A STUDY OF BLUE CROSS AND BLUE SHIELD OF INDIANA

BY

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ACCEPTANCE

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CHAPTER I

INTRODUCTION

Statement and Explanation of the Study

Hospitals, physicians, the government, employers, unions, insurance companies and the consumer must share the burden and blame for skyrocketing health care costs. The public must look to these same groups to try to bring these costs under control. The costs have increased tenfold over the past two decades because of the following reasons.

1) **Inflation.** Over the past few years, "double-digit" inflation has been commonplace in the economy and continued inflationary movement appears to be safely predicted for the future. It appears that inflation will continue to push health care costs upward. There are only limited opportunities to increase the health care productivity through mechanization. More workers, not fewer, will be needed to meet the rising expectations in the field of health care.

2) **The Growing Elderly Population.** One of the reasons for the nation's huge Medicare bill is that it has increasingly covered more people. According to predictions made by the U.S. Bureau of the Census, Americans over age 65 will

increase from 25 million in 1980 to 66 million by 2040. This growth represents an increase from 11 percent to 21 percent of the total population.[1] Senior citizens receiving better health care are living longer and thus extends the demand for continued medical treatment under Medicare. The related costs tend to increase near the end of life. For example, it has been estimated that much of the Medicare budget is spent each year to support people medically in the last years of their lives.

3) **Consumer Demand.** Today the philosophy of health care in the United States is that health care is a "right". A patient is entitled to the most advanced levels of treatment, almost regardless of what the cost is or whether the individual patient can pay for that service.

4) **Advances in Technology.** As the progression finds more ways to cure illnesses or prolong life with the development of new drugs, new surgical procedures and machines, more money will be needed to support the new advances in

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1 Joyce Riffer, "Elderly 21 Percent of Population by 2040," Hospitals, March 1, 1985, pp. 41-44.

technology. The significant cost of new medical machines and the training of the staff to run them is certainly a factor that will contribute to and affect the consumer's medical care bill.

5) **Increased Use of Diagnostic Procedures.** The medical professionals now can diagnose conditions with the new equipment that used to require extensive laboratory tests and/or exploratory surgery. There is now a wide variety of diagnostic tests which tend to be more expensive because of the equipment and training required for their use.

Because of these foregoing reasons, an increasingly important trend is that toward the integration of Diagnosis Related Groups which provide a first look at evolving new strategies for comparing costs of services among the suppliers of services. Health Maintenance Organizations are designed to make integrated health care products on a cost-competitive basis. Preferred Provider Organizations act as intermediary organizations that arrange for third party payers to purchase health care services for their subscribers from selected providers, including hospitals and physicians. Free-standing outpatient and urgent-care facilities are com-

peting on a price basis with existing health care institutions.

A major question this researcher asks is what does the future hold for the insurance industry in the next 20 years. Over the past thirty years, insurance has been viewed as an acceptable way to protect the policyholder from catatrosphic loss because of unexpected high health care events. The incentives built into these insured plans were intended to help the public protest their financial stability and their future health by encouraging the policyholder to seek proper care when their physicians decide it appropriate.

Our social philosophy of health care swung the farthest with the advent of Medicare and Medicaid making services available to the elderly and the poor--the two groups who needed it more but could least afford to pay.

It was not long before the first financial signs appeared indicating that there were few controls against the potential for over utilization of the Medicare and Medicaid programs. When the federal government introduced changes designed to limit its financial outlay for health care, providers often were able to make up for payment shortfalls by

shifting unmet costs to nongovernment payers.

As the cost to insurance companies for providing the increased health care rose and diluted profits, insurance companies naturally increased their rates. As costs to individuals and institutions went up both individual consumers and industrial consumers protested; government costs rose extraordinarly rapid in support of the increasing elderly populations' medical needs. Studies by insurance companies, by independent researchers and by government agencies attempted to find means to provide the necessary services but at a fair and affordable price and to reduce redundencies in the treatment provided by the medical profession and the hospital industry.

There have been various studies on the insurance industry in the past. This current study is undertaken to make a contribution to knowledge and understanding about the burgeoning costs as they affect the practices, policies and services offered by Blue Cross and Blue Shield in its changing role as a provider of health care insurance under the stringent government regulations imposed by Congress to reduce the health care bill without a reduction in essential

medical services to the patient. Therefore, this study will deal primarily with Blue Cross and Blue Shield in the industry.

Purpose of The Study

The results of this study may serve a threefold purpose. First, it should be helpful as a basis for a better understanding of the significance of BXBS as a forerunner of the redesigned insurance industry practices in the DRG environment. Second, the BXBS organization may use the results for the development and/or reorganization of current courses for BXBS employees. Third, by undertaking the study of BXBS of Indiana, the resulting recommendations may be instituted to other health care organizations such as the hospital, home health care agencies, HMOs, etc.

Delimitations of The Study

Due to the size of BXBS, specific delimitations are necessary to confine the problem to BXBS of Indiana. These delimitations are due in part to the volume of data available on BXBS.

Nature and Source of Data

The study grew out of the author's association with the health care industry as a trained professional in a regional hospital. The author has served as a statistician in the Medical Record Department and also as Assistant to the Director of Medical Education in a hospital of 227 beds serving an area of 25,000 people.

The general procedure consisted of the process of problem identification for major parties in the health care industry and steps being taken to solve these problems.

Due to the magnitude of the total health care industry and the developing problems growing out of increased involvement of government, insurance companies, medical practitioners, technical service specialists and after care participants; the author reduced the scope of the study to manageable proportions to permit expectation of completion in a reasonable time period.

Therefore, the delimitations presented in the foregoing section narrowed the study considerably but permitted in-depth treatment of the signficant component as identi-

fied during the design and refinement of the research approach.

Data were collected by personal interviews with key persons in the selected provider. In addition, library sources were drawn upon as well as literature published by Blue Cross and Blue Shield of Indiana.

The collected data were classified according to their relationship to the elements in the study as contained in the working outline for the study. Some modifications in the outline were made as new information was identified. The summary and observations represent the professional comments and understanding derived from this in-depth analysis of the role and function of Blue Cross and Blue Shield in the state of Indiana as the insurer adjusts to the changing medical practice and cost containment efforts.

Much of the historical explanation about the Indiana BXBS provider has been extracted from numerous printed plans and booklets distributed over the years by the Indiana BXBS organization. The author has drawn heavily on the historical statements thus provided. Additionally, where the data are somewhat technical, the printed statements by the Indiana

BXBS organization are relied upon for content and preciseness of statements since all such materials were subjected to legal scrutiny before release for printing. Consequently, the body of this study is left as uncluttered as practical from references and footnotes, without any intent to verify the source attributors as followed by all careful research writers.

The summary and observations represent the professional comments and understandings derived from this independent analysis of the role and function of BXBS of Indiana as the insurer adjusts to the changing medical practices and cost containment efforts.

CHAPTER II

HISTORY OF BLUE CROSS AND BLUE SHIELD

Prepaid hospital plans first started in Dallas, Texas in 1929 when Justin Ford Kimball, Ph.D., Vice President of Baylor University, conceived a plan for a group of school teachers, whose financial status he knew well. Under this arrangement, each teacher would pay 50 cents each month to the Baylor Hospital and would then be entitled to 21 days of hospital care, at no additional cost. The success of this initial plan was evident. By the end of the first year, 1,000 teachers had enrolled and Dr. Kimball was enrolling his second group of Dallas News employees.

Blue Cross Plans

The idea of single-hospital, single-group programs such as Baylor's was quite appealing during the 1930's Depression, when income from endowments and contributions fell off drastically. However, it became apparent that Baylor's program would not be feasible if a member of the paying group needed care and wanted it in another hospital. To meet this need,

hospital plans were organized in New York, Minnesota, North Carolina and elsewhere, most of them with the help of C. Rufus Rorem, Ph.D. who played an important role in the development of what came to be called Blue Cross Plans.

In St. Paul, Minnesota, a school teacher and salesman, E.A. van Steenwyk began using a "blue cross" as an identification symbol on his stationery, folders and posters for the Hospital Service Association. Residents in St. Paul began calling his Hospital Service Association the 'Blue Cross' Plans.

The 'patron saint' of the Blue Cross Plans, Justin Ford Kimball, had little interest in developing the Plans nationally. He was satisfied with the idea that he had created the concept; therefore, others took the idea and developed it into an organization. Four men are worth mentioning. They are Fran Van Dyk from New Jersey, C. Rufus Rorem from Illinois, John Mannix from Ohio and E.A. van Steenwyk also from Ohio. The most significant thing about these men is that they were not demonstrated leaders or business tycoons, their biggest advantage was their youth and idealism. As the number of Blue Cross Plans grew in the

1930's, the American Hospital Association received a grant from the Julius Rosenwald Foundation to organize the Committee on Hospital Service. The director, C. Rufus Rorem, called the first meeting of this committee in 1937 and in 1938, the committee issued 14 Standards of Approval which still exist, having been refined throughout the years. These standards deal with the composition of Plan Boards of Directors, the Plans' financial status and the level of covered services. In 1946 the name of this committee was changed to the Blue Cross Commission. Two years later, in 1948, it was expressed that there was a need for an organization that could help serve member groups that included employees in more than one Plan area. Therefore, the Blue Cross Association was incorporated in Illinois as a not-for-profit corporation. At this time, there was no paid staff until 1956 when the Association hired staff to help coordinate marketing and other services to the Plans. This Association now became the dominant organization serving the Plans and assuming most of the functions previously handled by the Blue Cross Commission.

In 1960, the Blue Cross Commission was dissolved and

the Blue Cross Association took over all of its duties. However, the approval program for the Plans remained with the American Hospital Association as well as the Blue Cross name and symbol which the AHA owned. In June, 1972, the American Hospital Association and the Blue Cross Plans formally separated by dissolving the joint Board membership between the Blue Cross Association and the American Hospital Association and thereby transferring the approval program and ownership of the Blue Cross name and symbol to the Blue Cross Association. The American Hospital Association seal was taken out of the cross and replaced with a stylized human figure.

Blue Shield Plans

After the growth of the Blue Cross Plans, interest grew in the idea of medical prepayment plans. Consumers of health care were responding well to the coverage of Blue Cross Plans. In California, physicians decided that there was a public demand for medical prepayment and decided that the best way was to introduce a voluntary program. The California Medical Association supplied the funds to establish

the first Blue Shield Plan-type organization, California Physicians' Service, which was incorporated as a nonprofit corporation in 1939. In the 1940's the California Physicians' Service entered into agreements with the Blue Cross Plans in California to work together to enroll people who wanted both Blue Cross and Blue Shield coverage. Enrollment in California Physicians' Service grew slowly. Because the subscribers were using more services than the Plan could pay for out of its membership fees, the participating physicians agreed to accept small payments for their services. This therefore guaranteed the financial security of the Plans and points up an important feature of the Plans, the physicians' acceptance of responsibility for the Plans' stability and success. If the physicians had not supported the early Plans, these Plans might easily have collapsed financially.

While California Physicians' Service was organizing their Plan, the Michigan State Medical Society organized the Michigan Medical Service in 1940. Other states and some county medical societies organized similar prepayment programs which were separate corporations. Details on the rates and benefits varied from state to state but the one

common feature was the sponsorship by the local medical profession.

The Blue Shield symbol was first used by the Plan in Buffalo, New York in 1939. The Plans' first president, Carl Metzger, created the symbol which was based on the U.S. Army Medical Corps insignia. The name and symbol were registered officially as the name and service mark of the Blue Shield Plans in 1951.

National Consolidation

In 1946, nine Blue Shield Plans joined together to form a national association. The national association was funded by a $25,000 grant from the American Medical Association and was named the Associated Medical Care Plans. The purpose of the Association was to coordinate the activities of the Blue Shield Plans and to lay down certain standards that Plans had to meet to qualify for membership and use of the Blue Shield name and symbol. Associated Medical Care Plans later changed its name to the National Association of Blue Shield Plans and in 1976 became the Blue Shield Asso-

ciation.

