THE FUND REPORTER

Published by The Consumer Commission on the Accreditation of Health Services

Volume II, No. 2 March-April 1984

NEW YORK POLICY ON HOSPITAL INSURANCE

WHAT'S GOOD FOR BLUE CROSS IS GOOD FOR NEW YORK

New York State intends to appeal the federal court decision in *Rebaldo vs. Cuomo* allowing self-insured welfare funds to continue their discount payment agreements with hospitals. In his request for a stay pending appeal, which was denied, New York Health Commissioner David Axelrod has revealed the state's special relationship with Blue Cross, and how this relationship is being used to stifle competition.

The state's legal brief declares: "The establishment by the Legislature of the differential in Section 2807-a(6)(b) was designed to address the fact that the state's interest in the provision of adequate hospital insurance for its citizens depends, in large part, on keeping Blue Cross competitive in the marketplace for large group hospital insurance."

In other words this section of New York law, which was overturned with regard to ERISA funds on March 12, existed only because Blue Cross was feeling the pinch of competition.

A few welfare funds had self-insured hospitalization benefits and stopped buying from Blue Cross. They went into the free market and negotiated with hospitals for discount rates almost as low as Blue Cross. They developed utilization review and coordination of benefits programs superior to those of Blue Cross. As a result the funds spent less for their participants' hospitalization benefits than when they had bought from Blue Cross. Self-insurance, when combined with hospital discounts, was a practical, economical way to provide hospital insurance for some citizens of New York who belonged to unions and were covered by ERISA welfare funds.

The response from Blue Cross was to lobby for legislation forbidding hospitals to negotiate with self-insured groups. The state, in defending this legislation, equates the state's interest with the interests of Blue Cross. It does not explain why paying more for hospital insurance serves its citizens better.

The state's court papers also make another argument for allowing Blue Cross to maintain its competitive advantage: "Blue Cross' ability to keep premium rates on community-rated insurance within the means of its subscribers depends on the net revenues it derives from its experience-rated business, *i.e.* groups such as the ERISA plans.

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CREEPING FIASCO IN NEW JERSEY HOSPITAL COSTS

by **Roxanne Young**, *Associate Editor*

In 1980 New Jersey instituted a hospital reimbursement system which was heralded as the most efficient and cost effective in the nation. The results of that system are now coming in and it looks like a windfall for the hospitals, a fiasco for cost containment and trouble for welfare funds.

New Jersey wanted a new tactic against rising hospital costs and a way to help some urban hospitals which provide vital primary care to poor people. Setting hospital rates according to their costs wasn't working. Hospital administrators had learned to manipulate the system onto a cost-plus basis, and rates kept shooting up. In hospitals where most patients had insurance, reported costs often included brand new buildings and the very latest technology. Hospitals which admitted many uninsured patients, who couldn't afford to pay even minimal costs, were deteriorating and were chronically in the red.

State health department officials decided to base rates not on a hospital's reported costs, but on what costs would be for a moderately efficient average hospital to treat an average patient with a particular diagnosis. They would allow hospitals to charge only a fixed amount for a given admission, regardless of how long the patient stayed and what tests and treatment were administered. This would bring direct pressure on hospitals to control costs, and hospitals would in turn pressure doctors to consider costs when prescribing treatment.

To decide these new rates, experts studied the medical records from thousands of hospital admissions. They studied how much it actually cost to treat those patients, and the usual length of stay for a given diagnosis. They divided all possible reasons for admission into 467 "diagnosis related groups," or DRGs. A series of complicated calculations produced a flat rate that each hospital can charge for any given

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HOW TO FIGHT DRG CREEP

Self-insured welfare funds have discovered an innovative method of investigating "DRG creep" in New Jersey hospitals, and of lowering a hospital's charges on individual cases. While it does not deal with the system-wide failure of the New Jersey DRG system, it is an inexpensive and cost-effective procedure for welfare funds.

The DRG legislation provides that the State Department of Health must investigate any hospital bill that is questioned on the basis of:

1) DRG assignment and/or excessive charges
2) Medical necessity
3) Appropriateness of care

If your welfare fund wishes to appeal a New Jersey hospital bill (a few funds appeal every such bill), send a letter to:

Health Economics Service
New Jersey Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, NJ 08625

Enclose a copy of the hospital bill, and include the following information in your letter:

Name of hospital
Name of patient
Patient's medical record number
Date of admission
Date of discharge

State why you are appealing the bill—because of DRG assignment, excessive charges, medical necessity or appropriateness of the care. If you believe that the admission is for a condition or purpose for which your fund does not provide benefits, mention that exclusion in your letter.

