 45 days inpatient in mental hospital, outpatient benefits at 50% coinsurance up to $500 up to 50 visits per year & services in comprehensive health service organization; community mental health center; by psychiatrist or psychologist. Inpatient in regular hospital--same as other illness.
Wisconsin	632.89	9-1-74	Grp Ks must include at least 30 days inpatient coverage and up to first $500 of outpatient service each calendar year.
Wyoming	26-25-102		No indl or grp policy providing coverage for mental illness or mental retardation shall exclude benefits for services provided by tax supported institution of state, provided such institution establishes and utilizes PSRO or comparable peer review programs, that its operations are subject to review according to federal and state law, and that charges are made for such services.

	Citation	Effective Date	Comments
Alabama	§27-19-38	4/27/75	Substantially model bill without notice provision.
Alaska	Title 21 21.42.345	8/24/75	Model bill
Arizona	Title 20 20.1342 20.1402	8/8/74	Substantially model bill
Arkansas	66-3249 66-3250 66-3248	7/1/75 7/1/75 3/13/81	Substantially model bill without notice provision. Coverage for newborn shall be same as for other family members and shall include coverage for illness, injury, congenital defect, premature birth, & tests for hypothyroidism & phenylketonuria as well as any testing of newborns hereafter mandated by law.
California	§10119 Bul.72-4	7/1/72 8/4/72	Model bill by interpretation.
Colorado	T.10,Art.8 10-8-121 10-16-134 10-17-130	7/1/72	Substantially model bill--elective coverage with regard to ind'l accident & sickness insurance policies.
Connecticut	Title 38 §38-174(g)	10/1/74	Substantially model bill
Delaware	18§3335 & 18§3510	11/23/74	Substantially model bill by interpretation, includes routine care.
District of Columbia	Law 3-33 Act 3-99	10/20/79	Ind'l & grp. policies shall include newborn children coverage, including premature birth. Applies to policies delivered, renewed, amended or reissued after 120 days following eff. date & to children born more than 120 days after eff. date.
Florida	627.6575 §627.641*	4/29/74 10/1/80*	Substantially model bill without notice provision; includes premature birth. Shall include transportation costs to & from nearest special facility to maximum of $1,000.*
Georgia	Title 56 §56-2441	11/1/74	Substantially model bill
Hawaii	Title 24 §431-454 S. 868 (Laws '81)*	6/12/74	Substantially model bill except does not include Blues. Adds well-baby care.*
Idaho	§41-2210 §41-2140	7/1/74	Interpreted as the model bill - ind'l, grp. & blanket disability insurance.
Illinois	356(c)	8/27/75	Substantially model bill, includes premature birth.

	Citation	Effective Date	Comments
Indiana	Ch. 5.6 27-8-5.6-2	10/1/75	Model bill
Iowa	T. XX Ch. 514C.1	1/1/75	Model bill
Kansas	Ch. 40 Art. 2 40-2.102 IDB 14	7/1/74	Substantially model bill
Kentucky	§304.17-042 §304.18-032 §304.32-153 §304.17.185 §304.18.033	10/1/76	Model bill Ind'l, grp., blanket, HMO, or service or indemnity Ks providing maternity benefits shall offer option for routine nursery care for well newly born child for up to 5 full days in hospital nursery.
Louisiana	T. 22 R.S. 22 §215.1	7/2/73 9/1/79	Substantially model bill--applicable to grp., family grp., blanket & franchise H&A insurance only. Policies providing coverage for family members shall offer coverage for transportation by ambulance, inc. airtransport, of newly born to nearest available hospital or neonatal special care unit within state for treatment of illness, injury, congenital defects & complications of premature birth. Policies in force on 9/1/79 have until 9/1/80 to offer such coverage. All other policies issued more than 90 days after 9/1/79 must comply.
Maine	24§2319 24A§2743 24A§2834	6/12/75	Substantially model bill
Maryland	48A-438A	1/1/75	Model bill
Massachusetts	C.175§47C C.176A§8b	1/1/75	Not model bill; includes premature birth; includes adoptive children
Michigan	§500.3403 §500.3611	3/3/75	Substantially model bill except does not include Blues.
Minnesota	§62A.042 §62C.14(14)	1/1/74 1971	Substantially model bill without notice provision.
Mississippi	§83-9-33	4/4/74 7/1/79	Model bill Transportation of newborn child to & from special facility.
Missouri	§376.406	8/13/74	Substantially model bill