The Blue Cross Association and the Blue Shield Association since their inception have been separate corporations, each with its own Board of Directors. Each separate association is the national coordinating body for its own member Plans. On January 1, 1978, the two National Associations combined their staffs into a consolidated organization under a single president, who is responsible to both Boards of Directors. At the same time, the Boards created a joint Executive Committee and 10 Joint Steering Committees to oversee the consolidated staff functions.

Differences Between BXBS and Third-Party Payers

There are some significant historic differences between Blue Cross and Blue Shield Plans and commercial insurance companies. Before 1948, commercial health insurance companies had been in the habit of cancelling or refusing to renew non-group policies if the use of benefits exceeded a certain level. The public was outraged with this practice and as a result, the insurance companies decided to end this practice. These insurance companies then in turn introduced

noncancellable and guaranteed renewable policies. Meanwhile, Blue Cross and Blue Shield Plans were conducting 'community open enrollment' during which non-group applications were accepted regardless of health history. The Plans had never cancelled subscribers or refused to renew non-group contracts because of claims filed. All Blue Cross and Blue Shield non-group contracts always have been noncancellable and guaranteed renewable.

In 1949 major medical coverage was introduced by commercial insurance companies. Blue Cross and Blue Shield, on the other hand, perceived little need for major medical coverage to supplement their already broad basic benefits at that time. BXBS benefits paid more dollars per service and for more kinds of service than the commercial plans so their plans for implementing major medical plans came at a later date when the costs of health services began their steep climb.

The predominant goal of the organization of the Plans has been to assure that their members can afford good quality health care through the prepayment system. BXBS has developed various kinds of protection and made themselves

household words along the way. According to a publication from BXBS, some of their innovative measures are:

1. They pioneered the idea of service benefits, basing payment on the actual charge to the subscribers.

2. They accepted the enrollment of all members of a group including dependents.

3. They made it possible for people who leave a group to continue their coverage on a direct pay basis.

4. They added many new benefits to the basic physician or hospital services.

5. They developed ways to cover subscribers anywhere in the country.

6. They developed unique relationships with physicians and hospitals to influence the quality of care subscribers received for payment rendered.

7. They entered the field of prepaid group practice and independent practice associations to offer their subscribers alternative ways to receive care.[1]

Like consumers and providers, third-party payers come in all types and sizes. They include commercial and mutual

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[1] W. T. Cosgrove, et al., An Orientation to Health Care Financing, Blue Cross and Blue Shield Association, 1979, page 2-2.

insurance companies, fraternal organizations, the federal government, and Blue Cross and Blue Shield Plans. These third-party payers provide an important service to both consumers and providers. For consumers, they assume the risk of the expense for health care at all times. For providers, they reduce the level of uncollectable fees for services rendered.

Through the services of third-party payers such as Blue Cross and Blue Shield Plans, consumers can afford health care at any time simply by paying a regular prepayment amount to a third-party payer in the form of a membership fee. According to the Training and Development Subcommittee of the Joint Marketing Advisory Committee there are three characteristics common to all third-party payers:

1. Each provides benefits to cover all or part of the cost of health care services delivered to its members.

2. Each sells a product that is composed of benefits and underwriting and rating policies.

3. Each derives income from rates charged to members or tax revenues.[2]

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[2] W. T. Cosgrove, page 6-4.

All third-party payers share these major characteristics but they may have different policies on operating methods and levels of service. All may be grouped, however, into three basic types:

1. Commercial carriers
2. Government
3. Blue Cross and Blue Shield Plans

Most commercial carriers are stock or mutual insurance companies that operate for profit. Health insurance is only one of the many types of coverage underwritten by commercial carriers and often is marketed as part of a group insurance package that usually includes life, accident, and disability coverage. The basic characteristic of a stock insurance company is that it issues capital stock as evidence of ownership by their policyholders, who thus become both the insurer and the insured. The company assumes the insurable risks of its policyholders and charges them a premium for doing so. Mutual companies are owned and operated by their policyholders who then become both the insured and the insurer. The company charges a premium for assuming the insurable risks of its policyholders.

Many people don't see it as such but the federal government also is a third-party payer; in fact, it underwrites health care benefits for more people than any other third-party payer through the following programs.

Medicare, Medicaid and the Federal Employee Program

Medicare is by far the largest of the federal health benefits programs. It finances health care benefits for persons over the age of 65 and for persons under 65 who are permanently disabled. Program benefits are administered by Blue Cross and Blue Shield Plans, commercial carriers and other agencies, under benefit guidelines established by the federal government. Medicaid provides health care benefits for persons whose low income qualify them for public assistance and is jointly sponsored by state and federal governments. Most states determine their Medicaid benefits, and contract with Blue Cross and Blue Shield or commercial carriers for program administration. The federal government as an employer spends more than $1.5 billion for health care coverage each year. Like Medicare and Medicaid, the Federal Employee Program is administered by Blue Cross and Blue Shield Plans and commercial carriers under benefit guidelines

established by the federal government. One such program, 'Champus', provides benefits for health care services to military personnel and their dependents outside government health facilities.

Blue Cross and Blue Shield Plans represent the non-profit, service benefit approach to health care protection as a third-party payer. This is an important difference from commercial carriers whose rates are designed to return a profit to their owners. Blue Cross and Blue Shield Plans, on the other hand, establish rates sufficient only to cover benefit payments and administrative costs, plus a reasonable contribution to reserve funds for unexpected fluctuations in benefit payments.

Blue Cross and Blue Shield of Indiana

Blue Cross began in the state of Indiana in 1937. The Indiana Hospital Association sponsored a number of meetings where those attending studied prepayment plans in other states, particularly the one in Michigan. The concensus was that the group felt that the Michigan Plan should be adapted

to Indiana's needs. A legislative bill was drafted by Mr. Albert Stump, an Indianapolis attorney, who had become an active supporter of the movement. The final draft was introduced in the 1939 session of the Indiana General Assembly and was passed with little opposition but later was vetoed because the word 'insurance' was not included in the title. At that time, there was a distinction between hospital prepayment plans and different types of insurance and Blue Cross contracts were drawn in the form of membership certificates rather than insurance policies.

On May 3, 1944, Mutual Hospital Insurance, Inc., commonly known as Blue Cross of Indiana, was created under the Articles of Incorporation prepared by the law firm of Claycombe and Stump. Following the formation of Blue Cross of Indiana in 1944, law partners Claycombe and Stump selected Guy W. Spring as Executive Director of the Blue Cross Association. After the incorporation of Blue Cross of Indiana, there was a requirement that $25,000 in prepayment premiums be placed in escrow and certified with the Department of Insurance. This problem was solved through an advancement from Mr. Benjamin Blumberg, a Terre Haute businessman and

a founding father, and another $21,000 for working capital obtained from various Indiana hospitals, Indianapolis stores and other interested persons.

Membership at the end of the first full year of business was 133,140. By the end of 1985, Blue Cross and Blue Shield of Indiana had increased to 721,377 members.

The first President of Blue Cross of Indiana was Charles W. Jones, former Superintendent of William H. Block Company, Indianapolis. On March 26, 1976, the current(1985) President, Mr. Lloyd J. Banks, was elected. Mr. Banks was a former sales representative and sales manager, marketing vice president and corporate officer, who had been with the Plan for 26 years.

In December of 1972 the Board of Directors of Blue Cross and the Board of Directors of Blue Shield of Indiana created the Joint Operating Agreement. Each Plan retained its own Board of Directors and president but the Plans were allowed to cross lines in writing benefits and processing claims. Richard C. Kilborn, President of Blue Shield of Indiana, was appointed Corporate Vice-President of Blue Cross and Blue Shield Joint Operations. Duplication of

operations was therefore eliminated by this move.

In January of 1946, the Indiana State Medical Association and the committee studying prepayment voted to organize Blue Shield of Indiana. The Indiana Plan was incorporated as Mutual Medical Insurance, Inc. commonly called Blue Shield of Indiana. The first membership contracts became effective in September of 1946.

One of the innovators of Blue Shield of Indiana was the late Walter U. Kennedy, M.D. who served as the first President of Blue Shield of Indiana. Mr. R.S. Saylor became Executive Vice President of the Indiana Blue Shield Plan shortly after its organization and guided the Plan until his retirement on January 1, 1966. He was succeeded by Mr. Richard C. Kilborn who became President in April, 1967. Mr. Kilborn still serves in this capacity(1985).

Blue Cross and Blue Shield plans around the country have consolidated their national activities in the Blue Cross and Blue Shield Association. The member groups have been asked to follow the same lead. The consolidation of Blue Cross and Blue Shield of Indiana became effective on June 29, 1985.

CHAPTER III

PRICING AND MARKETING OF THE BXBS PRODUCT

Since its inception, Blue Cross and Blue Shield has been committed to the payment of service benefits to hospitals as opposed to a fixed cash indemnity to subscribers. BXBS' underwriting policies are based on experiences, common sense and Plan policy. The Plans' financial status and growth objectives dictates policy and generally Blue Cross and Blue Shield Plans' underwriting regulations are a reflection of a community service motive. Because of this reason and the influence of community rating, the underwriting regulations were often less restrictive than those of a commercial insurance company.

Many commercial insurance companies have followed underwriting guidelines with a major emphasis on rating. Rates for groups and policyholders for example are made to reflect the risk as closely as possible. This type of rating is known as Risk or Equity Rating which implies that a profit can be made from any risk.

Recently, some Blue Cross and Blue Shield Plans began to use the more commercial insurance approach of Risk Rat-

ing. Today most BXBS plans offer group experience-rated contracts, particularly for large group policies, as well as community-rated policies for those individuals who are not able to obtain a group policy through their work or otherwise. Such programs as major medical are rated using data on age, sex, salary, industry, and other characteristics of a group's potential risk.

Blue Cross and Blue Shield Plans, as well as commercial insurance companies continually re-examine their rating and underwriting policies. Therefore, there is a tendency for the Plans to move away from community rating. For years the Plans have served the community and as long as they provide rates that are competitive, community rating along with risk rating will prevail.

Rating Standards

Rating insurance should meet three standards that are generally required by law and accepted by actuaries:

1) Reasonable - within reason and generally acceptable.

2) Adequate - sufficient to cover the cost of benefits, all administrative and acquisition expenses, and taxes.

3) Equitable - fairly and equally divided among all classes of insured. [1]

Reasonable rates are competitive, generally recognized as worth the cost, and approved by the state regulatory body. There are two good reasons why rates must be reasonable: rates that are unreasonable drive off good risks and retain the poor risks and in most states reasonable rates are required by law. There have been established regulatory agencies that police rate making and limit rates to what they consider reasonable.

Rates must be adequate so that there is sufficient income to cover the cost of claims and expenses. Contingency reserves are needed in addition to the losses and expenses that have been estimated.

The third rate making standard, equity, requires that each class of insured pays enough to carry its fair share of the loss and expenses. This rating standard is concerned with the fairness of the rate from class to class. It states that a high-risk class with a certain level of bene-

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[1] A Course in Individual Health Insurance, Health Association of America, 1983, pages 106-107.

fits should not be subsidized by a low-risk class or insured individuals who have different benefit levels.

Market Strength of the Product

There are two major characteristics that have distinguished Blue Cross and Blue Shield from most commercial insurance companies: payment of service benefits to hospitals rather than cash benefits to the individual insured and community rating, that is, the provision of benefits to all members of the community at the same rate, rather than higher rates to high risk groups. The "fully insured" basic hospital and medical surgical coverages are losing out to the newer innovative products. The decision makers are now interested in coverage which will be giving them the best value for each dollar spent.

