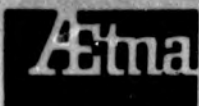


ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1714.3 SCOMM 68: HEALTH CARE COST CONTAINMENT TASK FORCE, 1989-91

3



Employee Benefits Division
Western Home Office
P.O. Box 8092
Walnut Creek, CA 94596-8092
(415) 932-7200

October 30, 1989

Mr. Pat Pachacek
Touche Ross & Co.
1600 Landmark Towers
345 St. Peter Street
Saint Paul, MN 55102-1656

Dear Pat:

Attached are the revised exhibits for the Retiree Medical coverage. We have re-rated this coverage using the September 1989 premium and adjusting the premium for the additional premium payment received in October 1989 for this coverage. Apparently, an audit was performed by the State on the Retiree Medical Premiums and they discovered that they had not paid the additional premium necessary for the rate increase on February 1, 1989. Using these additional premium figures, I develop a 3.5% increase including a 5% margin and a 1.7% decrease if we exclude the margin requirement. Please call Phil French at (415)932-7270 if you have any questions or if there is anything else you need.

Sincerely,

Betsy Killius

Betsy Killius
Account Coordinator
Western Home Office
Aetna Life Insurance Company

CC: Phil French
Lynn Withrow
Steve LeBrun

Aetna
LIFE & CASUALTY
STATE OF ALASKA
SUMMARY OF RATES

SUPPLEMENTAL BENEFITS OPTION I

Existing Rates

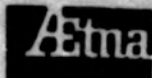
Employee	\$12.13
Dependent	\$20.86

Rates Effective February 1, 1990

Employee	\$18.62
Dependent	\$32.02

ACTIVES

Existing	\$431.72
Effective December 1, 1989	\$384.59
Effective February 1, 1990	\$408.43



STATE OF ALASKA

SUPPLEMENTAL BENEFITS OPTION I

CLAIMS (1/1/89 - 9/15/89)	\$1,119,428	
RESERVE	\$335,838	
INCURRED CLAIMS		\$1,455,266
PAID PREMIUM (1/1/89 - 9/15/89)		\$1,657,500
LOSS RATIO		87.8%

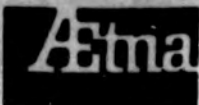
1. Expected Loss Ratio		87.8%
** 2. Trend		34.5%

3. Expected Loss Ratio 2/90-2/91		122.3%
4. Expenses	x	104.7%

		128.1%
5. Claim Fluctuation Margin	+	90.0%

6. Required Premium		142.3%
7. Indicated Change	Billed +	42.3%
8. Adjustment for Plan Change effective 12/1/89		11.2%
9. Net Required Premium		153.5%
10. Indicated Net Change	Billed +	53.5%

** Includes adjustment for expected increased utilization by employees enrolled in the SBS plan



Employee Benefits Division
Western Home Office
P.O. Box 8092
Walnut Creek, CA 94596-8092
(415) 932-7200

October 16, 1989

Mr. Pat Pachacek
Touche Ross & Co.
1600 Landmark Towers
345 St. Peter Street
Saint Paul, MN 55102-1656

Dear Pat:

Enclosed are the revised exhibits for the SBS Option I rating. After correcting the reserve and premium and adjusting the trend, the indicated change before any plan changes is +42.3%. The plan change is worth an additional \$13,482/month in SBS Option I premium. This is an additional 9.6% annually. Since the plan change is effective December 1, 1989 and the rates don't go into effect until February 1, 1990, I added an additional two months of premium bringing the additional cost for the plan change to +11.2%. The net increase then becomes Billed + 53.5%. Please call me at 415-932-7293 should you have any questions.


cc: Lynn Withrow
Phil French

The seven states presented as case studies in the National Governors' Association's overview of state health care plans were chosen because they demonstrate a variety of approaches toward health care cost containment. For more details on the plan design and funding of the state plans, see RR 308.3.-1 and following.

Florida. Florida's state employee benefit program covers approximately 211,000 employees, retirees, and dependents in FY 1983-84, at a cost to the state of close to \$87,800,000.

Cost containment strategies began in 1978, when the plan became self funded with an ASO contract. Since then, it also has pursued traditional approaches to holding down costs.

Coordination of benefits, coordination with Medicare, and subrogation rights saved the plan an estimated \$10,232,777 in 1983.

A maximum fee schedule for physician services saved the state an estimated \$9,889,485 in 1983.

An estimated \$15,519,947 was saved in 1983 through claims review.

