FINAL REPORT

Compliments of Health Policy
Corporation of Iowa

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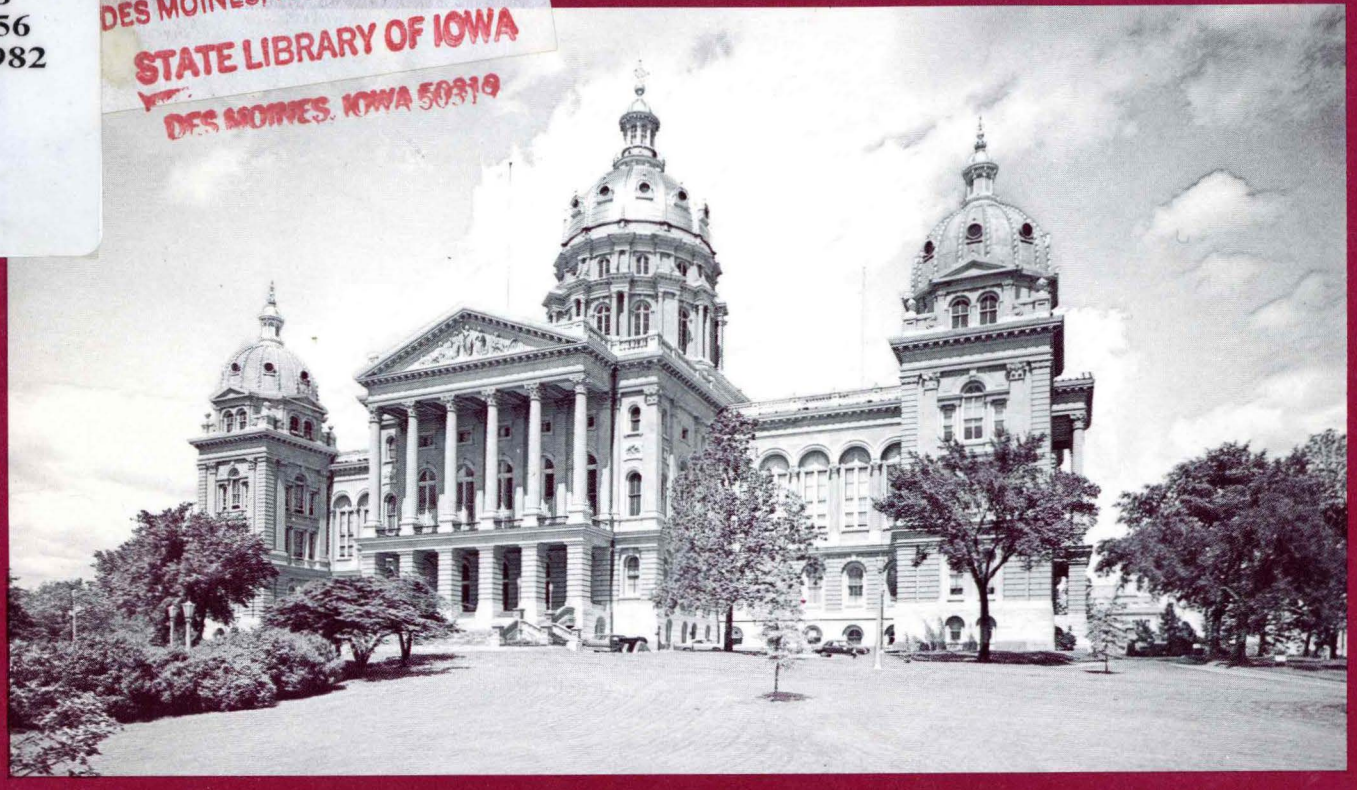

GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

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INTRODUCTION

In April, 1981, the Honorable Robert D. Ray, Governor of Iowa, appointed an eleven member Commission to review health care costs in Iowa and to develop recommendations for both public and private initiatives to contain increases in health care costs. In the sixteen months following the formation of the Commission, the group reviewed aspects of competition, regulation, hospital and physician payment, utilization review, long term care, mental health, substance abuse, primary care, preventive health care, and data needs, as they are related to the organization, financing, and delivery of health care.

This report summarizes the findings and recommendations of the Commission.

Process

Background papers were prepared by Commission staff for review by four "constituency group" task forces: health care consumers, health care purchasers, health care institutional providers, health care professional providers.

The task forces suggested alternative approaches for further staff analysis. Following review of these papers, the task forces developed general recommendations for the Commission's consideration. The findings of the task forces were communicated in monthly reports from June through December and in oral presentations by the chairpersons of the task forces at the December Commission meeting.

Based on the recommendations of the task forces the Commission developed principles and recommendations pertaining to competition, regulation, hospital payment, physician payment, and utilization review.

These principles and recommendations were circulated for review and comment. A public hearing was held on the tentative proposals on March 24, 1982. On April 13 and 14, 1982, the Commission discussed the statements made and comments submitted at the hearing, and adopted principles and recommendations to be contained in a preliminary report.

Following development of the preliminary report, the Commission formed four new work groups: primary care and preventive health care, long term care, substance abuse and mental health, and data needs.

The four work groups reviewed background papers, reviewed responses from a delphi-style survey, and developed principles and recommendations which were considered by the Commission in June and July.

The principles and recommendations contained in this report are organized in seven broad areas. An appendix to the report provides supporting background data and a glossary of terms. In addition, a companion volume contains the background reports, alternative analysis reports, task force reports, and the entire transcript of the public hearing.

The report of the Commission represents many hours of effort on the part of a number of concerned Iowans who participated in task forces and work groups, who responded to the delphi survey or who testified at the public hearing, as well as by Commission members and staff. The active involvement of many individuals was an important ingredient in the Commission's approach to the issues confronting the state. The Commission would like to acknowledge the contributions of all who participated in the process.

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FOREWORD

As are most states, Iowa is experiencing a serious problem of rising health care costs which are increasing at a rate nearly twice that of general inflation. Over the last twenty years the proportion of Gross National Product devoted to health care has doubled from about 5% in 1960 to 10% in 1980. Some critics believe that this increase has occurred without a commensurate improvement in health status. Health costs are straining governmental budgets at all levels: federal, state, and local. Employer health costs are regarded as increasingly prohibitive as employers compete in uncertain national and international markets.

Many attempts have been made to control health care costs while maintaining acceptable quality of services. Through governmental programs these efforts have included planning, utilization review, and capital expenditure review. Private and governmental payers have focused upon benefit design changes, modification of payment approaches, and the use of copayment and deductibles. Other activities have included health screening, education, and provision of preventive care. In spite of these developments, health costs have continued to escalate dramatically.

In recent years, health care providers and executives, as well as purchasers, consumers, and academics have debated the merits of various schemes to control costs while assuring quality. Much of that debate has focused on arguments about the relative superiority of regulatory or competitive proposals to restructure the health system. Proponents of regulatory proposals argue that the unique nature of the health industry does not permit the necessary ingredients for market competition and that it is monopolistic and must be regulated. Proponents of competitive solutions argue that the health industry can be prevented from behaving in a monopolistic fashion and that efforts to instill key elements of a competitive market will be successful over the long term. The Commission believes that the arguments over the relative merits of regulation and competition often present a false dichotomy. Some aspects of each position may be correct and descriptions about the nature of health care which have been provided by some proponents can be helpful.

While the Commission does not endorse any specific pro-competitive proposals for reform, it believes that some regulation of the industry will be required. The Commission is also of the opinion that regulatory activity should be made more efficient and more effective.

The Commission further asserts that certain elements of a competitive strategy show promise for containing increases in health care costs. Among these are suggestions that the industry can and will respond to changing economic incentives including market forces. In order to foster the interplay of market forces, purchasers and decision makers must have access to precise information. It is naive, however, to assume that change can be accomplished without a substantive governmental role. A proper mix of regulation and market forces will be required.

Many of the efforts to control cost increases that have been cited earlier have been conducted in simplistic fashion. It is the belief of the Commission that, often, the effect of such activity is cost shifting rather than cost control. Efforts to control the utilization of health services which are separated from efforts to control unit costs tend to increase unit costs. Efforts to control unit costs which are separated from efforts to control utilization tend to increase utilization. For these reasons, both utilization and unit costs should be controlled simultaneously. In a similar fashion, efforts of a single payer to reduce payment levels will be ineffective. For this reason all payers must be involved in cost control. The Commission believes that attempts to control the costs of health care will be most successful when they involve simultaneous attention to both price and use, and when the majority of payers are involved.

The Commission is of the opinion that the major problem area in the delivery of health services to Iowans is unnecessarily high utilization. Research conducted by Commission staff indicates that the relationship between inpatient use and per capita cost is stronger than that between per capita cost and length of stay,

charge per day, or physician charge. Therefore, control of admission rates to hospitals is, accordingly, a high priority.

Iowa's admission rates are significantly above the national average for the under 65 population. Iowa's under 65 use rate is a source of concern, not only because it affects health costs, but also because it may suggest problems in the delivery of appropriate care. Increasingly, medical educators are suggesting that national use rates are higher than necessary. The Commission has identified wide variations in use rates from county to county in Iowa. Understanding these variations is essential. The Commission feels strongly that the rate of use of hospitals can be reduced significantly with associated cost savings without risk to the population.

The Commission also believes that the methods of payment for hospital and physician services are major contributors to the utilization and cost problems. For this reason, innovative payment mechanisms and experimental approaches must be developed and implemented. Progress in payment systems and better monitoring and control of utilization must occur simultaneously. While innovative payment mechanisms and the provision of information to payers and consumers is the preferred approach to controlling costs, failure to implement appropriate alternatives may require a greater emphasis on regulatory approaches, including prospective rate review.

EXECUTIVE SUMMARY

The urgency of the problem of health care costs and the need for new approaches suggest that certain recommendations must be adopted and implemented immediately.

The Commission endorses an increased emphasis on market incentives and recognizes the need for enabling government legislation. The need for both market incentives and regulation is recognized. The Commission has endorsed an interim certificate of need program; an interim program must be in place during the next few years as market forces develop to the point where they are effective.

The Commission calls for legislative changes to allow, encourage, and reward the creation of both horizontally and vertically integrated delivery systems.

The Commission recognizes the need for better information systems as well as the importance of providing purchasers and consumers of health services with current and precise information. Mandated statewide agreements to develop such programs will be required.

The Commission recognizes that hospital payment methods should not preclude needed flexibility for operational efficiency. Payment and coverage for outpatient and out-of-hospital care should be expanded. Steps should be taken to limit cost shifting to private payers. Innovative experiments which address both hospital and physician payment are desirable.

The Commission emphasizes the importance of controlling utilization of services. Practice patterns must be analyzed and evaluated. The Commission strongly believes that costs can be controlled most effectively by reducing unnecessary hospitalization. Prior authorization of the use of the hospital may be a required approach to controlling unnecessary use in select instances. The Commission suggests that the review process focus increasingly on patterns of physician practice rather than on individual cases. The Commission also suggests that information resulting from utilization studies be disseminated to both providers and purchasers. There is a need to expand the continuum of care that is reviewed, and there will be the necessity to apply sanctions when all else fails.

The Commission asserts that the most important step that Iowans can take to reduce the rate of health care cost increases is to pursue healthful lifestyles and to seek health care services at the proper time. In addition, Iowans need to make appropriate use of mental health and substance abuse services. Providers, in turn, should work to assure their ability to judge when physical problems have their basis in substance abuse or mental illness.

Long term care services need the same intense scrutiny that has been given to acute care services. Such analysis should include investigation of variances in the use of different services by similar population groups. Experimentation in service stratification and payment methodology is needed.

Information is necessary for the comparison of cost and quality. These kinds of data have not always been available to health care consumers and buyers. Legislative action will be necessary to assure the availability of such information.

The recommendations of the Governor's Commission will be implemented by numerous individuals and organizations. While the Commission recognizes that such individuals and organizations are likely to express their own priorities, the Commission believes that the following recommendations must be accomplished within a one year period:

1. Revising the Iowa Certificate of Need Law;
2. Altering the Blue Cross reimbursement formula;
3. Developing a mechanism for use by Blue Shield to limit changes in customary charges;
4. Developing a consortium to conduct a relative value study;
5. Expanding the list of surgical procedures suitable for ambulatory care;
6. Developing individual provider profiles for use in the utilization review system;
7. Developing a statewide hospital pricing data clearinghouse; and
8. Implementing use of the uniform hospital billing

form (UB-82);

In addition other recommendations must be accomplished within the near future:

9. Development and implementation of an experimental hospital payment program;
10. Development and implementation of an experimental physician payment program;
11. Completion of a relative value study;
12. Development and implementation of an experimental payment program for the full range of long term care services; and
13. Development of a health promotion organization.

The Commission is convinced that implementation of its recommendations will result in significant reductions in health cost increases in the State of Iowa.

