COST: A KEY TO HEALTH CARE IN THE 1990'S

The Task Force met during the Fall of 1990 and early 1991, and heard testimony on rising health care costs.

FINAL REPORT OF THE LEGISLATIVE TASK FORCE ON HEALTH CARE COST CONTAINMENT

Adopted February 11, 1991

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Pursuant to 1990 Laws, Ch 534, Sec 2, subd 5 FINAL REPORT

EXECUTIVE SUMMARY

Why Is Cost So Important?

- Technology: An arms race mentality has contributed to rising technology costs.

- Changing Practice Of Medicine: New treatments and new technologies have changed the way doctors practice medicine, and this has been expensive.

- System Design: The health care system has a multitude of providers, payers, and profit centers, each seeking to enhance its own share of the pie.

- Excesses: High demand for services combines with a traditional lack of concern for costs to yield an expensive system.

- Incentives: Health insurance has been giving the wrong incentives to consumers, not encouraging them to care for themselves and to ration their own use of medical care.

- Administration: There is concern that administrative costs may be absorbing too much of the health care dollar.

- Medical malpractice costs, and the expensive, litigious medical malpractice system are a growing source of health care costs.

- Access: Critics of the health care system cite the growing number of uninsured persons as a problem to be considered along with costs.

How Can Costs Be Controlled?

- Managed Care: Insurers and third party payers are attempting to manage the amount of care they will pay for, and claiming that this reduces costs and improves treatment.

- Incentives: Health insurers could institute co-payments and deductibles as a way to make consumers aware of health care costs and to make them begin to self-ration.

- However, in the case of medical care for children, and primary medical care, deductibles and copayments may not be appropriate. Instead, incentives could be structured to encourage the use of early, preventive health care.

- Provider Networks: By contracting for medical services, cost containment strategies can be written into contracts up front.

- Technology Review: Technology should be studied before it is put into use, and providers should be encouraged to wait on new technology until it is proven medically.

- Public Education: Awareness of medical costs should be encouraged, and people should also be encouraged to be more responsible for their own health status.

COST: A KEY TO HEALTH CARE IN THE 1990s

Why is cost so important?

Since 1980 the cost of health care has risen at almost twice the annual rate of inflation. The cost of health care continues to rise faster than any other segment of the nation's economy. Medical costs are over 11 percent of the United States' Gross National Product, and rising.

This rising cost has implications for every aspect of the U.S. economy. Employers find it hard to pay for health coverage. Labor unions bargain harder on the issue of health care coverage than on most other issues. The average citizen pays a greater percentage of their income on health care today, and there are more people without insurance.

There is no easy explanation for rising health care costs, mostly because the entire health care system in all its aspects has been a source of rising costs. There are multiple cost-drivers. Pharmaceuticals and technology can be blamed, but so can doctors fees or insurer's administrative costs. It is important to avoid simplistic analysis because the problem is not at all simple.

Rising costs force unpleasant decisions. A small employer may have to suspend coverage if the group rate rises dramatically. A welfare mother may not be able to forego medicaid benefits for a low-paying job that does not offer health care. The state has budget problems, in part due to unexpected medical costs in some of its public programs.

A number of policy initiatives may be held hostage in coming years to cost problems. Increasing the level of benefits may be difficult due to the high cost of these benefits. Covering more people who do not have insurance may be expensive if medical costs continue to soar. The cost problem has to be addressed, or other reforms may be over-powered by continuous rises in health costs.

Containing costs is a simple prescription for a complex problem. It can mean accepting inferior care, or it can mean accepting delays and rationing of acceptable care. There is a psychological attitude towards medicine in the United States which goes against many cost containment efforts. Americans want the best care available, immediately. The problem of paying for this care grows.

This report is based on testimony taken by the Minnesota Legislature's Task Force on Health Care Cost Containment. Hearings were held in the Fall of 1990 and early 1991. The report is divided into two sections. The first part contains various outlines of the problem of rising costs and the factors to which it has been attributed. The second part contains some of the solutions proposed by witnesses for this problem.

WHY ARE COSTS RISING?

Escalating medical costs extract a cost from society. The steep and continuous rise of health care costs has prevented some from being able to afford coverage for their workers or their families. An ever greater percentage of America's economy goes into the health care system.

Witnesses before the Task Force presented their view of the problems with America's health care system. Together they provide a diagnosis of a troubled system. This section outlines the problems seen with the system, and the next section presents some of the proposed solutions.

TECHNOLOGY: Metropolitan Health Planning Board

The Metropolitan Health Planning Board is in the process of studying health care technology and its relationship to rising costs. Although their study is preliminary, they have documented an "arms race" mentality by purchasers of health care technology. All indications are that the pace of this health technology race will accelerate in coming years.