New and pilot programs include:

The health incentive program. This is modeled on the Mendocino County plan (see RR 330.-15). The three-year pilot project began in January 1982 as a voluntary option for state employees in Dade County. A financial incentive is paid to members whose annual claim submissions are \$500 or less. Members are also offered a health education/risk reduction workshop and educational material on self treatment, cost containment, and health promotion. Based on first-year data, the state has recommended not to expand the program statewide because of adverse selection affecting the insurance base of the other options.

Hospice care. The state began offering hospice care as a benefit in August 1983.

The patient-auditor program. Beginning March 1, 1984, the state plan began a patient-auditor program to encourage patient awareness of the financial aspect of illness by offering incentives to verify charges on medical bills. If a reported overcharge is verified, the patient-auditor is eligible for an incentive award of up to 50% of the overcharge, not to exceed \$1,000.

HIGHLIGHTS

This report capsules cost containment aspects of seven state employees' health care programs. These cost containment initiatives range from preferred provider arrangements to incentives aimed at modifying health utilization behavior in a variety of ways.

The information is from a report titled, "Harnessing State Expertise to Contain Health Care Costs: The Potential of Employee Health Benefit, Medicaid, and Health Planning Programs," prepared by the National Governors' Association, Center for Policy Research, Health Policy Studies.

Copies of the complete report may be obtained from the Publications Office, National Governors' Association, 444 North Capitol Street, N.W., Washington, DC 20001.

Changes in the Florida program must first be agreed to in collective bargaining and then recommended in the governor's budget and approved by the Florida legislature.

New options being researched by the plan for possible inclusion in FY 1984-85 include a preadmission certification program for screening nonemergency hospital admissions; a mandatory second opinion program for elective surgery; development of a preferred provider network; expanded use of alternative providers, such as nurse practitioners; alternatives to increase the cost savings from HMOs; and increased deductibles.

Illinois. In 1983, Illinois' total health care bill for its 225,000 employees and their dependents was \$118 million.

In 1981, the governor limited the acceptable health care cost increase to 15%. As a result, policies implemented in 1981 included mandatory ambulatory surgery for 67 procedures, preadmission testings, and a \$50 deductible for each emergency room visit.

A pilot utilization review program in Springfield has had measurable success. The program is based on the days of inpatient care on which no acute services are rendered.

(CONTINUED)

It was designed to identify practice patterns such as delays in discharge and early or unnecessary admissions, which can be measured in terms of the incidence of nonacute hospital days. The percentage of nonacute days was reduced from 23.1% of all days reviewed in 1981 to 8.7% in 1983, a reduction of more than 60%. This represented an annual savings of approximately 3,450 hospital days. Illinois officials believe that possible reasons for the reduction of hospital days in Springfield may be the sentinel effect, peer pressure on area physicians, and general excess utilization in the system. As a result of the success in Springfield, utilization review will be expanded in Illinois.

Another approach under consideration is implementation of a Medical Services Advisory program, based on an initiative by the Zenith Corporation (see RR 335.64.-5).

Illinois assesses the cost impact of its alternative delivery system options--in this case, HMOs. Because of the problems of adverse selection, the state has asked all HMOs to experience rate with the state.

Critical to all of Illinois' cost containment activities has been and continues to be the collection and analysis of data. Data are critically important to such activities as identifying specific cost escalation problems, assessing the cost impact of increasing employee enrollment in HMOs, and monitoring the effectiveness of implemented programs.

Kentucky. Kentucky provides health benefits to approximately 90,000 active and retired state employees and teachers, plus 70,000 dependents.

Kentucky in 1982 opened its plan to competitive bidding. The request for proposals for the bid included specifications pursuant to cost containment strategies. Blue Cross won the contract to continue as the state's insurance carrier. The state was granted a \$1.2 million rate credit by Blue Cross for the cost containment provisions in the new contract.

A number of cost containment initiatives have been implemented since the new contract went into effect. There is a second surgical opinion program. The employee will be reimbursed only 50% if a second opinion is not obtained for a selected list of fifteen elective procedures. The state estimated savings of \$820,000 in 1982-83 as a result of this program.

The Kentucky plan also has an incentive program for ambulatory surgery. The state has established a schedule of 45 procedures that can be performed safely on an outpatient basis. An employee is reimbursed only 50% of the cost if a procedure listed on the schedule is performed on an inpatient basis, with certain exceptions. Exceptions to the ambulatory surgery requirement are granted based on the type of procedure and the health status of the employee. Savings attributable to the ambulatory surgery program totaled \$991,000 from 1982 to 1983.

Kentucky also provides incentives for short maternity stays. Women who leave the hospital within two days of giving birth receive \$75; if they leave within one day they receive \$125. In addition, they receive \$100 for in-home services, which will not be considered as income on state taxes. This program has resulted in cost savings of \$27,500 in the first year of operation.