To remain a dominant force Blue Cross and Blue Shield must change to adapt to the following trends:

- In the group market the purchasers of health care coverage are changing. Today most decision makers are in the financial area and many of them are controllers, Vice Presidents of Finance or specialists in the risk management area.
- With the shift in purchasers, much of the em-

phasis in health insurance is placed on financial alternatives and all the elements surrounding cash flow.

- Health benefit levels are being legislated and mandated by state and federal governments.
- Group buyers are demanding to see the effect of the cost containment activities that carriers have talked about for years.
- Commercial carriers and some Plans are successfully marketing cost transfer programs, especially in the small and medium group market.
- Commercial carriers can many times offer benefits identical to Blue Cross and Blue Shield.
- Alternative delivery systems such as the HMO and IPA are springing up all over the country. This type of delivery system is being scrutinized by carriers and group buyers.
- Consultants and buyers are increasing in importance in major health insurance decisions.
- National accounts are continuing to grow in importance. Many local businesses and smaller national acounts are being acquired by larger national corporations.
- Carriers are showing a greater willingness to negotiate special financing arrangements such as interest credited to reserves, deferred and minimum premiums and stop-loss. Included in this trend is the willingness to offer Administrative Services Only which allows employers to assume the risk.
- Computers are having an increased effect on the product and services offered by carriers. An example is placing a computer terminal in the

accounts' offices as well as in providers' offices which show a change in the service of carriers. 2

The importance of this list of trends varies according to the Plan area. By developing the wide array of services that BXBS offers only supports the recognition and action that is associated with these various changes.

Calculating Payments For Hospitals

When the members have enrolled in a BXBS Plan and begin to use the services of institutional and professional providers, claims will begin to flow into the third party payer. Accordingly, the third party payer will begin to make payments to the providers or the members for covered services.

As a general rule the Plan sends its payment for basic hospital care directly to the hospital which in turn reduces the hospital's billing costs. There are five methods of calculating payment for institutional providers. They are as follows:

1) Billed Charges - This method has been abandoned by many Plans because it does not allow the Blue Cross Plan to retain

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2 W. T. Cosgrove, et al., The Product, Blue Cross and Blue Shield Association, 1979, pages 4-23 and 4-24.

any control over the hospital's charges. Blue Cross pays the amount billed by the hospital or a percentage of that amount such as 97 percent.

2) Per Diems - This method is based on a "per diem" amount which is stated in the contract as the maximum the third party payer will pay for each day's hospital stay. It is simple to administer and won wide favor among various BXBS Plans.

3) Actual Costs - This method is based on the actual cost to the hospital of delivering each service. To calculate payment, the Plan receives a financial statement from the hospital on an annual basis and audits the statement to determine the actual cost.

4) Annual Statements - This method pays each hospital bill on the basis of billed charges or per diems, but calculates actual costs at regular intervals.

5) Indemnity Benefits - With this method the insurer agrees to pay a flat amount for each service to a member. The list of these indemnity amounts is called a "schedule of benefits".

Methods of Reimbursing Hospitals

There are three major methods of reimbursing hospitals for their services: cost-based, charge-based and prospective reimbursement. Traditionally the hospital and the Plan negotiate the monetary arrangements and the method is

usually uniform for all participating hospitals. The three methods are explained as follows:

1) Cost-Based - This method pays the hospital the actual costs incurred for the covered services. Covered services are the ones payable under a subscriber's contract.

2) Charge-Based Reimbursement - This method reimburses the hospital the actual amount of their billings. It is more expensive than cost based because of the inclusion of a profit factor, bad debts and the cost of charity cases.

3) Prospective Reimbursement - A few Plans have developed this method which involves setting a payment rate in advance of the contract year which remains permanent for the whole contract year. This method does provide cost containment incentives because the hospital is responsible for all costs above the set payment rate.

The methods of cost-based and charge-based reimbursement are older more established methods of reimbursing hospitals. The use of the prospective-based reimbursement method has been influenced by government agencies, the consumer groups and the medical community group itself.

Methods of Reimbursing Physicians

Before payment is made to physicians and other profes-

sional providers, the Plans must screen the bills from the professional providers to determine whether the patient, the provider, and the services are eligible for benefits. If they are eligible, the payment amount is calculated and payment is issued.

The Plans' payment for medical care is usually sent directly to the provider. This helps reduce the provider's collection costs and assures payment for every eligible service. This also benefits the subscriber since no "up front" payment is necessary and treatment will be given wherever and whenever necessary.

Blue Shield uses two principal methods of reimbursing charges for professional services: fee schedules and usual, customary and reasonable allowances (UCR).

When using the fee schedule method, the third party payer agrees to pay a flat amount for each service to a member. The list of these amounts is referred to as a "fee schedule". The third-party payer is liable only for the amount listed in the schedule for each type of service, no matter what the actual cost or charge happens to be. The physician may bill the patient for the difference between

the fee and the Blue Shield payment.

The other type of payment method is known as Usual, Customary and Reasonable allowance. Subscribers with this type of coverage consider it a "paid in full" contract.

UCR payments are calculated by determining the fee the doctor most frequently charges for a given service, taking into consideration his location and specialty, and allowing for medical complications of unusual circumstances. UCR designations recognize that there will be differences in physicians' charges because of geographic locality, skill of the physician and complexity of the service performed. A physician who has signed a participating agreement with a Plan must accept the UCR payment as payment in full. The participating physician is contractually bound to write off the balance. The non-participating physician will bill the patient for any balance. Some Plans refuse to pay non-participating physicians or pay them a lesser amount for the same service by a participating physician.

Both the usual and customary amounts are based on the most common fees charged over a time period or by a particular group of physicians. The most important difference be-

CHAPTER IV

PRODUCTS OFFERED BY BXBS

The real products of Blue Cross and Blue Shield Plans extends far beyond the scope and level of the benefits listed on a contract. Since their beginning, Blue Cross and Blue Shield Plans have been innovators in benefit offerings. More specifically, such concepts as service benefits, continuity of coverage, and pre-admission testing are just a few of the many ideas pioneered by Blue Cross and Blue Shield Plans and offered in the categories of hospitalization, medical/surgical, major medical, dental, vision, and other allied lines. The objective in this chapter will be to look at the basic products offered by BXBS.

Basic Hospital Product

The basic Blue Cross product is hospital coverage. Hospital coverage is intended to pay for expenses incurred by the patient while he is in the hospital or treated in the hospital's outpatient department. These expenses can be considerable which makes hospital coverage the most important

and the most expensive component of the health care package.

The major objectives in the development of hospitalization coverage are:

1) to keep the patient from going into the hospital prematurely

2) to keep the patient from being confined unnecessarily

3) to release the patient from the hospital as quickly and as medically possible

Blue Cross hospital coverage offers the buyer a benefit that provides quality care and a commitment to cost containment, information that is vital to the buyer when he is comparing coverages. Most hospital benefit programs cover the following scope of benefits such as hospital room and board, ancillary services such as use of operating, treatment and intensive care rooms, outpatient care, skilled nursing home, and home health care. The level of basic hospital benefits covered varies from Plan to Plan. For example, the number of inpatient days covered most commonly are 70, 120 and 365 days. Usually Blue Cross member hospitals are paid in full based on Plan/hospital negotiations and relationships. Some Blue Cross Plans provide coverage for benefits in

skilled nursing facilities, as well as for home health care. Confinement in the skilled nursing facility must usually take place within 14 days of prior confinement in a hospital and must be ordered by the physician and be for the same illness or injury as the hospital stay. Home care is often provided as part of the basic hospitalization through local Visiting Nurse Associations (VNA) and Home Health Care Associations. This program pays benefits usually on a reasonable and customary basis and the patient must have been confined to a hospital for the same disability which is being treated under the home care program. Services include physical therapy, and intermittent or part-time nursing care. The services offered in this coverage must be performed by, or under the supervision of a registered nurse.

Basic Medical/Surgical Product

The basic Blue Shield product is medical/surgical coverage. This coverage is to pay the cost of physician services in and out of the hospital. The features of this Blue Shield product vary even more from Plan to Plan than do the features of the basic hospital or Blue Cross product.

For the most part, the scope of this product are as follows: surgery, assistant surgeon, anesthesia, in-hospital medical, intensive medical care, multiple procedures, and in-hospital oral surgery.

When surgery is done, whether it is done in the hospital, doctor's office, or in freestanding surgi-centers, these benefits cover all or part of the expenses of the surgeon. In most medical/surgical programs a percentage of the surgeon's benefits may be applied to the assistant surgeon's fee. Most programs limit the amount paid or use Usual, Customary and Reasonable to determine the fee a physician will be paid per visit. This benefit will normally be paid in the same manner the surgical benefit is paid. Most programs pay for two surgical procedures performed during one operation. Some coverages pay a benefit for each procedure and others will pay in full for the major procedure and a percentage for the second procedure. Usually medical/surgical programs pay for oral surgery resulting from an accident and removal of impacted teeth may also be covered when performed in a hospital.

Major Medical

This product provides a broad range of benefits once the insured has met certain contract deductibles and coinsurance provisions. Today most of the major medical programs are marketed with a benefit maximum of minimum days and dollars to unlimited. The cost to the carrier of increasing the maximum is often minimal. In most cases a subscriber would seldom incur $250,000 or $1,000,000 in claims, so many insurers offer the unlimited maximum. Most major medical plans restore the maximum amount once a year or after the subscriber incurs a certain dollar amount of claims.

Most major medical programs include a coninsurance feature. After the deductible is met, the coinsurance factor takes over. The period of time the coinsurance is applicable is the same as the deductible. The coinsurance maximum is normally $2,500, $5,000 or $7,500 for the consumer market. Again, the use of coinsurance factors along with the deductible affects the overall premium. After the coinsurance is met, 100% of the remaining covered costs are paid by the carrier. If the coinsurance is varied from 80/20 to 75/25 there is a subsequent decrease in the premium. The needs of the

account must be accurately gauged to know which major medical program to propose.

Comprehensive Major Medical

Comprehensive Major Medical provides hospital, medical/surgical and major medical benefits in one product. All covered benefits are subject to the deductible and subsequent coinsurance. This product has been marketed well by commercial carriers and by some Plans mostly to small and medium size groups. Comprehensive Major Medical is normally priced lower than separate hospital, medical/surgical and supplemental major medical programs. The lower price is a result of the front end deductibles and coinsurance. In addition to its lower cost many buyers and subscribers also mention the ease of understanding this product as their reason for buying it.

Basic Dental Product

The dental product is very popular today. Commercial carriers like Connecticut General have had great success in marketing this product. Blue Cross and Blue Shield Plans have generally not done as well in this product category be-

cause of higher premium cost and prior claims service. The benefits covered in dental programs include the following: diagnostic and preventive services such as xrays and routine examinations, restoration care such as fillings and inlays, crowns and caps, oral surgery in the office, use of bridges and dentures, treatment of gum disease and orthodontics.

Many Plans have used the building approach to dental coverage. This product design allows an employee to offer dental coverage to employees with the first block being preventive services and then the employer may add other services such as orthodontia, periodontia, and prosthetics.

The dental product is in some ways different from hospital medical/surgical and major medical lines of business. The utilization of services is greatly encouraged to avoid future benefit costs that may be much greater. Subscribers can more easily postpone dental utilization. Claims are in greater number and of lower cost than other lines of business.

Another type of dental plan offered through a subsidiary of BXBS, Health Maintenance of Indiana, Inc., is Dentacare. This plan offers comprehensive benefits and re-

quires the use of a contracting dentist. Out of pocket expenses will probably be less and there will be few, if any, claim forms.

Basic Vision Care Product

Another benefit program that has increased in popularity is vision care. Benefits in a vision care program include eye examinations, lenses, contact lenses only when medically necessary, frames, and fitting and adjustment. Most vision care products pay opthalmologists and optometrists for services rendered. Depending upon the subscriber's job, sometimes different types of lenses such as safety lenses are covered.

