STUDY OF HEALTH INSURANCE COVERAGE FOR HOME HEALTH CARE TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 7

COMMONWEALTH OF VIRGINIA
Department of Purchases and Supply
Richmond
1977

COMMONWEALTH OF VIRGINIA

JUNIE L. BRADSHAW
PRESTON C. SHANNON
THOMAS P. HARWOOD, JR.
COMMISSIONER

RICHMOND, VIRGINIA 23209

STATE CORPORATION COMMISSION

December 3, 1976

TO: The Honorable Mills E. Godwin, Jr.
Governor of Virginia

and

The General Assembly of Virginia

The report contained herein is pursuant to House Document No. 14 of the 1976 Session of the General Assembly of Virginia.

This report comprises the response by the Bureau of Insurance of the State Corporation Commission to the directive that a study be made of the question of ambulatory case and the degree to which insurance coverage should be changed to encourage less expensive coverage.

Respectfu ly submitted,

Junie L. Bradshaw, Chairman

Preston C. Shannon, Commissioner

Thomas P. Harwood, Jr. Commissioner

Table of Contents

REPORT OF THE BUREAU OF INSURANCE REGARDING THE MANDATIN G OF COVERAGE FOR VARIOUS TYPES OF SERVICES DESIGNED TO REDUCE HOSPITAL UTILIZATION .

I. Introduction

During the I976 session of the General Assembly, legislation was introduced that would require that every health insurance policy issued in the Commonwealth of Virginia provide coverage for home health care. Proponents of the legislation argued that mandating this coverage was desirable because it would encourage medical treatment in environments that were less costly than a hospital, thus contributing to efforts to control and reduce soaring health care costs.

In response to a request by the legislature for its opinion as to the desirability of mandating home health care coverage, the Bureau of Insurance testified that it had reservations about passage of the law prior to an analysis of the probable major effects of the legislation in all areas of the insurance and health care fields.

The Bureau pointed out that several other states have enacted similar legislation and the experience in these states had not been examined nor had alternatives been explored which might result in achieving similar cost savings. The Bureau recommended a more careful and thorough weighing of the costs and benefits of the proposal prior to its passage.

As a result of this testimony, the General Assembly deferred action on the proposed law and the Bureau of Insurance agreed *to* study the probable impact of mandated home health care coverage and report its findings to the legislature.

II. Summary of the Procedures Followed by the Bureau of Insurance in Examining Home Health Care Benefits Legislation and Problems Encountered in Analyzing Data.

In approaching this task the Bureau's first step was to establish an Advisory Committee composed of representatives of the various health care providers (e. g., hospitals, doctors and home health care agencies) and the insurance industry.

The Bureau then asked several members of the Advisory Committee to prepare papers on the various alternative services that are most frequently considered as means to reduce hospital utilization. The Bureau was also fortunate to obtain assistance from the Community Health Studies Program of the Department of Hospital and Health Administration, Medical College of Virginia -- Virginia Commonwealth University. A study team of students under the direction of Dr. Robin E. MacStravic prepared a report summarizing existing literature on the four most commonly considered services designed to reduce hospital utilization: (1) Home health care, (2) Second medical opinion, (3) Pre-admission testing, and (4) Ambulatory surgery. A copy of this report is attached as Appendix A.

All of these reports were then submitted to the Advisory Committee for comment.

After reviewing the reports and comments submitted by the Advisory Committee members, the Bureau synthesized all information received and compiled this report. Several problems became apparent. First, home health care involves relatively new services. The data regarding their effectiveness in reducing hospital utilization are

limited. Many pilot programs designed to develop additional information have not yet been completed. Second, it is of limited value to consider home health care insurance coverage in isolation from other more broad based efforts to better plan and regulate the way that health care is delivered.

This report is divided into three parts. The first will summarize the factors that must be considered in determining whether health insurance coverage for a specific service should be mandated. The second summarizes the information presently available regarding four major alternatives to hospital care and sets forth the Bureau's recommendations with respect to each. The last section will present the conclusions of the report.

PART I

Factors to be Considered in Determining Whether Consumers Should be Forced to Purchase Certain Types of Health Insurance Coverage.

In recent years, in this and other jurisdictions, there has been an increasing number of attempts to force consumers to purchase various forms of additional health insurance coverage whenever they purchase standard health insurance policies.

At the same time, it is universally recognized that the cost of health care has risen and continues to rise at such a rate that we are rapidly approaching the limit of resources available for even the purchase of the most basic coverages. 1/ Purchasers of health insurance are beginning to limit their purchases of coverage to the essential ones. The providers of health care and those involved in the health planning and regulatory processes may soon be forced to establish priorities regarding which services should and should not be offered.

Because of these considerations, the question of whether a certain coverage should be mandated cannot be answered by merely looking at the proposed service to be covered. Instead, a balance among a number of factors must be struck, such as: (1) the need for the new service relative to other services which either are presently provided or which can be provided; (2) the cost of providing the new service and the cost of other available alternatives; and (3) the likelihood that the proposed mandated coverage will realize its intended objective of assuring quality health care while increasing the efficiency of

1/ For example, after Blue Cross' and Blue Shield's recent increase in premium rates for the state health insurance program, many state employees have dropped the more generous option under the program and instead have purchased the much less expensive basic state plan.

the health care delivery system, thereby reducing costs. Each of these factors warrants further consideration.

1. Need:

Unfortunately in the past, the mandating of health insurance coverages has been done on a piecemeal basis. Usually, it has been done in response to the demands of a particular group of health providers who believe that their services are absolutely essential to good or more efficient health care. Because of the belief, common in the recent past, that unlimited resources were available for the purchase of health insurance, these piecemeal requests did not generate a great interest beyond those providers directly and immediately affected nor were they thoroughly examined by the entire health care community. There was little or no evaluation of the relative need for the insurance coverage under consideration. This apathy cannot continue, particularly in view of the now recognized limited resources available for the purchase of health insurance.

This problem can be dramatically illustrated by the increasing public and legislative concern over the rising cost of health care and the simultaneous efforts to mandate the purchase of additional health insurance coverages. For example, in the last several years the issue of mandating coverage has arisen in this jurisdiction regarding broadened coverage for mental illness, coverage for treatment of drug abuse, alcoholism, newborn infants, and home health care. Which of these should take precedence over the other? If there are only limited resources avilable, should these new coverages be mandated at the expense of existing and more traditional coverages?

These are difficult questions to answer when viewed as a whole. They are impossible to answer intelligently on a piecemeal basis.

2. Costs:

It is impossible to determine the actual cost of providing coverage for any new service with precision because there is little or no experience upon which to base future projections. This process is made even more difficult because of the fact that new coverages may result in an artificial demand for the covered services. Individuals tend to request and physicians tend to direct patients to those services that are paid for through the insurance mechanism. For example, in the absence of coverage for outpatient diagnostic tests, many doctors will admit patients to a hospital for such tests rather than have them conducted in a less expensive environment solely because insurance will cover the cost of these tests if done in a hospital.

One criticism now being directed with increasing frequency at existing insurance policies is that coverages are limited primarily to the more traditional and more expensive methods of providing a particular type of treatment. It is argued that if health insurance coverage were modified to pay for the same treatments in a less expensive environment, the overall cost of health insurance would decrease. This position has merit and is supported by the review of existing literature by the Community Health Studies Program of MCV-VCU. This study estimated that the four alternatives to hospital care that it examined -- home health care, pre-admission testing, second medical opinion and ambulatory surgery -- have the potential of reducing hospitalization by 23%. More specifically, the estimated potential impact of each is as follows:

	% Utilization Reduced
Home health care	2%
Pre-admission testing	10%
Second surgical opinion	7%
Ambulatory surgery	4%
Total	23%[2]

While these numbers are impressive, it is important to keep in mind that these are optimal estimates under ideal controlled conditions which would probably not be realized in most situations. Utilization of these alternative services depends heavily upon the effectiveness of the hospital's patient care evaluation and discharge planning programs. Unless inpatient care is routinely and continuously evaluated, it is unlikely that hospital lengths of stay will be significantly reduced. Similarly, without effective discharge planning programs, it is unlikely that patients will be promptly discharged to other, more appropriate levels of care, such as home care.

In fact, the increased use of these alternatives would probably not reduce the overall cost of health care in Virginia for the foreseeable future because there is a substantial excess of hospital beds

[2] This optimal estimate is also overstated in that some of the savings are redundant. For example, admissions prevented through a second surgical opinion by definition cannot result in a utilization decrease due to early discharge to home health care or a shortened length of stay as a result of pre-admission testing.

in this jurisdiction.[3/] This excess precludes substantial reductions in expenses since hospitals have already incurred the cost for the existing beds and this cost must be paid irrespective of how many patients occupy them. Consequently, when a hospital operates at less than total capacity, the patients it does have pay a somewhat higher per bed rate in order to meet these fixed costs. Since this increased per diem is usually paid for by insurance, this cost is passed onto the insurance purchasing public. Clearly, the effective use of the four alternatives designed to reduce hospital utilization probably would not reduce the overall cost of the system or health insurance premiums. Instead, the mandating of such benefits would probably result in a somewhat higher cost, i. e., the fixed cost of the existing system plus the cost of insuring the ambulatory care benefits.