The state program includes a 24-hour limit on hospital admissions prior to surgery and a program of preadmission certification for nonemergency hospital admissions, except maternity and psychiatric admissions. Physicians are required to get prior approval for admissions from a utilization review board, except for an emergency, when review takes place after admission. The state realized savings of \$98,000 attributed to limiting hospital admissions prior to surgery.

A number of additional cost containment initiatives were added recently. In October 1983, the state started an employee audit for hospital bills. Employees who find overcharges on their bills receive 25% of the money recovered by the state, up to \$125. Kentucky also is expanding the range of benefits covered--hospice care and birthing centers were added in January 1984, and home health care will be covered later in 1984.

In the future, Kentucky plans to develop programs to promote employee wellness. As a first step, employees will be administered risk assessment questionnaires. Results will be analyzed and employees given specific suggestions to improve their health status by altering their lifestyles.

North Carolina. In October 1982, North Carolina changed to a self-funded program incorporating traditional cost containment features and a performance-based administrative services contract.

(CONTINUED)

Although operational for only one year, self funding has proved to be a financial success. The investment earnings for the first 12 months have covered the costs of administering the plan.

North Carolina's contract with its administrator has a performance clause that holds the administrator fiscally accountable for inefficiencies and provides fiscal rewards for achieving cost savings. There are three elements to the performance contract:

1. If the claims processing error rate exceeds 5% of total plan dollars, as determined by an outside auditor, the administrator must pay a penalty.

2. If the administrator can reduce hospital days per thousand below a targeted number, through improved utilization review, education of providers, etc., the administrator receives 10% of the savings.

3. If coordination of benefits does not save between 4.5% and 6.5% of total paid claims, a sliding scale final penalty is imposed on the administrative agency.

Plan design features for cost containment include:

Second surgical opinion. For five selected procedures, the plan will pay its normal rate of contribution only if a second opinion has been sought. Without the second opinion for these five procedures, the plan will pay only 80% of the fee up to a cap of \$1,000.

Ambulatory Surgery. For any procedure done on an outpatient basis, the plan waives the deductible and coinsurance rates for the surgeon's and facility's fees.

Preadmission testing. The plan will pay 100% of the charges for tests performed on an outpatient basis within 14 days of a scheduled admission to a hospital. If the tests are performed on an inpatient basis unnecessarily, the plan will not pay the room and board costs.

Incentive for early discharge. For maternity cases receiving the approval of the attending physician, the plan will pay 100% of the first two newborn visits and the cost of the infant DPT and polio vaccines if the maternity stay for a normal delivery is two days or less, or if the stay is five days or less for a Caesarean-section.

Ohio. From 1980 to 1983, Ohio's expenditures for employee health benefits increased by 77%, while total enrollment of active state employees declined slightly. During the same time period, state employees' enrollment in HMOs rose from 15% to 40%.

Unfortunately, this shift to prepaid health plans appears to have created a problem of adverse selection. This problem became so great by 1981 that the insurance company refused to renew its contract with the state. As a result, Ohio determined that self funding with an ASO agreement was the most cost-effective arrangement for the state.

The Bureau of Insurance and Risk Management, which coordinates health insurance for Ohio's state employees, is developing a proposal that would offer employees a choice between two state health plans. One plan would be essentially the same as the current plan. The second plan would have a level of benefits that is similar to the existing plan but would alter the way in which employees use the benefits. The alternative plan would contain a mandatory ambulatory surgery program, increased coinsurance and deductibles, second opinions for surgical procedures, and economic incentives for low-volume utilization of health services, including a "pay-back" provision. The attractiveness of this alternative plan is that the Bureau believes it can offer employees a high level of benefits at a significantly reduced premium because of the cost-containment features. The plan would then be attractive to a broad cross-section of employees, be competitive with the HMOs, and reduce the effects of adverse selection.

Utah. The Utah plan became self funded and self administered in 1976. In 1983, the plan cost the state \$16,000,000 and covered 9,500 employees and their families. Cost containment programs include:

Incentives for shortened stays. When the inpatient hospital stay for 12 selected procedures is reduced one or more days from state-established norms, a \$50 incentive is issued to the insured when the claim is processed. Reductions in stay must have the consent of the attending physician.

Ambulatory surgery. The state will reimburse 100% of R&C charges for outpatient surgery for 100 identified procedures. If the procedures are done on an inpatient basis without medical necessity, the state requires 20% coinsurance on the full hospital bill (otherwise paid at 100%).

(CONTINUED)

5-84
FLORIDA, ILLINOIS, KENTUCKY, NORTH CAROLINA, OHIO, UTAH, WISCONSIN PROFILED

Preadmission testing. The state will pay 100% for preadmission tests performed within ten days of an inpatient admission. The tests are done on an inpatient basis, the normal coinsurance rate of 30% is required.