Basic Prescription Drug Product

The prescription drug product can be added to employee benefits at a low cost. Coverage for prescription drugs is included many times in a major medical program, but is subject to a deductible. Normally the benefits for the prescription drug program includes all prescription drugs, Insulin, and refills.

Most Plans have member or participating pharmacies

whom they pay directly. For services rendered in non-participating pharmacies, most Plans reimburse the subscriber directly for a certain percentage of the Usual, Customary and Reasonable payment for a particular drug.

One administrative problem with prescription drug programs is the low dollar amount per claim and the high volume of claims. This makes it very difficult and costly to monitor claims and payments.

CHAPTER V

ALTERNATIVE DELIVERY SYSTEMS

Among the more popular forms of alternative delivery systems are the growing network of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). In this chapter, I will trace the historical development and growth of HMOs and PPOs as alternative delivery systems.

Health Maintenance Organizations (HMOs)

One of the principal alternative delivery systems is the growing network of Health Maintenance Organizations (HMOs). The first development of HMOs was around the turn of the 19th century but they were not yet known as HMOs. They developed as a result of the opening of the West by the railroads and were known as prepaid group practices. The first example of a prepaid group practice was the Western Clinic in Tacoma, Washington. In 1906, Drs. Thomas Curran and James Yocum developed a fee-for-service partnership and later in 1910 became pioneers in the field of prepaid medicine when they entered into their first contract with the

lumber industry at a cost of 50 cents per member per month.[1]

What is an HMO? An HMO is an abbreviation for Health Maintenance Organization, a name initiated by Dr. Daniel Elwood of Interstudy, a medical think-tank in Excelsior, Minnesota. An HMO is an organized system of health care that assures the delivery of comprehensive, continuous health care services to a voluntarily enrolled group of persons under a prepayment plan. The HMO serves a particular geographic area and its customers are voluntarily enrolled either individually or through employee groups. Its revenues are fixed monthly prepayments. This method of payment differs from the traditional fee-for-service in one very important way. Payment is made to the medical group by the HMO which reimburses the group for health services they have been contracted to perform.

HMO basic services usually include all physician care, inpatient and outpatient hospital services, examinations by specialists, surgeries, laboratory and xray procedures as well as emergency medical services 24 hours a day. Preven-

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[1] "HMOs: Origins and Development", The New England Journal of Medicine, February 28, 1985, page 590.

tive medicine, such as physician care, immunizations and periodic health examinations, are emphasized. With HMOs, there is a real economic incentive to provide the most efficient and cost effective medical practice that can be had.

In an HMO, the group of physicians are paid in advance to give comprehensive care to patients enrolled in the HMO. The annual payment known as a capitation increases with the number of patients but not with the number of treatments. Because HMOs receive a fixed amount not based on the amount of service there is a financial incentive to provide care in the most economical way possible. In the traditional fee-for-service system a physician is encouraged to provide the most expensive treatment available because the more care he provides the more he will profit; in an HMO the incentive is just the opposite. If the budget has a surplus at year end, the HMO members recieve a bonus.

There are three types of HMOs: staff model, group model and the independent practice association. In the staff model the HMO contracts with individual physicians and pays them a negotiated salary. In the group model the HMO con-

tracts with several group practices and shares the risk of the venture with the doctors. Terms of the risk sharing are negotiated. In the independent practice association (IPA) the HMO contracts with physicians for an agreed upon fee schedule. Physicians work out of their own offices and are usually paid on a fee-for-service basis. Unlike other types of HMOs, enrolled persons are not required to receive all their care from a central clinic staffed by salaried physicians; instead, they are allowed to receive care in the offices of physicians who have signed agreements with the IPA.

How do HMOs achieve cost reduction? HMOs have a greater incentive than fee-for-service practitioners to treat patients on an outpatient basis rather than in the hospital, thus cutting costs. Historically, the pattern was to utilize inpatient hospital services than outpatient services. The HMO member will now have the opportunity to choose the most cost efficient form of treatment for its patients. Most HMOs have been successful in achieving sizable reductions in hospital admission rates and length of stay. "HMOs have proved to be an effective device for

changing the behavior of doctors and hospitals, and a very good form of organization around which to stage competition" said Paul M. Ellwood, Jr., M.D., president of Interstudy, who is often called the "father of the HMO movement".[2]

In recent years, HMOs have gained a growing share of the healthcare market. One good reason for this increase has been the federal government support for HMOs in the 1970's. In 1973 the Health Maintenance Organization Act required corporations employing 25 or more workers to offer an HMO as an alternative if one was available. On February 1, 1985 there was another law passed that made it easier for Medicare recipients to join HMOs. It also authorized the federal government to loan funds to new HMOs that could not obtain private funding.

People, enrolled in all health insurance plans nationwide, utilize hospitals at the rate of 1300 days per thousand enrollment per year according to a Blue Cross spokesman. With the Blue Cross plans, the rate is 1100 per thousand per

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[2] Emily Friedman, "A Decisive Decade for HMOs", The Hospital Medical Staff, April, 1985, page 23.

year and in well-run HMOs, 450 days per thousand is considered high. There is a definite incentive for the HMO physicians to reduce use of in-hospital care as a financial incentive.[3]

Insurance companies have been involved in HMOs either by establishing their own HMOs or by providing services to HMOs in the area of administration and benefit design. Both Blue Cross and Blue Shield and other commercial insurance companies have accelerated their efforts in developing HMOs. According to Mr. Bernard R. Tresnowski, president of the Blue Cross and Blue Shield Association, membership in Blue Cross and Blue Shield HMOs rose 26 percent in 1983. He also stated that since 1974 enrollment in BXBS plans' HMOs has increased at an average of 21.6 percent annually.[4] Statistics in Indiana reveal that HMOs in 1980 served a total of 31,246 subscribers and in 1984 there were 146,598 subscribers.[5]

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[3] Russell F. Lewis, "The HMO Movement", American College of Surgeons Bulletin, April, 1985, Vol. 70, No. 4, page 16.

[4] "Blues Plans' HMOs Report Enrollment Rose 26% in 1983", Modern Healthcare, May 15, 1984, page 12.

[5] Dave Rumbach, "Hansel Center Among Area's First to Experiment", South Bend Tribune, April 14, 1985, page B5.

HMOs could become equally strong competitors of the BXBS plans or strong components. When Blue Cross and Blue Shield establishes an HMO, its services usually are treated as another product line for the Plans to offer the market. In addition to the growth of HMOs operated by BXBS, there are HMOs who purchase administrative, actuarial and marketing services from the Blues' Plans. Competition in this market are Maxicare of Indiana, Inc., First Care, Pru-Care, Metro of Indianapolis and Physicians Health Plan of Evansville.

Many employers are beginning to push HMOs as an alternative to traditional health insurance. A survey done by Fortune 500 companies revealed that the number and percentage of surveyed companies offering employees HMOs rose from 76 percent in 1983 to 82 percent in 1984. When questioned about whether these companies would be offering HMOs in 1985, only 79 percent replied that they would.[6]

Preferred Provider Organizations (PPOs)

Another important form of healthcare delivery is a Preferred Provider Organization (PPO). PPOs can be traced

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[6] Steve F. Gardner, et al., "Big Business Embraces Alternate Delivery", Hospitals, March 16, 1985, page 82.

back to 1910 when Washington and Oregon passed Workmens' Compensation laws. In these two states the insurance companies negotiated with the physicians and hospitals so that they could provide care at discounted rates for workmen's compensation cases. In order to accomplish this, they signed up doctors to accept 50 cents instead of $1.00 for the office visit and then asked hospitals to accept $5.25 per day for the room-and-board rate rather than the usual $5.75. This system proved to work well and was later added to the insurance companies' regular lines of health insurance.[7]

What is a PPO? The Preferred Provider Organization is a departure from the traditional fee-for-service system. PPOs contract with employers to provide health care services at a negotiated and often discounted rate. The PPO offers a payer discounted rates for services provided to its beneficiaries. In return, the payer usually agrees to incentives designed to give the provider a predictable volume of business. Organizers of a PPO can be physicians,

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[7] Boyd Thompson, "The Preferred-Provider Approach", American College of Surgeons Bulletin, April, 1985, Vol. 70, No. 4, page 18.

hospitals, insurers, for-profit entrepreneurs, or business firms.

PPOs offer inpatient hospital services, outpatient hospital services, and physician services. Other services and programs offered by some PPOs are annual physicals, lifestyle screening, long-term care, vision care, wellness programs, home health care, chemical dependency programs and equipment rental.

With Preferred Provider Organizations, there are three main contract arrangements. They are as follows: 1) a contract between the payer and the PPO; 2) a contract between the payer and the individual providers of care who may be part of the PPO; and 3) a contract between the PPO and the providers themselves. Discounts under a PPO contract usually range from 10 to 20 percent for hospital services performed by the physician.[8]

A new PPO program, the General Motors (GM) Preferred Provider Organization program, became effective in Indiana on August 1, 1985. Open enrollment for GM employees was

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[8] Fred Rothenberg, "Preferred Provider Organizations", The Coordinator, January, 1985, page 19.

held at Indiana GM plant locations during the first two weeks in June. According to a News Capsule published by Blue Cross and Blue Shield of Indiana in May of 1985 the additional benefits under the GM PPO program are as follows:

1) The program covers 70 percent of the UCR allowance for office visits performed by a Preferred Provider.

2) The program will cover office visits to a Preferred Provider for children under one year of age.

3) The program covers certain immunizations by a Preferred Provider for children under age six.

4) The patient has only a $3 copayment for drugs rather than the $5 copayment under the Traditional Insurance Option program.[9]

Preferred Provider Organizations are one of this country's newest health care delivery systems. According to a survey of the Fortune 500 companies, in 1983, only 6 percent of respondents indicated that they offered a PPO option to employees. In 1984 that number had grown to 16 percent and in 1985, 30 percent of all companies surveyed

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9 "General Motors PPO Program", Blue Cross and Blue Shield of Indiana News Capsule, May, 1985, Vol. 4, No. 4, page 1.

expect to offer employees a PPO option. Perhaps the greatest growth in the alternative delivery systems will be the business encouragement of PPOs.[10]

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[10] Steve F. Gardner, et al., "Big Business Embraces Alternate Delivery", page 82.

CHAPTER VI

PREFERRED CARE OF INDIANA

Preferred Care of Indiana is a network of 61 full-service hospitals in Indiana who have agreed to work with Blue Cross and Blue Shield of Indiana to cut the cost of health care without reducing benefits. The current 61 full-service hospitals are spread throughout Indiana and have pledged themselves to provide Blue Cross and Blue Shield members with the finest health care services in the most cost efficient way possible.

Preferred Care of Indiana (PCI)

BXBS' preferred provider arrangement states that the 61 hospitals would offer the insurance company discounts on their usual costs in return for the insurance company steering patients to them. Preferred Care of Indiana (PCI) works in the following manner. If a BXBS patient seeks care at a "preferred" hospital, all covered charges are paid. On the other hand, if the patient seeks care from another hospital that is not designated as a PCI hospital then this patient may be expected to pay a deductible which may equal

up to one quarter of his hospital bill.

Preferred Care of Indiana was made possible by legislation enacted by the Indiana General Assembly and became effective December 31, 1984. This program was implemented in stages; the first stage was the current network of 61 full service hospitals. The next stage will add the physicians and the specialty facilities to the network and is expected to take place by the end of 1985. This statewide program is thought to be the largest change in health care financing in the 40 year history of Blue Cross and Blue Shield.

There are three objectives for the Preferred Care of Indiana network:

(1) To create a network of hospitals, physicians and other health care providers that delivers cost effective health care services to our members of other Plans.

(2) To provide health care services in the most appropriate setting.

(3) To create a health care system that is responsive to the concerns of our customers regarding escalating costs and excessive use of health care. [1]

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[1] Preferred Care of Indiana, Blue Cross and Blue Shield of Indiana, February, 1985.