REGULATION, COMPETITION AND MARKET FORCES

Health care expenditures have been increasing at an extreme rate because the system has no controls to discipline performance. This discipline can be accomplished in two ways. One way would be through strong "command and control" governmental regulation. Success would require the setting of prices, the setting (not simply the review) of capital expenditures, and the setting of utilization rates and treatment patterns. An alternative approach is to initiate the discipline of market forces and create incentives for efficiency in the health care system.

The Commission believes that the most effective strategy to controlling costs is to endorse market incentives coupled with enabling government regulation where necessary. This strategy will control the rate of increase in spending, and promote efficiency and effectiveness.

The Commission's evaluation of the Certificate of Need (CON) program, a capital expenditure review mechanism, is outlined below:

- The program has had limited success, deterring some types of construction, and preventing some unnecessary duplication of services. Capital expenditures would have been higher had the program not been in place.
- It cannot be expected to have had a major impact on total expenditures since it focuses primarily on capital costs and not operational costs.
- It does not address the "overutilization" issue.
- The public scrutiny of the review process has resulted in more deliberate and detailed long-run capital planning in institutions.
- The program is reactive, not proactive.
- It is inherently in conflict with the incentives of cost based reimbursement. It is difficult to say "no" when the reimbursement system makes the project financially feasible and when the institution demonstrates that the demand exists (regardless of whether it is being met elsewhere), or that it can be generated.

The Commission concludes that the CON program should be continued, in a simplified form, for at least the next 3 to 5 years. The program could possibly be phased out after the incentives have been restructured to reward cost-effective capital expenditure decisions.

Promoting market forces and market incentives is one cornerstone for the Commission's recommendations. Competitive market forces should be promoted in two ways:

- Employers should offer alternative delivery systems and other competitive options to their employees;
- Providers should examine alternative delivery system options and join them or start them.

The Commission also concluded that state laws and regulations governing the provision of health benefits should be similar across all groups so as to ensure fair competition. In addition, legislation should not dictate either benefit design or methods of payment.

Planning and Review — Principle and Recommendations

Principle I.

Health planning and review are important and necessary to the efficient and effective delivery of health services. There is a need for both local/private and state involvement. The policies and procedures of planning and review in Iowa should be simplified.

Recommendation 1

The State of Iowa should include the sanctions of the 1122 program in the Certificate of Need program. Subsequently the State of Iowa should terminate its contract to perform reviews under Section 1122 of the Social Security Act.

Recommendation 2

The State of Iowa legislature should amend the Iowa Certificate of Need law in such a way as to include all entities with the exception of construction of physician offices.

Recommendation 3

The State of Iowa legislature should amend the Iowa Certificate of Need law to be in conformance with the new Federal requirements with respect to dollar thresholds for State Certificate of Need programs.

Recommendation 4

Local health planning agencies should conduct no more than one review and hearing for each project submitted under the Certificate of Need program so that the number of Certificate of Need review levels will be reduced to two (one local and one state), except in the case of appeal by an applicant in a negative review at the local level.

Recommendation 5

In order to reduce the number of new service reviews, the Iowa State Department of Health (in consultation with representatives of health planning agencies, purchasers, and health care providers) should review the list of new services subject to review in the Certificate of Need program.

Competition — Principles and Recommendations

Principle I.

Employers have a responsibility to encourage fair competition.

Principle II.

Iowa legislation should facilitate provider efforts to create vertically and horizontally integrated organizations and arrangements for the delivery of health services.

Principle III.

Coverage of services and payment for services are a matter of negotiation between purchasers and provider. Legislation and regulation should not interfere with this principle. Simultaneously, purchasers should design benefits and negotiate payment in such a way as to promote a competitive market.

Recommendation 1

All employers, private and public, should offer alternate delivery systems and other competitive options to their employees.

Recommendation 2

Unions should promote multiple choice of alternative delivery systems and other competitive options to insure that each employee has individual choice of the plan best suited to his or her needs.

Recommendation 3

Existing and developing alternate delivery systems and other competitive options should develop mechanisms to make these options available to all Iowa residents.

Recommendation 4

The Iowa laws and regulations applicable to health insurance, health maintenance organizations, service plans, and self-insured plans should be revised to be equal in their requirements so that these programs can compete in a fair market.

Recommendation 5

Employers, insurers, providers, and interested community leaders should support the development of new and existing health care plans by providing managerial and marketing expertise — and financial support, if necessary — to providers who are forming new plans.

Recommendation 6

Providers should review both the existing health care plans and proposed health care plans to identify those plans that may be consistent with their own style of practice. The Commission urges physicians to seriously consider participating in such plans.

Recommendation 7

Employers and unions should actively promote the provision of simple, comparative information to facilitate employee choice of appropriate health plans.

PROVIDER PAYMENTS

The health care system responds to the incentives it confronts. Current provider payment or reimbursement methods contain incentives that reward inefficient, cost-increasing behavior. The most prevalent method of hospital reimbursement is cost based; higher payments flow to hospitals with higher costs. Payments for professional (physician) services are on a fee-for-service basis. The incentives are clear. The system rewards more costly types of care; few, if any, rewards exist for economy.

Providing incentives through changing the hospital payment mechanism is, perhaps, the most critical portion of the Commission's recommendations. When implemented, they will force increased cost consciousness. Some of the principles are highlighted below:

- Payment should reward efficiency and penalize inefficiency;
- Payment should encourage the most cost-effective modes of diagnosis and treatment in the most cost-effective settings;
- As in most industries, the efficient and effective providers should be paid enough to survive and prosper.

Some of the specific recommendations include:

- More price and charge information should be made available to purchasers so that they can make more cost-conscious choices about where to seek care;
- Alternative financing methods should be developed on an experimental basis such as a capitation payment approach;
- Providers should be "at risk" for medically unnecessary and overly intensive services;
- The rate of increase in maximum allowable fees should be tied to an economic index.

The recommendation on making price and charge information available is a critical component of creating market incentives for efficiency. The discipline of the market is embodied in the right to refuse to buy if the price is too high. The Commission addressed this important area and made recommendations which are in the section on Hospital Data and Information.

Hospital Payment

The recommendations for changing hospital payment methods take two forms: a set of principles and corollaries which describe the general attributes of a better system, and a competitive approach* to purchasing and delivering hospital services.

The Commission believes that one of the basic ingredients needed to stimulate this competitive approach is additional and more comparable information. Purchasers, in the broadest sense, should be able to make more informed choices. The recommendations which follow the principles recognize that there must be some mandated, statewide agreement to develop the information needed for competition to function.

*This endorsement of a competitive approach is not to be construed as advocating any specific pro-competition legislation.

Hospital Payment — Principles & Recommendations

Principle I.

Hospital payment systems should foster equity among payers and providers.

Corollaries A. Uniform service units should be established so that payers know exactly what they are buying and are better able to compare changes.

Note: Service unit charges should be uniform for all payers, including government, within an institution, but may vary from institution to institution. Although a hospital would charge all payers including governmental entities the same for a given service unit, there could be discounts to some payers for the actual economic benefit of the volume they controlled, administrative support they can offer, etc.

B. Service units should be defined in specific terms, such as diagnosis- or procedure-specific cases, etc.

C. Existing charge structures are dependent on the proportion of Medicaid/Medicare patients. In the event governmental payers do not pay full charges, some mechanism must be developed to compensate for the Medicaid/Medicare payment shortfall, so that charge variations do not reflect this patient mix.

Principle II.

Hospital payment systems should facilitate access to capital for replacement and improvement of services by efficient and effective providers.

Corollaries A. Full cost of hospital capital projects should be incorporated in hospital charges. The system should permit operating margins to generate sufficient equity for hospitals to compete in open capital markets.

B. Payment should encourage facilities to undertake new construction, renovations, and replacement projects which result in the most efficient facility.

Recommendation 1

Payers should develop payment systems with service unit based pricing. The data and definitions required to implement such systems must be mandated by the Iowa legislature.

Recommendation 2

Since it will take three to five years to design and implement service unit based pricing, transition activities should reward efficiency and promote competition. Blue Cross plans must replace their static growth and development payments with some variable payment tied to a measure of efficiency.

Recommendation 3

A third party payer working in conjunction with health planning organizations, hospitals, and purchasers, should develop an experimental payment program within the state. A hospital capitation payment experiment should be examined as one possibility.

Recommendation 4

Payment systems should encourage vertical and horizontal integration of services, multi-hospital service sharing arrangements, and alternate delivery systems.

Payment System for Professional Services — Principles and Recommendations

Principle I.

Payment systems for professional services should stimulate the efficient delivery of appropriate services in the most cost-effective setting consistent with patient health needs and public policy goals.

Principle II.

A variety of payment systems should be designed and periodically updated to reflect significant variations in the amount of time, degree of difficulty, and level of expertise required for a particular service or service mix, as well as changes in economic conditions.

Recommendation 1

Third-party payers should develop experimental programs and pilot projects (including capitation) which provide financial incentives for broader application of ambulatory care approaches. This will encourage cost effectiveness in physician selection of patient-care services and settings.

Recommendation 2

Third-party payers should limit physician payment to that level of reimbursement for services in the most cost-effective settings.

Recommendation 3

Third-party payers should develop systems of payment for professional services which encourage consumer participation in selecting the type and scope of services provided.

Recommendation 4

On request, third-party payers should provide purchasers and consumers with physician-specific information relative to program participation status and acceptance of assignment.

Recommendation 5

On request, physicians should furnish printed information to the public of their respective charges for those services each routinely provides.

Recommendation 6

In order to evaluate the fairness and equity of current charge patterns, a consortium of payers, providers, and intermediaries should conduct a relative value study of physician charges in Iowa for use by third-party payers.

Recommendation 7

Third-party payers using the UCR reimbursement methodology should incorporate a mechanism which limits changes in the "customary" charge level to a rate which is fair and equitable.

Hospital Payment of Physicians — Principles and Recommendations

Principle I.

Legal barriers should not preclude the design and development of cost-effective, health care systems, including alternative delivery systems.

Principle II.

Hospitals and physicians must not subject consumers to financial harm by lack of prudence and reasonableness in their contractual agreements.

Corollary A. Both hospital-based physicians and hospitals should be prudent and reasonable in their demands for contractual agreements in any type of relationship that may be entered into between hospitals and such physicians.

Recommendation 1

The Iowa legislature should take action to eliminate restrictions on the types of employment contracts which may be established between hospitals, other corporations, and physicians.

Recommendation 2

Hospitals and their medical staffs should re-examine their compensation arrangements with contracted hospital-based physicians and devise compensation systems that encourage cost-sensitivity. Placing these contracted physicians on a fixed salary may be the first step in this direction.

HOSPITAL DATA AND INFORMATION

The narrative of this section and its recommendations outline a strategy for improving the availability and utility of hospital data and information. This important need was identified by all of the Commission's task forces and by both the Hospital Payment and the Utilization work groups. The work group that was formed to address this subject was charged with outlining the types of hospital pricing and utilization data needed to: a) stimulate market forces for a more price-competitive environment, b) develop a prospective type of hospital payment system(s), and c) reduce the current high rate of growth in the intensity of services. In addition, the group was to develop a strategy for implementing the recommendations.

The first part of this section focuses on hospital pricing data needs. Data needs to lower utilization are the topic of the second part. The final part includes the recommendations.

Hospital Pricing Data

Two key principles in the preliminary Commission report provide a framework for this section. First, the hospital payment system should reward efficient producers of hospital services and, conversely, pay less to inefficient producers of hospital services. Second, to the extent practicable, there should be equity among payers for hospital services. With these principles in mind, the work group developed the following two propositions. All payers should pay on the basis of charges, although some payers may receive legitimate discounts for volume, timeliness of payment, or other factors. Those charges or prices should be determined in a more competitive environment.

Both the principles and propositions have significant implications for this report. The first, equity among payers, is important because at the present time some payers, primarily governmental payers, are reimbursing some hospitals at less than their cost. The hospital industry's response to this has been to set charges high enough to make up for this payment shortfall. This phenomenon has come to be called the "cost-shifting problem." The result of this cost-shifting is that payers who reimburse hospitals on the basis of their billed charges are paying more than their "fair share of the bill."

The second proposition, that of prices or charges being determined in a more competitive environment, is the result of the incentives that existing third-party reimbursement has created for both the hospital and the consumer. For the hospital, most of the third-party reimbursement is cost based; thus, hospitals with higher costs receive higher reimbursement. Obviously, a system such as this does not encourage a hospital to hold costs down, and, equally important, does not meet the principle of rewarding efficient production. The remaining portion of hospital payment has been based on billed charges, with few if any questions asked by either the third party payer or by the consumer. Neither of these payment approaches has incentives to hold costs or charges down. To the patient, insurance coverage of the hospital bill means that the consumer has no incentive to shop for a more efficient and cost-effective producer. Many consumers wrongly consider higher charges to be necessarily associated with higher quality care.

Both of these conditions are in marked contrast to the conditions of the classical market place. First, producers that hold down costs will be able to have lower charges, thereby generating more demand and more net revenue. They will be rewarded for their cost consciousness in the production process. Second, consumers in most sectors of the economy pay for those services directly out of their pocket and therefore have incentives to shop and the right not to buy if the price is too high. Although the Commission does not believe that the market for hospital services can fully behave as in the classical market place, it does believe that more price and cost sensitivity and awareness will result in more cost-effective production of hospital services.