	Citation	Effective Date	Comments
Montana	33-22-504(grp.) 33-22-301(ind'l) 33-30-1001	3/2/74 10/1/81	Interpreted as model. Amended to require immediate coverage of newborn under all ind'l policies including those that do not insure dependents.
Nebraska	44-710.19	1/1/76	Model bill
Nevada	Title 57 689A.043 689B.033 695B.193	8/31/75	Substantially model bill; includes premature birth. Major medical policies to include necessary transportation costs to nearest specialized treatment center.
New Hampshire	RSA415:22	7/5/75	Substantially model bill
New Jersey	§17:48A-5 §17B:26-2g §17B:27-30	11/27/75	Substantially model bill
New Mexico	59-18-21 59-18-22 59-19-50 59-19-51	6/20/75 7/1/78	Substantially model bill. Adds requirement that coverage include, where necessary to protect life of infant, transportation (including air transportation) to nearest available tertiary care facility. All policies providing maternity coverage on expense incurred basis must provide, where necessary to protect life of infant or mother, coverage for transportation (including air transportation) for medically high-risk pregnant women with impending delivery of potentially viable infant to nearest tertiary care facility for newly born infants.
New York	§164,Subs. 2(B)(3)	1/1/78	Family coverage shall provide coverage from moment of birth.
North Carolina	§58-251.4	5/7/73	Substantially model bill
North Dakota	26-03-38.1-38.3	7/1/79	Substantially AAP/HIAA model bill
Ohio	§3923.26	1/1/75	Substantially model bill
Oklahoma	T.36§6058	9/1/75	Model bill
Oregon	T.56§743.120	1/1/76	Substantially model bill except does not includes Blues.
Pennsylvania	Ch.2,Art.IX Ch.5§1(40PS771) §2(40PS§772) §3(40PS§773) §4(40PS§774)	8/1/75	Substantially model bill

	Citation	Effective Date	Comments
Rhode Island	R.I.Reg. XXIII	10/9/78	Requires newborn children coverage to the same extent as existing children or the insured.
South Carolina	§38-35-70		Model bill
South Dakota	58-17-30.2 58-17-30.3 58-17-30.4 58-18-32	7/1/76 7/1/77	Substantially model bill. All ind'l & grp. policies must provide coverage at next anniversary date of policy.
Tennessee	56-7-1001	4/22/76	Model bill
Texas	Art. 3.70-2(D)	8/27/73	Substantially model bill
Utah	31.33-2(6)	5/13/75	Substantially model bill
Vermont	T.8§4091	4/15/75	Substantially model bill
Virginia	§38.1-348.6	7/1/76	Substantially model bill
Washington	48.21.155(grp.) 48.20.430(ind'l) 48.44.212	2/16/74	Substantially model bill without notice provision.
West Virginia	§33-6-32	2/11/75	Substantially model bill
Wisconsin	632.91 Reg.3.38	6/1/76	Policies providing coverage for member of insureds family shall provide benefits applicable for children to newly born from moment of birth.
Wyoming	26-20-101, et seq.	5/30/75	Model bill

SOCIAL SECURITY OFFSETS
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona			
Arkansas	Reg. 18 §V.A.6(b)	4/15/75	Ind'l may not reduce benefits due to increased SSA benefits or other govt. plan after effective date of benefit period.
	HIAA IDB Ark. 1-80	9/80	Dept. will approve grp. Ks which include integration of SS benefit language subject to specific conditions.
California	10127.1	1-1-77	Cannot reduce benefits during a benefit period for increases in S.S. benefits. Applies to renewals, and to outstanding grp. Ks when renewed, amended or expiration of bargaining contract whichever is later.
	10127.15	7-7-77	Any provisions for reduction because of increase in S.S. benefits shall be null & void with respect to any increase which occurs on or after effective date.
Colorado	10-8-116(6)		Benefits may not be reduced for increases in S.S. effective after claim commenced
Connecticut	§38-174j	1-1-76 1/1/81	Grp. accident, health or accident & health or hospital or medical expense Ks cannot reduce benefits because of "the disability benefits" increases on or after date claim commences. No such policy shall contain an offset proviso.
	38-378(c)-1. (F)(3)	1/1/79	Ind'l--may not reduce benefits because of increase in SS benefits during benefit period.
Delaware			
Florida	Reg. C.4-37.06(6)(c)	1/1/75	Ind'l--no reduction in benefits because of increase in SS benefits during benefit period.
Georgia	§56-2444	7-1-79	Prohibits grp policies from reducing benefits because of changes in level of S.S. benefits.
Hawaii	431-521	1-1-78	Grp. disability Ks cannot reduce benefits due to S.S. increases effective after claim incurred.