The period of investigation takes from two to nine months. The hospital is prohibited from initiating collection procedures during the review process, so members and funds are protected. Many bills have been reduced after review.

Here are excerpts from some responses received to funds' requests for investigation:

"The recent appeal which you filed was forwarded to (a Physician's Review Organization) for review. . . . The Reconsideration and Appeal Panel carefully reviewed the medical record, DRG assignment, and hospital bill. After a thorough investigation, the assignment of DRG 119 was confirmed.

"The Panel noted that the DRG price was $3,467.96; controlled charges totalled $1,664.90. It was concluded that the DRG price was not in line with the resources consumed and that application of the DRG system in this case would result in inequitable consequences. By copy of this letter the hospital is advised to. . . adjust their billing to. . . controlled charges. . . ."

In a similar case, the response was: ". . . the assignment of DRG 185 was confirmed. The Panel noted a large difference between the DRG price and the total itemized charges for this hospitalization, and determined that application of the DRG system in this case would not be equitable. They concluded that the case should be treated as an ' outlier,' and that the bill be adjusted to reflect the actual charges. . . ."

In a case where the original bill was based on controlled charges, the appeal response was: "After careful review of this bill, it was determined that for (this) admission you were billed the actual charges incurred. . . . The Department does not usually appeal this type of case. As a payer, you may request a review based on DRG assignment, medical necessity or appropriateness of care. In each instance, sufficient documentation to support the appeal would be necessary."

The Fund Reporter is a publication of the Consumer Commission on the Accreditation of Health Services.

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DRG, differing from one hospital to another according to the hospital's general financial condition.

Each hospital's basic DRG rate, which is the major portion of every hospital bill, ignores the patient's length of stay and the actual cost of treating the patient. It is based only on the diagnosis. The final bill includes a small surcharge which is pooled to pay for the care of indigent patients throughout the state. There is an added charge to reflect the hospital's current operating expenses, and adjustments for unusually long or short admissions.

The theory was to motivate hospitals with both a carrot and a stick to control their costs. A very efficient and cost-conscious hospital, which treats a patient for less than the DRG allows it to bill for that diagnosis, keeps the leftover money to do with as it pleases. A very inefficient hospital, which spends more than the DRG allowance, cannot bill for the difference.

Meanwhile, the urban hospitals with a high proportion of indigent patients have increased overall revenues. The pool established by the state, as a result of the surcharge on paying patients, now pays for the care of indigent patients.

The theory sounds good but as always the practice works out differently. When New Jersey hospital administrators recovered from the shock of change, they quickly spotted the loopholes in the new system.

One of those loopholes is vividly described as "DRG creep." When a patient is admitted to a New Jersey hospital, his or her illness or injury is assigned to a DRG. The hospital rate is pre-determined by the DRG. All a hospital has to do to produce a higher revenue is to find a way for the diagnosis to "creep" into a more expensive DRG category, or into multiple categories. Some hospitals have encouraged doctors as well as interns and residents to code the patient's condition in a DRG category that generates a higher economic return for the hospital. Many people are hospitalized for more than one reason. A different DRG number on the claim form submitted to the insurance carrier or the welfare fund allows a higher charge for the admission.

To determine if the bill is coded properly, the medical records must be audited. Welfare funds and insurance carriers find it nearly impossible to verify whether they are being charged the proper amount. No individual fund or insurance carrier can audit the complete medical record for every patient hospitalized in New Jersey. In the accompanying article (see page 2) one effective and inexpensive way of investigating claims for this and other problems is explained.

Another method hospitals have used to maximize their income is to pressure doctors to discharge patients at the earliest possible moment. The DRG system was intended to discourage prolonging hospital stays beyond medical necessity. Now hospitals are tempted to cut stays dangerously short in order to keep more of the DRG allowance, and to admit as many patients as possible. Many patients now feel pushed out of New Jersey hospitals prematurely, before adequate home care or other alternatives to hospitalization can be arranged.

If the patient has not fully recovered, early discharge can lead to prompt readmission. This situation, called "churning" admissions, means hospitals can bill twice for treating one illness or injury. Welfare fund claims processors should be alerted to watch for multiple admissions for the same patient, and to investigate thoroughly for "churning."