The Commission identified three key missing ingredients. First, the lack of an agreed-upon definition of the products of the hospital. Second, the absence of price or charge information on defined units of service. And

third, the lack of mechanisms to encourage either producers or consumers to take actions and make decisions based on that price information. Each of these key ingredients will be addressed.

The importance of defining the output is based on the fact that purchasers need to know first what it is they are buying and how many units of that product they are buying. The Commission believes that the best units for measuring hospital output are cases (admissions) on a diagnosis-specific basis. Cases are the appropriate measure of output because most care is sought to treat specific episodes of illness. Diagnosis-specific cases are important because the treatment for some diagnosis is substantially more costly.

At the present time, minimal price information is available to the purchaser. The limited amount of information that is available tends to be only for the daily room charge portion of the hospital bill. Total price information on a diagnosis-specific basis would provide information from which both purchasers and providers could make more informed decisions. The emphasis on total charges per case rather than the various components such as routine care, x-ray, lab., etc., is simple and represents the "bottom line." Hospitals and physicians may wish to focus on the charge components as part of their management function; the component information, however, may be of little value to purchasers.

The Commission believes that having price information available will encourage the development of a prospective payment system. Actions based on the price information will restrain the rate of increase in health care costs. Providers of care will be able to make comparisons of the efficiency with which they treat various cases. This type of information will help purchasers make decisions about where to buy their health care.

Hospital Utilization Data

The section on Utilization Controls includes two suggestions: One, that more emphasis be placed on the rate of hospital admissions and the rate of growth in the intensity of services. Two, that feedback information based on utilization profiles and patterns should be made available to providers, purchasers and consumers.

Currently, the emphasis in reducing utilization is on reducing the length of stay once a patient is hospitalized. The Commission has identified two critical challenges for containing inpatient hospital costs — reducing inappropriate admissions, and the rate of growth in ancillary services (such as x-ray and laboratory procedures). The existing utilization data system is limited in its ability to address these challenges because it focuses on cases after they are admitted. Population-based analysis is needed to identify and provide information concerning the types of procedures, diagnoses, geographical area, and providers that are characterized by high rates of admissions and ancillary service use.

Utilization profiles have been developed and are in the process of being refined. Issues of confidentiality (who controls and owns the data) have minimized the use of the information. In those cases where the information has been made available, the limitations in sampling make it difficult to establish conclusive patterns.

More emphasis should be placed on developing utilization profiles and using them to provide feedback. Many providers need and want information on their relative performance so that they can identify areas for increased cost-effective delivery of care. Providers not inherently interested in utilization issues would have an incentive to be more aware if utilization profiles were subject to more "public scrutiny." Purchasers and consumers need this type of information to be able to seek out and use cost-effective providers.

Hospital Data and Information — Principles and Recommendations

The following principles and recommendations rely on claims data to generate both pricing and utilization information. This approach has the advantage that the data are already collected by third party payers and it would not add the burden of another reporting system.

Principle I.

Additional data and information are needed by providers, purchasers, and the general public to improve the cost-effectiveness of health care services. Both price (charge) and utilization data should be compiled and disseminated on a routine basis. State legislation will be needed to ensure that data of this type are available, timely and comparable.

Principle II.

To avoid additional costs of collecting data, the additional data needs should be met, to the extent practicable, by compiling and analyzing data and information currently being collected.

Principle III.

The individual patient's identity must remain confidential; data identifying individual providers should not be confidential. Comparative data and information on individual providers that will improve decision making should be made available to providers, purchasers, and the general public.

Recommendation 1

The Health Policy Corporation of Iowa should develop a statewide hospital pricing data clearinghouse that:

a. generates annually, hospital-specific price/charge per case information for the 20 to 40 most frequent diagnoses;
b. has access to needed claims information, while maintaining patient confidentiality;
c. prepares and distributes the information to hospitals, physicians, major purchasers and the general public;
d. provides the utilization review system information on ancillary charge per case to improve the assessment of ancillary services utilization and growth and variations in the intensity of services.

In addition, the information should be interpreted and its strengths and weaknesses described. Hospitals should be provided the opportunity to comment on their data.

Recommendation 2

A majority of third party payers and all hospitals of 100 beds or more should document a commitment to voluntarily implement the uniform hospital billing form (UB-82) during CY 1983. In the event this voluntary approach is not documented by January 1, 1984, the Iowa General Assembly in the 1984 legislative session should mandate UB-82 for all third party payers and all hospitals.

Recommendation 3

The medical records (discharge abstract reporting) system is a key ingredient for utilization review activities. This data system should be improved by:

a. including uniform physician coding numbers that would be used by all hospitals;
b. including a number that is also on the claims form. This would facilitate linking individual claims to individual discharge abstracts;
c. auditing medical record abstracts and claim forms for consistency.

Recommendation 4

Population-based utilization studies, such as the one currently being coordinated through the Iowa Voluntary Cost Containment Committee, should be continued on an ongoing basis. The results of such studies should be available upon request.

Recommendation 5

Issues of confidentiality and liability relative to the use

of claims information and medical abstracts information, as described above, should be clarified by HPCI and if necessary by the legislature.

Recommendation 6

In light of the recent revisions in the Iowa Certificate of Need Law, the Iowa State Department of Health should reassess data needs for both planning and capital expenditure reviews. The Department should proceed to collect and analyze the needed data and information.

UTILIZATION CONTROLS

One of the main causes of high health care costs in Iowa is the high rate of use of inpatient hospital care. Relative to the rest of the country, Iowans spend more time in the hospital than appears to be medically necessary. The wide variations in incidence rates for various procedures, in average length of stay, and in admission rates for different areas of the country and within Iowa, establish that factors other than medical necessity are dictating behavior. Local styles of practice differ; what may be considered medically necessary in one community would be considered excessive and wasteful in another.

This major problem in Iowa requires special attention over and above the market incentives previously described. The recommendations reinforce economic incentives and shorten the time lag for results. The market forces of a competitive system will eventually result in a more self-regulating system. In the short run, however, special tools are needed to change behavior. Based on an assessment of the causes of high use, on extensive evaluation of the existing utilization review system in Iowa, and on comparisons with other approaches to controlling use of medical services (especially inpatient hospital care), a number of recommendations have been developed. They fall into two categories: one focuses on utilization review, the other is more general.

The utilization review recommendations are summarized below:

- More emphasis must be placed on reducing unnecessary admissions. A prior authorization process should be established for elective care that can be provided on an ambulatory basis.
- The system should focus more on practice patterns rather than individual cases. Provider profiles should be developed and feedback information on relative performance should be made available to all providers. Purchasers developing reward and penalty incentive programs should also receive this information.
- Cost-effective norms for utilization should be developed. Using existing Iowa average rates of use as points of comparisons, or targets, will probably serve to reduce the variations, but will probably result in only a slight reduction in overall use.
- Consumers need more education on the appropriate use of health services.
- An experimental program should be developed that includes the review of ambulatory and ancillary services.

The more general recommendations designed to help reduce Iowa's high use of hospital care include:

- Establishing a malpractice arbitration board to lessen the cost associated with the practice of "defensive medicine."
- More emphasis on insurance policies with coinsurance and deductibles. Consumers are more sensitive to costs when they are financially involved.
- Increase individual responsibility for health by encouraging programs that reward healthy lifestyles.

Utilization of Health Services — Principles and Recommendations

Principle I.

The utilization review systems should foster quality care and the efficient, effective and economical use of health care resources.*

Corollaries A. The utilization review systems should promote proper, and correct improper, provider performance through information/educational efforts, a prior authorization/certification process, and provision of information to payers and intermediaries for use as a basis to impose rewards or sanctions while maintaining the confidentiality of patient-specific information.

B. Utilization review conducted and controlled by peers is the preferred methodology and should be continued as long as the review process promotes effective and appropriate utilization.
C. The utilization review systems should allow providers the opportunity to justify the services provided through peer review.
D. Utilization review should be gradually expanded, as economically feasible, to cover the whole continuum of medical services.

*Efficient refers to providing the necessary health services with a minimum of wasted time and effort. Effective relates to providing only those services which are expected to result in the desired outcome. Economical means utilizing a minimum of resources.

Principle II.

The utilization review systems should foster educational services for providers and purchasers designed to promote quality and the efficient, effective and economical use of health care resources.

Corollaries A. The educational services should focus on the cost and health implications of appropriate and inappropriate health care utilization.
B. The utilization review systems should encourage and assist providers and purchasers in becoming aware of the cost of health care services.

Principle III.

The utilization review systems should establish goals/parameters of appropriate care and develop profiles of provider practice patterns. This information should be communicated to the providers and purchasers.

Corollaries A. The utilization review systems should compare the profile data to the goals, parameters, and outcomes of appropriate care in order to identify variations in practice patterns.
B. The goals for use should approach the national use rates.
C. The utilization review systems should make feedback information available to purchasers and providers for comparative and educational purposes.
D. Special utilization review processes should be required for aberrant practice patterns that do not respond to educational efforts.

Principle IV.

Individual consumers should be educated to be more aware of and responsible for their health and their use of the health care system.

Corollaries A. Employers and third-party payers should develop incentive programs for employers who practice a healthful lifestyle.
B. The media should re-evaluate their advertising and public service policies to ensure they promote good health practices.
C. As appropriate, consumers should be rewarded for using less expensive settings or types of medical care.
D. Purchasers and insurers should offer optional health insurance plans of which at least one has provisions for cost-sharing (i.e., deductible and coinsurance).

Principle V.

The negative impact of defensive medicine on utilization requires that professional liability claims should be quickly and fairly resolved.

Principle VI.

Utilization review systems should recommend when and on what basis new procedures and new technology should be used in light of long-run effectiveness, costs, and utilization implications.

Recommendation 1

The IFMC should continue as the main coordinator for utilization review. The IFMC board, while predominantly comprised of physicians, should be more broadly representative.

Recommendation 2

The delegation of utilization review to hospitals should be restricted to those facilities which have effective utilization review programs as demonstrated through their actions and results.

Recommendation 3

The utilization review systems should develop individual provider profiles. The profiles should focus on identifying aberrant practice patterns and be used in informing/educating providers about their styles of practice.

Recommendation 4

A pre-admission certification/prior authorization process can be effective and should be used in appropriate cases. Appropriate cases include:

a. Providers which have practice patterns consistently falling outside accepted parameters, and
b. Categories of services/admissions in which it is believed that most of the work can and should be done on a non-inpatient basis (ambulatory?).

Recommendation 5

The organizations conducting utilization review activities, in consultation with the affected parties, should establish goals, parameters, and outcomes of care and employ them in the utilization review process (goals, parameters, and outcome should approach national use rates).

Recommendation 6

The utilization review system should continually evaluate and expand the list of medical and surgical procedures suitable for ambulatory care.

Recommendaton 7

The utilization review system, in conjunction with third-party payer, labor and consumer groups, should develop and conduct informational/educational forums to improve the understanding and acceptance of the importance of appropriate health care utilization.

Recommendation 8

Utilization review systems must have incentives to be effective, and should be used in appropriate cases. Appropriate cases include:

A. Neither patients nor third-party payers should be held financially responsible for care rendered after the utilization review systems have deemed the care to be inappropriate, unless the patient agrees in advance to assume full responsibility of the care. Evidence that such care was deemed inappropriate should be admissible in court. In addition, the federal government and other parties with a contractual relationship with physician and hospital providers should not pay for medically inappropriate care and should incorporate "hold patient harmless" clauses into their contracts.
B. Purchasers including the State of Iowa, should adopt the following model language for benefit plans:

Limitations/General Provisions

Only medically necessary services in appropriate settings are eligible for payment under this plan and the employee/enrollee must use a health care provider participating in the utilization review program performed by a physician-based, external review organization (name of U/R program/s) in order for full policy benefits to be paid. If the employee/enrollee has non-emergency services performed in the area served by the above program/s, by a health care provider not participating in the specified utilization review program, pay-

ment will be limited to _____ percent of covered charges. For services provided outside the area served by the above designated utilization review program, the full benefits of this policy will be paid whether or not the provider of the service participates in an organized utilization review program.

Recommendation 9

Utilization Review Experimental Program: The IFMC or another appropriate entity should establish and evaluate an experimental physician utilization review program. This pilot program should include the following features:

a. inpatient and ambulatory services review;
b. intensity of service review;
c. local peer review;
d. detailed information/feedback system;
e. standardized billing form;
f. nondelegated hospital review;
g. physician incentives/disincentives to encourage broad participation and appropriate utilization;
h. basic ambulatory/office insurance coverage.

Recommendation 10

While cost sharing by the consumer is highly desirable to influence appropriate utilization of health services, copayment and deductible provisions should not be set at levels which result in under-utilization of needed health care services by low income groups.

Recommendation 11

The Insurance Department of Iowa should work with and assist purchasers and insurance companies/plans in developing policies that provide incentives for healthful lifestyles.