Second surgical opinion. The program pays R&C charges in full for the consulting physician's exam, and for ten identified procedures will pay the insured a \$25 bonus for obtaining the second opinion.

Lifestyle programs. All employees are eligible to participate in a state-paid fitness and nutrition profile and risk assessment program. Additionally, the program offers cash rebates to employees who quit smoking, lose weight, or engage in regular exercise programs.

Wisconsin. Tremendous increases in the cost of state employee health insurance benefits provided the impetus for cost containment. Expenditures have increased from approximately \$44.3 million in 1980 to \$75.5 million in 1983.

In 1983, Wisconsin enacted legislation to provide incentives for employees to choose low-cost alternative health care plans, primarily HMOs. These changes are an effort to change the behavior of health care consumers and providers. The state's contribution rate is based on the price of the lowest cost plan offered to employees.

This program has had a number of immediate impacts. First, the number of HMOs offered to employees increased from eight to 16. Second, the percentage of state employees enrolled in HMOs increased from about 15% to more than 66% in one enrollment period. The state intends to share the cost savings with employees.

Wisconsin plans to continue efforts to contain the costs of employee health benefits. Next on the agenda is to develop incentives for the administrator of the fee-for-service plan to do more to restrain costs. One proposal under consideration would share saving accrued from audits of large hospital bills with the administrator.

* * * * *

The rising cost of health care has caused employers to adopt a wide range of measures to manage and control medical benefit expenses. Public sector employers do not seem to be as aggressive as their counterparts in the private sector in using cost management techniques. This is one of the findings in a survey of 336 public employers conducted by William M. Mercer-Meidinger, in cooperation with the Public Risk and Insurance Management Association.

Most of the respondents (61%) were city or town agencies; 19% were county or parish agencies; 8% were school boards or districts; and 3% were state agencies.

The median population of the agencies' jurisdictions in the Mercer-Meidinger study was 57,000. The median number of employees of the responding agencies was 520. About 26% of the agencies cover more than 1,000 employees in their medical plans; 19% between 500 and 1,000 employees; 29% cover fewer than 250. In 40% of the agencies, medical benefits are negotiated in labor agreements.

Plan Design

Among the respondents, the most commonly used medical plan is basic medical/surgical plus major medical, which was offered by 60% of the agencies to their salaried employees, with 29% offering first-dollar coverage on hospitalization. Half of the agencies continue to offer basic coverage for their hourly employees, with 23% offering first-dollar coverage on hospitalization.

Thirteen percent of the public employers in the survey have recently changed to comprehensive plans for their salaried employees, compared to 26% a year ago, and another 11% said they are considering such a change.

Deductibles

About 13% of the agencies have recently increased deductibles for salaried employees, and 11% increased deductibles for hourly employees. By contrast, deductibles were increased by 30% for salaried and 24% for hourly employees. For most of the agencies, however, these amounts are still relatively low. Deductibles are \$150 in 70% of the salaried plans and 68% in the hourly plans.

Other changes in plan design the survey respondents have made or are considering:

--increasing maximum out-of-pocket limits. About 15% have changed, 15% are considering. In 29% of the salaried plans and 27% of the hourly plans, the

HIGHLIGHTS

This Research Report is taken from a William M. Mercer-Meidinger study of public employers' health care plan cost containment features.

Copies of the survey report are available at no charge by writing William M. Mercer-Meidinger, Incorporated, marketing department, 2600 Meidinger Tower, Louisville, KY 40202-3415.

out-of-pocket limit is \$500 or less; 38% of salaried plans and 41% of hourly plans have \$1,000 limits.

--increasing or adding employee contributions for medical coverage. About 9% have contributions for salaried employee coverage, almost 11% have contributions for dependent coverage.

--using a flexible spending account for health care expenses. Only 7% have actually made the change, but about 13% are considering doing so.

Retiree Medical Benefits

Several forces have created significant liabilities for private sector employers offering health care benefits to retirees. According to the Mercer-Meidinger survey, 73% of the survey respondents provide medical benefits for retired employees. Of these, 46% supplement Medicare and 45% provide identical benefits received by active employees.

More than 75% of the cost is paid by the retiree in 63% of the agencies, while in 24%, the retiree pays nothing.

Some 68% of the responding agencies provide medical benefits for dependents of retirees, and 14% absorb the entire cost of dependent coverage.

In an effort to contain costs, survey respondents overwhelmingly (78%) indicated that they are planning to pass on future cost increases to retirees.