This does not mean that such programs are not worth pursuing. Instead, it means that their immediate benefit may not be a reduction in the overall cost of health care, but rather the possible reduction of pressure for additional future beds in this jurisdiction.

In summary, it is unrealistic and impractical to rely solely upon the insurance mechanism to rectify the inefficiencies of the

3/ In Virginia, the overall hospital bed occupancy rate has always been low, ranging between 75%-80%. In many hospitals it is even lower. Even with this obvious and well-known over-capacity, the number of available beds in this jurisdiction continues to increase every year. Hospital Statistics (1970-1975 editions) prepared from the American Hospital Association Annual Survey. In fact, recent projections indicate that by 1980 Virginia's general hospitals will have 2,632 more beds than needed. This is so even though the required need assumes an 85% occupancy rate. Interim Virginia Medical Facilities Plan, 1976, Virginia State Department of Health, Division of Health Planning and Resources Development, September, 1976. If reductions cannot be realized in an environment where everyone acknowledges existing and projected over-capacity, it is not likely that the mandating of certain benefits will yield a different result.

present system. More direct action is required. The health community must take action to reduce the number of hospital beds in operation before significant cost savings can be realized through reduced hospitalization.

3. Administrative and Related Implementation Problems:

Even when it has been determined that a particular coverage would be beneficial, careful consideration still should be given to the difficulties of implementing and paying for the service. The introduction of a new coverage on a widespread basis may create increased demand that may not presently be available. This increased demand may be satisfied by new entities not subject to the licensing and utilization controls presently applicable to the more traditional and established providers or current licensing and utilization controls may not be adequate to safeguard against abuse and waste.

Another consideration is the degree to which the services that would be covered are available to all citizens of the State. If such services are not widely available and are not likely to become so, a form of discrimination results in that all citizens would be required to pay for the coverage while only a portion of them would be able to take advantage of it.

Finally, and of even greater importance, is the ability and willingness of those responsible for administering and providing access to the covered services to do so in an efficient manner. This is particularly so with respect to the various forms of alternative care designed to reduce hospitalization. The success of this legislative program designed to provide low cost services would depend upon the willingness of physicians to utilize these services and the ability of hospitals to administer the program effectively. In the

utilization of home health care alternatives, a successful program is dependent upon other numerous considerations such as the natural tendency of hospitals to strive to keep their beds filled, the lack of willingness by physicians and hospitals to view home health care services as an appropriate substitute for the more traditional methods of delivering health care, and the degree to which potential malpractice suits will cause physicians and hospitals to emphasize more traditional approaches as a means of reducing their risk.

Also, it appears that the attitudes of the patients are crucial. Pre-admission testing or obtaining a second medical opinion may be viewed as an inconvenience to be avoided. In addition, there is considerable evidence that patients are not aware of the existence of insurance coverages for alternate types of health care when it is available. (See Page 20)

The foregoing sounds rather pessimistic. This is not its intent. Instead, it is designed to narrow the gap between expectations and performance a necessary ingredient in any objective evaluation. Frustration with the escalating cost of health care should not be used as an excuse for adopting "solutions" that either do not work or work only to add to the already prohibitive cost of health care.

PART II

Selected Alternatives Designed to Reduce Hospital Utilizations.

This section of the report will apply the considerations of cost, need and administrative feasibility to several insurance coverages of services designed to reduce the cost of health care by providing treatment in less costly environments.

1. Home Health Care:

Home health care is the provision of various types of services[4/] to sick or disabled persons in their residences or in a facility other than an acute care hospital. Generally, these services are provided through a public or private home health agency.

Many advocate that home health care is useful because (1) in certain circumstances the home setting may be more conducive to recovery of certain patients; and (2) it would permit the delivery of care in the home that is presently delivered in a more expensive institutional setting such as a hospital. According to the CHSP review of the published literature on the subject (see Appendix A), home health care will produce the least potential savings of the four alternatives under consideration in this report. Even so, these savings may be potentially large. The CHSP study estimates that approximately 2% of hospital utilization nationally could be reduced under optimal circumstances. Translated to Virginia, it appears that this could result in a savings of two million dollars to two and one half million dollars annually.

4/ These services can include: (1) medical care; (2) dental care; (3) nursing; (4) physical therapy; (5) speech therapy; (6) occupational therapy; (7) social works; (8) nutrition; (9) homemaker-home health aid; (10) transportation; (11) laboratory services; (12) medical equipment; and (13) medical supplies.

It should be noted, however, that the CHSP estimates are based on selected published studies that dealt only with those pilot or experimental programs that have demonstrated some success. The CHSP review stresses this bias.

The CHSP review also indicates that the successful programs were carefully controlled and may not yield similar results in an uncontrolled environment. It should be emphasized that in most instances the successful programs involved hospital-based home health care agencies where the hospital had an effective patient care evaluation system and a carefully monitored discharge program. The use of a hospital-based agency may provide the centralization and resources required for the maintenance of continuity of care and access to all necessary services. Whether similar success in reducing utilization could be realized in the absence of this kind of hospital-agency coordination is a subject of considerable doubt.

Insurance coverage for various types of home health care is presently available to some extent.[5/] In addition, both the Medicare and Medicaid programs provide for home health care benefits. The scope of coverages differs somewhat between that provided by Medicare and that provided by Medicaid.[6/] The data regarding the nature and

5/ One 1974 study found that in Wisconsin, among companies providing 88% of the health insurance in that state (some 44 companies), 25% covered home health benefits under individual hospitalization policies; 26% provided such coverage in group hospitalization policies; 82% under major medical coverages; and 70% provided the coverage under other policy forms.

6/ e. g., Medicare is primarily skilled-care oriented. Medicaid is somewhat broader in that it also covers non-medical support services such as house cleaning -- that cannot be done by the patient.

extent of home health care coverages available in Virginia is incomplete. The Bureau of Insurance has instituted a survey of all health insurance carriers licensed to do business in Virginia. This study has not been completed. Results will be forwarded to the legislature as part of a supplemental report when they are available.

Despite the lack of a completed study, most policy forms approved in Virginia which provide coverages for hospital confinement and physician care in a hospital do not provide for home health care. Some home health care coverage is provided in most major medical plans under large group insurance contracts or broader, more expensive, individual contracts.

In summary, fairly broad coverage for home health care exists for the elderly and for those qualifying for Medicaid. Coverage for the remainder of the population is sporadic and when it is available, varies greatly from policy to policy.[7/] Consequently, mandating such coverage would assure its availability to large segments of the population that do not presently have it.

At the same time, the availability of home health care services is fairly widespread in Virginia. Approximately 130 agencies have

7/ According to a 1973 survey of the Health Insurance Association of America, the vast majority of companies providing this coverage through their major medical contracts provide it separately as opposed to an "in lieu of" basis, i. e., services that would otherwise have been performed in a hospital. Approximately 60% of those providing such coverage did not have exclusions or limitations regarding a patient's diagnosis. The remainder had exclusions for alcoholism, mental illness, and pregnancy. Similarly, 60% did not require prior confinement in a hospital or extended care facility. The remainder did.

received certificates of compliance for the rather stringent standards established for Medicare and Medicaid payments. These are located in every county and city in Virginia. However, the services available vary greatly and it is possible that some citizens who live in remote areas will incur difficulty in availing themselves of some types of home health care services.

Even if availability of services is determined not to be an obstacle in mandating home health care coverages, merely mandating coverage without adequate regulatory controls could result in the imposition of an additional health insurance expense without conferring comparable benefits. For example, the key to using home health care effectively is the identification of those individuals and circumstances where such care is both beneficial and efficient. This, in turn, requires: (1) informing doctors and hospitals of the availability of such services; (2) the creation of appropriate administrative machinery and experienced personnel to institutionalize the identification process and to assure continuity of treatment and access to all necessary services; and (3) the appropriate independent regulatory machinery designed to assure quality service, prevent unnecessary utilization, and eliminate abuses such as these that have recently come to light under the Medicare and Medicaid home health care programs.

Although legislation mandating home health care coverage has been introduced in many states,[8] only five states have enacted such legislation. While not enough time has elapsed since the institution of these programs to ascertain how well they have worked in the states that have mandated covergage, a few general observations can be made. First, the rates charged to date for this coverage are relatively modest.[9] Whether they will remain at these levels cannot be predicted with any certainty. In addition, those responsible for implementing these programs, indicated that these programs have not resulted in any decrease in utilization to date or reduction

8/ Arizona - effective 1971; Connecticut - effective October 1, 1975; New York - effective April 1, 1976; Nevada - effective September 1, 1975; and Maryland - effective July, 1977. In each instance, the state moved cautiously in that such legislative action was preceded by pilot programs necessary to develop the requisite experience to administer such programs.