Requests for participation were sent to Indiana hospitals inviting them to participate in the PPO of which 61 were chosen for the network. On November 14, 1984, 80 hospitals in Indiana filed an antitrust lawsuit in the U.S. District Court seeking an injunction against the preferred provider program organization of Blue Cross and Blue Shield of Indiana. The Indiana Hospital Association was not a party to the suit but was requested by the Indiana Hospital Association Board to manage the action through its general counsel.

This specific lawsuit accused Blue Cross and Blue Shield, the largest health care insurer in Indiana, of using its share of the market to enroll hospitals as preferred providers thus violating federal anti-trust laws and four other state statutes. The plaintiff hospitals claimed that the proposed Blue Cross PPO agreement was an attempt by the insurer to use its monopolistic power in the insurance business to force a discount which would only benefit itself and result in higher costs for other customers. The proposed PPO contract was offered to the hospitals on a 'take it or leave it' basis and Blue Cross had refused to negotiate the terms of the proposed plan.

On November 16, 1984 Blue Cross publicly announced that there were 73 positive responses received from the hospitals by the November 15, 1984 deadline, and other bids were in the mail. Some hospitals who did not respond indicated that the PPO contract was a cost shifting procedure. In response to the hospital's claim of cost shifting, Blue Cross stated that they felt hospitals should be operating more efficiently under today's competitive DRG environment. The Indiana Hospital Association immediately responded to this on behalf of the hospitals and stated that many of the hospitals had submitted bids because of economic pressures and these same hospitals had joined the antitrust lawsuit.[2]

The hospitals directly involved in this lawsuit were not opposed to preferred provider organizations but opposed the way Blue Cross had set up its network. The lawsuit also claimed that Blue Cross had used the rate review program for its own benefit by offering exemptions from rate review to the hospitals who had agreed to participate in the preferred provider program. A release from the Indiana Hospital Asso-

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[2] "Sixty-One Hospitals Join Antitrust Action Against Blue Cross: Seventy-Three Submit PPO Bids", Harmony, Indiana Hospital Association, November, 1984, page 1.

ciation stated that Blue Cross had refused to disclose the criteria to be used in accepting hospitals into the network, as was required by Indiana law. The hospitals also feared that patient safety might be threatened because the preferred provider organization would require that hospitals and their medical staffs perform 300 different operative and diagnostic procedures only on an outpatient basis. If a patient is admitted to the hospital rather than using outpatient services, the hospital would not be paid for inpatient services. There is also a built in incentive to use the preferred hospital because the insurance plan would pay the entire bill. On the other hand, if another hospital would be utilized, a deductible would be charged.[3]

On December 6, 1985 the Plans filed a countersuit against one of the plaintiffs, Methodist Hospital of Indianapolis and unnamed co-conspirators alleging conspiracy and boycott against the PPO. In addition, the Indiana Hospital Association was identified as participating in the conspiracy.

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[3] Ibid., page 1.

Federal Court Decision

The attempt by 80 hospitals to prevent Blue Cross and Blue Shield of Indiana from implementing a preferred provider organization failed in federal court in March of 1985. After eleven days of hearings, the hospitals felt that it was important for Preferred Care of Indiana to be evaluated in the courts and they believed that some points were clarified. One of the main questions poised was whether county hospitals could offer discounts. Judge Steckler ruled that the PPO does not compel any hospital to price discriminate in violation of the County Hospital Statute. County hospitals could join the PPO and charge all patients the same price they bid to Blue Cross and Blue Shield. The 61 hospitals involved in the preferred provider network decided to charge their Blue Cross patients the same prices they listed in their bids they submitted to join the network. They also agreed to follow the utilization review guidelines that ensured care being rendered was necessary.

Opinions on the decision made by Judge Steckler were published in the article "Hospitals Lose Battle Against PPO" found in the Indianapolis Business Journal. In his 31

page opinion, Steckler denied the hospitals' requests stating that the plaintiffs had failed to establish that the defendants had monopoly power or the ability to exclude others from the market. Judge Steckler also had the following to say:

> "The product (the PPO) has the potential to save Indiana consumers millions of dollars in health-care premiums. If a preliminary injunction were issued, it would prevent Blue Cross/Blue Shield from offering its competitive PPO product to the market. The public would be injured and would forfeit the benefits of competition and the opportunity for decreased health-care costs". 4

Mr. Jerold Knight, senior vice-president for corporate affairs at Blue Cross and Blue Shield commented on the ruling:

> "It was probably as strong an approach to dealing with the health-care issues as seen anywhere. It was a well-reasoned and supportive opinion for those of us who believe competition has to be given its day as a health-care issue". 5

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4 Bennett, Tamara, "Hospitals Lose Battle Against PPO", Indianapolis Business Journal, March 11-17, 1985, page 5A.

5 Ibid.

From the opposing side, Mr. Ken Stella, president of the Indiana Hospital Association, said:

> "What the judge has done is make completely clear that, in his opinion, hospitals should charge what they want. The decision changes the method of health care that has existed in Indiana for the past 25 years. Since 1960 Indiana hospitals have charged uniformly for services". 6

Decision Appealed

A second attempt was made to stop the BXBS' plans to implement a "preferred provider" program in 61 of Indiana's 115 hospitals. The appeal was filed by 47 hospitals with the 7th U.S. Circuit Court of Appeals in Chicago and sought to overturn a March ruling by Judge William E. Steckler in Indianapolis. These hospitals are seeking to have Blue Cross and Blue Shield of Indiana declared a monopolist and to halt development of its preferred provider organization which steers patients to selected hospitals. These 47 hospitals who filed the appeal were among the 80 that brought the original suit to court.

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6 Ibid.

CHAPTER VII

BXBS MAJOR COMPETITORS

Today, more than 85 percent of the Blue Cross and Blue Shield Plans' subscribers are members of a group which range in size from a handful of people to several million. The major portion of the Plans' business is in the local group market which can be made up of small groups of 2-24 employees, medium size groups of 25-99 employees and large groups of 100-200 plus employees.[1]

The Small Group Market

The Plans usually consider a small group market of 2-24 employees. Since the inception of the Plans, there has always been an emphasis placed on marketing to these small groups. This is evidence of BXBS' commitment to provide access to health care to the entire community.

There are a number of factors that characterize the small group market. Compared to large groups the level of risk appears to be higher in the small group market due to a

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[1] W. T. Cosgrove, et al., Market and the Competition, Blue Cross and Blue Shield Association, 1980, page 4-2

tendency of the employee purchasing insurance to use it immediately and the addition of non-eligibles as employees in the small business market. The Plans face a major disadvantage when the preference for insurance packages for this group includes not only hospitalization, medical and Major Medical, but also life and accidental death. There is also a tendency for the small groups to change carriers more frequently than do large groups. One of the most important reasons for this is the fact that the decision maker has to listen to the employee's complaints when there is dissatisfaction or bad service. In the small group market there is less economic stability than in the larger groups due to the possibility of bankruptcy or going out of business and there is greater difficulty in maintaining minimum size group requirements.

To meet the needs within the small group market there must be a variety of benefit design and underwriting guidelines. Today the Plans try to offer the small group the same benefit options as what is offered to the larger groups. One such option has shifted from covered services to alternate payment mechanisms which include deductibles and co-pay-

ment. Due to the size and level of high risks, small groups require the use of more restrictive underwriting guidelines. There are waiting periods for pre-existing conditions due to the tendency of the employee purchasing coverage because they expect to have a need for it in the very near future. With this small group market there is a requirement for a larger employer and employee contribution as compared to the larger groups.

In the small group market there are new small businesses constantly starting up and creating new opportunities for health insurance providers. BXBS' major competitors in this group are Life of Indiana, Golden Rule, Ohio State Life and Prudential. The major difference between BXBS and its competition is the deductible. Without a deductible, co-insurance is 80/20.

The marketing department at BXBS does understand the particular needs of small businesses. Claims are submitted with minimal paperwork and the members are reimbursed quickly and accurately. Competent employees of Blue Cross and Blue Shield are there to answer questions concerning claims. Most important, the benefit packages

that are offered at a price which compares favorably with their competitors.

There are two methods utilized by Blue Cross and Blue Shield to reach the small group market. The first method utilizes 28 contracted brokerage agencies. With this method the agents or brokers recommend Blue Cross and Blue Shield coverage if they are convinced that the customer will be pleased with this coverage instead of the total package of health, life and added insurance coverage. The other effective marketing technique is TeleMarket which is particularly popular in the small group market of 2-9 employees. This has proven quite effective because the salesman is able to call on several people a day. It has been proven that most customers would rather be contacted by telephone first and then have a contact person at the Plan who is there to answer any questions.

The Medium Size Group Market

The medium size group market consisting of 25-99 employees finds its major competition with AUL, Lincoln, Aetna and Travelers. Humana, Inc., a for-profit corpora-

tion, is also a strong competitor in this group. BXBS has begun to expand their coverage with supplemental benefits such as vision and prescription coverage known as the "building block" approach. This approach is used widely by Blue Cross and Blue Shield to give the customer the opportunity to choose the most feasible benefit program at a price he is willing to pay. This market utilizes brokers and in-house agents in their approach to reaching the medium size group market. These agents and brokers apparently will recomend Blue Cross and Blue Shield if they believe that this coverage is the best for the client. They will often recommend Blue Cross and Blue Shield to avoid claim problems.

The Large Group Market

The large group market consists of 100-200 plus employees. Major competitors in this market include Prudential, Aetna, Traveler's, Lincoln National and Metropolitan. In this market, the different financial arrangements are more important than the benefit design. The Plans offer maximum benefits at a reasonable cost compared to their competition.

Non-Group Subscriber

Blue Cross and Blue Shield of Indiana assures their customers that regardless of employment status or health condition they will be allowed to continue coverage from group subscriber to non-group subscriber. Whether their health deteriorates, they change jobs, or become unemployed, a subscriber is guaranteed continuity of coverage which means that there are no waiting periods for benefits when they transfer to another group or convert to direct payment.

There are three types of Blue Cross and Blue Shield Plan non-group subscribers. They are the left-group or conversion, regular non-group and Medicare Supplemental.

Left-group subscribers otherwise known as conversion subscribers are persons who quit their jobs where Blue Cross and Blue Shield coverage was their carrier. These subscribers can only receive coverage by BXBS if they convert to a non-group, direct pay contract.

The rate charged for conversion charge is much higher than the rate paid by the group member for the same benefits for two reasons. There is a higher level of risk and higher utilization by these non-group subscribers. The

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benefits under conversion coverage are based on a standard contract.

The person who purchases an individual contract is the second type of non-group direct pay subscriber. There are three types of regular non-group subscribers. They are the professional and self-employed persons who are members of a trade that does not offer coverage, students who are not eligible for student group coverage, and bank customers in Plans that market regular non-group direct pay coverage through local banks.

The regular non-group subscribers also receive benefits based on a standard contract and pay a rate that is somewhat higher than a group member paying for the same level of benefits. There is a significant difference between BXBS and other commercial insurers in that BXBS does not age-rate or area-rate regular non-group subscribers except in the case of student. Some Plans have been known to require physicals or medical histories for these new applicants but others do not.

Blue Cross and Blue Shield of Indiana now offers an insurance plan for the non-group market known as The Personal

Security Plan (PSP). BXBS of Indiana offers three different financial plans from which the subscriber can choose from. Most individual insurance programs do not offer this wide choice of plans. Whichever plan is selected, BXBS guarantees that the subscriber will receive full PSP benefits.

The benefits offered by this program are numerous. There is the 72-hour accident benefit which requires BXBS to pay for all covered outpatient charges incurred within 72 hours of the accident. Other benefits are catastrophic coverage, hospital room charges, ancillary care and supplies, physician's fees, rehabilitative therapy, mental illness treatment, and ambulance service. Whether the subscriber purchases the optional pregnancy rider, PSP will cover expenses resulting from pregnancy complications.