Technology creates a competitor's dilemma. "While most providers want to make decisions to acquire new technology based on patient and community need, they are increasingly being compelled to make those decisions based on market factors that have little or nothing to do with the needs of their patients or of the overall community."

For example, if Hospital A buys a new wonder machine Hospital B must have it. If Hospital B forgoes the machine doctors may leave Hospital B to work at Hospital A, where the machinery is better. Patients may allege in malpractice suits that Hospital B has not met "community standards" for technology. Hospital B may get a reputation for having poor technology.

Note that this dilemma is not tied to results. Some of the technology is "halfway" technology, innovative but medically unproven. The new machine may not be a proven performer. Hospital B may not have the time to wait and see if its strategy provides better health care in the long run.

CHANGING PRACTICE OF MEDICINE: Group Health

According to Group Health, "The primary reason for health care cost increases is the changing practice of medicine in big ways and small."
Group Health documents this claim by discussing their cost trends over the last several years. Basic costs have risen at manageable levels. Staff costs have risen with price increases ranging from 6 to 8 percent over the last several years. Hospital costs have risen from 4.5 percent to 8 percent. Administrative costs are a steady 9.0 to 9.4 percent of revenues.

The Group Health basic increase, with just physician salaries, other clinic salaries, administrative wages and salaries, all other administrative costs, and their contribution to their reserves, would be steady and relatively low.

	1988	1989	1990	1991
Basic Increase	6.3%	6.8%	7.9%	7.4%

However, additional factors have come into play---the changing practice of medicine, changes in the health status of the population they serve, and the aging of the general population. Changes in the practice of medicine include changing technology, changing treatments, and pharmaceutical developments. These additional factors have almost doubled the rise Group Health has seen in health costs.

	1988	1989	1990	1991*
Basic Increase	6.3%	6.8%	7.9%	7.4%
Additional Factors	4.2%	7.2%	9.6%	7.1%
Total Rate Trend	10.5%	14.0%	17.5%	14.5%

(*=projected)

The Group Health explanation for rising costs is based on changes in medical practice, or the accepted ways of treating patients. Examples are offered---new drugs costing much more than old drugs, new imaging machines costing more than X-rays, new procedures costing more than old procedures.

These changes are an expected part of a system that is striving to improve the efficacy of treatment. However, the changes are made and the costs are incurred in a system that is not designed to provide an overall efficiency.

And at times the appropriateness of care is not known---community standards govern.

Group Health describes the health care system as being designed to "sub-optimize" profits. Each sector of the system attempts to maximize its own profits, regardless of overall efficiencies. For example, the pharmaceutical companies and pharmacists want to protect and maximize the profits for their sector of the market, as do doctors, hospitals, various therapists and specialists, insurers, and everyone else in the system. An overall design might forgo profits in one sector in the name of overall efficiency, but our system is not equipped to make this decision.

HEALTH CARE COST TRENDS: Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota (BCBSM) studied cost trends from 1982-1988, based on their experience. They broke down costs into several categories.

- Inpatient facility care has been steady in cost.

- Outpatient facility care, mandated care, Value Health Sciences procedures, and high cost cases have all increased as cost factors.

- Technology and Professional care have shown the greatest expansion as cost factors.

One example: new technologies often do not completely replace old technologies---the two may exist side by side. This is seen with angioplasty procedures, which have not replaced cardiac bypass procedures. Magnetic Resonance Imaging has not replaced or greatly reduced usage of CAT scans or X-rays. Instead all three survive and this duplication raises costs. A second layer of treatment and costs is added to the system without reducing the first layer.

Other trends are clear--the move from inpatient to outpatient treatment, cost expansions due to new procedures and new technology. However, BCBSM estimates that without their cost control programs they would have paid as much as 24 percent more in costs. In 1988 alone, their cost containment programs saved $199.2 million.

HEALTH SYSTEM EXCESSES: Northwestern National Life

Insurers are turning to managed care as a response to certain excesses in the current health care system. Some of these excesses:

- Extraordinarily high demand for medical services in the United States;
- Rapid diffusion of new technologies, such as new surgical techniques or drugs;
- Unilateral fee setting and increases by medical providers, lack of a market mechanism to competitively price medical services;
- Large variability in physician practice styles, choices of treatment;
- The medical-legal system supports high costs, preferring to spend huge amounts on terminal individuals rather than risk law suits.

These costs have traditionally been ignored by insurers who were willing to take the medical system prices as a given. This is past history; the new climate requires an insurer to get involved before costs run away.

According to NWNL, it is a mistake to hold that administrative costs in the health insurance industry are a major factor in rising health care costs. In three-fourths of the insurance industry administrative costs are about 5-7 percent.

HEALTH INSURANCE: University of Minnesota

The Health Services Research and Policy Department at the University of Minnesota had three main points to make about health cost developments in recent years.