9/ The rates presently approved for the State of New York are illustrative:

A. Individual Policies or Hospital Insurance.

(1) No deductible, no coinsurance

	Annual Premium
Each Adult Age 18 - 49	$2.00
Each Adult Age 50 - 65	$4.00
All Children	$ .50

(2) $50 deductible, 75% coinsurance

	Annual Premium
Each Adult Age 18 - 49	$1.00
Each Adult Age 50 - 65	$2.00
All Children	$ .25

B. Individual Major Medical Insurance.
No additional premium to be approved, since major medical coverage already includes substantially the same coverage.

in hospital costs. In summary, the mandating of home health care has resulted in a modest increase rather than a decrease in the cost of health care as reflected in insurance premiums.

In each state mandating home health care coverage, the law permits coverage only for services provided by an agency licensed by a state or federal regulatory authority.[10/] In addition, attempts have been made to minimize unnecessary utilization, such as requiring a physician to prescribe the services or requiring that the covered services would have actually been rendered in a hospital were it not for the availability of home health care.[11/]

While it is impossible to estimate the effectiveness of these controls at this time, there is reason for concern. At present, the most stringent controls are those for Medicare and Medicaid programs. During the last year, the Medicare and Medicaid programs have been subject to extensive audits and study. As a result of these efforts, the House Ways and Means Subcommittee on Health of the

10/ Strict licensing laws have been established prior to mandating coverage in Arizona, Nevada, New York and Maryland. In Conecticut coverage extends only to those agencies that have qualified for Medicare-Medicaid benefits.

11/ New York law provides that home health care shall be defined in each insurance policy as continued care and treatment of a covered person who is under the care of a physician but only if (i) care is provided in a nursing home ...(ii) the covered person has been in a hospital for at least three days immediately preceeding admittance to the nursing home ...(iii) further hospitalization would otherwise be necessary. (See New York Senate Bill 7037)

U. S. Congress, began a series of hearings in September, 1976 regarding apparent widespread instances of home health care abuses under the federal programs. The findings and recommendations of the Committee will not be available until early next year.

The foregoing demonstrates that, in the absence of careful and extensive preparation, the mandating of coverage could result in additional expense and waste.

Because of these considerations and because the mandating of coverage will not produce savings until Virginia's hospital bed over-capacity is reduced, it is the recommendation of the Bureau of Insurance that coverage of home health care services should not be mandated at this time. Instead, it is recommended that a pilot program be instituted under appropriate controls. This pilot program would serve several purposes: (1) it would enable insurers and health care providers to experience firsthand how to manage home health care services effectively; (2) it would provide time and the environment necessary for doctors and hospital personnel to better appreciate the benefits and limitations of home health care; and (3) it would enable appropriate state regulatory authorities to determine the type of regulatory controls needed to assure the delivery of quality services in an efficient manner and to minimize the abuses that have occurred under the Medicare and Medicaid programs.

To this end, the Bureau of Insurance has approved policy forms for a Blue Cross/Blue Shield Pilot Home Health Care Program in Tidewater, Virginia. The Bureau will also work with the Department of Health regarding the development of appropriate regulatory controls that should be in place before any action is taken by the legislature regarding coverage. The Bureau of Insurance, the Department of Health and the legislature should continue to review the results of the Congressional hearings regarding home health care and the

experience of other states in order to develop appropriate safeguards with respect to the delivery of this service within Virginia.

2. Second Medical Opinion:

Efforts to reduce elective surgery and, thereby, hospital utilization have been of interest to those attempting to find ways to control health care costs for some time. In recent years, attempts have been made to realize these objectives by either requiring a second medical opinion prior to elective surgery or requiring that health insurance carriers offer coverage for second opinions. Usually, such consultations are rendered by medical specialists in the field under consideration. Under a mandatory program one of two results occur when the consultant concludes that surgery is unwarranted: (1) the original physician may be persuaded by the consultant to forgo surgery; or (2) a third surgeon may be called in to resolve the conflict. In those programs where consultation is optional, the patient decides whether to accept the findings of the consultant or to continue with surgery. It should be noted that there is some disagreement in the medical profession as to a standard by which "necessity" is to be measured. Some, for example, would include psychological factors in the termination. Other practitioners would not.

The potential for savings is large. Although estimates vary, it is generally conceded that 50% to 75 of hospital admissions for surgery are for elective surgery. It is also estimated that the imposition of a second medical opinion program could reduce hospital utilization from 8% to 10%. In Virginia, this would result in a reduction of 4,000 to 5,000 bed-patient days.

There are a number of potential disadvantages associated with second medical opinion programs: (1) required consultation with another doctor may undermine the patient's relationship with his attending physician, weakening the therapeutic effectiveness of his physician; (2) a second medical opinion costs money -- $50 to $75 per consultation if additional X-rays and diagnostic testing are needed; and (3) there is evidence that both patient and his attending physician may be reluctant to obtain a second opinion or be reluctant to accept the findings of the consultation.

Despite the existence of a number of studies that show that second medical opinions can reduce utilization, the existing information is extremely limited (See Appendix A). Pilot programs have been instituted in a number of jurisdictions[12/] but not enough time has elapsed to warrant definitive conclusions regarding results. Even so, it does appear that where second medical opinion coverage is instituted on a voluntary, as opposed to mandatory basis, few patients avail themselves of this opportunity -- because: (1) patients are not aware of the program; or (2) patients are reluctant to obtain a second opinion regarding treatment prescribed by their attending physician; or (3) there is some inconvenience associated with obtaining a second

12/ e. g., Blue Cross and Blue Shield of Greater New York established a voluntary experimental program covering 150,000 people on January 1, 1976; the New Hampshire - Vermont Blue Cross/Blue Shield Plan recently completed a 90 day pilot program. This was extended another 60 days until June 1, 1976; Pennsylvania Blue Shield instituted a pilot program on January 1, 1976; Michigan Blue Shield implemented a pilot program on September 1, 1976; Massachusetts Blue Shield instituted a pilot program with one of its major groups in June, 1976; Delaware Blue Shield has included second opinion coverage in the contract it has with the State effective July 1, 1976.

opinion -- particularly for those living in rural areas. For example, in New York (Albany and Western New York) only 214 people availed themselves of the benefit during the first year out of an estimated insured population of over 100,000 persons. Less than half of those who did request a second medical opinion actually obtained it.

In Virginia, there is virtually no coverage for a second opinion in basic health insurance coverage. For example, although Blue Shield contracts do provide consultation for a hospitalized patient where there is doubt regarding the advisability of surgical procedures, the basic Blue Shield contracts do not provide coverage for outpatient pre-surgical consultation. However, it does appear that while such coverage is not specifically alluded to under standard comprehensive major medical group plans, payments are often made for a second opinion under this coverage.[13/] More definitive estimates of available coverages will be available once the Bureau completes its health care coverages survey now underway.

Probably because of the problems associated with the implementation of a meaningful second medical opinion program, the skepticism, and in several instances, vehement opposition of the medical

13/ e. g., such outpatient pre-surgical consultations are covered under the Blue Cross/Blue Shield Major Medical Contracts, subject to the appropriate deductible and co-insurance.

profession[14] and the cost associated with such programs[15], only one state -- New York -- has enacted legislation mandating that insurance carriers provide and policyholders purchase coverage. Even here, the mandating of coverage is limited to policies that provide for inpatient surgical care. Nor does the legislation require a second opinion prior to elective surgery. Instead, the patient is permitted to seek consultation at his option. In a very real sense, this "option" is not a true option at all. Patients generally lack the knowledge that enables them to decide whether to seek a second opinion regarding an elective surgical procedure, or whether that second opinion should be sought from another physician in the same specialty, or from a physician in an entirely different field. Patient education programs in the field of surgery are needed.

Because of these considerations and because of Virginia's present excess of hospital beds, the Bureau cannot recommend the mandating of second medical opinion coverage at this time.

14/ e. g., The American College of Surgeons has not endorsed such programs. In Michigan, the State Medical Society vehemently opposed the Michigan program. The Medical Societies for New Hampshire and Vermont do not feel there is a need for such a program. At the same time it should be noted that the Massachusetts Medical Society is cooperating with the pilot program but will not adopt an official position until more experience has been developed. Somewhat similar positions have been taken by the Medical Societies in Pennsylvania and Delaware.

15/ e. g., The Florida Insurance Department refused to permit Blue Shield to provide such coverage in order to contain costs.

Instead, the Bureau recommends that the legislature await the outcome of the numerous pilot programs underway elsewhere and in particular, the experience under New York's statute which went into effect on August 25, 1976. The Bureau also recommends that Blue Cross and Blue Shield institute a pilot program in Virginia in order to obtain experience regarding how such a program would work in Virginia and to educate the medical community and patients regarding its usefulness.