SOCIAL SECURITY OFFSETS
7-81

	Citation	Effective Date	Comments
Idaho	41-2141 41-2216	7-1-78	Cannot reduce benefits due to S.S. increases. Provisions to contrary to be null and void with respect to any increase occurring on or after effective date.
Illinois	355.1	10-1-73	Claim for individual or grp. loss of time benefits may not be reduced because of S.S. cost of living increase while benefits for that claim are payable.
Indiana			
Iowa			
Kansas	KSA 40-2209 40-2210 Rule 40-30(C)	7-1-77	Grp. or blanket disability Ks may not reduce benefits because of S.S. increases which become effective after first day for which disability benefits become payable. Ind'l--may not reduce benefits because of increase in SS or similar benefits in benefit period.
Kentucky			
Louisiana			
Maine			
Maryland	48A§470F, 477G	7-1-75	Ind'l, grp. & blanket Ks may not reduce benefits because of SS increases.
Massachusetts	175§110F	10-1-74	Individual & grp. disability Ks cannot be reduced by an increase in federal S.S. benefits once payment of disability benefits has commenced.
Michigan			
Minnesota	62A.18	1-1-76	Individual & grp. Ks cannot reduce benefits due to increases in S.S., Railroad Retirement, Veterans Compensation or Workmen's Compensation effective after loss commences.
Mississippi			

SOCIAL SECURITY OFFSETS
7-81

	Citation	Effective Date	Comments
Missouri	Reg. 190-14.090§5	3-1-76	Disability Ks may not reduce benefits due to S.S. payments unless policy provides a minimum benefit after such reductions of at least 15% of stated benefits or $50 per month, whichever is greater. No reductions permitted for S.S. increases after claim incurred.
Montana			
Nebraska			
Nevada			
New Hampshire	415:18(I)(o)	6-7-75	Grp. & blanket A&H Ks may not reduce loss of time benefits as a result of increases in benefits under S.S.
New Jersey			
New Mexico			
New York	Reg. 62 52.18(b)(13)	5-1-72	No subsequent reduction in benefits following change in S.S. levels
North Carolina	12NCAC.0545 4NCAC.0313(2)	9-26-78 1979	Grp. & ind'l policies integrating benefits shall not reduce benefits because of changes in level of SS benefits.
North Dakota			
Ohio			
Oklahoma			
Oregon			
Pennsylvania	Title 40 619.1	1972	No claims for loss of time in grp. & individual A&H shall be reduced by reason of cost of living increase under S.S. while benefits are payable for that claim.

