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HEALTH POLICY BULLETIN

FOCUS: C. EVERETT KOOP, M.D.

In the first of the Citizens Symposia to be held this fall, C. Everett Koop, M.D., former surgeon general of the United States, held forth. Koop took on virtually every facet of the health care delivery system in a one-hour performance that was well received by his audience.

He commented that Medicare, "despite its holes," is "one of the most decent things we have ever done." Nevertheless, our entire system needs financial and conceptual reform because it leaves out too many people. Some of his most stinging comments were reserved for Medicaid. He cited the well-known example of Alabama, where a family of three people with an income of $1,460 a year is "too rich for Medicaid." Insurance companies also came in for some criticism. Koop notes that the 2.5 million bad risks are uninsurable because "insurance companies compete on the basis of excluding people," and "insurance costs too much because health care costs too much." In his view, we should have basic coverage for all Americans that provides for primary, preventive, and catastrophic care; the insurance should be employer based.

Why does health care cost too much? In addition to the great villain technology, and the fact that new equipment only supplements existing technologies rather than replaces them, he cited the "dueling hospitals of Kalamazoo," whose intense competition has raised costs in that city considerably. Other contributors to health care costs are increases in physician fees, capital costs for replacement buildings, increases in the salaries of allied health professionals such as nurses, the price of pharmaceuticals, the practice of defensive medicine, and the costs of liability insurance. Two other problems, he observed, are AIDS and the growing elderly population—the health care costs for someone over age 65 are eight times those of someone under age 65.

The causes of the crisis, according to Koop, require solutions with spiritual dimensions: The primary causes are poverty, our most prevalent social disease, and greed. He said that not only are doctors and hospitals greedy, but also patients, who are the most greedy of all because they expect medical encounters to end in perfection.

During the question-and-answer period, Koop had acerbic comments to make on various subjects. On Jack Kevorkian: "He is a criminal." On the Oregon plan (an explicit rationing plan that would exempt the greatest users of Medicaid from rationing): "Taking from the poor to give to the poor." He also noted that Oregon's Medicaid program had the second highest administrative costs in the nation. On the plus side, he observed, "The Oregon plan has made the country realize you can't have everything all the time."

According to Koop, the nation is caught between the politics of demand versus prevention; we are interested in the glamorous events but are unwilling to spend money on prevention. "Insurers," he said acidly, "will pay $150,000 to treat a case of lung cancer, but not $64 for a smoking cessation course."

FOCUS: ADMINISTRATIVE COSTS IN HEALTH CARE

Administrative costs are a main source of frustration with our health care delivery system. Many claim that if administrative costs could be reduced to a reasonable level, all the people who are now uninsured could be insured, the costs of health care would be lowered, and everything would be all right. There is, however, one thing wrong with this scenario—it ain't necessarily so. In fact, it is probably not true at all. With that in mind, we share with you a recent article that we found worthwhile.

"Administrative Costs in the U.S. Health Care System: The Problem or the Solution," which appeared in the journal *Inquiry*, reports on a workshop sponsored by the Robert Wood Johnson Foundation and conducted by the Alpha Center, Washington, D.C.

Workshop participants pointed out that there is no consensus about what are administrative costs. For example, government programs like Medicare do not count the costs of collecting revenues or peer review organization costs, while private insurers count both in computing the costs of administration. Comparisons of costs among insurers, especially when compared to costs of government programs, are difficult and often meaningless; for example, participants pointed out, if Medicare costs are divided by claims, the administrative cost is low, but if Medicare costs are divided by the number of people covered, the administrative cost is high.

The workshop explored five options that may lead to reduced administrative costs: the revolution in medical information management, a single-payer authority demonstration, standardization of utilization review, reform of the insurance market to eliminate inefficiencies, and changes in the adversarial relationship between physicians and insurers.