3. Pre-Admission Testing:

Pre-admission testing (PAT) involves scheduling basic X-ray and laboratory work-ups on an outpatient basis prior to actual admission rather than during the first days of an inpatient stay. Current programs emphasize such testing prior to elective surgery, but tests could be conducted on an outpatient basis for any scheduled admission.

The advantage of pre-admission testing is its potential for reducing the length of hospitalization, with a resulting savings in hospitalization costs. Few studies documenting the actual amount of savings are available. However, the Blue Cross Association reports that testing in six Des Moines, Iowa hospitals cut patient stays and trimmed cost by $340,000.[16/] Other studies suggest that an average of 1½ inpatient days could be eliminated by pre-admission testing. If such testing were appropriate prior to half of all admissions, it would save roughly 10% of all inpatient days.[17/]

16/ EMPLOYEE BENEFIT PLAN REVIEW, August, 1976, Page 70.

17/ CHSP Study. (See Appendix A)

Certain practical problems may prevent realization of savings of this magnitude. If the patient fails to follow the physician's instructions prior to testing, the tests will not be valid and must be repeated following admission resulting in additional costs rather than savings. Also, pre-admission testing is an inconvenience to a patient who must travel some distance to the hospital, and is inappropriate for the patient whose condition prevents or limits travel. Physicians may limit their use of pre-admission testing: (1) as a matter of convenience; (2) for fear of a malpractice suit: or (3) because of a preference for having the patient under the control and supervision of a trained hospital staff.

Whether the patient receives PAT is, in actuality, a decision made by the attending physician and it is his responsibility to schedule PAT in lieu of an earlier admission. The physician must not only be aware of PAT, but must be confident that the test will still be valid upon admission.

Hospitals must also support such a plan for it to be successful. If overcrowding or over-utilization exists, it would be to the hospital's advantage to promote PAT. However, if there is an overcapacity in hospital beds, an increase in charges for use of inpatient facilities will be required to offset the decline in patient days.

On the basis of a recent informal telephone survey of hospitals in the Richmond Metropolitan area by a local life insurance company, pre-admission testing appears to be widely, if not universally, available. Insurance coverage for pre-admission testing appears widespread. More definitive data will be available when the Bureau's survey of existing coverage is completed.

Only two states are known to have enacted legislation mandating insurance coverage for pre-admission testing. A 1971 Arizona law requires each hospitalization insurance policy contain a provision that benefits be paid for the performance of any service in a hospital's o tpatient department if such service would have been covered if performed as an inpatient service.

In 1976, ew York enacted legislation requiring pre-admission testing to be covered if inpatient hospitalization is covered. The pre-admission tests must be ordered by a doctor as a planned preliminary before the patient can be admitted as an inpatient for surgery in the same hospital. The law also provides that benefits for such tests can be paid only if all of the following conditions are met: (1) the tests are necessary for and consistent with the diagnosis and treat ent of the condition for which surgery is to be performed; (2) reservat ons for a hospital bed and operating room have been made; (3) surgery takes place within seven days of the pre-surgical testing; and (4) the patient is physically present at the hospital for the tests.

The Bureau is not aware of any studies demonstrating the effectiveness of the Arizona law. Nor, is there any experience available regarding the ew York law since it will not become effective until January 1, 1977.

It is the conclusion of the Bureau that the mandating of coverage for PAT would be unnecessary because coverage appears to be widely available. Even if such coverage were not available, the mandating of such coverage would not reduce the costs of health care -- in view of Virginia's unused hospital bed capacity. Therefore, the Bureau of Insurance recommends that insurance coverage for PAT not be made mandatory.

4. Ambulatory Surgery:

Ambulatory surgery involves performing surgical procedures without admission to the hospital on an inpatient basis. This approach is not new; minor surgery traditionally has been performed in hospital outpatient departments (principally on an emergency basis) or in physicians' offices. Recently ambulatory surgical centers have been developed to serve the patient whose surgery cannot be performed in a doctor's office, but is not sufficiently major to require inpatient accommodations.

Procedures which are generally felt to be suited to in-and-out surgery are those which require anesthesia other than by means of local infiltration, and might include,among others, dilation & curretage, tonsillectomy and adenoidectomy, cystoscopy, vasectomy, myringotomy, oral surgery, hernia, cyst or tumor removal and various kinds of ear, nose, throat, and eye surgery, gynecological, urological, orthopedic, and plastic surgery procedures.

One of the main objectives of ambulatory surgery is the reduction of inpatient hospital days, with a resulting savings in health care costs. One measure of the savings which might be achieved is obtained by multiplying the percentage of surgical procedures which could be handled on an ambulatory basis by the percentage of inpatient days associated with surgical admissions. Estimates of the percentage of surgery which could be done without hospital confinement vary widely - from 10% to 50% - and roughly half of all inpatient stays include surgery. Based on these estimates, the potential savings could range from 5% to 25%. Another measure of the savings is obtained by multiplying the caseload of an operating ambulatory care

center by the estimated cost which would have resulted had the pat'e.ts een hospitalized for the same procedures. On this basis, in 9 5, the Minor Surgery Center of Wichita, Kansas achieved sav'ngs of $399,000 (2,119 patients); the Northwest Surgical Ltd. of Ar ington Heights, Illinois, savings of $482,000 (2,605 patients); and the Amb atory Surgical Facility of Hollywood, Florida, savings of $8 ,000 (2,400 patients).

er advantages cited for ambulatory surgery include psychological be ef'ts. The patients (especially children) avoid the trauma of an unf 'liar hospital environment; increased utilization of hospital operating room facilities for major surgery; and more efficient use of the surgeon's and anesthesiologist's time.

ng the disadvantages of ambulatory surgery is the possibility that competent medical assistance will not be available if post-operati e complications develop. In face of a continuing concern over ma practice suits, this may well be a deterrent to achieving the maximum potential savings. In addition, hospitals have certain fixed cos s which must be met, regardless of occupancy rates. In V'rg'nia there is no shortage of hospital beds nor is one projected. The sa ings from ambulatory surgery, therefore, may be offset by higher charges to the remaining inpatients. Also, ambulatory surg'cal centers will have additional start-up costs and operating expenses. Finally, the availability of ambulatory surgical facilities may lead to an increase in elective surgery, offsetting projected savings, and perhaps even resulting in an increase in total health care costs.

At the present time, only one ambulatory surgical center is known to exist in Virginia. However, most, if not all, hospitals permit ambulatory surgery for certain procedures, provided the surgical facilities are available.

Insurance coverage is virtually universal for ambulatory surgery performed in hospital outpatient departments. At the present time, all major carriers doing business in Virginia provide coverage for the use of ambulatory surgical facilities.

Arizona (1971), Minnesota (1976), Missouri (1975), and Oklahoma (1976) have enacted legislation requiring insurance coverage for ambulatory surgical facilities not directly associated with any hospital. The Missouri and Oklahoma statutes specifically define the requirements for recognition as an "ambulatory surgical center" as follows:

> "any public or private establishment with an organized staff of physicians; with permanent facilities that are equipped primarily for the purpose of performing surgical procedures; with continuous physician services and registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patients to stay overnight."

The Minnesota statute requires the facility to be reviewed and approved by the State Board of Health. The Arizona statute has been interpreted not to recognize doctors' offices, clinics, dispensaries, and first aid stations as freestanding surgical facilities.

Section 222(b) of Public Law 92-603, (the Social Security Amendments of 1972) authorizes the Federal Department of Health Education and Welfare (HEW) to conduct research involving ambulatory care facilities, particularly those providing surgical services, to determine whether those services provided by ambulatory facilities results in economies and more effective utilization. Part of the research plan developed by HEW calls for intensive analyses of ambulatory surgery facilities at several sites around the country with prior attention given to the Phoenix Surgicenter[18/] to determine the following:

What effects and changes have occurred since the establishment of the Surgicenter in the health care delivery system in Phoenix and in the patterns of providing health care in the Surgicenter's service area in terms of : (a) accessibility, availability, and utilization of the components of health care; (b) the demand for surgery of a particular type in the service area; (c) revenues earned and fees charged by other components of the service area's health care delivery system; and (d) financial or revenue problems, if any, encountered by those components since the Surgicenter began operation;

2. How the costs of surgery provided in the Phoenix Surgicenter compare with the costs of comparable surgery performed on comparable patients in other surgical settings; and

18/ The Phoenix Surgicenter was established in 1969 through the pioneering efforts of Doctors John L. Ford and Wallace A. Reed. It is given the credit for paving the way for the development of many of the independent ambulatory surgical care centers.

3. How the quality of the total surgical process, including pre and post-operative activities, in the Surgicenter compares with that in other surgical settings.

The evaluation project, undertaken by the Orkland Corporation, was begun on July 1, 1974 and is to terminate on December 31, 1976. In the evaluation, data are to be collected from other freestanding ambulatory surgical centers and hospital-affiliated ambulatory surgical facilities as well as at hospitals and physicians' offices.