SOCIAL SECURITY OFFSETS
7-81

	Citation	Effective Date	Comments
Rhode Island			
South Carolina	Reg.R2-76 Reg.69-34 §G(6)(c)	7-19-76 7-13-81	Ind'l & grp. disability Ks cannot reduce due to increases in SS effective after claim incurred.
South Dakota	58-18-11.1 58-17-10.1	7-1-76	Individual & grp. disability Ks cannot reduce due to increases in S.S., Railroad Retirement, Veterans Disability, Workmen's Compensation, or similar loss, effective after claim incurred.
Tennessee			
Texas			
Utah	Reg. 80-12 §7.F.3.	9-1-80	Ind'l--no reduction because of increase in SS or similar benefits during benefit period. Does not apply to business buyout coverage.
Vermont	Bul. 28 Reg. 80-1 §7.F.(3)	2-14-75 7-1-80	Ind'l & grp.--may not reduce benefits because of SS or other govt. program increases. Ind'l--same as above; does not include business buyout coverage.
Virginia	Reg. 19 §8.E(3)	1-1-81	Ind'l--shall not reduce benefits because of increase in SS of similar benefits during benefit period (applies to new policy forms approved after 7/1/81 & policies delivered or issued for delivery after 7/1/82).
Washington	WAC 284-50-355(2)	3-1-77	Ind'l--may not reduce benefits because of increases in SS benefits.
West Virginia	Reg. 33-28, Series XIII §4.07(C)	4-1-75	Ind'l--may not reduce benefits because of increases in SS or similar benefits. Does not include business buyout coverage.
Wisconsin			
Wyoming			

SURGICAL CENTERS
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona	20-826 20-1342 20-1402	1974	Services covered in a hospital must be covered in free standing surgical facility. Applies to individual & grp. policies.
Arkansas	66-3212(10) H. 524 (Laws '81)	7-6-77 7-20-79* 3-12-81	All individual or grp. hospital or medical expense policies issued more than 120 days after effective date must provide benefits for treatment in licensed outpatient surgery centers on equal basis as treatment in hospitals or related facilities. *Includes out-of-state grp. Ks. If policy provides inpatient benefits, must offer identical coverage for such services delivered on outpatient basis. Grp. Ks shall conform on first anniv. of issue date after eff. date. Policyholder may reject in writing.
California			
Colorado			
Connecticut			
Delaware			
Florida	395.22 395.01(5)	10-1-77	Ambulatory centers - Grp. & Individual expense incurred policies must provide coverage if it would have been covered on an inpatient basis. Defines ambulatory surgical centers
Georgia	56-3016(c)& Reg. C. 120-2-10.03	9-1-80	Ind'l policies providing medical & surgical inpatient benefits shall provide for outpatient benefits, at certain outpatient facilities, including physician & dentists services.

	Citation	Effective Date	Comments
Hawaii			
Idaho			
Illinois			
Indiana			
Iowa			
Kansas			
Kentucky	KRS C 304.17 304.19 304.32	10-1-78	All individual, grp. or blanket policies providing coverage on expense incurred basis shall provide coverage for treatment by ambulatory surgical center on same basis as coverage provided for same treatment in hospital.
Louisiana	RS22:223	9-9-77	All health & accident insurance policies providing surgical coverage shall provide benefits for services in licensed ambulatory surgical center up to limit in policy, provided such services would have been covered if performed on inpatient basis.
Maine			
Maryland			
Massachusetts			
Michigan			
Minnesota	62A.153	8-1-76	All Ks must specifically include coverage for ambulatory surgical centers approved by State Board of Health.
Mississippi			

	Citation	Effective Date	Comments
Missouri	Reg. 190-14.090 (6)	3-1-76	Individual & grp. Ks must cover same ambulatory surgical center services as covered for inpatient - benefit levels not prescribed
Montana			
Nebraska			
Nevada			
New Hampshire			
New Jersey			
New Mexico			
New York	164-7-j	1-1-77	Ind'l Ks providing inpatient benefits shall offer coverage for ambulatory care.
North Carolina			
North Dakota			
Ohio			
Oklahoma	S. 774	6-15-76	No entity providing grp. coverage may discriminate in payment for or recognition of ambulatory surgical centers; however, benefits are not prescribed
Oregon			
Pennsylvania			
Rhode Island			
South Carolina			

	Citation	Effective Date	Comments
South Dakota			
Tennessee			
Texas			
Utah	26-32-17	1976	Third party payors shall reimburse benefits for licensed ambulatory surgical facility same as hospital.
Vermont			
Virginia			
Washington			
West Virginia			
Wisconsin			
Wyoming			