Nor can welfare funds negotiate discount rates with hospitals under the DRG reimbursement model. In most states, a hospital rate varies according to who pays the bill. Blue Cross usually gets a large discount, for instance. In New Jersey, the rate is the same no matter who pays the bill, except for modest discounts for Blue Cross and for speedy payment. Hospitals are not reimbursed on the basis of posted charges or on an all-inclusive per diem rate as in most states, but only according to the DRG.

The Health Care Financing Administration recently found that hospital cost increases in New Jersey for the 1979-1982 period were more than 8% above inflation. Before this data was available, the federal government instituted another kind of DRG system for paying hospital bills for Medicare and Medicaid patients in almost all states. The federal system has fewer DRGs, no surcharge to pay for the care of indigents and a different way of computing overhead costs. Nevertheless, some members of Congress are having second thoughts about the cost control advantages of DRGs.

The DRG system has been an economic bonanza for some New Jersey hospitals, while patients have suffered through premature discharge and welfare funds from excessively high bills. *The New York Times* was exactly right in its April 2, 1984 editorial: "If hospitals have a new incentive, it's to manipulate the system to keep the money flowing, not to reduce costs."

BLUE CROSS

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"... the state's interest in maintaining Blue Cross' ability to provide affordable community-rated insurance will be damaged by the departure of other experience-rated ERISA plans from Blue Cross.... Without the revenues generated by these large experience-rated groups, Blue Cross will not be able to subsidize its losses on the community-rated business."

In this case, the Health Commissioner's arithmetic is as bad as his public policy. Blue Cross presently covers more than 5 million people under experience-rated contracts, with a combined premium income of more than $1.2 billion. It is required to allocate 1% of that income to subsidize community-rated contracts. In financial statements filed in 1983 with the State Insurance Department, Blue Cross reported an underwriting gain of nearly $28 million on community-rated hospital insurance contracts, in addition to a $12 million gain on experience-rated contracts.

If in fact the state's sole interest is in "the provision of adequate hospital insurance for its citizens," it must give equal consideration to all the ways in which that insurance might be provided. Instead, New York State has simply helped Blue Cross and Blue Shield of Greater New York to become the largest health insurer in the United States.

Some ERISA funds have found a better way than Blue Cross to provide insurance for their participants. New York State continues to try to crush their ability to compete in the open market. The State Health Department, in defending the Blue Cross monopoly, maintains that what is good for Blue Cross is good for New York.

BREAST DISEASE AND BREAST HEALTH

by Leslie Strong, M.D.

Breast cancer is epidemic among American women. It is the leading cause of death among women 35 to 44, and the survival rate hasn't changed for fifty years. *But* most lumps on the breast are not cancerous. Over 80% are the result of benign conditions and can be treated without chemotherapy, radiotherapy or disfiguring surgery.

The most common cause of lumps in the breast is fibrocystic disease, which affects women predominantly between the ages of 25 and 45 years. The cysts that accompany this condition may at first be mistaken for tumors. However, the accumulation of fluid can be aspirated with a very fine needle, and the cyst disappears. Surgery is usually not necessary for this condition unless the cysts continue to recur and fluid continues to accumulate. A diet free of coffee, tea, cola and chocolate containing methylxantene is beneficial, as is the taking of 600 I.U. of Vitamin E daily.

Nipple discharge is an alarming condition which usually has a benign (non-cancerous) cause. The most common cause of nipple discharge is a benign tumor called an intraductal papilloma, a small tumor in the duct of the breast. Nipple discharge of various colors is often associated with fibrocystic breast disease. The treatment of most nipple discharges which are significant and abnormal is simply the removal of the affected duct.

A fibroadenoma is the most common of breast tumors. It is benign (non-cancerous) and does not pre-dispose to cancer. It appears as a well defined, localized, firm mobile lesion like a small marble or pea in the breast. It is sensitive to hormonal changes and usually increases in size during pregnancy. Needle aspiration confirms the solid rather than cystic nature of the lesion. This tumor is easily treated by a simple excisional biopsy.

An excisional biopsy is the complete, total removal of a breast lump. The patient can be given local or general anesthesia, depending on the size and depth of the tumor. The excised tumor is then submitted immediately to a pathologist, who performs a frozen section and can tell the surgeon within moments the type and nature of the tumor. This procedure is done on an out-patient ambulatory basis. *No* hospitalization is necessary. Usually the patient is admitted and discharged within a few hours of the same day. An incisional biopsy is the removal of only a portion of the tumor. This can be performed in a doctor's office, but is not as accurate as an excisional biopsy.