For the subscriber there are the monetary benefits such as fixed rates with no increase for at least one full year. The program has also lowered member out-of-pocket limits by 15-20 percent in order to further reduce the subscribers' health care costs. Most hospitals will complete and send the subscriber's claim forms directly to Blue Cross and Blue Shield of Indiana. If a patient has a pre-existing

condition, there is a one year waiting period before coverage on that specific condition begins. This is in contrast to other providers' policies that require a two year waiting period.

The Personal Security Program has a higher administrative cost and a higher premium than other individual insurance programs. There are approximately 20,000 subscribers who have enrolled in Blue Cross and Blue Shield's Plan in Indiana. The majority of the subscribers are professional people and real estate agents.

The subscriber who purchases coverage to supplement Medicare benefits is the third type of non-group direct pay subscriber. All Blue Cross and Blue Shield members are offered the opportunity to convert to Medicare Supplemental coverage at the time they become eligible for Medicare benefits, regardless of their health status. The Medicare Supplemental coverage usually includes front-end deductibles and co-payment. Most Medicare Supplemental coverage is billed on an individual basis.

Blue Cross and Blue Shield of Indiana does offer open enrollment periods for Medicare beneficiaries who had Blue

Cross and Blue Shield Plan coverage but did not transfer to Medicare Supplemental when they first became eligible as well as those who did not have Blue Cross and Blue Shield coverage but wish to enroll with the Plans for Medicare Supplemental benefits. There are some Plans which do require health condition information from applicants who did not transfer to Medicare Supplemental or direct pay while they were first eligible.

The major competitor to Medicare Supplemental coverage offered by BXBS of Indiana is the American Association of Retired Persons (AARP) which is underwritten by Prudential Insurance Company. Other competitors are Maxicare and Metro, the two strongest HMOs in Indiana. Generally the retired teachers and some government groups comprise the 30-40 percent of BXBS subscribers who have this Medicare Supplemental Coverage.

BXBS Plans' marketing approach to the non-group subscriber is expanding due to the substantial growth potential of this market. The Plans continually evaluate the market potential, identify delays in delivering conversion information, and simplify the process of converting to non-group

coverage wherever possible. The Plans have been more aggressive recently in pursuing enrollment in the supplemental coverage market through advertising and telephone solicitation.

CHAPTER VIII

PROSPECTIVE PAYMENT SYSTEM

"Prospective Payment was designed as an incentive to change behavior, and I believe it will change a lot of persons' behavior," says Dr. Carolyn K. Davis, administrator of the Health Care Financing Administration (HCFA) which oversees the payment system.[1] Recent implementation of the Prospective Payment System is one of the major changes in hospital financing in this country.

History of the Prospective Payment System

In April, 1983 the Social Security Amendments Act of 1983 (P.L. 98-21) was signed into law by President Reagan. Title VI of the law pertains to the Prospective Payment System for hospitals. October 1, 1983 marked the beginning of Medicare's Prospective Payment System (PPS) based on Diagnosis Related Groups (DRGs).

Diagnosis Related Groups (DRGs) were developed by Yale researchers by taking all diagnoses identified in the Inter-

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[1] Judith Alsofrom, "Playing The Numbers Game", Medical World News, October 24, 1983, page 38.

national Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM) system and then classifying them into 23 major diagnostic categories (MDCs) based on organ systems. These 23 MDCs are then broken down into 470 distinct groupings. The prospective pricing system then establishes payment rates for each DRG.

The DRG classification forms the basis for payment under the PPS. The new PPS pays a flat fee per case regardless of the type and cost of treatment provided. Hospitals will no longer be reimbursed for the cost of providing care to Medicare patients, on the other hand, they will now be paid according to the patient's diagnosis based on predetermined established rates. The reimbursement formula is quite complex but payment in general is based on the DRG weight and the dollar rate.

In assigning a case to a DRG five pieces of information are necessary. They are: the patient's principal diagnosis and up to four complications, treatment procedures, patient's age, sex, and discharge status. These five pieces of information are then submitted to the hospital fiscal intermediary who determines the DRG and calculates

the appropriate payment.

The prospective pricing system applies only to inpatient care provided to Medicare patients. All hospitals are covered under the PPS except for psychiatric hospitals, rehabilitation hospitals, children's hospitals, long term care hospitals, and hospitals with an approved waiver.

DRGs are being phased in over a three year period concluding September 30, 1986. The first year DRG payments were based on 75 percent of the hospital's historical cost and 25 percent of the average federal rate based on regional data. In the second year the percentages were 50 percent historical and 50 percent federal rates and the third year reveals the percentages to be 25 percent historical and 75 percent federal rates. Beginning with year four, 100 percent of the payment will be based on a regional DRG rate adjusted for urban and rural locations.

PPS vs. Price-per-case Reimbursement

Since the 1930's hospital reimbursement has been on the basis of actual costs retrospectively determined. There was no incentive to produce cost saving strategies. To protect the Social Security system, legislation was passed for imple-

mentation of the Prospective Payment System. With this new system Congress hopes both to decrease the growth in Medicare expenditures and also to change the incentives created by the retrospective cost-based system. The Prospective Payment System places the hospitals at risk for any treatment costs incurred above the DRG payment. The hospital also retains any positive difference between the payment and the actual treatment costs. Hospitals are therefore motivated to ensure that the costs do not exceed the flat rate paid. This is done by discharging patients as soon as they are able to recuperate elsewhere, cutting down on unnecessary diagnostic tests and ancillary services, and increasing the efficiency of the various departments.

Federal Regulations

Federal regulations apply to all hospitals subject to the prospective payment system which began with hospital cost reporting periods on or after October 1, 1983. Included in the Federal Register are: how the rates and additional payments are calculated; how the interim payments are made; how certain hospitals are to receive special

treatment; appeal rights under the prospective payment system; changes in review activities; payment for nonphysician services; and changes in the Medicare provider arrangement applicable for hospitals paid under the prospective payment system. In addition there are amendments and revisions to these regulations that are considered necessary to the implementation of the Prospective Payment System.[2]

Impact on Hospitals and Medical Staff

For hospitals, the reason to change to more cost-conscious behavior is clear. Hospitals are at financial risk for administrative and clinical costs. The appropriate balance of what the extent of administrative and clinical changes might be different for each hospital. There will also be a combination of strategies to reduce Medicare costs and manage total revenues. One must increase the productivity of the hospital's human and other resources. There will also be some hospitals who decide to specialize in some areas and drop other areas where they would be duplicating

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[2] Federal Register, January 3, 1984, Vol. 49, No. 1, page 235.

services of their neighbor institutions.

Generally, hospitals must have medical staff cooperation to do well under Medicare prospective pricing. However, the reasons for physicians to cooperate with hospitals to keep down per case costs are not as direct as hospitals' incentives. Most physicians are paid under a fee-for-service payment system that has no relationship to the hospital payment system. Physicians responding to these incentives to modify habits and emphasize cost effective treatment do so out of institutional and patient loyalty to ensure the financial well-being of the place where they treat their sicker patients.

If the Prospective Payment System proves to be effective in controlling costs for Medicare patients, it will undoubtedly be spread to all payers and will not be confined to Medicare patients only.

How Indiana Hospitals Are Doing

Under the Prospective Payment System, hospitals in Indiana are doing fairly well. Indiana hospital costs are lower than the national average and also lower than other states such as Illinois, Michigan and Ohio which are grouped

into Indiana's region for the initial DRG cost structure. According to Kenneth Aldrich, president of the Alliance of Indianapolis Hospitals, Indiana's average rates for care are below those of neighboring states because of a Blue Cross and Blue Shield of Indiana rate review system which has been operational since the 1960's. This is the reason why many hospitals in Indiana are able to care for Medicare patients at a cost below the prospective payment. Statistics from the Indiana Hospital Association show that the average length of stay in Indiana hospitals decreased 11 percent, which is more than double the national decrease of 5.2 percent. Patients under age 65 decreased their lengths of stay by 8.1 percent and Medicare patients decreased their length of stay by 13.9 percent. In Indiana admissions were reduced by 3.1 percent compared to a national decrease of 3.9 percent.[3]

To prepare for future cutbacks in Medicare reimbursements Indiana hospitals are already undertaking measures

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[3] Tamara Bennett, "DRGs One Year Later: Local Hospitals Profit Under New System, But Will It Last?", Indianapolis Business Journal, March 18-24, 1985, page 9A.

such as closing wings and laying off employees. There are also hospitals that are automating diagnostic units of the hospital to reduce the time it takes a physician to diagnose a patient's problems.

CHAPTER IX

MEDICARE

The Medicare Program was enacted by Congress in 1965 to provide insurance protection for older people against the costs of health care. Since then coverage now includes some disabled persons and certain individuals who suffer from end-stage renal disease (ESRD). Disabled persons who are eligible for Medicare coverage are disabled workers, disabled children, disabled mothers and disabled widows and widowers. The second group eligible for Medicare coverage besides the retirees over the age of 65 are the individuals requiring dialysis or renal transplantation for end-stage renal disease.

There are two distinct parts to the Medicare Program: Medicare Part A which is Hospital Insurance and Medicare Part B which is Supplemental Medical Insurance.

Medicare Part A

Part A provides benefits for hospitalization up to 90 days during each specific illness. The patient has to pay a deductible at the beginning of each illness after

which the program pays for confinement in a hospital room for 60 days. If the patient is hospitalized for more than 60 days, the program pays all but a portion of the daily expenses for the next 30 days of hospital care. There is an additional reserve of 60 days (after the 90 days have been used up) during which the patient is required to pay part of the cost while Part A pays the rest.

Part A of Medicare also pays for 20 days of care in a nursing home or extended care facility (ECF) if confinement occurs within 14 days after hospitalization of at least three days. After those 20 days, the program pays for up to 80 more days, but the patient must pay part of the charge. The deductible and the patient's portion of charges for hospital and nursing home confinement change each year.

The last benefit Part A will pay for is the cost of home health care visits. This coverage is for the services of visiting nurses, physiotherapists and other health care providers but not physicians.

Medicare Part B

Part B of Medicare (the Supplementary Medical Insurance

Program) helps to pay for doctors' services and medical items and services that are not covered under Part A. Participation in Part B is voluntary. The individual pays a monthly premium that is adjusted from time to time.

Part B pays up to 80 percent of reasonable charges for various covered services after the patient has met a deductible for the calendar year. In some cases, the patient may have to pay considerably more than 20 percent of the actual bill. Part B covers the services of physicians and surgeons; home health visits for persons not covered by Part A; services such as laboratory tests, x-ray examinations and surgical dressings and splints; hospital outpatient services; and the purchase and rental of certain medical equipment.

Under the direction of the Health Care Financing Administration (HCFA) which is under the Secretary of Health and Human Services (HHS) the Medicare Program is administered through carriers and intermediaries. Blue Cross of Indiana is the intermediary and Blue Shield of Indiana is the carrier for the Medicare Program with the exception of Railroad Retirees. Travelers Insurance Company is the

carrier for this group of Medicare beneficiaries in Indiana.

The primary responsibility of the Plans as Medicare Program intermediaries is to ensure that the program is administered accurately and efficiently. The Plans verify that Medicare funds are spent only for services covered by the program and that the services delivered were necessary and appropriate for the particular diagnosis. The Plans also must verify that total costs are kept as low as possible and consistent with the program's goals.

Medicare provides substantial coverage for hospital and medical expenses. However the senior citizen is not fully protected against the considerable financial loss that may result from long term hospitalization because of Medicare's deductible, copayment provisions and benefit limits. Under Part A, the Medicare patient must pay a deductible of $400(1985) before Medicare pays anything. The deductible has gone up considerably in the past few years. This deductible is paid each time the patient goes into the hospital under a different "benefit period". A benefit period begins the day the patient is admitted to the hospital and ends 60 days after they are discharged from the hospital or a

skilled nursing facility. Medicare Part B costs a monthly premium of $15.50 a month or about $186.00 a year. There is also a $75.00 Part B deductible which must be paid first. Once the deductible is satisfied, Medicare pays 80 percent of what it used to call a "reasonable" amount for the procedure that was performed.