UNIFORM CLAIM FORMS
7-81

	Citation	Effective Date	Comments
Alabama			
Alaska			
Arizona			
Arkansas			
California			
Colorado			
Connecticut			
Delaware			
Florida	Ch. 77-46	1-1-78	Requires Commissioner to prescribe standard claim forms for hospitals & physicians. Excludes claims submitted or processed by electronic or electro-mechanical means.
Georgia			
Hawaii			
Idaho	Reg. 35	8-15-80	In the absence of insurer's claim forms, providers shall use AMA uniform claim form.
Illinois			
Indiana	Ch. 5.5	6-1-77	Requires Commissioner to prescribe uniform accident & health claims forms. Insurers may also accept other forms for additional information.
Iowa			

	Citation	Effective Date	Comments
Kansas			
Kentucky	S. 40 (Laws '80)		Requires Commissioner to prescribe uniform claim forms to be used by insurers.
Louisiana			
Maine			
Maryland	S. 1073 (Laws '80)	7-1-80	Ind'l & grp. claim forms must conform to requirements of commissioner.
Massachusetts			
Michigan			
Minnesota	§62A.025	8-1-75	Requires Commissioner to prescribe uniform claim forms for each class of provider.
Mississippi			Requires Commissioner to prescribe proof of loss form in consultation with the Health Insurance Council, State Hospital Association & State Medical Association.
Missouri			
Montana			
Nebraska			
Nevada	689A 689B Ins. Dept. Bul. LH-5	7-1-75 7-1-76	Authorizes Commissioner to establish by regulation uniform claim forms, & requires hospitals to use AHA approved hospital forms. Department regulation deems HIAA uniform forms developed with AMA & ADA approved for uniform use. Other forms may be used upon approval.
New Hampshire			
New Jersey			

	Citation	Effective Date	Comments
New Mexico			
New York	174-a subd. 7	1-1-78	Requires Superintendent to establish standard claim forms for hospital, physician, & other health care provider claims after a review of claim forms currently utilized by carriers & providers. Carriers not precluded from using additional forms for further claim information.
North Carolina	58-257.1	1955	A&H claim forms must conform to standard language approved by Commissioner.
North Dakota			
Ohio			
Oklahoma			
Oregon	Dept. Reg. IC-56		Prescribes health insurance claim forms applicable for all health care provider services except vision, drugs & claims other than on an expense incurred basis.
Pennsylvania			
Rhode Island			
South Carolina			
South Dakota			
Tennessee	56-7-1008		Allows Commissioner to prescribe uniform claim forms to be used by health care providers.
Texas			
Utah			
Vermont			

UNIFORM CLAIM FORMS
7-81

	Citation	Effective Date	Comments
Virginia			
Washington	Ins. Comm. Bulletin 78-4	3-22-78	Requests all insurers to use uniform claim forms (as per HIAA uniform forms program).
West Virginia	Reg. 33-2 Series XVII	1-1-81	Prescribes uniform claim forms for all health insurance claims with exception of disability income, credit disability and vision care.
Wisconsin			
Wyoming			

	Citation	Effective Date	Comments
North Dakota (Cont.)			
Prisoner Coverage (Cont.)	26-03.1-13	7/1/77	Continuation of coverage for juvenile delinquint while in legal custody of state institution or agency as long as juvenile meets all other usual qualifications and continues to pay premiums.
Ohio			
Hospitals	H. 1215 (Laws 76)	8/26/76	Policies providing coverage for mental illness shall provide for confinement in tax-supported institution of state or municipality thereof.
Kidney Dialysis	3923.25	1972	Policies providing for kidney dialysis shall include benefits whether inpatient or outpatient.
Oregon			
Hospitals	743.116	1/1/72	May not exclude coverage, except for mental illness or psychiatric care, for service rendered in hospital owned or operated by state or political subdivision.
Rhode Island			
Hospitals	Reg. XXIII, Part VII, §3(B)(2)(d)	10/9/78	Hospital indemnity policies--VA hospitals: same benefits must be provided for 1st 35 days of any one confinement same as other hospitals; may reduce to 2/3 benefit after 35th day.
South Dakota			
Worker's Comp	H. 1111 (Laws 81)	7/1/81	Grp insurers required to offer to extend coverage for persons opting out of worker's compensation.
Tennessee			
Hospitals	56-26-124	1/1/75	Indl/grp Ks cannot exclude benefits on grounds that service rendered in tax supported institution if such institution charges patients in absence of insurance.
Sterilization	56-7-1006	7/1/76	If providing benefits for sterilization, no disclaimer, restriction or limitation because of insured's reason for procedure.