It is the recommendation of the Bureau of Insurance that coverage for freestanding ambulatory surgery should not be mandated at this time. The result of the HEW study will not be released until sometime next year. This study should provide better insights than are currently available regarding need, patient receptiveness, cost and other problems regarding such centers. In addition, there appears to be only one such facility in Virginia. Mandating coverage today would result in unfair discrimination since the vast majority of Virginians would be required to purchase coverage they could not use. Mandating coverage for surgery in existing hospitals on an outpatient basis is not necessary because such coverage appears to be widely available now. Consequently, legislative action would have minimal impact.

Conclusions and Summary of the Recommendations Made by the Bureau of Insurance to the Legislature Regarding Mandatory Coverages Designed to Reduce Hospitalization and Thus, Health Care Costs.

In examining the desirability of mandating insurance coverages for home health care, or a second medical opinion prior to surgery, or pre-admission testing, or ambulatory surgery, it became apparent that the major consideration was an attempt to reduce the overall cost of health care. The most persuasive argument in favor or requiring these coverages is that existing health insurance policies cover only the more expensive methods of providing health care. Since individuals tend to request, and physicians tend to direct patients to those services that are paid for through the insurance mechanism, a mis-direction of resources is now the result.

The four alternative health care services that are treated in this report are all aimed at reducing hospital use. However, in Virginia, if universal insurance coverage for these four services were in effect, it is highly unlikely that a reduction in overall health care costs would result. This is so because hospitals have incurred fixed capital debt to pay for existing hospital beds and this cost must be paid irrespective of how many patients use the beds. When a hospital operates at less than total capacity, the patients it does have pay a higher per bed rate. In Virginia there is an over-supply of hospital beds. Until this over-supply is eliminated, reducing hospital use cannot result in reduced health care costs. For this reason the Bureau of Insurance recommends that mandatory coverages for the health care services treated in this report not be required by the legislature at this time.

There are other reasons which support the recommendation of the Bureau. Although the cost of the insurance for these alternati e services has been non-existent or modest in the states where coverage has been mandated, and there is a need for these services, altho gh the extent of the need is debatable, these two factors are outweighed by a number of disadvantages such as, lack of patient-physician receptivity to use of the services, lack of regulatory and administrative quality controls and the potential discrimination due to lack of availability of these services. Also, insurance coverage for pre-admission testing and ambulatory surgery is already widespread and readily available in Virginia. Consequently, legislative action mandating coverage in either of these two areas would have little impact.

In the cases of home health care and second medical opinion prior to surgery, insurance coverage is not now universal in Virginia. Currently, coverage for a second medical opinion seems to be rare or non-existent in the Commonwealth and, while payment for home health care insurance coverage is available to Medicare and Medicaid recipients, coverage for the rest of the population for this serv ce is sporadic. In these two instances, while legislation would assure broad coverage, the Bureau of Insurance recommends the implementati - of Pilot Programs designed to gage more accurately the probable effects of mandatory coverage in Virginia and to develop adequa e services, regulatory controls and patient-physician receptivity pri r to requiring Virginia's citizens to purchase such coverage. If these

quality and administrative problems can be overcome and the cost of such coverage is within acceptable limits, the mandating of such coverage would hopefully have the beneficial impact of reducing the pressures for additional hospital beds in the Commonwealth.

PROGRAM ALTERNATIVES TO HOSPITAL INPATIENT CARE

A Report to the Commissioner
of Insurance and the
Ambulatory Care Task Force
of the
State Corporation Commission
Bureau of Insurance
on a
Study Conducted Through
The Community Health Studies
Program of the Department
of Hospital and Health
Administration, Medical
College of Virginia - Virginia
Commonwealth University

May, 1976

Robin E. MacStravic, Ph. D. - Project Director

Study Team

Richard M. Brechen
Gloria R. Cameron
Raymond T. Curtis
Leonard W. Daugherty
Steven C. Hoelscher
Mark F. Montgomery
Mark Parrington

Program Alternatives to Hospital Inpatient Care

Each of four programs designed to reduce hospital inpatient utilization have been examined. Literature on each has been analyzed to determine its potential impact on inpatient utilization, the extent to which such programs have been implemented, and barriers to optimal performance. Each program is analyzed briefly, and the total potential impact is discussed. Additional descriptions and analysis of the four programs are appended to the basic report.

Summary

HOME HEALTH CARE

Home health services would be appropriate for roughly 2% of all hospital patient days. In addition, home health services might substitute for nursing home care. Costs of home health services should average roughly $5.00 per day, though this assumes only two or three visits per week. In addition to saving up o 2% of all hospital utilization, home health services would probably be appropriate for vast numbers of people not receiving any ins i'u 'onal care.

Indications are that half the people appropriate for home hea h services are under 65. Yet current programs and insurance coverage tend to be limited to the elderly population. The es imated savings to the community of an effective home health care al erna 'ive to hospital care are on the order of $75 - 100 million per year nationally. The savings in Virginia would translate to approxima e y $2 - 2.5 million. Additional savings could occur where home care could substitute for nursing home care. Additional costs would occur if non-institutional people used home care services offered.

Problems associated with successful implementation of home health services as alternatives to further hospitalization include:

- Administrative difficulty in arranging discharge referral to home health agency
- Necessity for ensuring that home enviroment is appropriate for discharge

- Difficulty in getting physicians to make follow-up visits to home

- Resistance to having sick people at home

Should PSRO and utilizations review programs threaten payment for hospital care when a less expensive alternative would be appropriate, the pressure to overcome these problems could become intense.

PRE-ADMISSION TESTING (PAT)

The idea of pre-admission testing is simply to have basic laboratory and X-ray work-ups done on scheduled admissions prior to actual admission rather than during the first days of inpatient stay. Current programs emphasize such testing prior to elective surgery, but tests could be conducted on an outpatient rather than inpatient basis on any scheduled admission where the patient could come to the hospital prior to admission.

The expected impact of an effective pre-admission testing program is potentially enormous. Studies suggest that patients who go through testing prior to admission tend to have lenghts of stay shorter by roughly 1.5 days than the average. Even recognizing that these are likely to be the less sick patients, this impact is substantial. If even half of all admissions could go through PAT prior to admission, and thereby reduce their stay by 1 1/2 days, it would save roughly 10% of all patient days annually.

Some of the problems associated with implementing pre-admission testing programs include:

- Necessity for repeating tests if admission is delayed
- Difficulty in arranging transport to test and return, or resistance to additional travel by patients
- Confusion over whether such tests are covered by health insurance
- Lack of incentives for hospital to reduce inpatient stays

Pre-admission testing programs have been implemented by large numbers of insurance companies, though the use of such programs is substantially less than optimal.

SECOND SURGICAL OPINION

The idea of a second surgical opinion program is that if consultation by a surgical specialist is used, very often it is found that surgery is unnecessary - the costs of such program lie in the cost of consultation plus the cost of whatever additional tests are ordered. Savings lie in the admission and surgical procedures avoided.

On the basis of a recent study, as many as 25% of procedures might be avoided if a second surgical opinion were required on all elective surgery. Given that roughly half of all hospital admission are surgical, and three-fourths of these are elective, almost 10% of all hospital admissions might be eliminated by required consultation.

Only a few examples exist of such a program, though an extensive experiment is under way in New York.

The resistance to such a program by medical staff may make implementation difficult. Costs are increased when a third opinion is needed to resolve conflicts. Presumably, however, the quality of

care is improved, and where truly unnecessary surgery is avoided, the patient also benefits.

AMBULATORY SURGERY

Ambulatory Surgery refers to the performance of surgery without inpatient admission. Patients receive testing prior to surgery on a PAT basis, have their surgery and are discharged the same day without being admitted to an inpatient bed. This has been heralded as offering psychological advantages to the patient as well as fiscal advantages to the community.

On the basis of studies, from one-tenth to one-half of all surgery could be performed on an outpatient basis. If as many as four million procedures out of the 16 million performed annually could be done on an outpatient basis, each instance would involve a savings of roughly two to three days inpatient stay. Thus, as many as 8-12 million inpatient days might be saved.

Problems associated with ambulatory surgery include:

- Difficulty of predicting which patients are appropriate for surgery on an ambulatory basis.
- Scheduling problems where inpatients naturally get preference.
- Difficulties in arranging transportation for such patients.

In general, all forms of these programs have demonstrated promise of savings by reducing hospitalization; either shortening the length of stay (Home Health Care and Pre-Admission Testing) or eliminating an admission entirely (Second Surgical Opinion and Ambulatory Surgery).

It would be easy to overestimate the potential savings however. First, there is the question of whether the potential will ever be achieved in practice. Studies suggest that some resistance to those programs is likely, and optimal performance rarely achieved.