No biopsy should be performed without a mammogram. Mammography is the only technique available today which can detect the characteristics of a breast tumor as to whether it is benign or cancerous. A mammogram allows the doctor to see what he feels, and to gain an understanding into the breast architecture. It also gives information about the opposite breast to make sure that it is normal before the biopsy is performed on the tumor.

With modern equipment and film, the dose of radiation from a mammogram is minute (1/50th of a rad). The American Cancer Society advises that all women over age 35 should have a baseline mammogram even if physical examination of the breast is totally normal. They suggest that mammography be repeated every five years thereafter until age 50, and yearly thereafter. More frequent mammography is recommended if certain risk factors are present. These include:

1. A family history of breast cancer.
2. Early onset of menstruation.
3. Late menopause.
4. A breast biopsy revealing a pre-cancerous lesion.
5. Hypertension, obesity and diabetes, in combination.

Certain types of breast architecture also place women at a higher risk, and can be seen only on a mammogram. Only a mammogram can detect microcalcifications of the breast, 25% of which prove to be an early stage of cancer.

Sonograms, which basically bounce sound waves off the breast to produce a picture, are useful in differentiating a solid tumor from a cystic one. They are also used to supplement mammography where more information is needed in severe fibrocystic disease.

A thermogram is a test of the heat distribution of the breast. Different heat patterns are recorded as different colors. Some tumors show up as areas of increased heat. Cysts appear as areas of decreased heat. This is a very non-specific type of exam, and is used as a screening procedure on women who have no symptoms of breast disease. An abnormal thermogram must be followed up by a mammogram, a more exact diagnostic test.

Breast self-examination is the mainstay to proper breast care. Most lumps are still detected by the woman herself, and 80% of all lumps are benign. A breast specialist can teach you this technique. It should be performed every month, four to seven days after the menstrual cycle has ceased.

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ANESTHESIA EXPLAINED—Part II

by Arthur A. Levin, M.P.H.

In our last column we described some of what an informed person facing surgery should be aware of in order to avoid problems. This month our focus will be on the different kinds of anesthesia.

General anesthesia is defined as a reversible state of unconsciousness with loss of the sensation of pain over the entire body. Drugs used for general anesthesia can be administered in several ways: intravenously, by inhalation, intramuscularly, orally and rectally (the latter two are rare).

The general anesthetics produce deep levels of anesthesia. The problem is that the deeper the anesthetic the more prolonged is the postoperative period of unconsciousness and recovery. There is also greater risk of postoperative vomiting, as well as cardiac and respiratory arrest.

Indications for the use of general anesthesia are as follows:

- Infants and young children (local or regional anesthesia is usually psychologically inappropriate)
- Extensive surgery
- Prolonged surgery (local and regional are limited in their duration)
- Patients with a history of toxic or allergic reactions to local anesthetic drugs
- Patients on anticoagulant treatment
- Persons who express a preference for general anesthesia even though local or regional has been suggested as safe and effective

Inhalation anesthetics are gases which are absorbed from the lungs into the blood and circulated in the tissues (including the brain), where their depressant effects produce the desired unconsciousness. There are a wide variety of such anesthetics, varying in potency as well as in the degree of hypnosis, analgesia, reflex depression and muscle relaxation they can produce. Some familiar agents are nitrous oxide, ether, cyclopropane, chloroform, ethyl chloride, Halothane and Trilene.

Muscle relaxants are another form of general anesthetic. These achieve anesthesia by blocking transmissions at neuromuscular junctions—so that a nerve stimulus will not cause a muscle contraction. Put another way, the body's muscles become paralyzed. Since this includes the muscles used for breathing, positive pressure ventilation must be used. These drugs include tubocurarine, Flaxedil, Pavulon, and succinylcholine.

Local anesthesia may be preferred to general anesthesia for several reasons:

- less disturbance to body functions
- less nausea and vomiting
- less bleeding
- lower incidence of pulmonary complications
- can be used when the patient has recently ingested food
- less postoperative care and observation required
- less expensive, since technique is simple and minimal equipment is required
- drugs are nonflammable

Ultrashort-acting barbiturates are administered intravenously to provide a rapid and pleasant onset of the general anesthesia administered later. Barbiturates can be used alone to produce all the stages of anesthesia, but they can also cause serious depression of the cardiovascular system. Because of this, their use is usually limited to short, minor procedures. They are often used in combination with nitrous oxide and oxygen. Familiar names are Pentothal and Brevital.