MISCELLANEOUS
MANDATED BENEFITS
7/81

	Citation	Effective Date	Comments
Texas			
Hospitals	Art. 3.42B		May not prohibit payment for nonindigent person in state or local govt. hospital provided charges are regularly and customarily charged to nonindigent persons.
	Art. 3.70-2(D)		No policy providing coverage for mental illness/retardation may exclude benefits provided in tax-sponsored state institution provided charges are regularly and customarily made to nonindigent persons.
Vermont			
Hospitals	Reg. 80-1 §6.D.	7/1/80	VA exclusion prohibited in hospital indemnity policy.
Washington			
Hospitals	WAC 284-50-320(5)	3/1/77	VA exclusion prohibited in hospital indemnity policy.
Right to Die	H. 264 (Laws 79)	6/2/79	No insurer shall require person to execute directive for withholding or withdrawal of life-sustaining procedures as condition of being insured.
West Virginia			
Hospitals	Reg. 33-28 Series XIII §3.01(F)	4/1/75	VA exclusion prohibited in hospital indemnity policy.
Wisconsin			
Hospitals	632.89(2)	1/1/81	Grp Ks may not limit coverage of services provided by state or county inpatient facility other than as limited for other inpatient treatment.
	632.89(2m)	1/1/81	Any insurer providing hospital treatment coverage liable to state or county for costs incurred for inpatient services regardless of patient's liability for service to extent insurer is liable to patient for service provided in other inpatient facilities.

	Citation	Effective Date	Comments
New Hampshire			
Hospitals	Reg. 19 §IV.A.5	1/1/77	May not exclude benefits for hospitals operated by state, county, city or other political subdivision.
Reconstructive Surgery--Dependent Children	Reg. 19 §VI.M.	1/1/77	Indl, grp & blanket Ks may not exclude coverage for reconstructive surgery incidental to or following surgery resulting from trauma, infection or other disease of involved part or for congenital disease or anomaly of covered dependent child which resulted in functional defect.
Specified Disease	Reg. 19 §III.G.	1/1/77	Specified disease coverage not permitted unless K also provides basic hospital expense, basic medical-surgical expense, hospital confinement indemnity or major medical expense coverage.
New Jersey			
2nd Surgical Opinion	17B:26-2.2 17B:27-46.2 11:4-16.6(a)g	7/19/80 3/20/81	Indl/grp Ks covering surgery on inpatient basis shall offer 2nd surgical opinion program which must cover 3rd surgical opinion in same manner. If insurer provides such services at no cost to insured or patient, insurer may provide reduced benefits for surgical charges for elective surgery if performed without first obtaining 2nd or 3rd confirming opinion.
Specified Disease	Cir. Ltr. 76-3	5/17/76	Dept. no longer considers for filing any specified disease benefits.
New Mexico			
Hospitals	Rule 80-6	1/1/81	Insurer may not limit or restrict freedom of choice in hospitals maintained by state or political subdivision.
Right to Die	S. 166 (Laws 77)		No insurer shall require person to execute right-to-die document as condition of being insured.
New York			
Emergency Care	164-7-h	1/1/77	Indl Ks providing inpatient hospital benefits must include coverage for emergency medical care in medical facility. Need not be provided unless care rendered within 12 hrs after 1st appearance of illness or 72 hrs after accident.