The total effect of all four programs, if successfully and optimally implemented might be expected to be as high as a 23% reduction in hospital inpatient utilization, achieved as follows:

Home Health Care	2%
Pre-Admission Testing	10%
Second Surgical Opinion	7%
Ambulatory Surgery	4%
TOTAL	23%

This expectation is slightly overstated, however, in that some of the savings are redundant. That is, admissions prevented through second surgical opinions or ambulatory surgery cannot contribute to savings from earlier discharge to home care or shortened length of stay from pre-admission testing. Moreover, some of the inpatient days saved through ambulatory surgery might also have been eliminated via second opinions. On the other hand, studies have indicated that as many as 8% more hospital utilization could be eliminated via effective discharge planning and management. In addition, Health Maintenance Organizations such as Kaiser on the West Coast have demonstrated that Ambulatory Care may substitute for medical admissions as well as surgical. One recent study estimated that as much as one-third of all hospital utilization might be eliminated if effective alternatives were used. [1]

Aside from the question of potential savings, the results achieved in practice suggest lesser expectations. Pressures from malpractice suits may push physicians into doing more things in the hospital as a means of reducing their own risks. Pre-admission testing is an inconvenience to the patient and frequently isn't understood as an option by consumers. In general, it can be said that the cost-benefit of additional hospital days is almost invariably on the benefit side to patient, physician and hospital.

Since the patient doesn't pay the costs directly for additional days, any perceived benefit comes at no apparent cost; moreover, the physician most directly controls the fact of admission and lengths of stay. The physician again incurs no cost, indeed receives added income for more admissions and longer stays. If physicians see benefit to the patient, it also appears to come at no direct cost. The hospital needs patients to justify its programs and provide revenue. Only the community, of insurance policyholders and taxpayers, pays one cost. While it may consider the cost-benefit of questionable admissions and added lengths of stay to be heavily on the cost side, it does not enter into the specific decisions regarding any admission or length of stay. Unless the incentives can be adjusted to make the overall cost-benefit relationship of each admission and discharge decision felt by those who decide, it is unlikely that the suggested savings in hospital utilization from alternatives to inpatient care will be achieved.

Complicating this situation is the fact that while we might save hospital utilization, we won't save as much money as we expect. We already have the hospital facilities, equipment and personnel to deliver inpatient care at its current utilization rate. If we were able to cut back utilization by 10, 15 or even 25%, we wouldn't cut our expenditures by anywhere near that much. Given our existing resources, the unused hospital beds would still cost from $50-100 per day standing empty. The additional facilities required for ambulatory surgery would cost money. Moreover, the alternatives themselves cost money - home health care costs roughly $15 per visit. Ambulatory surgery still requires surgeons' fees as well as operative costs for the facility, laboratory and X-ray expenses as inpatient testing, second surgical opinion generates consulting fees as well as additional tests.

The literature suggest that there is substantial potential for reducing hospital inpatient utilization by implementing any of the four programs discussed. Of all the programs analyzed, home health care appears to have the least potential. On the other hand, an effective discharge planning program which would be required to implement a home care alternative should produce additional savings from earlier discharges to nursing homes and to the patient's family. All four programs could be moved forward through changes in the insurance laws requiring that appropriate benefits be included in all health insurance written in Virginia. On the other hand, such changes

by themselves are unlikely to achieve the maximum potential of any of the programs. The alternatives must be developed and accepted by those whose decisions now determine the extent of hospital utilization - the physician, the hospital and the patient.

Reference

1. Health Research Group - The $8 Billion Hospital Bed Overrun. Washington, D. C. 1975

HOME HEALTH CARE

The American Public Health Association defines "home care" as...

> ...that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.[1]

The concept of home care also carries the support of the American Hospital Association and the American Medical Association.[2]

A comprehensive home health care program should include, but not necessarily limited to, the following services: (1) medical care; (2) dental care; (3) nursing; (4) physical therapy; (5) speech therapy; (6) occupational therapy; (7) social work; (8) nutrition; (9) homemaker-home health aid; (10) transportation; (11) laboratory services; (12) medical equipment; (13) medical supplies.[3] The extent of care needed by the patient in the home traverses three levels: basic, intermediate and intensive.[4] The various services can be matched to meet the extent of care necessary for the individual patient. The basic and intermediate levels of need of the patient require the services of visiting nurses, therapists, social workers and home health aides and these have traditionally, though sporadically, been provided by voluntary and public health sponsored agencies. The intensive health care needs of the patient require services by medical, nursing and allied health personnel and, because of the scope and quality of the services required, demands the involvement of the hospital.

To determine the potential impact of home health services in reducing inpatient hospital utilization, the available literature was

searched to identify the numbers of people who could be discharged earlier to a home health care program. Studies[5] which were analyzed indicate that roughly 10% of all hospital utilization could be eliminated via more effective discharge planning and management of extended hospital stays, 5.5% should be transferred to nursing homes, 2.5% sent home without requiring health services, and 2% referred for home health services. Thus, of the 25 million inpatient days utilized in 1975,[6] roughly 0.5 million might have been eliminated through use of home care alternatives.

A detailed review of the literature resulted in the selection of five home care programs for further analysis. While it can be argued that this analysis does not address itself to other than successful home care programs, it must be noted that the literature does not appear to mention other than successful home care programs. It could be safely assumed that unsuccessful attempts at implementation and maintenance of home care programs have occurred and will continue to occur in the future. However, one does not anticipate broad publications of such failures. Problems which lead to unseccessful experiences will be discussed in detail later.

The home care programs to be discussed include: the Mount Sinai Hospital Home Care Program (Milwaukee, Wisconsin)[7]; the Nassau County Department of Health Home Care Program (Nassau County, New York);[8] the home care program developed by a teaching hospital in Cali, Columbia (Study made possible through a grant by Tulane University);[9] the home care program of the Kaiser Foundation

Hospitals (Portland, Oregon);[10] the home care program of the Los Angeles County-University of California Hospitals (Los Angeles, California).[11]

A compilation of the age data from all five studies indicates that 49% of all patients involved in these home care programs were under the age of 65. Current provisions in Medicare legislation are designed to provide home care coverage for those over age 65. While Medicare expenditures for home care amounted to less than 1% of all Medicare expenditures,[12] it is felt that such meager response is not due to the viability of home health care programs but rather to restrictive criteria as evidenced in Title XVIII legislation and the fact that services offered by existing programs at that point in time would not have corresponded ideally with the medical needs of that particular patient population.[13] The development of home care programs which could provide services corresponding more ideally to patient needs is further thwarted, as is the case with many small businesses, by increasing amounts of bureaucratic red tape and administrative demands.

A study of the medical classifications of the patients involved in these home health programs and an analysis of that data indicates that patients with a variety of diagnoses can be referred for home health care. While orthopedic, neurological, cardiac and oncological conditions predominate, a number of the diagnosis, including those which involve surgery, have also been referred successfully.[14]

Maintenance of continuity of care and access to all necessary

services (e.g., physical therapy, X-ray, social service, dietary) require coordination and planning which does not exist generally outside the hospital setting. The team effort needed for an effective home care program must be organized and supported by the providers. A home health department in the hospital or some form of centralized control for coordination is essential and may be difficult to initiate. The degree and form of physician involvement will vary with diagnosis; visits to hospital clinics and use of services will require administrative coordination to optimize cost savings and quality medical care.

The extent of services provided in the home or on an outpatient basis may complicate payment, cost analysis, and payment mechanisms. It must be determined which mechanism will properly reimburse the provider and equitably charge the patient. The optimal combination of the two must be correctly determined.[30, 31]

Utilization review is an integral element in controlling costs of home care programs. It is more difficult to monitor patient management in a situation removed from the hospital. There is a tendency to leave patients on home care too long and mechanisms for timely discharge must be present. Standard discharge criteria must be determined and an organized method of utilization review developed. This will be a difficult and time-consuming process.

The success of a home care program is ultimately dependent upon the attitudes of health care providers and patients and their families. Social, cultural and medical considerations encompass

difficulties encountered in changing patterns of practice, personal habits, and roles. The willingness of the patient to accept home care and the commitment and capability of the family to support it is a function of preconceptions of "correct" and effective health care in terms of facilities and qualified personnel. American lifestyle often does not accomodate caring for the sick in the home. Factors affecting acceptability of home health programs include economic, social, and ethnic backgrounds. Flexibility of these attitudes and the impact of these factors on utilization is unknown. Physican refusal to use home health programs is a barrier between the patient and the service. The extent of change in physician attitudes in the future is a function of payment mechanisms, utilization review and successful medical outcome and administration.