Recommendation 12

A binding arbitration board should be developed by the State Insurance Department (in cooperation of IMS, ISOPS, IHA) for non-judicial adjudication of professional liability claims to lessen the impact on costs of defensive medicine.

Recommendation 13

Continuing education for health care providers should increase its focus on cost-effective procedures and patterns of practice.

LONG TERM CARE SERVICES

Long term care encompasses a broad range of health care components. Long term care includes whatever supportive services people of any age may require due to a functional inability to take care of themselves. These services may be provided in a facility or out in the community within some independent living arrangement. These services may be required indefinitely, or, in the case of (re)habilitation candidates, for some more limited period of time.

The long term care service delivery system is a complex structure of widely varying formal and informal supportive arrangements. For people who, because of medical or other personal care requirements, are unable to obtain sufficient supportive services in the community, formal institutional services may be the appropriate alternative. Institutional long term care services are provided by a range of licensed facilities variously targeted toward broadly defined resident populations requiring a particular grouping of services. The most familiar type of long term care facility is the nursing home. Most moderate sized Iowa towns have a nursing home. The residents placed in a specific long term care facility are determined by facility licensure, admission policy, third party payer, utilization and reimbursement policy, as well as availability of alternate long term care resources.

Although institutional services are more visible, most long term care services are delivered in the home. Whereas institutional long term care is a formal support system, home health services are primarily provided on an informal basis by relatives, friends, and neighbors of the long term care recipient. For those persons needing long term care for whom such informal arrangements are either unfeasible or insufficient, many communities also have a variety of more formal in-home supportive care programs. Such programs include visiting nurses services, home health aide services, homemaker services, chore services, home-delivered and congregate meals, monitoring services, adult day care, and social services. The availability of these services varies considerably across Iowa.

Long term care is receiving increasing attention because of the amount of resources it is consuming. More people are demanding more services which simultaneously are becoming more expensive. There are several reasons for this increasing demand: increased longevity, declining incidence of life-threatening infectious diseases, increasing incidence of chronic diseases, and changing social patterns which reduce the incidence of family provision of long term care services.

The demographic and utilization trends which are reflected in these increased expenditures show no signs of abating. Consistent with the increasing portion of health care dollars being consumed by long term care services will be increased scrutiny of the cost-effectiveness of the various approaches to the delivery of services. Variations in the use of long term care service and variations in those costs must be addressed, just as variations in acute care use and cost have been addressed by the Commission. New approaches to the organization and delivery of services must also be explored.

Long Term Care Services — Principles and Recommendations

Principle I.

Long term care services should be designed to maximize each patient's overall functional capacities.

Principle II.

Appropriate long term care services should be accessible to all functionally dependent elderly and disabled persons.

Principle III.

Long term care services should be provided within the least medically intensive environment consistent with patient needs.

Principle IV.

Long term care programs should be designed to encourage and assist families to accept responsibility for long term care service provision.

Principle V.

Essential long term care regulatory activities should be performed in an efficient, coordinated, and consistent manner.

Recommendation 1

Health Policy Corporation of Iowa should review existing studies and conduct an in-depth study, if necessary, of Iowa's long term care service delivery system. This study should include population-based analysis of variations in use of long term care services, including home health care services (by age, sex, income level), service availability, and other factors. Health Policy Corporation of Iowa should develop strategies to promote the development of services shown to be cost-effective.

Recommendation 2

The Department of Social Services working in conjunction with the Department of Health, interested providers, and other affected parties, should develop one or more experimental reimbursement programs. These programs should provide for an appropriate system for classification payment of services along a continuum from dependence to independence.

Recommendation 3

The Iowa Foundation for Medical Care, in conjunction with interested providers and other affected parties, should develop and implement a case screening program applicable to all long term care facility admissions.

Recommendation 4

The Department of Health, in conjunction with interested providers and other affected parties should identify and establish a network of long term care facilities specializing in the provision of intensive habilitative and rehabilitative treatment for patients who show potential for progress.

The Department of Social Services and other third party payers should establish a separate payment formula for facilities participating in such a network.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

Substance abuse services and mental health care are important components of health care. The Commission believes that appropriate use of cost-effective services in these two areas may lower the total cost of health care. Efforts should be made to expedite transfer and referrals between types of substance abuse care or mental health care settings, perhaps through formal agreements. Because Iowa has combined drug and alcoholism authority (the Department of Substance Abuse) and a single agency overseeing nearly all mental health care (the Department of Social Services), we are in an excellent position to eliminate administrative barriers to access. Both the agencies and providers have made great strides in this area and are aware of improvements which still could be made.

For both substance abuse and mental health services, cost-containment rests heavily on three factors: the proper functioning of standards for professionals and services; research; and education. The Commission believes it is appropriate and necessary for the state to set minimum standards for professional training and for organizations providing services. The work of the Iowa Department of Substance Abuse and the Department of Social Services in developing standards should be continued.

The Commission considers research, especially program evaluation, to be essential to containing costs in the long run. We recognize that we are in a period of shrinking resources. Even in such times, there should be outcome studies and program evaluations because these are keys to reducing waste and increasing the effectiveness of services. The need for research is broader than that described by the recommendations below and is particularly pressing in substance abuse and mental health care, where basic knowledge of disease etiology and treatment is still growing. The recommendation for a study on substance abuse treatment is possible only because of the work already done in Iowa to link basic client data files and to follow clients after treatment in different settings. Iowa may be one of a very few states in which a more comprehensive study could be done. In mental health, there is a long history of research on, and development of, assessment tools (means of identifying specific dysfunctions) and scales for measuring the intensity of illness. There has been much less work comparing program outcomes. Such studies are, of course, beyond the scope of this Commission, but we consider them essential to cost containment. Utilization review and the research to back it up will be required in order to deal with new services and, possibly, new providers.

Education also is a topic of significance much wider than is reflected in our specific recommendations. Beyond the desirability of instructing other health care providers to recognize substance abuse and mental health problems and the effect of these problems on overall health and health care costs, there is much which could be done to make people more alert to problems and more accepting of treatment and of those needing care.

Education is also the first step in preventing problems. Education aimed at preventing substance abuse is a particular concern of the Commission, which believes such efforts should be greatly strengthened and should focus primarily on grade school children. Over the past five years, the State Department of Health and Department of Public Instruction have discussed statewide guidelines and requirements for such efforts as part of comprehensive health education in elementary and secondary grades. While the Commission recognizes the complexity of the curriculum and program issues involved, we think it is time for effective action.

Business and private organizations can be stimuli for including these topics in school curricula and can provide continuing support for programs. The private sector recognizes its social obligation to be involved in these issues and its potential as a catalyst for new services and for improvements in existing services.

Education of persons in many fields will be needed to assure that substance abuse and mental health services can make their proper contribution to the general health of Iowans and to containing costs.

Substance Abuse and Mental Health Services — Principles

Principle I.

Substance Abuse services and mental health care are essential parts of Iowa's health care system.

Principle II.

Such services should be dealt with as other health care services are dealt with in law and in regulation.

Corollary Where possible, the state should assure minimum professional competency and service effectiveness.

Principle III.

Planning and evaluation are important and necessary functions in the delivery of such services.

Principle IV.

Payment systems for services should stimulate the efficient delivery of appropriate services in the most cost-effective setting consistent with patient health needs and public policy goals.

Principle V.

Any citizen of Iowa should have prompt access to appropriate substance abuse or mental health care in the most cost-effective setting.

Corollaries
A. There should be no financial, legal or administrative barriers to the use of the most cost-effective care.
B. Citizens should know the services available and the methods of access.
C. Physicians and other general health care providers should be able to judge when physical problems have a basis in substance abuse or mental illness, and when referral is appropriate.
D. Inappropriate or ineffective utilization of services should be curtailed.

Principle VI.

The determination of the most cost-effective substance abuse and mental health services requires research, including comparing program outcomes.

Recommendations Concerning Substance Abuse Services

Recommendation 1

Public and private substance abuse providers should continue to improve linkages between levels and settings of substance abuse care in order to facilitate the access of clients to other levels and settings. The Iowa Department of Substance Abuse should be responsible for monitoring and assuring the effectiveness of these linkages. The rights of clients to confidential treatment and the elimination of duplicative assessments should be priorities in developing easier access (transfer of information, simplified referral arrangements, referral protocols, etc.).

Recommendation 2

Substance abuse providers and other health care providers, both individuals and organizations, should seek close working relationships to ensure that the most appropriate and cost-effective services are immediately accessible, no matter where care is first sought. Providers and their professional organizations should work together to develop referral protocols.

Recommendation 3

Substance abuse providers and purchasers should expand investigation of the outcome of treatment in terms of the ability of a client to function in society.

—The State Department of Substance Abuse should obtain advice on the design and cost of a study to evaluate alcoholism treatment outcomes. A secon-

dary purpose of this study should be to determine the elements and basic design of a management information system which incorporates utilization review.

—The State of Iowa should fund 75% of the cost of the study through a surtax on state retail alcohol sales for a period of one or two years.

—The Iowa Department of Substance Abuse should seek corporate funding for 25% of the total cost of the study.

—The study should make provision for full reimbursement for providers' participation and administrative costs.

Recommendation 4

Review of substance abuse services through Certificate of Need should be expanded beyond hospital-based, inpatient care. The Department of Health should determine which outpatient services can practicably be reviewed.

Recommendation 5

The Governor's Commission on Health Care Costs recognizes that the appropriate use of substance abuse services may lower the total cost of health care. Providers and purchasers should determine where use of substance abuse services can result in net savings.

Recommendation 6

Providers and purchasers should negotiate benefit packages which cover a range of substance abuse treatment settings, particularly in child and adolescent populations, and which incorporate utilization controls and incentives for use of the most cost-effective setting. These incentives should include consumer cost sharing provisions similar to those required for other health care benefits. (This cost participation should not be set at such levels as to preclude access to needed services.)

Recommendation 7

The State Department of Health and the State Department of Public Instruction should work with each Area Education Agency and through them with each school board to institute more effective preventive education on alcohol and drug abuse. The state agencies might develop two or three different approaches if no one approach is acceptable to all school boards. (This should be considered an experiment and evaluated accordingly.)

Recommendations Concerning Mental Health Services

Recommendation 1

Building on the opportunity provided by recent changes and reorganization, mental health providers should continue to improve linkages between levels and settings of mental health care, in order to facilitate the access of clients to other levels and settings. The Iowa Department of Social Services should be responsible for monitoring and assuring the effectiveness of linkages among its agencies. The rights of clients to confidential treatment and the elimination of duplicative assessments should be priorities in developing easier access (transfer of information, simplified referral arrangements, referral protocols, etc.).

Recommendation 2

Mental health and other health care providers, both individuals and organizations, should seek close working relationships to ensure that the most appropriate and cost-effective services are accessible no matter where care is first sought. Providers and their professional organizations should work together to develop referral protocols.

Recommendation 3

Providers and purchasers should continue to investigate the outcome of treatment in terms of the ability of a client to function in society.

Recommendation 4

Purchasers should negotiate benefit packages which require implementation of peer utilization review during 1983. (An example of such review is the system developed by the American Psychological and American Psychiatric Associations.)

Recommendation 5

Review of mental health services through Certificate of Need should be expanded beyond hospital-based inpatient care. The Department of Health should determine which outpatient services can practicably be reviewed.

Recommendation 6

The Governor's Commission on Health Care Costs recognizes that the appropriate use of mental health services may lower the total cost of health care. Providers and purchasers should determine where the use of mental health services can result in net savings.

Recommendation 7

Providers and purchasers should negotiate benefit packages which cover a range of mental health care settings and providers, and which incorporate utilization controls and incentives for the use of the most cost-effective setting. These incentives should include consumer cost sharing provisions similar to those required for other health care benefits. (This cost participation should not be set at such levels as to preclude access to needed services.)

PREVENTIVE HEALTH AND PRIMARY CARE SERVICES

The Commission believes that the most effective strategy for reducing health care costs is to motivate the public to actively pursue healthful lifestyles. In other words, it is more sensible and cost-effective to prevent illnesses rather than try to cure them at the acute stage. Public education, which fosters risk reduction activities and commits the public to maintain a healthful lifestyle, will generate significant reductions in health care costs, as well as enhance the overall quality of life.

There is growing recognition that the complex of interrelating factors affecting one's health necessitate that health care be approached from a total perspective. Primary care services, especially preventive health care services, have not received sufficient attention and resources. Despite the encouraging evidence on potential benefits (i.e., better health, fewer and smaller doctor and hospital bills, longer life, greater productivity and effectiveness, improved ability to cope with everyday stresses, etc.), estimates are that less than two percent of the total amount spent for health is devoted to keeping people well.

Study of health promotion program results and common sense support the Commission's belief that the availability of health promotion materials and programs is highly desirable. The Commission encourages further analysis of existing programs and research into alternative programs in an effort to determine which programs should be promoted.