	Citation	Effective Date	Comments
New York (Cont.)			
Nursing Homes	164-7-i	1/1/77	Indl Ks providing inpatient hospital benefits shall offer nursing home care coverage.
Outpatient Diagnostic Study	164-7-e	1/1/70	Indl Ks to reimburse for lab tests and diagnostic xrays whether done inpatient or outpatient.
2nd Surgical Opinion	164-7-g	7/1/76	Indl Ks providing inpatient surgical benefits must include coverage for 2nd surgical opinion.
Specified Disease	Reg. 52.16	5/1/72	Prohibits policies which provide additional benefits for specified disease unless policy qualifies as basic hospital, basic medical or major medical insurance.
North Carolina			
Hospitals	58-251.6	1975	Grp Ks may not exclude benefits for hospital or physician charges in state tax-supported institution, including charges for care of cerebral palsy, orthopedic and crippling disabilities, mental and nervous disorders, mental retardation, alcoholism and drug dependency and respiratory illness. Benefits must be no less favorable than if rendered in or by other public or private institution or provider. Includes community mental health centers and other health clinics certified as Medicaid providers.
North Dakota			
Assignment of Payment	26-03-39.2(1)	1979	Indl/grp Ks may not deny or prohibit insured from assigning to Social Service Board any rights to medical benefit coverage.
Medicaid	26-03-39.2(2)	1979	Indl/grp Ks may not limit or exclude payment if insured eligible for medical assistance benefit.
Prescribed Drugs	26-03.1-04.1	7/1/79	Grp & nonprofit medical service corp.--as option, coverage for prescribed drugs.
Prisoner Coverage	26-03.1-12	3/27/75	Incarceration not grounds for cancellation. Continuation of coverage to same extent coverage continued for general public as long as prisoner meets all other usual qualifications and pays premiums.

	Citation	Effective Date	Comments
Illinois (Cont.)			
Mastectomy (Cont.)			may be limited to provision of prosthetic devices and reconstructive surgery to within 2 years after mastectomy.
Rape Victim	356e 367(11)	8/26/75	Hospital or medical expense incurred K may not preclude benefits for expense of examination, testing or treatment of victim of rape or attempted rape.
Indiana			
Laetrile	Bul. 38	8/22/79	Policies not excluding laetrile treatment must cover if prescribed by physician.
Kansas			
Right to Die	S. 99 (Laws 79)	7/1/79	Insurer shall not require person to execute declaration directing withdrawal or withholding of life sustaining procedures as condition for being insured.
Louisiana			
Hospitals	22.659.A		Insurers may not exclude payment of benefits rendered in state-owned hospital.
Medicaid	22.659.B		Insurers may not exclude payment of benefits reimbursable in whole or part by Medicaid.
Maryland			
Blood	48A§470G 477H	1975	Indl/grp Ks may not exclude payment for blood products which would otherwise be covered under K.
Dept. of Health & Mental Hygiene	48A§470N 477U	1980	On notification by Dept., indl/grp insurers shall reimburse Dept. for cost of its services to insured regardless of any K provision which would require payment to policyholder or other payee.
Hospitals	48A§470B		Indl/grp Ks covering TB, mental illness or other illness may not exclude payment for treatment in state or municipal hospital, even if institution deemed charitable.

	Citation	Effective Date	Comments
Maryland (Cont.)			
Medical Assistance Program	48A §§470L 477Q	1978	Indl/grp Ks may not deny or reduce benefits because service rendered to insured eligible for or receiving state medical assistanee.
Massachusetts			
Hospitals	Reg. 211 CMR 42.00		VA exclusion prohibited in hospital indemnity policy.
	C.175 §22, para. 2		Policies may not exclude certain expenses in soldiers' homes.
Specified Disease/ Cancer Only	Reg. 211CMR 47.07(1)(a)-(e)	9/79	Such coverage must be sold as supplement to basic hospital ins. benefits, to begin when basic coverage exhausted. Must cover 11 other diseases than cancer.
Minnesota			
Mental Retardation/ Epileptics	H. 1251 (Laws 79)	5/23/79	Insurers may not reduce or deny benefits because services rendered to persons eligible for assistance or services rendered by agencies administering to mentally retarded or epileptic.
Reconstructive Surgery-- Dependent Children	62A.046	7/1/80	Health Ks must provide benefits for reconstructive surgery of covered dependent children as result of congenital disease or anomaly.
2nd Surgical Opinion	62E.06(1)(e)	7/1/79	Comprehensive Health Act requires coverage for 2nd surgical opinion on procedures expected to total $500 or more.
Mississippi			
Hospitals	83-9-7	8/6/68	Ks providing coverage for TB, mental illness or other illness shall not exclude benefits when patient hospitalized in tax sponsored institution of state or municipality thereof.
Missouri			
Hospitals	Reg. 190-14.030	12/74	VA exclusion prohibited in hospital indemnity policy.