Because of the limitations within the Medicare program's benefit structure and a growing population of senior citizens, there has been a growing development of Medicare Supplemental insurance. These insurance policies are designed to fill the gaps in Medicare's coverage: the gap represented by deductibles and co-payments, the gap between the Medicare approved amount and what providers actually charge and the gap of what Medicare simply does not cover at all.

There are some major alternatives to buying a Medicare-supplement policy. They are as follows:

1) Health Maintenance Organizations (HMOs)- These prepaid plans can possibly meet the health care needs of some Medicare patients. The main advantage to joining an HMO is the sense of security in knowing that your fixed membership fee covers all the medical services you need. Membership is not cheap however and not all HMOs allow people over 65 to enroll.

There is also the disadvantage that the patient may not live close enough to an HMO to use its services conveniently.

2) Continuation of group insurance- If the person 65 or older has been covered by an insurance policy where they were employed they should check and see if they are still receiving health insurance as a fringe benefit. In some cases, this insurance coverage can take the form of a Medicare supplemental policy.

3) Major-medical insurance- This policy is to cover large medical bills. The newest version of major medical is called "catastrophic coverage" which pays extraordinarily large bills. Major medical insurance has a sizable deductible such as $500 or $1,000 that the patient must pay before the insurance company pays anything.

   In some parts of the country it is very hard for a person 65 or older to buy major-medical insurance. When buying major medical the cost must be weighed carefully to see if the policy does cover Medicare's deductibles and co-payments.

4) Hospital-Indemnity Policies- These policies pay a specified dollar amount such as $50.00 or $100.00 for each day that the patient is in the hospital. One disadvantage to these policies is that they do not give any protection against inflation in health care costs. They leave the subscriber unprotected against large medical bils that do not entail hospitalization. They are widely advertised and easy to under-

stand.

5) Medicaid- This program is for the people who have a low income. The eligibility rules and the benefits vary from state to state and is a joint federal-state program.

CHAPTER X

BXBS COST CONTAINMENT PLANS

Health care costs were about $103 billion in 1973, nearly $400 billion in 1983 and studies indicate that by 1990 health care is expected to cost $481 billion.[1] Because the cost of health care is rising so drastically, BXBS of Indiana currently offers several comprehensive cost containment programs which have saved all Hoosiers billions of dollars in health care costs. Through those efforts, BXBS has become the acknowledged leader in cost containment programs in Indiana.

BXBS's cost containment programs were designed to do three things: 1) slow the rise in subscriber health care cost or even lower it, 2) improve employee productivity, and 3) make employees healthier.

Areawide Planning

Blue Cross and Blue Shield Plans work closely with the area Health Systems Agencies through regular contact with HSA

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[1] "Cost Guard", Health Care Benefit Management System, Blue Cross and Blue Shield of Indiana, January, 1985, page 1.

staffs, presentations at HSA meetings or service on HSA governing boards. BXBS of Indiana helped institute Health Care Planning. One of the early results has been to discourage or prevent construction of unnecessary new health care facilities. This type of planning has resulted in the expansion of existing facilities to meet growing demand, rather than the more costly approach of building new facilities and spending millions of dollars on unneeded hospital beds.

Hospital Rate Review

In 1960, Hospital Rate Review began as a program to establish and maintain reasonable hospital rates in Indiana. Rate Review is based on an agreement between Blue Cross of Indiana and the Indiana Hospital Association and began as a commitment to the most economical and efficient use of members' premium dollars. The proposed annual budget for each hospital is reviewed monthly by a 20-member committee comprised of health care and business professionals. This program has saved more than $2.5 billion to date and those savings have resulted in Indiana's per-day hospital cost being almost 30 percent lower than the national average. It should be noted here that the Hospital Rate Review has

brought about savings for all health care consumers in Indiana and not just Blue Cross and Blue Shield of Indiana's insureds.

Effective October 31, 1985, the Hospital Rate Review panel disbanded. The decision was announced by Mr. Lloyd J. Banks, Chairman and Chief Executive Officer of BXBS and Mr. Kenneth G. Stella, President of the Indiana Hospital Association. According to Mr. Stanley A. Huseland, manager of public affairs for BXBS, this system had outlived its usefulness and therefore it made sense to dissolve it.[2]

Voluntary Incentive Program (VIP)

The VIP Program began in 1982 and has been effective in containing the cost of health care by placing a limit on the amount the consumer pays. This amount is agreed to by a physician as payment in full, eliminating any unpaid balance for the insured. As of this date, seventy-five percent of the doctors in Indiana have chosen to participate in this program. This program has also allowed Blue Cross and Blue Shield to better anticipate future increases in

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[2] "Health-care Costs System Dies", La Porte Herald Argus, October 5, 1985, page 1.

physicians' charges.

Utilization Review

In 1974 Utilization Review was established as a separate unit at Blue Cross and Blue Shield. Utilization Review influences the use of health care to prevent unnecessary care; insures that payment is made only for medical care that is necessary; and oversees that the customer, the insured, and the provider contract requirements are met.

Utilization Review consists of prepayment review, postpayment review, and analysis of hospital profiles. Prepayment review analyzes and reviews claims before payment. Postpayment review analyzes historical data to find improper utilization over the years. Hospital profiles are used to show health care utilization patterns, monitor utilization review effectiveness, evaluate concurrent review, focus on utilization problems, and educate providers in developing cost-effective health care practices. These profiles have been performed for ten years at Blue Cross and Blue Shield of Indiana and results of these hospital profiles are shared with the hospitals in a effort to resolve any areas of concern that may be identified.

Concurrent Review

Concurrent Review consists of a review of admissions and continued stays of patients during their course of hospitalization with appropriate planning for discharge. Blue Cross and Blue Shield of Indiana insureds who come under this program are those with individual or group hospitalization and Major Medical. This type of review involves local peer review, which gives the involved hospital's Utilization Review Committee or the medical review organization the responsibility for the development of a program to meet their needs and to conduct the review process. The three objectives to concurrent review are: to improve patient care, ensure appropriate use of hospital care, and to contain the cost of care. There is an important part of Concurrent Review known as Focused Review which concentrates on specific problem diagnoses, procedures and or practitioners that may be identified during the review process or are referred to the Utilization Review Commmittee. At this time there are 31 hospitals in Indiana which are participating in this program and many of BXBS large customers support this program because it works to assure

more efficient use of health care resources without sacrificing quality of care.

Outpatient Care

BXBS has an Outpatient Surgery Program which consists of Ambulatory Surgery and Same Day Surgery. These programs encourage or require that certain operations be performed outside of the hospital setting when possible -- preferably in the outpatient department, ambulatory surgery centers, or the doctor's office.

Other outpatient care consists of four programs: Outpatient Diagnostic, Outpatient Radiology/Radiation Therapy, Preadmission Testing, and Outpatient Physical Therapy. These programs are also designed to encourage certain kinds of health care to be delivered in an outpatient setting rather than in more expensive inpatient setting.

Outpatient Psychiatric Care is provided by clinics which treat emotional and personality disorders at less cost than the hospital inpatient departments. This type of outpatient care as a cost containment measure has just been started but appears to have potential.

Emergency Clinics

Another lesser cost alternative to inpatient care are emergency clinics. These clinics are staffed and equipped to treat only less serious conditions and the cost of care in such a clinic is less than that of a hospital emergency room. There are several advantages to these clinics such as savings of 30 to 50 percent of the cost of a hospital emergency room and greater patient satisfaction because the wait at these clinics is much shorter than hospitals which means less time from work.

Skilled Nursing Facility

The Skilled Nursing Facility benefit is another favorable cost containment program which utilizes the concept of stepping down the level of care from the expensive hospital environment to a less costly but equally effective place of treatment. This is the skilled nursing facility. Such facilities might be an intermediate recovery step between the hospital and home care for recovering patients.

Home Health Care

Home Health Care is designed to encourage the patient

to leave the hospital inpatient unit as soon as he or she is able to do so and continue to receive care at home where it is less costly. This program has another benefical result of returning the patient to his or her family and home as soon as possible.

Worksite Based High Blood Pressure Control Program

Blue Cross and Blue Shield of Indiana's Worksite Based High Blood Pressure Control Program is another beneficial cost containment program that helps to stabilize employees' blood pressure to avoid serious consequences like heart attacks and strokes. The program consists of informing employees about the effects of high blood pressure; screening them to find out who may be experiencing it; referring those who have blood pressure problems to their physicians; and long term monitoring of those persons at their worksite to help them keep their blood pressure under control.

Blue Cross and Blue Shield of Indiana provides educational materials, assistance in planning and conducting the program, orientation for the occupational health staff to schedule follow-up and maintenance activities, help in training personnel for follow-up and monitoring, ongoing

consultation, and periodic reports of the program's progress. The expected benefits of this program are improved employee health, improved productivity, savings in employee retirement and replacement costs, savings in short and long term disability payments, and reduction in the costs of health care insurance premiums.

Cost Sharing (Coinsurance and Deductible)

Cost sharing is the most widely used means of controlling unnecessary care by shifting more out of pocket costs to insureds. These programs deal with initial costs rather than with excess costs after the fact. The incentive value to reduce costs is functional at the subscriber level by requiring the insured to pay for some of the initial cost of care. In the case of the deductibles, the insured must pay a dollar amount of his care during a preset time period before his insurance benefits will begin to pay. In the case of coinsurance, the insured must pay a specified percentage of the cost of health care with his insurance benefits paying the rest up to the maximum, if any.

Studies have shown that the use of health care coverage

is more frequent when insureds bear little or no cost than when they bear some of the cost. Thus cost sharing for all involved has a restraining effect on the use and resulting cost of health care.

Benefit Maximums

Benefit maximums are limits placed on certain benefits in insureds' contracts. They place a limit on payments for certain kinds of care over some period of time- calendar year, policy year or lifetime. The kinds of care that usually feature benefit maximums are care for mental and nervous conditions, alcoholism and drug abuse, and orthodontia. The savings from benefit maximums vary with the amounts selected; however, it has been found that limits placed on payments for health care services tend to limit the use of the care as well.

Indemnity Programs

Indemnity programs, like benefit maximums, are limits placed on certain kinds of health care. They limit payments for care on a "per procedure" basis. These indemnity programs consist of a set of specific allowances- sometimes

called an indemnity schedule for surgery, room and board, and the like. Indemnity programs have the effect of encouraging the insureds in seeking less costly service since the insured must pay the cost above the indemnity limit.

Health Education

Blue Cross and Blue Shield of Indiana provides health education materials on a variety of health subjects. These materials inform the consumer and help to meet the objective of reducing the unnecessary use of health care services to treat preventable illnesses, and consequently, reduces costs to all parties.

Staying Well Program

The Staying Well Program contains health care costs by informing employees of ways to reduce the need for health care by becoming and staying healthy. This program includes a film presentation, a published guide, a personal fitness diary for each participant, a wellness self-evaluation test and Food, Fitness and Stress Reduction materials. In addition to the foregoing efforts, Blue Cross and Blue Shield provides an instructor for a day of onsite consultation to

introduce the program to the respective employees.

Mandatory Second Surgical Opinion Program

The Mandatory Second Surgical Opinion Program is one of Blue Cross and Blue Shield's newest cost containment programs. Like others, this program also is aimed at reducing or eliminating unnecessary inpatient care by encouraging insureds to seek a second and, if necessary, a third opinion to confirm the need for certain elective operations. Operations performed without a second opinion are considered medically unnecessary and are payable at less than the normal amount, with the provision that the insured is liable for the balance. Therefore, there is a strong incentive for seeking a second opinion.