- Health insurance in Minnesota has caused costs to increase dramatically over the last 10 years and has allowed an inefficient provider system to flourish. Providers can practice as they wish and charge what they want. Consumers expect and demand far too many health services.
- The proper use of coinsurance and deductibles promotes a more conscientious use of services, and improves consumer awareness of the costs of care.

- Insurance plans should not add benefit coverage without considering structural measures to assure the appropriate use of services and the control of costs. In many ways the health care system is being captured by the providers and held hostage for payment.

From this perspective, health insurance must begin to serve a function as a cost regulator in the health care system. Control must be exercised by installing deductibles and coinsurance, with the aim of making the consumer aware of the cost of services. Consumers will then self-ration health care. Insurers should also limit the amount they will pay providers, and stop paying for inefficient, outdated, or useless procedures.

This might seem like a large burden to put on insurers. However, managed care efforts are already moving in this direction. And the point is raised that without these measures the health insurance system sends the wrong message to the providers. The message should be one of cost control rather than one of unlimited ability to charge and receive payment.

EXCESSIVE ADMINISTRATIVE COSTS: Health Care Campaign of Minnesota

The Health Care Campaign of Minnesota (HCCM) studied the administrative overhead of insurers in the health care system, and concluded that these administrative costs are a major cost factor that could be reduced.

The HCCM study found that, "Minnesota wasted $191 million on insurance company overhead in 1988, enough money to have insured 60 to 80% of Minnesota's uninsured." According to the HCCM, this is only a fraction of the waste in Minnesota's $10.9 billion annual health care bill.

The HCCM study compared the overhead expenses of commercial health insurance companies with the overhead costs of the Canadian health insurance program and of the U.S. Medicare program. The level of benefits was compared to administrative costs. Savings would come from lowering the administrative costs of the health insurance system to the amount seen in the Canadian or Medicare systems.

In practical terms this means a single payer model. A single payer model is a government organized entity which collects taxes and pays all medical bills. This has the advantage of lowering the administrative costs, on the theory that one administrative system is cheaper than dozens of them, and more efficient.

A reform which embraced the single payer concept would mean a radical break with the existing structure of medical service delivery and payment.

Critics have questioned the accuracy of HCCM data, and have suggested that some of the administrative costs of Medicare and the Canadian models are buried, under-reported.

The HCCM presented testimony on other aspects of the health care system, including the inflation of medical costs, which far outstrips the costs of the general economy.

HEALTH INSURANCE: Health Insurance Association of America

The Health Insurance Association of America (HIAA) finds that the cost of hospitals and physicians has outpaced inflation. Premium costs reflect the high cost of the practice of medicine. This places a burden on small business, which cannot access the health insurance market.

According to the HIAA, Minnesota cannot afford public financing of health care. Health care is more costly when centrally financed by a bureaucracy. Instead, the insurance industry recommends a set of small group market reforms.

These market reforms are aimed at making insurance affordable to small employers. Reducing state mandated benefits is one element of a small group plan. Another: once someone was insured they could not be dumped. Some rate regulations would be installed. If these reforms lowered premiums by 20 percent or more many employers might enter the market and insure their workers.

Insurers see cost problems with the over-capitalization of high technology. The link between new technology and better patient outcomes is becoming tenuous.

Administrative costs are not the problem, with 8 percent costs seen at many firms. Eliminating insurer's overhead is a flawed idea for two reasons: A) the cost saving is illusory, as some other administrative bureaucracy, possible less efficient, would then have to be created; B) the real problems of the rising costs of medical practice would be ignored.

Insurers are facing the problem of costs through managed care procedures. Managed care is the oversight of medicine, with doctors and computer generated statistics providing some care guidelines that both improve efficacy and also save money. One of the best antidotes to cost is better information on the reasons why costs are rising.

Insurance companies are sometimes blamed for problems that are endemic to the health system as a whole. This ignores the important role insurers are now playing on cost containment, and unfairly blames one portion of the system for a systemic problem.

CHANGING ENVIRONMENT: Minnesota Hospital Association

The 1980s were a traumatic decade for the hospital industry. New payment policies, Diagnostic Related Groups, managed care, and other strategies all put the pinch on hospitals. The site of care was shifting, with more outpatient care and less in-hospital treatment. Patients in hospitals were more often seriously ill. The hospital population aged, and per-patient expenses leaped.

Hospitals accounted for 4% of GNP in 1982, and also in 1990. They saw higher resource prices and personnel costs. For example, a nursing shortage has driven nursing wages up, without adequately easing the shortage.

The average hospital patient is now more ill, and the average hospital treatment is higher cost, due in part to new drugs and new technologies. Drugs were up 200 percent in the 1980s. Medical malpractice also doubled, from .75% of hospital costs to 1.5% of those budgets.