The main thrust behind the Commission's recommendations is to encourage adoption of healthful lifestyles. Some of the general concepts used as a basis for the recommendations include the following:

- Health care providers, employers, third-party payers and the government should cooperate to ensure that consumers have educational materials and programs readily available to assist them in becoming knowledgeable of risk factors, preventive health measures, and appropriate utilization of the health care system.
- Health care providers, employers, third-party payers, and the government should provide incentives to encourage consumers to pursue healthful lifestyles.
- Financial obstacles should not impede access to preventive health and primary care services.
- A state-wide effort should be made to ensure that all Iowans are aware of their risk factors, the dangers such factors pose, and the intervention opportunities available to reduce such factors.
- State intervention is appropriate to reduce risk factors or financial impact where it is socially desirable because of the massive burden borne by the population at large.

The principles describe fundamental beliefs of the Commission, and general concepts applicable to the area of preventive health and primary care services. The recommendations, based on the principles, are intended to be specific, action-oriented initiatives which the Commission feels will facilitate creation and use of preventive health and primary care services. Necessarily, specific recommendations focus on certain groups; this is not intended to be a reflection of their past activities, but a recognition of the importance of the role they share in promoting health for Iowans.

Preventive Health and Primary Care — Principles

Principle I.

Health care providers, employers, third-party payers, and the government should work together to ensure that consumers have informational/educational materials and programs available to assist them in being knowledgeable of risk factors, preventive health measures, and appropriate utilization of the health care system.

Principle II.

Health care providers should strive to ensure that all patients are properly counselled regarding their health risk factors and appropriate ways to lessen those risk factors. Consumers should be encouraged to become knowledgeable about and actively involved in preventive health activities. Consumers also have the responsibility to follow the recommendations of their health care providers.

Principle III.

A community effort should be made to identify populations at risk and assist them in monitoring and controlling health problems.

Principle IV.

Health care providers, employers, third-party payers, and the government should provide incentives to encourage consumers to pursue healthful lifestyles.

Principle V.

The public has a right to basic health care services, including preventive health and primary care services, regardless of their financial ability.

Principle VI.

A community effort should be made to educate consumers on the importance of having a primary care physician and encouraging the selection thereof.

Principle VII.

Health care providers should strive to achieve a distribution of health professionals and services such that the public has reasonable access to health care services.

Principle VIII.

All health professionals should serve as role models and promote healthful lifestyles, both personally and professionally.

Principle IX.

State intervention is appropriate to reduce risk factors or financial impact where it is socially desirable because of the massive burden borne by the population at large.

Recommendations Concerning Educational and Informational Initiatives

Recommendation 1

A health promotion organization should be established by health-related organizations in the State of Iowa to focus on preventive health and primary care. It should be charged with the following responsibilities:

a. coordinate the development/attainment and promote the dissemination of informational/educational materials (e.g., pamphlets, films, posters, etc.) on a broad range of health concerns such as risk factors (e.g., stress, hypertension, obesity, etc.), appropriate utilization of the health care system, and preventive health measures (e.g., exercise, nutrition, stress management, etc.);
b. establish and offer a lifestyle intervention program (i.e., train people to conduct a program for community/employer groups which would involve a lifestyle appraisal, fitness assessment, counseling on risks and available programs, encouragement to utilize programs/materials, and a retest).

Recommendation 2

Employers should actively experiment with health promotion programs in order to counteract the problems of absenteeism, excess number of sick days, and rising health insurance premiums. Some methods that should be considered are:

a. development of in-house health promotion programs;
b. selection of effective programs in the community (ideally the employer will, at least, share in the cost of the programs, provide the programs on-site and make a long-term commitment to the programs);
c. inclusion of financial incentives in insurance policies/benefits to promote healthful lifestyles and appropriate health care service utilization; and
d. careful evaluation of the impact of these programs on morbidity, disability, absenteeism, productivity, etc.

Recommendation 3

Health professionals should be encouraged to take an active role in promoting preventive health and primary care to the community.

Recommendation 4

Screening programs, such as health risk appraisals and limited physical check-ups, which aid in the early detection and control of disease should be encouraged, especially for high risk populations, i.e., persons with genetic, physical, or lifestyle problems. The following efforts should be encouraged:

a. employers should offer periodic assessment of health status to their employees (e.g., have employees complete a health risk appraisal questionnaire). Employers should facilitate appropriate action for significant problems. (It is noted that there is a need to maintain the confidentiality of individual assessments.) Employers may choose to provide alternate coverage to employees who refuse periodic assessment of their health status; and
b. the Department of Social Services, health care providers, health insurers and other health organizations should facilitate periodic screening programs.

Recommendation 5

The Health Policy Corporation of Iowa, in cooperation with health organizations and other interested organizations, should establish a task force with two main responsibilities:

a. to identify how a health promotion strategy may best be developed and implemented throughout the state;
b. to evaluate the cost-effectiveness of intervention programs that already exist and design an evaluation system to uniformly monitor the cost-effectiveness of new intervention programs across the state.

Recommendation 6

The Department of Public Instruction, in conjunction with the State Department of Health, should develop minimum standards relating to such areas as obesity, dietary problems, and chemical use for judging the health and fitness of the school-age population. Where established standards are not met, the Department of Public Instruction and individual school districts should focus their curriculum development and intervention efforts in problem areas and be held accountable for meeting these standards.

Recommendation 7

The curricula for future health professionals and continuing education courses for practicing health professionals should ensure providers are knowledgeable and supportive of preventive health and primary care issues and problems. Such educational programs should, at a minimum, include training on the complexities of behavioral/attitude interventions, the underlying causes of and recent findings about risk factors, and alternative preventive health/primary care programs.

Recommendation 8

All health professionals should have, as part of their studies, training in geriatrics and gerontology.

Recommendation 9

The training of health professionals should ensure that sufficient emphasis is initiated and/or maintained on the special needs and problems associated with rural and agricultural populations.

Recommendation 10

Farm organizations, such as the Farm Bureau of Iowa, should develop and promote programs aimed at assisting the rural and agricultural populations to solve their health care needs and problems.

Recommendations Concerning Incentives and Financing

Recommendation 1

Employers should be encouraged to experiment with incentives (e.g., financial rewards, days off, additional insurance benefits, etc.) aimed at promoting healthful lifestyles, preventive health and appropriate utilization of health benefits.

Recommendation 2

Health insurers should experiment with and assess the effectiveness of expanding insurance coverage to include preventive health and primary care services.

Recommendation 3

The Commissioner of Insurance should develop guidelines to enable insurance companies to design and market health insurance policies with premiums that are scaled based on lifestyle factors.

Recommendation 4

Health insurers should conduct pilot studies for policies wherein premium charges are correlated to risk factors and lifestyle characteristics, e.g., smoking patterns, level of physical activity, etc. Particular attention should be paid to those risk factors under the control of the individual.

Recommendation 5

Third-party payers should review intervention programs and identify their cost-effectiveness. Should the programs be determined to be cost-effective, third-party payers should consider extending coverage to them or providing some other financial incentive to encourage their use.

Recommendation 6

Insurance policies and federal health programs should be reviewed to ensure that current provisions do not discourage the performance of a medical procedure on an outpatient basis when appropriate and cost-effective.

Recommendations Concerning Accessibility

Recommendation 1

Physicians and other health professionals should be encouraged to offer office hours suitable to the working population, i.e., weekends and evenings.

Recommendation 2

Physicians should consider new ways to use allied health providers to deliver high quality care in a more accessible and efficient way (i.e., nursing homes, community outreach, mobile units, etc.).

Recommendation 3

Appropriate utilization of the emergency room, which is important from the perspective of both cost and quality of care, should be encouraged in the following ways:

a. Physicians, to avoid unnecessary emergency room visits, should consider expanding their office hours to improve access.
b. Hospitals should promote appropriate use of the

emergency room by referring non-emergency patients to a primary care physician.

c. Insurance policies should include incentives to discourage inappropriate emergency room utilization.

Recommendation 4

Hospitals, operating in areas where problems in accessing health care service are noted, should be encouraged to investigate the need and feasibility of establishing a mobile clinic to reduce the access problems, e.g., for elderly, school children and other special groups.

Recommendations Concerning Environment

Recommendation 1

Analysis of and counseling on risk factors (e.g., obesity, hypertension, stress, etc.) and lifestyle characteristics should be included in the routine physical exams given by every primary provider in the State of Iowa. This analysis should include such determinations as: a) smoking habits; b) physical activity level; c) nutritional pattern; d) chemical usage (alcohol, caffeine, drugs, etc.); e) weight, blood pressure, cholesterol levels, etc.; and f) potential genetic problems.

Recommendation 2

Because the counseling role of physicians is extremely important to patient compliance and satisfaction, continuing education courses regarding this aspect of medical practice should be make available and attendance encouraged.

Recommendation 3

In an effort to enhance a patient's commitment to lifestyle changes, physicians and other health care professionals should be encouraged to enter into a contract-like relationship wherein patients agree to abide by various lifestyle modifications and providers agree to provide various support services.

Recommendation 4

Inasmuch as motor vehicle accidents are a major cause of death and injury, the State should endorse, promote and where possible, legislate:

a. programs aimed at facilitating and encouraging the use of child restraint devices for infants;
b. programs aimed at promoting the use of automobile safety belts;
c. programs aimed at promoting the use of helmets by motorcyclists; and
d. programs aimed at promoting the use of headlights by all motor vehicles, especially after 4 P.M. and in inclement weather.

Recommendation 5

Motorcycle owners, being a high-risk population group, should be required to present proof of minimum health and disability insurance coverage during their annual relicensure.

Recommendation 6

Since recent studies have noted increased consumption of cigarettes by teenage girls, a special education campaign should be aimed at this group. This campaign could also address the additional medical hazard for the segment of the population that both smokes and uses a contraceptive pill. The educational campaign could be a joint effort of the Iowa Women's Political Caucus, American Association of University Women, Junior Leagues, health organizations and other appropriate and interested groups.

GLOSSARY

Acute Care: Refers to short-term hospital care (usually 30 days or less).

ALOS: Average length of stay.

Ambulatory Services: A broad range of services which may be rendered to a patient who is not required to stay overnight in a health care facility.

Ancillary Services: Hospital or other inpatient health program services, other than room and board, and professional services (may include x-ray, drug, lab and other services not separately itemized).

Appropriate: Suitable for a particular condition, occasion or place; proper; fitting.

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person.

Case-Mix: The diagnosis-specific makeup of a health program's workload. Case-mix directly influences the length of stays and the intensity, cost and scope of services provided by a hospital or other health program.

Certificate of Need (CON): Certificate issued under a regulatory function of state government. Certificate of Need programs are established on the premise that the distribution and capacity of health care facilities and the cost of services provided through these facilities are interrelated and should be certified on the basis of the need for such facilities and services.

Coinsurance: A cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services.

Consumer: An individual who utilizes health services.

Continually: Regularly; on a systematic basis.

Cost Containment: The control of the overall cost of health care services within the health care delivery system.

Criteria: Measures used to assess the performance of proposed or existing health services.

Economical: Utilizing a minimum of resources.

Effective: Providing only those services which are expected to result in the desired outcome.

Efficiency: Refers to providing the necessary health services with a minimum of wasted time and effort.

Fee-for-service: Method of charging whereby a physician or other practitioner bills for each encounter or service rendered.

Gross National Product (GNP): A measure of the total value of all goods and services produced in a country for a given period of time, usually one year.

Health Maintenance Organization (HMO): A private organization that provides, through affiliated doctors and hospitals, comprehensive health care services to voluntarily enrolled subscribers for a fixed monthly fee.

Horizontal Integration: The process of combining or coordinating across categorical divisions those entities or functions operating at similar levels of activity, responsibility or complexity.

Iowa Foundation for Medical Care (IFMC): The designated Professional Standards Review Organization for Iowa.

Outpatient: A patient who is receiving ambulatory care at a hospital or other health facility without being admitted to the facility.

Preventive Health: Lifestyle aimed at prevention of disease or its consequences — includes health care programs aimed at warding off illnesses.

Primary Care: The routine care and services that people receive on their first contact with the health system for a particular health incident.

Professional Standards Review Organization (PSRO): A physician-sponsored organization charged with comprehensive and ongoing review of services provided under Medicare, Medicaid and Maternal and Child Health care programs.

Prospective Reimbursement: Any method of paying hospitals or other health programs in which amounts or rate of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on charge or cost increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs.

Provider: An individual or institution which gives medical care.

Purchaser: Those who pay for health care services, health insurance premiums, or arrange for the financing of health care; example would include consumers, employers, union, union trust funds, and governmental programs.

Quality: A measure of the degree to which health services delivered meet established professional standards and judgments of value to the consumer.

Retrospective Reimbursement: Payment to providers by a third party carrier for costs or charges actually incurred by subscribers in a previous time period.

Section 1122 Review: Reviews performed under a section of the Social Security Act. The section provides that payments will not be made under Medicare or Medicaid with respect to certain disapproved capital expenditures determined to be inconsistent with state or local health plans.

Skilled Nursing Facility (SNF): A nursing facility participating in the Medicaid and Medicare programs that meet specified requirements for services, staffing and safety.