This cost containment program results in the elimination of a number of unneeded operations in the hospital inpatient department. The program has two major effects: first, it reduces the number of inpatient operations actually performed, and second, it reduces the number of such operations that may be proposed. The threat of different opinion may be a strong deterrent. Research on similar programs have shown a cost benefit ratio ranging from .79 percent to 5.5

percent.[3]

Stay Alive & Well

Stay Alive & Well is a cost containment program developed by the American Health Foundation and used at Blue Cross and Blue Shield of Indiana on its own employees over a five year period. This specific program shows employees how to get control of habits and lifestyles that lead to illnesses such as cardiac problems, stroke and cancer. The employee is shown how to get control of such habits such as smoking, obesity, high blood pressure, alcohol and drug abuse. Once the employees have control, Stay Alive & Well helps them to keep control and stay well.

Stay Alive & Well has saved Blue Cross and Blue Shield of Indiana more than $1.4 million in health care costs and absenteeism costs during this past five years.[4] It provides three major benefits for the employer: healthier employees, increased productivity (less time off due to illness), and

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[3] "Programs That Reduce the Demand for Health Care", Comprehensive Cost Containment, Blue Cross and Blue Shield of Indiana, February, 1985.

[4] Ibid.

lower health care costs.

Implementation of the program **Stay Alive & Well** requires a minimum of time and physical space. The nursing or training staff administers the program. Blue Cross and Blue Shield provides the training, recruiting materials, Vita-Stat blood pressure computer, consultation, training manuals, screening materials, educational materials to stop smoking, nutrition and weight reduction classes, and data services to help the staff analyze and interprete the results.

Blue Cross and Blue Shield of Indiana holds the exclusive license to market this program nationwide through an agreement with its affiliate company, Regional Marketing, Inc., who owns it.

Cost Guard

One of Blue Cross and Blue Shield's newest cost containment programs, **Cost Guard**, was implemented on November 1, 1984. Cost Guard helps hold down health care costs by controlling expensive inpatient hospital care and by making sure that the insured is aware of the less expensive options that may be available. There are eight controls Cost Guard uses

to help health care costs. They are as follows:

1) Preadmission Certification, Continuing Review of Inpatient Care and Discharge Planning - Includes evaluation of planned hospital stays before admission (or in the case of emergency or maternity care, right after admission).

2) Mandatory Second Surgical Opinion Incentive - Requires the patient to seek a second opinion when the doctor recommends certain types of inpatient surgery.

3) Ambulatory Surgery Incentive - Makes sure that needed surgery is performed on an outpatient basis rather than on a more costly inpatient basis whenever possible.

4) Preadmission Testing - Monitors patient's stay in the hospital so that the stay in the hospital is no longer than needed. Required tests may be done at less cost prior to entering the hospital.

5) Early Admission Deterrent - Cost Guard administrators will require an explanation as to the medical need for an early admission. They will review the patient's case and determine if an early admission is needed. Then the doctor will advise the patient of the decision and if hospitalization is approved, and when the admission should occur.

6) Weekend Admission Deterrent - Discourages the patients from entering the hospital on Friday, Saturday or Sunday with no treatment scheduled until Monday.

7) Coordination of Benefits Enhancement - As-

sures that Blue Cross and Blue Shield of Indiana pays only its share of covered health care expenses when other insurance companies may have coverage on the patients.

8) Individual Patient Care Benefit Management - Patients facing a serious and long illness or disability are helped to plan with their physicians, for the least cost care when the patient relies upon the insurer to pay the greatest share of the confining illness period. 5

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5 "Cost Guard", pages 2-13.

CHAPTER XI

CONCLUSIONS

A series of concluding statements are provided as the author's professional judgments about the financing of health care services, based upon the findings in the foregoing chapters. This study of Blue Cross and Blue Shield of Indiana, as an innovator in the health care insurance industry, should make a contribution to a better understanding of financing health care.

Americans may have grown accustomed to rising health care costs in recent years, but that does not mean that they will welcome unreasonable increases as demand for inpatient health care decreases. There also is a suspicion that some people without medical care coverage are not using hospital health care resources when needed most. Families of the working poor with little or no insurance, for example, may be living with serious ailments simply because they cannot pay for treatment or fear they cannot pay. When they can no longer endure the malady, they may be persuaded to enter hospitals, sometimes well past the point where they

can be best served.

Cost-effective health care is a critical issue which demands attention from: patients, doctors, hospital administrators, health insurers, and public officials. Such across the board cooperation to seek a reasonable solution should help create a quality medical care delivery system within the reach of all who need it at a reasonable price.

There are various reasons why health care costs have risen so rapidly. One major reason is that third-party payers acting in response to the social expectations of the period have poured increasing amounts of dollars into the health care system. Furthermore, the tendency exists for employees to take unreasonable advantage of their company's benefit programs, assuming it is "free". Benefits were increased substantially when it was "convenient" for employers to respond to employees' expectations to provide additional fringe benefits rather than direct salary increases because of the tax advantages for both. Under unrestrained benefits and low inflation, individual users were not accustomed to making a decision about the cost of health care. They were able to receive substantial paid

benefits and good coverage with little control over costs paid. Consequently, consumers freely used those benefits; but they did not have to make decisions as to who paid the cost and how much it was. For a long time reimbursement programs for both hospital and physician services were based on charges incurred. Whatever costs were incurred, that is what was paid. Such reimbursement programs had a positive effect on the demand for services and stimulated an increase in the number of health care providers in the business.

As a leading health insurer in Indiana, Blue Cross and Blue Shield is well aware of the health care cost explosion. For the past fifty years, BXBS plans across the nation have had an historical commitment to provide widespread financial reimbursement of cost for such health services. The management of the Plans still believe in the fundamental concept of comprehensive benefits and first dollar coverage. According to the 1983 Annual Report published by Blue Cross and Blue Shield of Indiana, the Plans have restructured their corporations to do five things that are vital to the satisfaction of their "customers" and their success in the future. They are as follows:

1) Work more closely with their customers in the various market segments to help them analyze their health care benefit needs in order to make effective decisions.

2) Become more flexible and have a greater capacity within their product lines to offer a wider variety of traditional health insurance benefits and alternative delivery options.

3) Offer a greater array of financing services and financing arrangements.

4) Respond more quickly to market changes and meet member needs for more efficient service.

5) Maintain and improve their traditional relationships with the health care provider communities. [1]

Today, the buyer of health insurance for organization members is looking for a different product, one with greater emphasis on cost sharing. This raises questions by concerned users about first-dollar coverage and comprehensive benefits which may have been Blue Cross and Blue Shield's hallmark for many years. Although there is still that fundamental belief in first dollar coverage and comprehensive

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[1] Blue Cross and Blue Shield of Indiana 1983 Annual Report, 1984, page 2.

benefits, Blue Cross and Blue Shield found it necessary to respond to the marketplace; and therefore, developed new products. This transition period led to the growth of Health Maintenance Organizations, Preferred Provider Organizations and other health care financing arrangements. These new health care delivery systems will help share the responsibility to use health care benefits more carefully among provider, purchaser and user.

The Prospective Payment System in 1983 was the beginning of a powerful incentive plan to hold down costs in the hospital setting. Making an adjustment in payment philosophy of this magnitude would require the shifting of massive amounts of funds, literally millions of dollars, from hospitalization to ambulatory care, and from institution to physician. As a result, Medicare, Medicaid, Blue Cross and Blue Shield, commercial health insurers, federal and state agencies, and private individuals would spend an enormous amount of time protecting themselves against someone else's costs or shifting their own costs to somebody else. The essence of insurance is the sharing of catastrophic costs, not the shifting of costs from one to another. The manage-

ment services provided in managing this cost should be entitled to a fair and reasonable profit or "fee".

Implementation of the Prospective Payment System for all providers is one of the answers for solving the Medicare cost crisis. Instead of loading new costs on workers and deep benefit cuts on the elderly, it is time to control health care costs at the source. This study has amply identified those cost units. It is reasonable to expect that with new technology, services, and inflation that there should be increases from time to time in the premiums paid by those covered by Medicare; even increases in the annual deductible choices and also where agreements are entered into to provide exclusive service, that that service be subject to control over the charges which may be allowed for payment by Medicare. Outside such agreements, the free market governs agreements and charges. Proposals for the solution of reducing the heavy financial drain on Medicare funds are: 1) raising the Medicare eligibility age to 67 by 1991 (with the eligible age for beginning service continuing to go up thereafter, 2) increasing the $75.00 deductible, 3) making employer-paid health insurance taxable as income in order to

raise revenue for Medicare, and 4) increasing alcohol and tobacco taxes to cover the remaining Medicare deficit. Americans want to be insured against large catastrophic medical bills; they do not want the poor to suffer for lack of funds to pay for health care. Therefore, with strong advocacy from the concerned citizen, the Medicare program, has been undergoing a major transformation.

In today's health care environment it is essential for the Blue Cross and Blue Shield Plans to provide a level of performance equal to or better than their competitors in the marketplace. Internal cost controls are initiated by Blue Cross and Blue Shield Plans such as encouraging the use of second surgical opinions, advocating nonhospital care for the convalescing and terminally ill, providing for outpatient surgery, and requiring pre-admission testing. These programs are cost-effective without diminishing the quality of medical care. Internally they have strengthened the claims review process to help meet the goal that all claims are paid quickly and efficiently and that questionable claims are investigated before payment. The Plans screen hospital bills for accuracy and utilize consultants for examination of

specialized claims. They have provided their customers with statistics regarding hospital stays, comparisons of providers' costs, and other data which are effectively used by the Plans to track coverage and expenses and encourage conformity to reasonable standards.

Two of the new effective and promising cost control systems are Health Maintenance Organizations and Preferred Provider Organizations. These delivery systems encourage group policyholders to use specially designated physicians and hospitals for their health care needs. A patient retains the right to choose a non-designated provider but the reimbursement or guaranteed payment schedules are adjusted so the patient pays a higher percentage of the costs. It seems apparent that Blue Cross and Blue Shield in the future will be heavily involved in these alternative delivery systems.

Various views are held about the types of plans discussed above and what has to be done in the future to continue to restrain the ever rising cost of health care. There are direct and bold steps available to solve many of the problems. Several of these steps have been taken by

Blue Cross and Blue Shield. For example, BXBS is monitoring hospitals and doctors closely to find ways and means to reduce the number of unnecessary hospital admissions, tests, procedures, and the length of stay.

The expectation is that health care insurers, working with the provider and the users in a cooperative manner can best serve the needed health services of all the participants in private organizations. The undesirable alternatives would be socialization as practiced in the socialist countries with all its impediments and controls when it is "free for the asking". This author believes that private American enterprise, working under reasonable rules of conduct to assure least unfair advantage is taken by unscrupulous members of the groups involved, is the better plan for the foreseeable future in the United States.

ADDENDUM

After the thesis was approved and prepared for binding, the following information from the March 6, 1986 issue of the South Bend Tribune became available in regards to the appeal filed with the 7th U.S. Circuit Court of Appeals as referred to in **Chapter VI** of my study.

The ruling which was released on March 5, 1986 was written by Judge Frank H. Easterbrook and upheld a decision by District Judge William E. Steckler in Indianapolis. The appeals court ruled that 80 Indiana hospitals may not stop a cost cutting insurance plan offered by BXBS of Indiana. Attorneys for the hospitals had argued that the insurance plan which would steer patients to 61 "preferred" hospitals would also give those patients lower rates which was a violation of anti-trust legislation.

In his decision, Easterbrook wrote that instead of harming the public, the insurance plan, known as Preferred Care of Indiana, would increase competition and aid the public. Senior District Judge Hubert L. Will wrote a brief opinion concurring with Easterbrook's decision adding that the district judge used discretion in deciding preliminary injunction questions.

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VITAE STATEMENT

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