(CONTINUED)

HMOs And PPOs

Forty percent of the survey respondents said they were interested in health maintenance organizations because of their ability to reduce health care costs. However, 54% felt that adverse selection might lead to an increase in the costs of traditional plans.

More than half (54%) of the agencies surveyed offer HMO options. Of these, 61% offer more than one HMO. In 1985, 52% of the surveyed employers offered HMO plans, and only 30% offered more than one.

The most important feature in evaluating an HMO is the quality and number of hospitals and physicians available, according to 62% of the respondents. Many respondents (41%) considered the full service aspect of the HMO benefit schedule important, and 34% said geographic location was important.

PPOs have become more aggressive in their marketing of the public sector. About 22% of the respondents offered PPOs in 1986, compared to only 13% in 1985.

Employers currently without PPO options seem receptive to offering such options in the future: 27% said they would offer a PPO from a quality organization; another 49% said they might. Only 23% said that they would consider a PPO attractive if they thought they would save 11% or less.

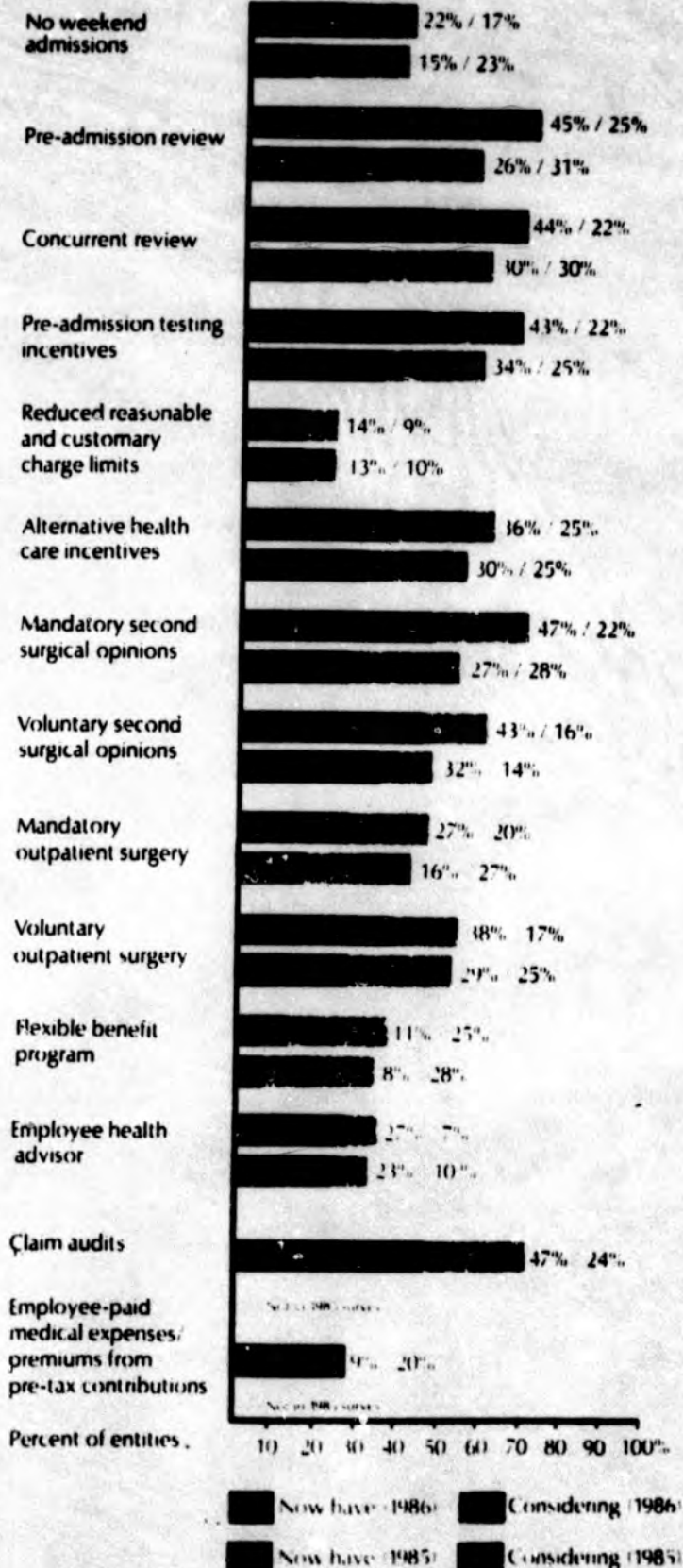
The most important features of a PPO, according to the survey respondents, are quality of providers, discounts on service, and accessibility to employees. The most serious criticism, on the other hand, was employee resistance to limited choice of provider (58% of respondents, compared to 68% last year).