Tertiary Care: The most highly developed and specialized health care services.

Third Party Payer: Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

UCR: Usual, customary and reasonable plans: Health insurance plans that pay a physician's full charge if: it does not exceed his usual charge; it does not exceed the amount customarily charged for the service by other physicians in the area; or it is otherwise reasonable.

Utilization Review: Evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures, and facilities.

Vertical Integration: The process of combining or coordinating those entities or functions, which, while dissimilar in activity, responsibility, or complexity, all contribute to the same category of service or product.

DATA APPENDIX

Health Care Expenditures Per Capita

Per capita expenditures for health have increased much faster than the general rate of inflation. The dollar increase in Iowa has been almost $300, a 74% increase, from 1974-1979. Iowa's expenditures per capita compare favorably to national levels, $693 to $839, respectively. The average annual percent increase was 15% for Iowans and 16% nationally.

ESTIMATED HEALTH CARE EXPENDITURES PER CAPITA, 1974 and 1979

	1974	1979	% Increase	Average Annual % Increase
Iowa	$399	$693	74%	15%
U.S.	$469	$839	79%	16%
Consumer Price Index*	$148	$218	47%	9%

Source: Iowa Health Systems Agency, Health Care Expenditures in Iowa, 1966-1976 and Preliminary Estimate of Health Expenditures for Iowa, 1979

*Base Year 1967 = 100

Expenditures per capita both nationally and locally have increased substantially faster than the general rate of inflation. Over the five year period the general price level increased at an average annual rate of 9%. Iowa's average rate of increase in health expenditures per capita was 15% over the same period.

Physician Expenditures

Expenditures for physician services is directly related to the fees (price) per unit of service and the number and type of services provided. The chart below indicates that physician expenditures in Iowa may be increasing at a rate above the national average. (The Iowa data were estimated using Blue Shield charges per subscriber. The U.S. 1981 range of 15-16% is a national estimate.)

PERCENT INCREASE IN PHYSICIAN EXPENDITURES

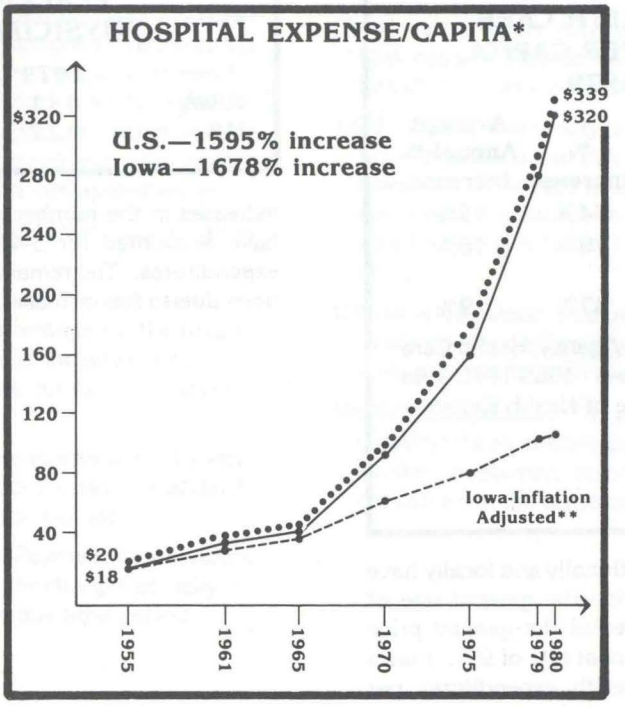
	1979	1980	1981
IOWA	13.1	14.6	15.5
U.S.	12.7	13.5	15-16

Increases in the number and type of physician services have accounted for 3-4% of each year's increase in expenditures. The remaining 9-11% of the increase has been due to fee increases.

Hospital Expenditures Per Capita

Almost half (45%) of health care expenditures are for hospital services. The chart below shows the increase in hospital spending on a per capita basis from 1955 to 1980. Nationally, the increase has been from $20 per person to $339, a 1,595% increase. For Iowans the increase has been from $18 to $320, a $1,678% increase. After adjusting for inflation, the Iowa increase in constant 1955 dollars has been from $18 to $104, almost a sixfold increase.

Spending for hospital services has increased at higher rate than for other health services. In 1955, total health care expenditures per capita were $96 in the U.S. The hospital portion was $20, 21% of the total. By 1979 the portion had more than doubled, increasing to more than 45% of the total health spending.



*Community Hospitals only.

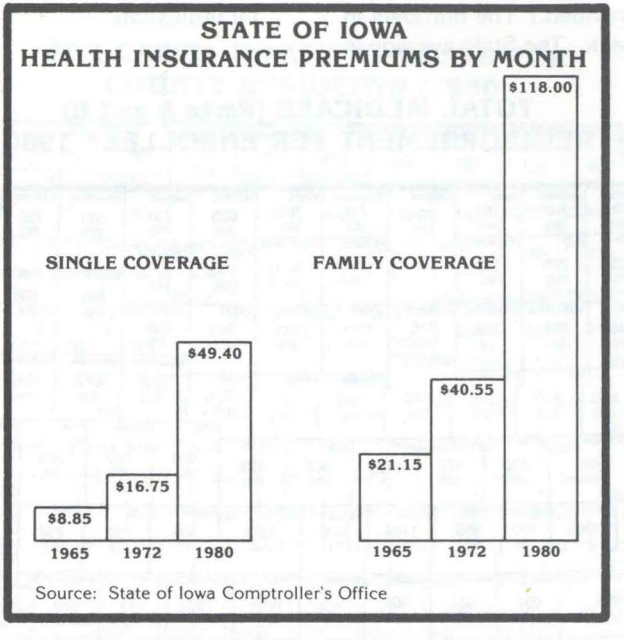
**Hospital Expense/Capita expressed in constant dollars utilizing 1955 as base year.

SOURCE: "Hospital Statistics," AHA, 1980, 1976, 1971, 1966, 1962 and 1956 Eds.

Increases in Monthly Health Insurance Benefits

Increases in monthly health insurance premiums directly reflect increasing health care costs. Premiums have been rising substantially faster than the general rate of inflation. The chart below shows monthly health insurance premiums for employees of the State of Iowa in 1965 and in 1980. For family coverage the increase has been from $21 a month in 1965 to $118 in 1980. The increase over the 15 year period has been 458%; the CPI has increased 161%.

These increases for State of Iowa employees are similar to the experience of many Iowa employers and employees. Over the period 1970 to 1980 both wages and inflation have increased by about 100% i.e., real income has remained fairly stable. Over the same ten year period health insurance premiums have increased 250 to 300%. To the employer this represents increasing costs of production and lower profits; to the employee this represents less take home pay.

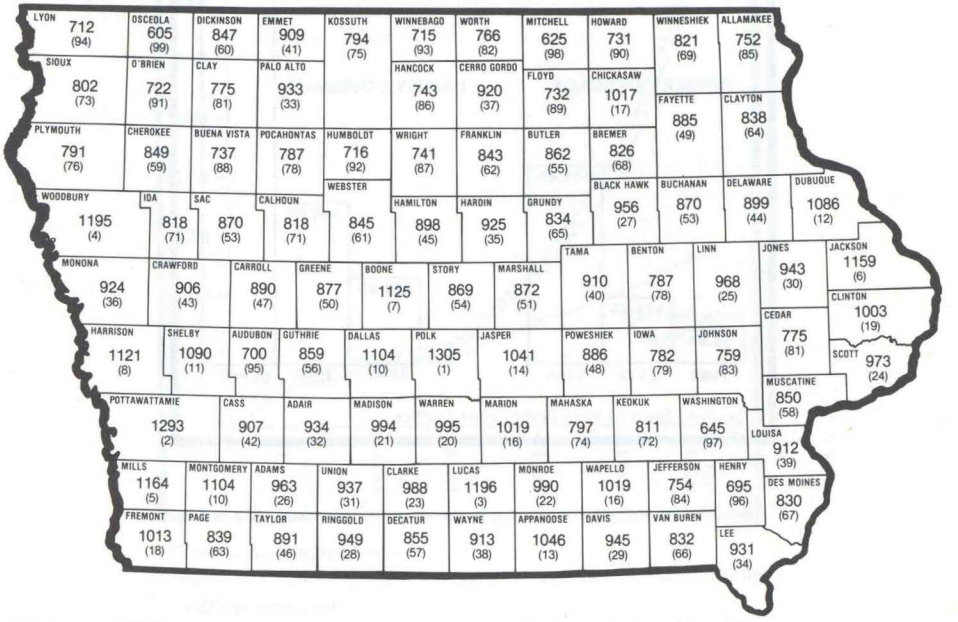


Medicare Costs Per Enrollee

The Medicare program provides health services to the elderly. Coverage under Part A is primarily for inpatient hospital services; physician services are the major component of Part B coverage. The map below shows the variations in 1980 Medicare Reimbursement Per Enrollee by county of residence of the enrollee. It is defined as: total federal reimbursement in 1980 on behalf of enrollees residing in a county divided by the number of enrollees residing in the county. (Note that these data are based on the county of residence, not the county where services were provided.) The numbers in parenthesis show the county rank. The State average in 1980 was $953 per enrollee. The range was from a low of $605 in Osceola County to a high of $1305 in Polk. From 1974 to 1980, reimbursement per enrollee in Iowa has increased from $377 to $953, a 153% increase.

The wide variations from county to county raise questions as to the medical necessity and efficiency with which services are being provided. The patterns are stable from year to year. In addition, high cost counties are strongly correlated with high rates of inpatient hospital utilization.

TOTAL MEDICARE (Parts A and B)
REIMBURSEMENT PER ENROLLEE* 1980



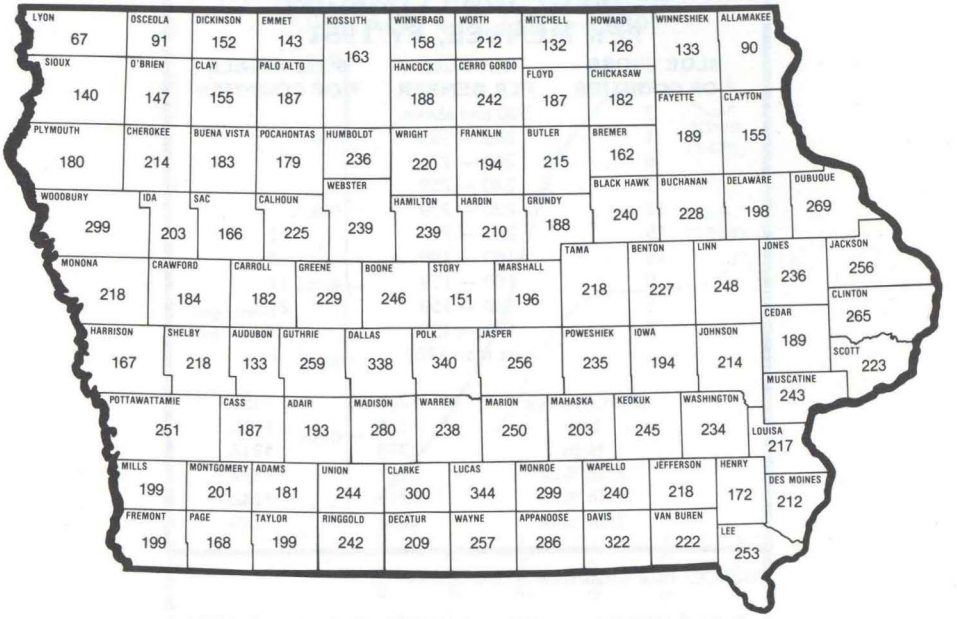
*In $/Enrollee
( ) Indicates Rank: 1 Highest and 99 Lowest
STATE AVERAGE: 953

Inpatient Hospital Costs Per Capita, By County, 1980

Per capita costs for inpatient hospital care are also variable within Iowa. The map below shows the estimated cost per capita for each Iowa county in 1980. As with the previous Medicare data it is by county of residence, regardless of where services were provided. (For example, Tama county does not have a hospital, but county residents are hospitalized. These costs were allocated back to the Tama county population.) Those estimates show variations from $67 per capita for Lyon county residents to $344 for Lucas residents. Costs were below $150 for 10 counties and above $250 for 16 counties.

High cost counties were counties with high rates of hospital use. The Iowa HSA report calculated that $93 million would have been saved if hospital use (in terms of patient days of care per 1000 population) for the state as a whole had been similar to utilization in the 25 Iowa counties with lower rates of hospital use.

PER CAPITA INPATIENT COSTS FOR COUNTY RESIDENTS (1980)



SOURCE: Iowa HSA: **Cost Savings Through Reductions in Hospital Use,** 1982

Blue Cross and Blue Shield Charges per Member

Variations in per capita expenditures for the employed and under — 65 years of age population also vary. The chart below shows county variations in Blue Cross and Blue Shield charges per member for the 73 counties in the BC/BS of Iowa Plan area. County of employment rather than county of residence was used as the basis for aggregating the data; this method is a reasonable approximation for the county of residence approach. The data are based on claims submitted to Blue Cross and Blue Shield for services rendered on behalf of employed groups located in the county; they are not Blue Cross and Blue Shield premiums. The range is substantial for both groups. In 10 counties the Blue Cross charge per member exceeded $260; 12 counties were below $180. For Blue Shield, 7 counties were above $180 and 7 were below $120.