HOME HEALTH REFERENCES

1. "Home Health Services: A National Need: American Public Health Association Position Paper" American Journal of Public Health 64:2 Feb 1974 pp. 179-183

2. Richter, L. & Sommerman, A. "Home Health Services and Hospitals" Hospitals, J.A.H.A. 48 May 16, 1974 pp. 113-116.

3. Reference 1.

4. Rawlinsin, H. "Planning Home Care Services: Hospital, J.A.H.A. 49 June 16, 1975 pp. 66-71

5. Zimmer, Jr. "Length of Stay and Hospital Bed Misutilization" Medical Care 12:5 May, 1974 pp 453-462 found 9.1% excessive utilization. Gertman, P 1 Bucher, B "Inappropriate Hospital-Bed Days and their Relationship to Length of Stay Parameters" mimeographed paper presented to the 99th Annual meeting of the American Health Association, Minneapolis, Minn. Oct. 11, 1971 reported 11.9%

6. "Hospital Occupancy Statistics" Hospitals, J.A.H.A. 50 Feb. 16, 1976 pp. 31-32.

7. Stone, J. et al. "The Effectiveness of Home Care for General Hospital Patients" JAMA 205 July 15, 1968 p. 96

8. Wartski and Green, "Home Care Program Evaluation," Medical Care 11(1973):

9. Echeverri et al. "Postoperative Care: In Hospital or at Home," International Journal of Health Serivces 2(1972): 102.

10. Arnold V. Hurtado et al. "The Utilization and Cost of Home Care and Extended Care Facility Services in a Comprehensive, Prepaid Group Practice Program," Medical Care 10(January-February 1972): 11.

11. A Elconin, R. Egeberg, and O. Dunn, "On Organized Hospital Based Home Care Program," American Journal of Public Health 54(July 1964): 1112.

12. Reference 1.

13. McGuire, H. "Better Continuity Needed" Hospitals, J.A.H.A. 50 April 1, 1976 p. 89

14. Reference 9.

PRE-ADMISSION TESTING(PAT)

Pre-Admission testing involves scheduling diagnositc laboratory and X-ray work-ups for elective admissions on an outpatient basis one to three days prior to actual admission. Scheduling is easiest for purely elective surgery, but has been used for any kind of admission which is not of an emergency nature. Estimates are that from 80-90% of all hospital admissions are scheduled rather than emergency and theoretically could incorporate pre-admission testing.

In general, the expected impact of pre-admission testing lies in its eliminating one or two days from the beginning of a typical inpatient say. Routinely, the first day of a hospital stay would be eliminated if all necessary tests had been performed prior to admission. For complicated cases, two or even three days might be eliminated. Studies suggest that from 1.4 to 2.0 days are saved from each stay by PAT compared to stays of patients who had all tests done following admission.

Since pre-admission testing requires travel of the patient to the hospital and back for tests, then repetition of such travel for actual admission, it is of some inconvenience to the patient. For patients living great distances from the hospital, or whose condition contraindicates such travel, pre-admission testing would not be appropriate. If only 50% of all admissions could have tests done on an outpatient basis, with an average savings of 1.5 days from typical length of stay, this would reduce inpatient utilization by an average

of 0.75 days per admission. With an average length of stay of 7.5 days, this would mean a 10% reduction in total hospital utilization.

Experience of PAT programs in practice suggests that only limited success has been achieved thus far. Frequently, it is found that patients and physicians are unaware of the pre-admission testing option where is is covered by insurance. Moreover, where it involves no benefit direct to the patient or physician, there is little incentive for its use. Where hospitals have relatively low occupancy, there is likely to be little pressure exerted to implement such a program. If incentives can be devised whereby hospitals and especially physicians benefit from use of pre-admission testing, greater success may be achieved.

REFERENCES

1. Bickers, C. "How to Enaugurate Pre-Admission Testing" Hospital Financial Management Dec. 1969 pp. 25-26.

2. Busbaum, R. "Pre-Admission Testing" Hospitals, J.A.H.A. Dec. 16, 1970 P. 14.

3. Lavin, J. "Pre-Admission Testing: Shortcut for MDS" Medical Economics Nov. 14, 1966 p. 153.

4. Mebs, Jr. et al. "Pre-Admission Testing" Hospitals, J.A.H.A. Jan. 16, 1971 pp. 48-51.

5. Shu, C. "Pre-Admission Testing" Hospitals, J.A.H.A. Sept. 16, 1970 p. 16.

6. Baum, R. et al "Reduction in Initial Diagnostic Test Turnaround Time and In Length of Stay Through Prescheduled Early Testing" Collection of Case Studies in Improvements in Productivity. National Cooperative Services Center for Hospital Management Engineering Richmond, Va. April 1975.

SECOND SURGICAL OPINION

Recently attempts have been made to reduce what is considered to be unnecessary surgery by requiring a second consulting opinion prior to elective surgical admissions. Typically such consultation is rendered by a specialist in one field and where the consultant concludes surgery is unwarranted, one of two results occurs. The original physician may be persuaded by the consultant to forego surgery, or a third surgeon maybe called in to resolve the conflict.

The second opinion entails some costs, obviously. The consultant not only adds his fees to the cost of care, but may request additional or up-dated tests on which to base his opinion. Where this program has been implemented, however, the reduction in surgery has been found to cover the costs of consultation.

Since half of all hospital admissions are surgical, and at least 75% of these are elective, the potential for savings is great. One study[1] found that 353 of 1356 or 26% of the scheduled surgical admission were eliminated following a second opinion. Other studies suggest that 20% of all surgery could be eliminated via a second opinion.[2] The overall impact of eliminating such surgery would be a reduction of from 8 to 10% of all inpatient utilization: 20-25 million patient days nationally, or 4-500,000 in Virginia.

There has been relatively little experience with second opinion programs compared to home care or pre-admission testing. A number of Blue Cross plans recently inaugurated programs offering

the option of obtaining and either following or ignoring a consulting opinion prior to surgery.[3] Pending the findings of such programs, it is difficult to estimate the likelihood of reducing hospital inpatient utilization via this approach. Some surgery may merely have been delayed, or patients may substitute medical inpatient care for surgical. The common feeling is that there is excessive surgery in this country and that such programs may reduce it. A counter to this feeling may be interpreted from one study which found that physicians and their wives (or husbands) experience even more surgery than the average person[4].

1. "McCarthy, E. "Effects of Screening by Consultants or Recommended Elective Surgical Procedures" New England Journal of Medicine Dec. 19, 1974 pp. 1331-1335.

2. Williams, L. How to Avoid Unnecessary Surgery Case Publishing Co. Los Angeles, 1971.

3. "Blue Cross, Others Plan Second-Opinion Options" Richmond Times-Dispatch.

4. Bunker, J. & Brown, B. "The Physician-Patient as an Informed Consumer of Surgical Services" New England Journal of Medicine 290:19, pp. 1051-1055 1974.

AMBUALTORY SURGERY

Ambulatory Surgery entails performance of certain surgical procedures without housing the patient in the hospital overnight. Typically a patient will have routine tests and consultation prior to scheduled surgery. On the day of surgery, the patient will present himself to an ambulatory surgical center or unit, be prepepped, undergo the operation, go through recovery procedures, be monitored for some time and permitted to go home, all within a normal working day.

Such procedures are most often done on relatively healthy people, where surgery does not involved major intervention in the lung and abdominal cavities. Where only local anesthesia is used, surgery can often be done on an ambulatory basis, though general anesthesia doesn't rule it out. Since such surgery is most appropriately done in the morning it is subject to fluctuation of operating room scheduling for inpatients.

The potential impact on hospital inpatient utilization may be inferred from published studies. One author has suggested that from 1/3 to 1/2 [1] of all surgery now performed could be done on an outpatient basis. Other studies in individual hospitals have concluded that at least 10-20% of all surgical procedures [2] could be done on an ambulatory basis. With 16 million surgical admission annually in this country, [3] the conversion of as many as 25% or 4 million to ambulatory surgery could reduce total utilization by 8-12 million patient days. This assumes that most such procedures now done

on an inpatient basis involve two or three day stays rather than the six days average of surgery generally.

In general, the literature has been very positive in describing the potential for ambulatory surgery. In addition to cost savings, patients (especially children) avoid the typically impersonal and unfamiliar conflicts of the hospital and lose less time away from work and family. Hospitals can increase utilization of operating room facilities. There is some risk, of course, that procedures heretofore performed in the physicians' offices might be switched to ambulatory surgical facilities. The overall demand for surgery might conceivably increase if it were so convenient and inexpensive. Some concern has been expressed over whether a free-standing surgical center can provide the safety and back-up for emergencies as are available in the hospital setting.

In general, the ambulatory alternative to inpatient surgery offers promise of reduction in inpatient utilization, in costs of care, and even increases in efficiency for (Existing) resources. It has been successfully implemented in many areas, especially where full insurance coverage is available. The total savings in inpatient utilization may be as high as 8 to 16 million inpatient days or up to 7.5% of all hospital utilization.

REFERENCES

1. Beaton-(Mamale), M. "The Case for Ambulatory Surgery" Dimension in Health Services Jan 1975 pp. 42-44.

2. Cliborne T. A Study of the Feasibility of (Limitating) an In-Out Surgical Unit at Memorial Hospital of Martinsville and Henry County unpublished (Master's) Thesis Medical College of Virginia Virginia Commonwealth University May 1974.