Communications

Twenty-eight percent of the respondents said that a good communication program can have significant impact on helping reduce costs; another 56% said it can have a moderate impact.

About half of the agencies in the survey have put in special communication programs to deal with various aspects of health care--52% to introduce changes in benefit plans, 35% to enhance employees' understanding of their roles as purchaser, 50% to increase general health awareness, 49% for specific health education programs, and 31% to enlist employees' help in containing costs.

Cost containment features in medical plans



Claims Administration

While 58% of the agencies said information provided by their claims payors was helpful in managing costs, only 45% have made any changes in their plans based on such information. Seventy-six percent said their claims reports are not compared to norms such as national, regional, local, or industry.

In 41% of the agencies, health plans are fully insured. Of those, 26% are fully experienced rated (down from 56% last year) and 8% are pooled (down from 35% last year). Twenty-four percent have ASO arrangements and 22% of those have stop-loss coverage, compared with 91% in 1985.

Blue Cross/Blue Shield is used by 37% of the agencies, 24% use independent TPAs, 27% use commercial carriers, and 4% are self-administered. During the past year, 21% have changed their administration arrangements.

More than half of the survey respondents (55%) thought employee lifestyle had only a moderate effect on medical costs, while 39% thought it had a significant effect.

About 24% thought they could do little or nothing to change employees' lifestyles, while nearly two-thirds thought they could have a moderate effect, and 12% thought they could have a significant effect.

The most popular program was alcohol and drug abuse treatment (offered by 52% of the agencies), followed by blood pressure screening (45%) and employee assistance (48%). The greatest leap in wellness programming was in the area of physical fitness. Programs emphasizing fitness are now offered by 27% of the agencies, compared to 21% last year.

As shown in the chart on the previous page, public sector employers increased their use of virtually every medical intervention feature in 1986, compared to last year.

Asked which groups can and should act to bring health care costs under control, the agencies first named coalitions of employers and providers. Hospitals ranked second. Despite these opinions, only 23% of the agencies belong to any local employer cost containment group.

As shown in the chart, the survey employers have adopted a number of cost-containment features in their medical plans.

* * * *

Cost management policies will work only if they control the costs of those who use the health care system most often, declares the Equitable. To get a profile of these "heavy users," Louis Harris and Associates questioned 32 million patients—nearly one in five American adults—who had been hospitalized at least once or had visited their doctors at least ten times in the past 12 months.

The overall object of the survey was to provide policymakers in both the public and private sector with information relevant to the design of future health insurance programs and health plans. The survey examines ways to manage the high cost of providing health care services to those who use them the most without preventing or inhibiting them from getting the services they need.

This Research Report summarizes the findings of the fifth comprehensive survey conducted by the Harris agency on the state of the health care system in America. For additional information about this and previous surveys in the series, contact Andrew Plessner at (212) 489-6900.

A newly released study of the state of health care in America suggests that some of the steps taken to curb spiraling health care costs may not be as successful as is being reported.

Despite a slower rate of inflation, increased cost sharing, reduced benefits, and the growth of health maintenance organizations and preferred provider organizations, medical prices continue to rise about three times faster than the Consumer Price Index.

Louis Harris and Associates suggests in a comprehensive study on the state of the American health care system that policymakers may need to reevaluate their cost containment strategies. The researchers conclude that "any policy which seeks to change the behavior of health care consumers must change the behavior of the heavy users. These people use most of the available services and incur most of the costs." But, they caution, "heavy users will be hurt first, and hit hardest, by any policy that reduces access to or the quality of care."

The Equicor Survey of Hospital Patients and Other Heavy Users of Health Care Services is the fifth in a series of health care studies conducted by Louis Harris and Associates for The Equitable. To identify the heavy users, the Harris firm interviewed a nationwide cross-section of 8,400 individuals in 3,900 households during May and June of 1986. The heavy users, who represent 18% of the population, were comprised of

966 patients (12%) who had been hospitalized, and 548 people (6%) who had visited a doctor at least 10 times during a 12-month period.

As shown in the chart on the following page, the profile of heavy users of health care services differs from the general population in these ways: twice as many females (69%) as males are heavy users; they are older; they have worse health status; and they are more likely to be disabled and covered by Medicare.

Heavy users are similar to the general population in terms of income levels with the largest percentage having incomes of less than \$15,000. Two-thirds, or 69%, of heavy users are covered by health plans provided by employers or unions; 5% have no health insurance.

Health Status

In terms of health status, one-quarter (26%) of all heavy users suffered from hypertension during the previous 12 months, 14% suffered from heart disease, 11% were victims of accidents or injuries requiring hospitalization, and 9% have diabetes. In addition, 18% of all female heavy users had given birth in the previous 12 months.