These charges are a direct function of the price per unit of service and the number of services provided. An analysis of the data demonstrated that high charges per member were strongly related to hospital admissions, somewhat correlated with hospital charge per day and slightly related to average length of hospital stay.

BC/BS OF IOWA CHARGES PER MEMBER, FY 1981

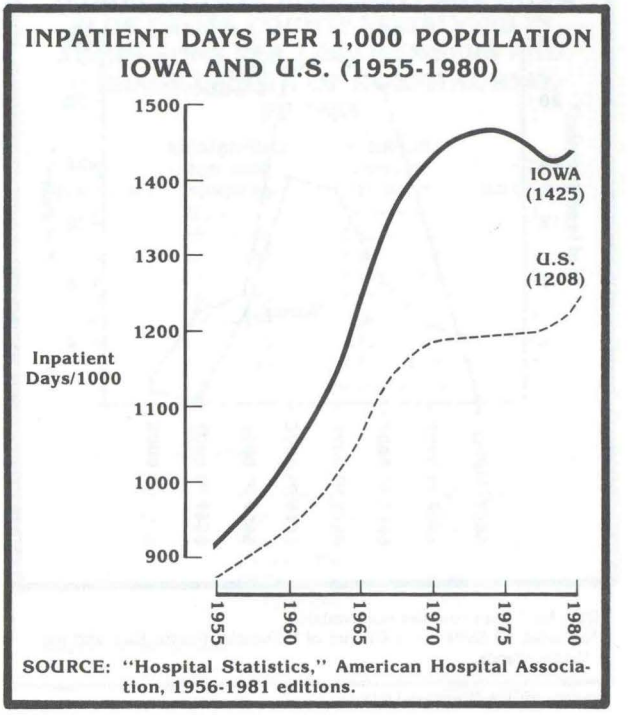
BLUE CROSS # OF COUNTIES	CHARGES PER MEMBER	BLUE SHIELD # OF COUNTIES
3	300 and above	
1	280 — 299	
6	260 — 279	
7	240 — 259	
12	220 — 239	
15	200 — 219	2
16	180 — 199	5
9	160 — 179	11
1	140 — 159	21
3	120 — 139	27
	less than $120	7
Plan Average	$222	$154
Low	$128	$ 94
High	$378	$218
25th %ile	$192	$132
50th %ile	$211	$142
75th %ile	$234	$159

SOURCE: Blue Cross/Blue Shield of Iowa

Per Capita Use of Hospital Services

One of the causes of increased hospital spending has been the growth in the use of hospital services. Hospital patient days per 1,000 population is a frequent measure of the use of hospital services. The chart below shows the trend of this measure from 1955 to 1980. The rate of use in Iowa in 1980 was 18% above the national average. The increase in Iowa over the twenty-five years has been 55%; nationally the increase has been 37%.

High rates of hospital use are a major problem nationally and especially for Iowans. By all measures and using variations sources of data, Iowans spend more time in the hospital than the average American. At least some of this can be attributed to Iowa's higher concentration of elderly. Although this may explain some of higher rate of use in both 1955 and 1980, it does not explain Iowa's higher rate of growth in the use of hospital services. The national rate of growth in the elderly population from 1955 to 1980 has been greater than Iowa's. Therefore the higher rate of growth in hospital use in Iowa is attributable to factors other than the elderly population.

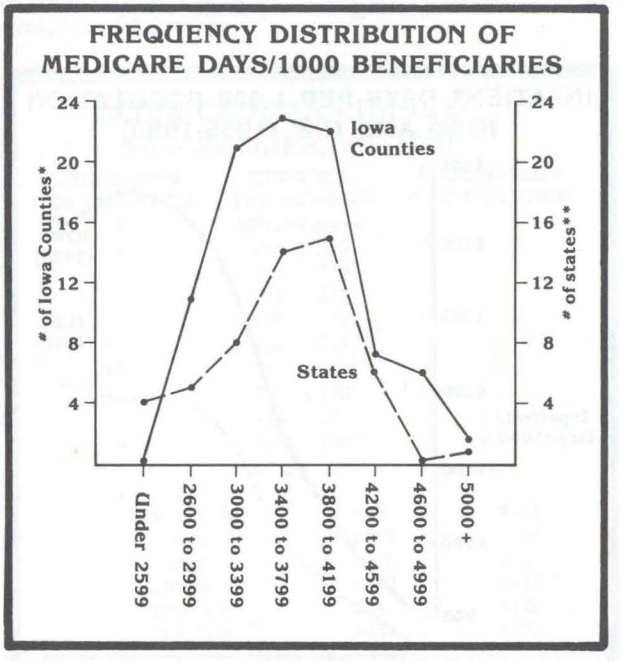


SOURCE: "Hospital Statistics," American Hospital Association, 1956-1981 editions.

Variations in Use for the Elderly Population

Rates of hospital use vary substantially from state to state and within Iowa. The graph below shows variations in patient days per 1,000 population for the 65 and over (Medicare). Medicare enrollees residing in 45 Iowa counties and 29 states had utilization rates between 3,400 and 4,199 patient days per 1,000 beneficiaries. Some counties and states had substantially lower rates of use; others were much higher. A total of 32 Iowa counties and 17 states experienced rates below 3,400. Rates of use were above 4,200 days per 1,000 for 15 Iowa counties and 7 states.

These wide variations suggest that inpatient care can be provided at rates substantially below the current average rates of use. Although this chart focuses on the elderly population, similar patterns exist for the under 65 age group.



*Data for 7 Iowa counties not available.
**Includes 50 States plus District of Columbia, Puerto Rico and the Virgin Islands.

Source: HCFA Medicare Data

Admissions and Length of Stay Variations for the Under 65 Population

Patient Days per 1000 population is directly related to the rate of admissions to hospitals and how many days patients stay once hospitalized. The chart below shows variations in both of these factors. The data were provided by BC/BS of Iowa. As with the previous charge per member data, it is by county location of employer. The variations from county to county are quite high. Employees and their dependents in 10 counties were admitted to hospitals at a rate in excess of 180 admissions per 1000 members. In twelve counties, the admission rate was less than 130. Average length of hospital stay was also quite variable; nine counties over 5.8 days and ten counties under 4.8.

A less costly style of practice is delivered in some areas of Iowa. Many of the recommendations in this report are directed at reducing unnecessary hospital utilization.

BLUE CROSS COUNTY VARIATIONS IN ADMISSIONS PER 1,000 MEMBERS AND AVERAGE LENGTH OF HOSPITAL STAY, FY 1981

# OF COUNTIES	ADMISSIONS PER 1000 MEMBERS	AVERAGE LENGTH OF STAY	# OF COUNTIES
6	200+	6 days +	6
1	190 — 199	5.80 — 5.99	3
3	180 — 189	5.60 — 5.79	10
5	170 — 179	5.40 — 5.59	13
9	160 — 169	5.20 — 5.39	15
11	150 — 159	5.00 — 5.19	8
16	140 — 149	4.80 — 4.99	8
10	130 — 139	4.60 — 4.79	5
9	120 — 129	Less than 4.6 days	5
2	110 — 119		
0	100 — 109		
1	Less than 100		

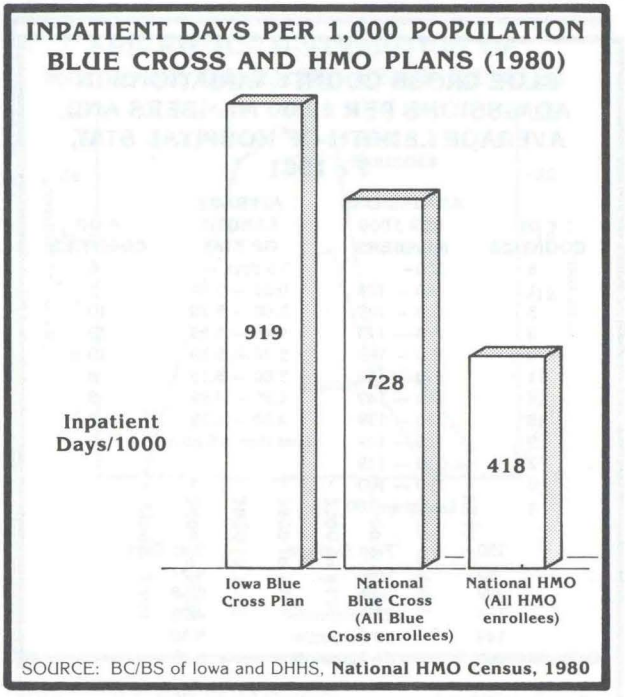
150	Plan Average	5.45 Days
83	Low	4.31
309	High	6.48
138	25 Percentile	4.98
149	50 Percentile	5.36
165	75 Percentile	5.73

Source: BC/BS of Iowa

Hospital Use for Blue Cross Members and HMO Enrollees

Hospital use is higher for Iowans under 65 years of age than for the rest of the country. The chart below shows patient days per 1,000 members for BC/BS of Iowa, the experience of all Blue Cross Plans and for health maintenance organizations (HMOs). The rate of use for Iowa Plan members is over twice the HMO rate and 26% above the national Blue Cross rate.

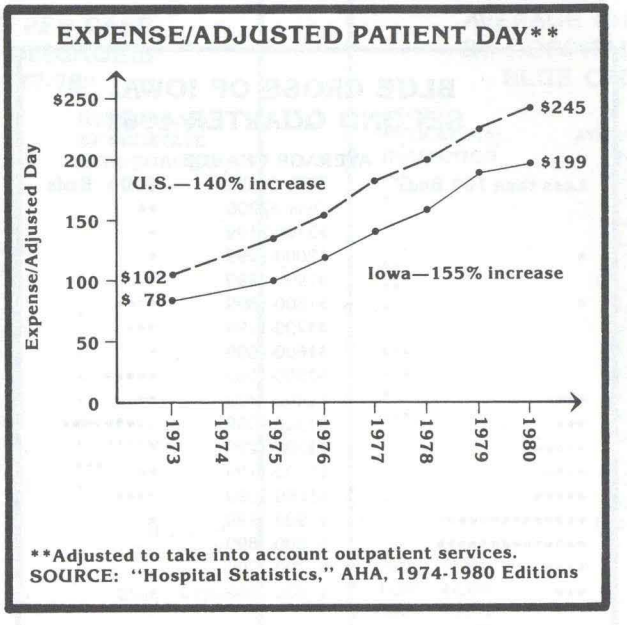
Analysis of Iowa's high rate of hospital use shows that Iowa has more of an admissions problem than a length of stay problem. Blue Cross of Iowa members were admitted to hospitals at a rate of 159 admissions per 1000 in 1980; this was 35% above the national Blue rate of 118. Iowa's length of stay was 7% below the national average. HMOs are a delivery system based on a set of incentives that encourages ambulatory rather than inpatient care and which discourages overutilization of services.



Cost Per Day of Hospital Care

One cause of increasing health expenditures has been increasing prices per unit of service. The chart below shows increases in the cost per day of hospital care. The data have been adjusted to account for outpatient hospital services. Expenses per day were $78 for Iowa hospitals in 1973; they had increased to $199 in 1980, a 155% increase. Nationally the cost per day was higher throughout the period, but the rate of increase was lower. The CPI increased 86% over those 7 years.

Iowa's lower cost per day is partially attributable to a lower cost of living in Iowa. Labor costs, which account for approximately 55-60% of the hospital budget, are lower than the national average. In 1980, the average hospital employee in the U.S. earned about $15,000; in Iowa they earned about $13,500.



Average Charge Per Hospital Admission

The average charge per hospital admission varies considerably from one hospital to another. The table below shows the average charge per case in the 96 hospitals in the Blue Cross of Iowa Plan area during the second quarter of 1981. The data are grouped into a less than 100 bed size category and a 100+ bed category. The average charge per case of two of the smaller hospitals was over $1800; seven were under $800. For larger hospitals, 9 hospitals had average charges per case in excess of $1800 and 8 facilities were under $1200.

These wide ranges raise questions as to the efficiency with which these services are produced. Is the cost-based reimbursement system encouraging higher costs and charges? How much is due to long lengths of stay? How much is due to variations in the charges and use of ancillary services? How do the variations in the type of cases treated offset the hospital's overall average?

BLUE CROSS OF IOWA,
SECOND QUARTER 1981

Less than 100 Beds	AVERAGE CHARGE PER CASE	100+ Beds
	Over $2200	••
	$2100-2199	•
•	$2000-2099	•
	$1900-1999	•
•	$1800-1899	••••
	$1700-1799	•••
	$1600-1699	•
	$1500-1599	•••••
••••	$1400-1499	••
•••	$1300-1399	•••••••••
•••••	$1200-1299	•
••••	$1100-1199	••
•••••	$1000-1099	••••
••••••••••••••	$ 900- 999	•
••••••••••••••	$ 800- 899	
••••	$ 700- 799	
•••	$ 600- 699	•

LOWEST	$ 618.	LOWEST	$679.
25th	$ 858.	25th	$1319.
50th	$ 963.	50th	$1411.
75th	$1146.	75th	$1779.
HIGHEST	$2092	HIGHEST	$3260.