MISCELLANEOUS
MANDATED BENEFITS
7/81

	Citation	Effective Date	Comments
Alabama			
Hospitals	27-19-28	9/20/71	Indl/grp Ks providing coverage for psychiatric treatment or mental illness shall not exclude hospitalization benefits for mental patients in tax-supported institutions of state or municipality thereof.
	S. 103 (Laws 80)	5/19/80	Insurers cannot take state appropriations to Univ. of Alabama and Univ. of South Alabama in account on patient care costs.
Arizona			
Sickle Cell Anemia	36-797.43	7/31/80	Dept. of Health Services to develop & operate program for diagnosis, care & treatment of children with sickle cell anemia. Third party payors to reimburse Dept. for part or all costs based on responsibility to pay.
California			
Children's Preventive Care	10123.5 11512.17 1367.3	1979	Grp Ks & hospital, medical or surgical plans shall offer benefits for comprehensive preventive care of children as may be agreed upon between insurer and policyholder.
Hospitals	10178	1978 1980	No denial of claim for hospital, medical or surgical service in nongovt. charitable research hospital which makes no charge for services in absence of insurance.
Mastectomy	10123.8	7/1/80	Grp & self-insured plans providing coverage for mastectomy shall include coverage for prosthetic devices and reconstructive surgery.
Prisoner Coverage	10123.11 11512.21	7/1/80	Grp Ks shall not deny claims for sole reason insured confined in city or county jail as prisoner or in juvenile detention facility if otherwise entitled to benefits under policy.
Sterilization	10120	1970	If providing benefits for sterilization, no exception, reduction or limitation based on insured's reason for procedure.
Connecticut			
Hospitals	38-378(b) 1		VA exclusion prohibited in hospital indemnity policy.

MISCELLANEOUS
MANDATED BENEFITS
7/81

	Citation	Effective Date	Comments
Connecticut (Cont.)			
Specified Disease	Bul. HC-17	4/1/76	Specified disease Ks prohibited and policies & riders previously approved withdrawn.
Florida			
Hospitals	627.645	10/1/77	No claim for payment of medical care or treatment of child in licensed nonprofit hospital shall be denied solely because treatment & care primarily of charitable nature.
		10/1/80	May not deny claims for services in hospitals accredited by Jt. Com. on Accreditation of Hospitals & Amer. Osteopathic Assn. of Rehabilitative Facilities solely because hospital lacks major surgical facilities & is primarily of rehabilitative nature, if rehabilitation specifically for treatment of physical disability.
Georgia			
College Students	56-3105(8)	1/1/79	K shall continue coverage of dependent child until age 25 (even if child has reached age specified in policy for termination) so long as child continues to be both dependent and full-time student for 5 calendar months or more in secondary institution.
Idaho			
Hospitals	Reg. 30		VA exclusion prohibited in hospital indemnity policy.
Illinois			
Homemakers	370d	1/1/80	Business overhead expense coverage must be made available to homemakers covering expense incurred by members of household due to incapacity of homemaker; 80% of eligible expense or $300 per month, whichever is lesser.
Mastectomy	356g 367	7/1/81	Indl/grp Ks providing coverage for mastecomy shall offer coverage for prosthetic devices or reconstructive surgery for mastectomies performed after 7/1/81. If no evidence of malignancy, offered coverage

	Citation	Effective Date	Comments
Wisconsin (Cont.)			
Kidney Disease	632.78(2)	6/2/76	Policies including hospital expense incurred coverage must contain provision for hospital inpatient and outpatient kidney disease treatment; may be limited to dialysis, transplantation and donor related services in amount not less than $30,000 per year.
Skilled Nursing Care	632.78(4)	11/29/79	Policies providing hospital benefits, with exception of hospital indemnity policies, shall provide coverage for at least 30 days skilled nursing care to insured entering such facility within 24 hrs after hospital discharge. Coverage shall apply only to care certified as medically necessary and for continued treatment of same medical or surgical condition for which insured treated in hospital.
TB	632.90	8/5/73	Policies including hospital or medical expense coverage must contain provision for maximum 90 days continuous coverage of costs for TB charges, fees or maintenance, including inpatient and outpatient dispensary charges or fees.