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➤ ***Revolution in Medical Information Management*** Using "smart cards" and common formats and standards for information would create a system that would allow insurers to maintain their own claims-processing function but streamline billing, thus reducing errors and costs, permitting point of service access to eligibility and authorization approval, and speeding up payments. When linked to a secure computerized medical record, the system will let providers and insurers share information easily and quickly, resulting in lower administrative costs and improvements in the quality of care.

➤ ***A Single-payer Authority Demonstration*** Twenty-eight hospitals with 12,000 beds in New York agreed to participate in the project. The state is sponsoring an on-line electronic billing, claims processing, and payment system that is intended to reduce administrative costs by being less complex and more efficient. Reducing the number of billing staff, eliminating billing services that are unique or specific to one payer, and cutting interest costs (money hospitals borrow against receivables) should result in savings twice as great as the cost of operating the administrative authority. Estimates suggest that a reduction of five days in the age of accounts receivable could achieve a one-time savings of $500,000 for the average 250-bed hospital; this could be done by switching from a paper claims system to an electronic transmission system.

➤ ***Standardizing Utilization Review*** An option sure to capture the imagination of any hospital executive, a single, standardized utilization review system would allow a sampling of cases from every hospital to establish a system encouraging appropriate care. Hospitals could be ranked by the "level of appropriateness" of the care they provided. Since hospitals would receive feedback on their performance, those that did well on the scale of appropriateness could be rewarded, while those that did not could be penalized. The advantage to hospitals would be that they would need to provide only one set of records to a utilization review entity regardless of the number of payers involved. It also would eliminate separate reviews for each service provided to the patient.

➤ ***Reforming the Insurance Market to Eliminate Its Inefficiencies*** Because only 25 to 30 percent of the population is affected by state regulation of insurance and one of the prices of flexibility in a large and diverse market is inefficiency, reforming the insurance market will be difficult. Nevertheless, targets for reform do exist: the elimination of duplicate regulation by the states and the federal government (state regulations governing conversion privileges that are already covered by federal COBRA legislation and federally qualified health maintenance organizations) and the overlapping regulatory authority between insurance and health departments that occurs in many states. Changing state and federal tax policy and laws governing underwriting to ensure that all third-party payers operate in a fashion designed to reduce inflating premiums for substandard risks and adverse selection would make it easier for small businesses to get insurance and to remain with one insurer. (The costs of marketing to small groups that have high rates of turnover is often cited as an insurance market inefficiency.)

➤ ***Changing the Adversarial Relationship between Physicians and Insurers*** Increasing the use of integrated systems (e.g., group and staff model health maintenance organizations that include the insurer who designs and markets the plan, the physicians who provide care, and the hospitals that provide services through contracts negotiated with the plan and physicians) would help reduce administrative costs. Such systems work well when both the plan and the physician share the risk and deal with each other exclusively, because participation by providers in several networks effectively removes the element of shared risk necessary to make an integrated system work. Physicians and insurers would no longer need to evade the controls imposed by each other, and the hospital would know its service population, thus permitting both rational budgeting for the needs of that group and rational decisions about expansion and the acquisition of equipment.

➤ ***What About the Tradeoffs?*** The questions asked and answered during the design phase for a new health care system will affect administrative costs. A single-payer system would standardize the payment system, while an all-payer system would standardize the rate payment structure; the result would be more efficiency and less fragmentation in the insurance market. Employer-based insurance is difficult to make efficient and effective because about half of the work force is employed in small businesses. There are four options: expand employer coverage through mandates affecting either the employer or the employee; establish multiple-employer purchasing arrangements; finance insurance through taxes rather than premiums; and replace employer-based health insurance with a universal system operated by the government.

OF INTEREST

The legislature returns November 5. In the next 30 days, look for

- the House Committee on Public Health to take up SB 305 (chiropractic scope of practice), SB 501 (reopens death records), SB 371 (nursing home beds for special populations), SB 1106 (reimbursement of physicians' assistants), HB 5248 (creates office of nursing), and HB 5262 (licensure of medical technologists), and
- the Senate Committee on Health Policy to take up HB 4491 (moves registration of social workers from the commercial code to the occupational code).

—Frances L. Faverman, Editor

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