Source: BC/BS of Iowa

Average Charge Per Case by Diagnosis

At least part of the variation in the charge per case in the chart on the previous page can be attributed to differences in the "case-mix" from one hospital to another. A hospital that, on the average, treats more complicated cases can be expected to have a higher charge per case. The charts below show variations in the average charge per case for four selected diagnoses. The two on the left are for fractured hip (with surgery) and prostate surgery; the data are for Medicare patients during 1977-1978. Each dot represents a hospital. For example, six hospitals had an average charge per fractured hip above $3500, while five hospitals were below $2500 on the average. The data on the right side are for 1981 Blue Cross patients hospitalized for either acute myocardial infarction or gallbladder surgery. Wide variations exist from hospital to hospital.

AVERAGE CHARGE PER CASE BY HOSPITAL, BY DIAGNOSIS MEDICARE, 1977-78*

FRACTURE NECK OF FEMUR	AVERAGE CHARGE/CASE	HYPERPLASIA OF PROSTATE WITH SURGERY
••	Over $3900	
•	$3700-3899	
•••	$3500-3699	
••	$3300-3499	
••	$3100-3299	
•	$2900-3099	
•••••	$2700-2899	•
••	$2500-2699	
••••	$2300-2499	•
	$2100-2299	•
	$1900-2099	•
•	$1700-1899	•••••
	$1500-1699	••••••••••
	$1300-1499	•••
	Less than $1300	•
HIGH: $4027.		HIGH: $2761.
LOW: $1829.		LOW: $1049.
75th: $3519.		75th: $1861.
25th: $2613.		25th: $1502.

*Sample of 27 "large" Iowa hospitals

AVERAGE CHARGE PER CASE BY HOSPITAL, BY DIAGNOSIS BLUE CROSS, 7/80-6/81

ACUTE MYOCARDIAL INFARCTION	AVERAGE CHARGE PER CASE	CHOLELITHIASIS (Gallbladder) WITH SURGERY
•••	Over $6100	
•	$5100-5299	
•	$4900-5099	
	$4700-4899	
••	$4500-4699	
••	$4300-4499	
•	$4100-4299	
	$3900-4099	•
•••	$3700-3899	
•••	$3500-3699	•
•	$3300-3499	•
•••	$3100-3299	•••••
•	$2900-3099	•
	$2700-2899	••••
•	$2500-2699	•••
•	$2300-2499	••••
	Less than $2300	••
HIGH: $6373.		HIGH: $4066.
LOW: $2386.		LOW: $1790.
75th: $4670		75th: $3227.
25th: $3229.		25th: $2422.

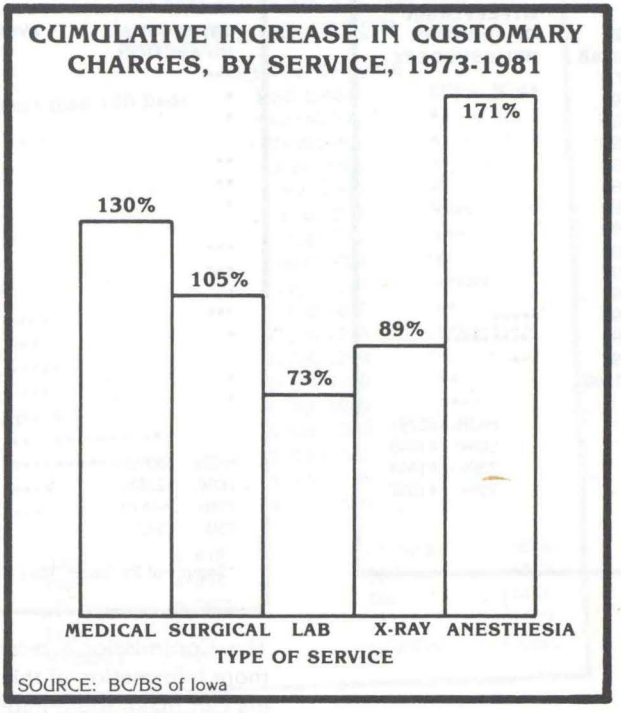
*Sample of 25 "large" Iowa hospitals

The Commission's recommendations address making more information of this type available so that purchasers can make more informed and price conscious decisions about where they seek care.

Physician Fee Increases

The increase in physician fees has been on the average slightly above the rate of inflation. Both nationally and in Iowa, physician fees have increased at an average annual rate of 10.1% over the period 1973-1981. The rate of inflation averaged 9.4%. The rates of increase for different types of physician services have been quite variable. The chart below shows the cumulative increase in the "customary charge" for five different types of physician services. (The "customary charge" is the maximum reimbursible charge. It is defined at the 90th percentile charge from the previous year's billings.) The increase in the CPI over this period was 102%. Increases for anesthesia and medical services were substantially above the general rate of inflation at 171% and 130% respectively. Lab and x-ray fee increases were below the general rate of inflation.

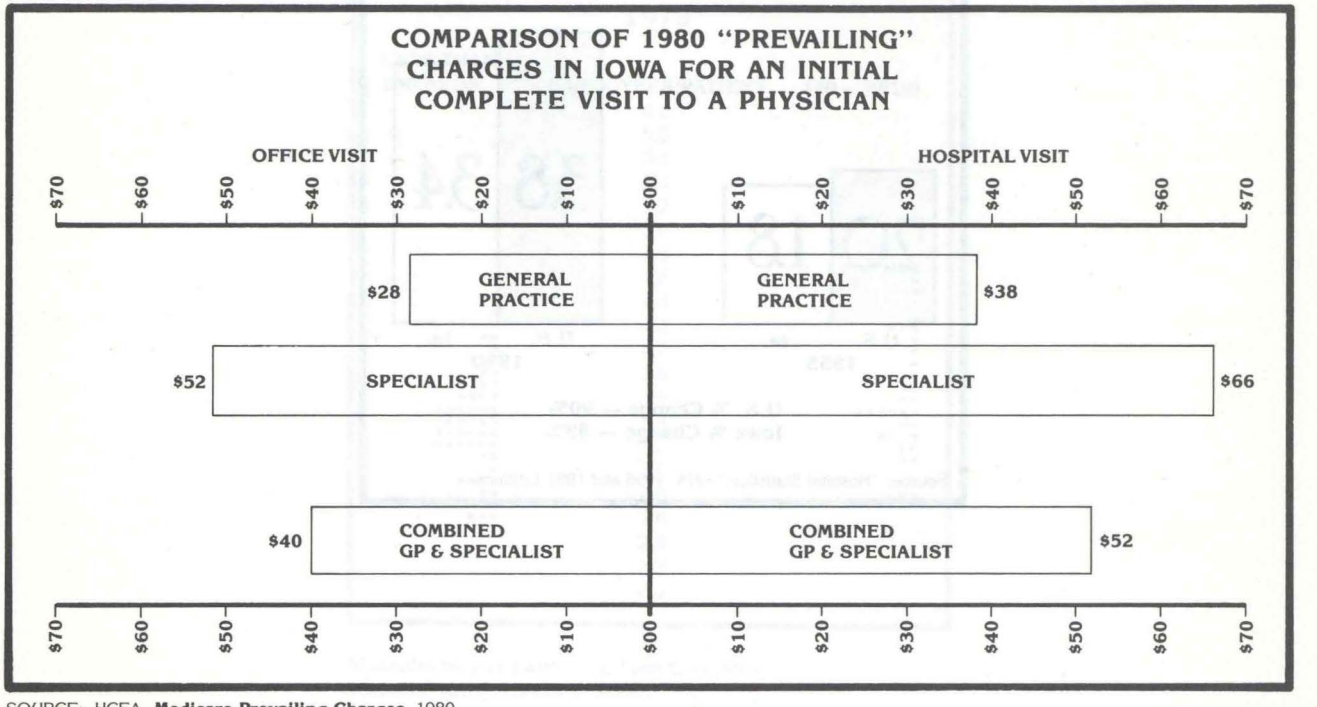
These variations in fee increases suggest that factors in addition to the general rate of inflation are influencing physician fees. One of the Commission's recommendations was to develop a fee increase limit tied to economic indicators. The existing price-adjustment mechanism enables fee maximums to increase at a rapid rate.



Physician Fees — Office vs. Hospital

Physician payments for service rendered while a patient is hospitalized are frequently higher than for a similar service provided in the office. The chart below shows the 1980 "prevailing" charge for a complete initial visit. ("Prevailing" charge is a Medicare payment term. It is similar to the "customary" charge concept previously defined.) For general practitioners, a charge of up to $38 was allowed for a hospital visit; a similar visit in the office had a limit of $28. The specialist was allowed to charge more for a hospital visit also.

Physician charge structures can create incentives that influence where care is provided. Studies have shown that where physicians are paid (rewarded) more for hospital care than for similar care in the office, they tend to hospitalize more patients.

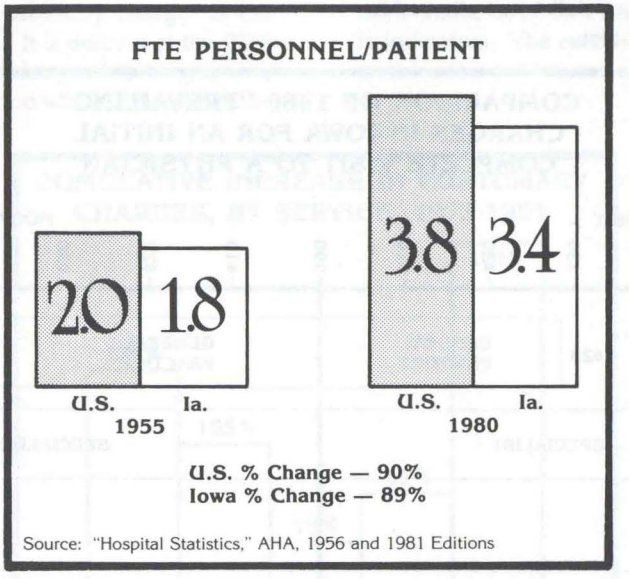


SOURCE: HCFA, **Medicare Prevailing Charges,** 1980

Increases in Hospital Employees

One measure of the increase in the intensity of hospital services over time is the increase in the number of hospital employees per patient. The chart below shows the magnitude of this increase over the period 1955-1980. Currently for both Iowa and the nation, almost twice as many people are employed per patient as just 25 years ago.

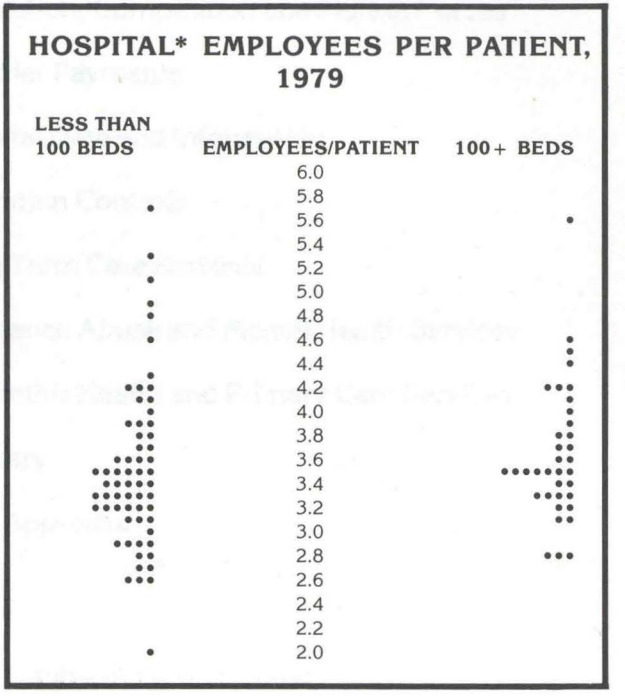
This increase in the number of employees is not the result of substituting human resources for capital resources. In fact, quite the opposite has occurred. The increases in technology have necessitated additional staff to provide the new services and procedures.



Variations in Hospital Employees per Patient

The number of employees per patient varies from one hospital to another. The chart below shows the number of fulltime equivalent employees per patient. Ten of the smaller hospitals had more than 4 employees per patient; 13 facilities had fewer than 3 per patient. Similar variations existed for the larger (100+ beds) hospitals.

These variations can be explained in part by factors such as "case-mix" of the patients, different types of personnel and perhaps productivity and efficiency. Critics of cost-based reimbursement, and the incentives that such an approach creates, suggest that at least part of the variation is the direct result of the lack of incentives to closely scrutinize the use of resources.



*Excludes hospitals with Long Term Care Units
SOURCE: AHA, Hospital Statistics, 1980