Local and regional anesthesia is accomplished through the use of drugs that block conduction of nerve impulses. Surface or topical anesthesia is produced by application of local agents to damaged skin or mucous membranes. Infiltration anesthesia results from injection into the area to be anesthetized. Block anesthesia is carried out by injecting a nerve trunk some distance from the area to be anesthetized. The procedure is named for the area injected (for example, paracervical block). Drugs used for local and regional anesthesia include procaine (Novocain), lidocaine (Xylocaine) and bupivacaine (Marcaine).

Spinal anesthesia is accomplished by injecting a local anesthetic into the spinal subarachnoid space. The nerves anesthetized are determined by the degree of the drug's passage upward in the spinal subarachnoid space. This is in turn influenced by the person's position during and after injection, his/her movements, the curvature of the spine, the size of the space, the site and rate of the injection and the chemistry of the solution. The person remains conscious. Tetracaine is the most used spinal anesthetic and lasts for one to two hours. Other drugs used are procaine, lidocaine, and mepivacaine.

Readers are cautioned that local anesthetics are not free from risks. Possible complications include life-threatening adverse reactions, usually the result of overdose or faulty technique. The increasing amount of ambulatory surgery is probably being accompanied by an increase in use of local/regional and intravenous anesthetic drugs.

One study done between 1955 and 1964 examined 115,000 anesthetics (general, spinal and local/regional) administered by a group of practitioners. Slightly less than 1% (1000) of the patients died in the hospital, 65 of them from complications with anesthesia. The chief mistakes were improper administration and poor postoperative management. The authors conclude that the error in almost all the deaths was a lack of proper monitoring. Depending on the type of surgery and selection of anesthetic(s), monitoring should include respiration, pulse, blood pressure, central venous pressure, blood gases, temperature and the brain and heart electrical activity. Mechanical devices have been developed to assist the anesthesiologist in observations, but the experts caution that there is no substitute for personal contact and observation in producing sound clinical judgement.

There are often several choices of anesthetics appropriate for a given operation. The drug or drugs selected will depend on a number of factors, including the length and nature of the surgery, the anesthetist's preference based on his or her experience and to some extent on the health of the person having the operation. Some people may express a personal preference; for example, a local or regional anesthetic rather than a general. Even if you do not usually have a say in choice of anesthesiologist, you can have a say in the choice of methods. Understanding what is involved will help make that choice an informed one.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

BREAST DISEASE

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Here is a summary of the changes that you should be able to detect while practicing breast self-examination:

1. A lump in the breast or a local lumpy area (not to be confused with normal fatty tissue lumps).
2. An unusual increase in the size of one breast.
3. One breast unusually lower than the other.
4. Puckering or dimpling of the skin of the breast.
5. A localized redness to the skin of the breast.
6. A change in contour of the breast.
7. A turning in of the nipple not previously noticed.
8. Fluid escaping from the nipple.
9. A skin rash on the nipple or areola (the dark circular area of skin around the nipple).
10. Swelling of the upper arm.
11. Enlarged glands under the armpit.

If you find any of these changes, you should contact a breast specialist at once. Early cancer detection can change the survival statistics, and can limit the need for disfiguring surgery. Most breast disease is not cancer, and every disease is most easily treated at its earliest stages. The combination of breast self-examination, examination by a breast specialist and modern diagnostic techniques is the best way to breast health.

Dr. Leslie Strong is medical director of the Breast Health Program of New York, a breast surgery consultant for the Strang Clinic, a member of the New York Metropolian Breast Cancer Group, and Surgical Attending at Beth Israel, Mt. Sinai and Methodist Hospitals.

WHERE TO FIND A SPECIALIST IN BREAST DISEASES

Any of the following institutions and organizations can refer you to a specialist in breast diseases. Some also provide education, diagnosis or treatment.

American Cancer Society 19 West 56th Street New York, NY 10019	**212-586-8700**	Referrals (list of specialists)
Breast Health Program of New York 115 East 72nd Street New York, NY 10021	212-737-3353	Diagnosis, education, treatment
Cancer Information Service Hotline	**800-4-CANCER**	Referrals, information on treatment alternatives
Guttman Institute 3 West 35th Street New York, NY 10001	**212-689-9797**	Diagnosis, referrals
New York County Medical Society	**212-399-9048**	Referrals
Strang Clinic 55 East 34th Street New York, NY 10016	**212-683-1000**	Diagnosis, referrals

Published by Consumer Commission on the Accreditation of Health Services, Inc.
200 Park Avenue So.
New York, N.Y. 10003
Telephone: 477-6823

Non-Profit Org.
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New York, NY
Permit No. 7681