3. "Calendar Year Statistics 1974-1975" Hospitals, J.A.H.A. April 16, 1976 p. 48.

4. Hawthorne, D. "Hospital - Based Unit Improves Utilization" Hospitals, J.A.H.A. Oct. 1, 1975 pp. 62-65.

5. Knapp, M. et al. "Minor Surgery Center" The Journal of the Kansas Medical Society Dec. 1973 pp. 446-449.

6. Kohlman, H. "Hospital is Proper Focal Point for Short-Stay Surgery" Hospital Financial Management June, 1974 pp. 22-24.

7. O'Donovan, Thomas R. "Future Trends in Ambulatory Short-Stay Surgery" Dimensions Health Service Aug. 1974 pp. 40-41.

BIBLIOGRAPHY

1. American Public Health Association. "Home Health Services: A National Need: American Public Health Association Position Paper," American Journal of Public Health 64(February 1974): 179-183.

2. Baker, T.D. "Rising Cost of Health Care and Underutilization of Visiting Nurse Services in Baltimore," Maryland State Medical Journal 21(March 1974): 48-52.

3. Berg, R.L., Browning, F.E., Hill, J.G., and Wenkert, W. "Assessing The Health Care Needs of The Aged," Health Services Research 5(Spring 1970): 36-59.

4. Burwell, Lawrence B. "Hospital Bed Needs: A Projection Technique," State of North Carolina, Department of Human Resources, Raleigh, North Carolina (Not Dated) (Xeroxed).

5. Buxbaum, Richard J. "Blue Cross Provision of Coordinated Home Care Programs," Inquiry 4(October 1967): 69-82.

6. Commission on Professional and Hospital Activities. Length of Stay in PAS Hospitals, United States, 1973. Ann Arbor: Commission on Professional and Hospital Activities, 1974.

7. Echeverri, O., Manzano, C., Gomez, A., Quintero, M., and Cobo,A. "Postoperative Care: In Hospital or at Home? A Feasibility Study," International Journal of Health Services 2(February 1972): 101-111.

8. Elconin, A., Egeberg, R., Dunn, O. "An Organized Hospital Based Home Care Program," American Journal of Public Health 54(July 1964): 1106-1117.

9. Gee, David A. "Cost Factors in a Hospital-Based Home Care Program," Inquiry 4(October 1967): 61-68.

10. Greenlick, Merwyn R., Burke, Donald W., and Hurtado, Arnold V. "The Development of A Home Health Program Within A Comprehensive Prepaid Group Practice Plan," Inquiry 4(October 1967): 31-40.

11. Griffith, John R. "McPherson Community Health Center Home Care Program," Inquiry 4(October 1967): 5-30.

12. Harmon, E. L. "Third Party Payment Increases Utilization of Home Care Services," Hospitals 42(September 1, 1968): 68.

13. "Hospital Occupancy Statistics," Hospitals 50(February 16, 1976): 31-32.

14. Hurtado, Arnold V., Greenlick, Merwyn R., McCabe, Marilyn, and Saward, Ernest W., "The Utilization and Cost of Home Care and Extended Care Facility Services In a Comprehensive Pre-Paid Group Practice Program," Medical Care 10(January-February 1972): 8-16.

15. Hurtado, Arnold V., Greenlick, Merwyn R., and Saward, Ernest W. "The Organization and Utilization of Home-Care and Extended-Care Facility Services in a Prepaid Comprehensive Group Practice Plan," Medical Care 7(January-February 1969): 30-40.

16. McDonald, Michael P. "Blue Shield Coverage of Home and Hospital Calls," Inquiry 2(November 1965): 16-17.

17. McGuire, Helen D. "Better Continuity Needed," Hospitals 50(April 1, 1976): 16-17.

18. Mather, William G. and Hobaugh, Robert J. "Physician and Patient Attitudes Toward A Hospital Home Care Program," Inquiry 4(October 1967): 47-54.

19. Massachusetts Department of Public Health. "Clients of Home Health Agencies," The New England Journal of Medicine 293(December 11, 1975): 1261.

20. Messier, E.A. "Reimbursement For Home Health Agencies," New York HFMA Newscast (September 1971): 8-10.

21. Rawlinson, H.L. "Planning Home Care Services," Hospitals 49(June 16, 1975): 66-71.

22. Richter, L. and Gonnerman, A. "Home Health Services and Hospitals," Hospitals 48(May 16, 1974): 113-116.

23. Ryder, Claire F. and Stitt, Pauline G. "Physician Involvement In Home Care," Inquiry 4(October 1967): 41-46.

24. Schutchfield, F. Douglas. and Freeborn, Donald K. "Estimation of Need, Utilization, and Costs of Personal Care Homes and Home Health Services," HMSHA Health Reports 86(April 1971): 372-376.

25. Starkweather, David, Dr. P.H. Visiting Professor, Department of Hospital and Health Administration, Medical College of Virginia, Virginia Commonwealth University, Richmond, Virginia. Conversation 6 April 1976.

26. Stiefel, Joseph B. "Use and Costs of AHS Coordinated Home Care Programs," Inquiry 4(October 1967): 61-68.

27. Stone, Joseph R., Patterson, Elizabeth, and Felson, Leon. "The Effectiveness of Home Care For General Hospital Patients," Journal of the American Medical Association 205(July 15, 1968): 95-98.

28. Thom, A. and Stafford, K. "Time For Evaluation of Home Care Services," Hospitals 46(October 1, 1972): 57-60.

29. Trager, B. "Home Health Services and Health Insurance," Medical Care 9(January-February 1971): 89-98.

30. U.S. Department of Health, Education, and Welfare: Public Health Service, Division of Medical Care Administration. "Portraits In Community Health: Tri-Hospital Home Care." Washington D.C.: United States Government Printing Office, Public Health Service Publication Number 1344-5.

31. Van Dyke, F. and Brown, V. "Organized Home Care: An Alternative To Institutions," Inquiry 9(June 1972): 3-16.

32. Veney, James E. "Home Care: An Introduction," Inquiry 4(October 1967): 3-5.

33. Wartski, S.A. and Green, D.S. "Evaluation of A Home-Care Program: Nassau County, New York," Medical Care 9(July-August 1971): 352-364.

34. Zimmer, J. G. "Length of Stay and Hospital Bed Misutilization," Medical Care 12(May 1974): 453-462.

Appendix B

COMMONWEALTH of VIRGINIA

JAMES B. KENLEY, M.D.
COMMISSIONER

Department of Health
Richmond, Va. 23219

November 24, 1976

Mr. John G. Day
Commissioner of Insurance
State Corporation Commission
Blanton Building
P.O. Box 1157
Richmond, VA 23219

Dear Commissioner Day:

Thank you for the opportunity to review your Bureau's draft report, dated December 1, 1976, to the Legislature concerning the mandating of insurance coverage for Home Health Services. I concur with the recommendations contained in your draft, including the conclusion that it would not be wise to obtain legislation, at this time, to mandate the inclusion of Home Health Services in all health insurance policies written in the Commonwealth.

From my review of the draft report, I would like to offer the following additional comments: a) Although I do not concur with all of the back-ground information and justifications for opposing legislation to mandate Home Health Services coverage, I certainly agree with the conclusion that before such a step is ever undertaken, an adequate pilot program must be instituted and evaluated to insure that the desired objectives will be attained. b) the present pilot program that has been instituted by Blue Cross will not, as it is presently designed, provide appropriate evaluation of this approach because it will not yield the critically needed information required to make a judgement on this issue. It is my understanding that since this project began in June of this year (covering metropolitan Richmond and the Tidewater areas), there have been only three recipients of home health care, which offers an inadequate population sample. Additional recipients should be added by the extension of this test to cover some non-group subscribers to allow inclusion of more high-risk persons than are within the contract groups. Further, the pilot program should be extended to residents of the southwestern area of the State so as to yield information relative to providing health services to rural populations.

I would like to call your attention to another aspect of health insurance in Virginia which is pertinent to Home Health Service benefits. Since January, 1976, as you know, all federal employees and all unionized auto

workers in the nation have had "first dollar" home health insurance benefits included in their health insurance. This new coverage has, however, not been implemented in Virginia, because Blue Cross of Virginia has not yet negotiated contracts with the available Home Health Services providers. According to my information, there are 208,389 federal employees in Virginia who are eligible for this coverage and who also are subscribers to Blue Cross plans. There may be at least twice this many potential participants in the northern Virginia area who are covered by GHI. Because this element of the coverage is not available, some Virginians who could use Home Health Services are kept in the hospital, or they pay the deductible co-insurance associated with home health coverage. I recommend your personal attention to encouraging the implementation in Virginia of home health coverage for federal employees and auto workers.

Thank you for the opportunity to review the proposed report of your Bureau and for members of this Department to serve on the Task Force which studied these issues.

Sincerely,

James B. Kenley, M.D.
State Health Commissioner

kfa