All of the above conditions (except maternity and accidents) are highly correlated with age. Age becomes a factor also when multiple conditions are present as shown below.

PROFILE OF HEAVY USERS OF HEALTH CARE SERVICES

	<u>All Heavy Users</u>	<u>Number Of Nights In Hospital</u>					<u>Nonmaternity Heavy Users</u>	<u>All Adults* (Total Public)</u>
		<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>6-10</u>	<u>11 Or More</u>		
Base	1,514	548	238	291	223	198	1,338	Varies
Sex								
Male	31%	30%	22%	26%	37%	46%	35%	47%
Female	69%	70%	78%	74%	63%	53%	65%	54%
Age								
18-29 years	23%	19%	36%	30%	16%	14%	18%	29%
30-39 years	23%	27%	27%	25%	14%	13%	20%	21%
40-49 years	14%	14%	13%	15%	12%	14%	15%	13%
50-64 years	20%	20%	14%	14%	28%	29%	23%	20%
65 and over	20%	20%	9%	16%	28%	30%	23%	17%
Household Income								
\$15,000 or less	31%	34%	24%	25%	28%	41%	32%	32%
\$15,001 to \$25,000	19%	18%	22%	18%	19%	16%	18%	20%
\$25,001 to \$35,000	19%	19%	17%	23%	17%	16%	18%	15%
\$35,001 to \$50,000	14%	13%	19%	14%	11%	11%	13%	14%
\$50,001 or more	10%	10%	13%	10%	11%	7%	11%	12%
Health Status								
Excellent	27%	27%	44%	40%	21%	15%	22%	44%
Good	41%	45%	39%	42%	36%	35%	43%	46%
Fair or poor	31%	34%	17%	18%	40%	50%	35%	10%
Disabled								
Yes	28%	31%	12%	16%	31%	52%	31%	15%
No	72%	69%	88%	84%	67%	48%	68%	85%
Number Of Nights In Hospital In Last Year								
0	36%	100%	—	—	—	—	41%	88%
1-2	16%	—	100%	—	—	—	13%	3%
3-5	19%	—	—	100%	—	—	15%	4%
6-10	15%	—	—	—	100%	—	16%	3%
11 or more	13%	—	—	—	—	100%	14%	2%
Health Insurance								
Through work or union	69%	68%	73%	74%	70%	60%	64%	68%
Through self, family, or group	40%	40%	37%	37%	42%	46%	36%	46%
Medicare A or B	25%	24%	13%	20%	32%	41%	27%	20%
Medicaid	7%	8%	6%	4%	7%	8%	7%	6%
No health insurance	5%	5%	7%	4%	5%	5%	5%	5%
Sources Of Care								
Have usual source of care	85%	84%	85%	85%	88%	88%	85%	88%
Have one personal physician	76%	73%	—	—	—	—	76%	80%
Marital Status								
Single	14%	17%	13%	11%	11%	16%	15%	22%
Married	64%	57%	75%	77%	62%	57%	62%	58%
Divorced/separated	10%	23%	8%	6%	11%	9%	10%	11%
Widowed	11%	13%	4%	5%	16%	17%	13%	9%

* Notes: (1) Some of these tables add to less than 100% because of "not sure" responses and refusals.
(2) The "All public" data come not from this survey but from a variety of other Harris surveys.

continued on next page

	Ages				
	18-29	30-39	40-49	50-65	65+
One condition	25%	30%	48%	59%	67%
Two conditions	3%	4%	11%	26%	28%

Hospital Choice

Until recently, noted the Harris firm, it was assumed that doctors, not patients, determined the choice of hospitals. The results of the survey reveal, however, that the doctor chooses the hospital for only 43% of the heavy users. A further 6% said the decision was made jointly by doctor and patient.

The tendency to let the doctor choose the hospital increases steadily with age: from 34% among those age 18-29 to 47% for those age 50-64 and 47% for those age 65 and over.

In terms of criterion used in choosing hospitals, the survey findings show that "very few patients shop around to compare hospital prices." A hospital's reputation for providing quality care is the principle criterion used by 74% of heavy users in choosing hospitals. Also considered, by 58% of heavy users, are the hospital's location (presumably close to the patient's home) and previous experience at the hospital. All three of these factors were considered more important than the out-of-pocket costs, which only 38% of heavy users singled out as "very important" in their choice-making.

The importance of out-of-pocket expense in choosing a hospital differ by age and income. Higher income groups are less likely to cite this as a "very important" reason for choosing a hospital compared to only 8% of heavy users with incomes of \$15,000 or less.

Health care payors have placed emphasis on the price competition among hospitals as a determinant in their selection of "preferred" hospitals. These findings show that "if price competition is to grow, it will be the buying power of the third-party payors, not the consumers," perhaps because hospital price information is not readily available to consumers.

How long a patient stays in the hospital has been greatly influenced by the Medicare prospective payment system. The medium number of nights heavy users were hospitalized was four; this number embraces the 11% who stayed one night and 20% who stayed 20 or

more nights.

Length Of Stay Varies

Length of stay varied by income group (highest and lowest spend more time than those earning between \$15,000 and \$50,000), sex (men stayed longer than women), and by age (those over age 50 spend more nights than those under age 50).

The impact of this findings should be tempered, according to the Harris firm, by the fact that this is the first national survey to ask whether DRGs and other cost containment mechanisms are causing more patients to be discharged "quicker and sicker" than they were in the past. Therefore, these findings "do not provide a definitive answer." However, 12% of the heavy users believe they were hospitalized for "too short a time," a finding that is, according to the Harris firm, "large enough to cause concern."

What was the consequence of being discharged at a time perceived as being "too early?" A 59% majority of those who believe they were discharged too early say their condition got worse; 18% said there was no effect, while 3% said the condition got better by itself. Three of every 10 (32%) said they were readmitted sometime during the year because they were still ill.

Employers instituted specific policies to control costs that included increased deductibles and cost sharing as well as preadmission, concurrent, and retrospective reviews. The pollsters conclude that "any substantial increases in cost-sharing and preadmission reviews are likely to be widely unpopular among the heavy users. Many health plans have probably reached the limit to which they can shift costs to health care consumers without triggering negative backlash or reducing access."

This conclusion was based on the large differences between the replies of heavy users and those of employees, relating to cost-sharing. Heavy users indicate that increased cost-sharing is viewed very critically. They, of course, tend to be affected more adversely than the rest of the population.

Access/Quality

The Harris firm observed that in terms of access and quality of care, the "policymakers and health care providers have every reason to be pleased with these findings: Heavy users were "satisfied" with these aspects of health care services:

- ability to see a doctor when necessary (90%)
- quality of their doctors (89%)
- health insurance policy (74%)
- quality of hospital care (82%).

How many heavy users are slipping through the safety net of the current health care system? Only 7% of the heavy users said they failed to get the care they needed. But the pollsters injected this fact: "that 7% represent more than two million people."

The proportion of those who fail to get needed care was somewhat higher among the lowest income group (12%), those who are disabled (13%), those on Medicaid (15%), and those without health insurance (16%). The two most common reasons why people failed to get the health care services they needed are that services cost too much (33%), or they do not have adequate insurance coverage (25%).

Doctor/Patient Relationship

The pollsters note that "the inability of patients to see their own doctor has often been given as a criticism of HMOs." However, this survey indicates that "for the majority of Americans this is not particularly important."

Findings show also that "substantial economies may be possible through the use of lower cost health care professionals in the treatment of some patients." Less than one-third (29%) of all heavy users said they "mind a great deal" if they are treated by a medically trained nurse-practitioner or a physician's assistant, when a doctor is not available.

As in the selection of hospitals, consumers are less likely than employers or other third-party payors to allow a doctor's fee to influence their choice. "These data show conclusively that even with increased cost-sharing in many health plans, most patients cannot, or do not, shop around between doctors on the basis of price." The survey showed that only one in ten of all heavy users chose their doctors because their fees were

lower. Younger heavy users were slightly more likely to do this. And, only a 16% minority said that the fees were an important reason in their choice of physician. Those eligible for Medicaid (24%), those currently without health insurance (19%), and those in the lowest income group (21%) are more likely than are other heavy users to say that fees are important.

Alternative Treatments

While HMO membership has undoubtedly been growing among heavy users, no more than 9% of them have joined an HMO. Membership ranges from 14% in the West, 11% in the Midwest, and 6% in the South and in the East.

At the time of the survey, 5% of all heavy users were PPO members. The pollsters noted that when responses to questions about PPOs are compared with those about HMOs, "it is clear that the restrictions which both place on patients' choices are not fundamental barriers." It should be noted, they added, that "HMO growth has been fueled by employee and public support, an increased understanding among employers that a capitation-based payment system fundamentally changes the motivation of health care providers. Discounted fee-for-service methods such as PPOs do not do so."

Lifestyle

There is no evidence that heavy users of health care services have less healthy lifestyles, or higher risk factors. A previous survey conducted by the Harris firm for *Prevention* magazine showed that there is a tendency for many people to change their behaviors and reduce their risk factors only after they have suffered a health problem. "The challenge," then "is how to persuade those who are fit and healthy to adopt healthy behaviors and reduce their risk factors—and so reduce their chances of becoming heavy users." ■