As more information is required by managed care systems, billing is getting more complex and expensive. Costs are on the rise for hospitals. In 1989 one-third of hospitals lost money. In 1989 Minnesota hospitals had $3 billion in revenue but only $10 million in profit.

15 hospitals closed during the 1980s. Closings will continue, as competition shrinks the industry.

The average stay in a hospital shrank by two days in the last decade. The stay was more intensive, and the treatment more invasive, but the length fell as more outpatient treatment became standard.

RESPONSIBLE MEDICINE: Minnesota Medical Association

The Minnesota Medical Association (MMA) represents about 7,000 practicing physicians. The MMA has noted a change in the practice of medicine which affects both cost and service.

Third party payers have intruded between physicians and patients, and have become a new element of the medical equation. Physicians are having to hire additional staff just to figure out what reports have to be done and when a third party payer has to be notified before treatments commence.

The problem is in the multiplication of payers, each with its own set of requirements that have to be met. This creates a set of costs associated with these "cost containment" measures.

Physicians doubt the adequacy of managed care programs for several reasons:

- Physicians are not apprised of the practice parameters against which their practices are judged, and therefore do not know if managed care guidelines help patients, or merely help the payer's profits.

- Physicians may or may not have helped develop practice parameters---the medical credibility of these guidelines is low.

- Should corporations, who increasingly decide when care is or is not given, share in the professional liability of these decisions when they go wrong?

- Peer review is sometimes not accomplished by true peers of similar medical backgrounds and skills.

According to the MMA, managed care practices have "swung too far" and many times threaten the quality of care at the same time they impose extra costs.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION: Center For Policy Studies

The Minnesota Comprehensive Health Association is a special case in the broader health care cost discussion. MCHA is a risk pool, serving those Minnesotans who meet a statutory requirement that they have been turned down for insurance, have been offered restrictive insurance policies, or who have an illness that is presumed sufficient to allow them into MCHA.

MCHA provides coverage for enrollees who meet these criteria. MCHA is at issue because enrollment has expended in recent years. The Center For Policy Studies is conducting a two year study of MCHA, and reported to the Task Force on the progress of their study.

The Center reported that MCHA costs and enrollment have been rising continuously since 1983. The growth rate is due to high rates of enrollment in MCHA, and also to a falling off in recent years of the rate of disenrollment from MCHA.

Average medical costs for MCHA enrollees are 20 percent higher in the Metro area than they are in outstate Minnesota. Seventy-six percent of enrollees had health insurance immediately prior to enrolling in MCHA, and their previous length of coverage averaged 11.3 years. These findings are unexpected, and will be further explored in the next year by the Center for Policy Studies.

Other preliminary findings were discussed----the fact that Medicaid is enrolling some people into MCHA, and the demography of the population. MCHA is changing in part as a reflection of changes in the insurance market. The final report of the Center will be ready in November 1991.

ACCESS IS THE ISSUE: Minnesota Health Care Access Commission

The Access Commission reported to the Cost Containment Task Force on the need for Minnesota to see access as a real problem, but one amenable to solution. The Access Commission has spent over a year formulating a proposal for the 1991 Legislature. The Access proposal would provide health insurance for all Minnesotans.

Such a sweeping proposal has an impact on health care costs. The Access proposal is designed to be a step toward a single payer model---therefore Access can be seen as providing the costs and benefits of such an approach. Access would mean many uninsured people would receive care---an increase in costs. Access would mean many who receive but do not pay for care would have a way to pay for it---a shift in costs.

An Access system would change nearly every aspect of the cost equation in Minnesota. Mandated benefits might change, as would underwriting. The primary message of the Access Commission to the Cost Containment Task Force is that uninsured Minnesotans need consideration, and that the time for studies has passed and the time for action is here.

ACCESS NEEDS IMPROVEMENT: MN Council of HMOs

The Minnesota Council of Health Maintenance Organizations testified on the Access Commission report and its shortcomings. The Council supported the project in its early stages, but semi-final drafts of the Access report contained findings that were problematic for the HMOs.

Although the Council agrees with many Commission findings---including mandating universal coverage----the Council is concerned by many initiatives, such as the creation of a new state agency to run the Access program.

Many of the Council's concerns are directly about the issue of cost in the health care system. If cost is not controlled, the new Access system could well yield future cost problems. However, under the Access system the State could be on the hook for these new rising costs.

HOW CAN COSTS BE CONTROLLED?

Solutions to the rising costs of health care are hard to come by, and are mostly partial in nature. The complexity of the health care problem stops simplistic solutions short of making sense. Some experts say that a number of small reforms will be necessary. Others call for a radical break with the existing system and the establishment of a new model. The next section outlines the proposals of witnesses who came before the Task Force.

MANAGED CARE: Northwestern National Life

At the Task Force's request, representatives from Northwest National Life presented an outline of managed care techniques, and how managed care has come to be a major tool in efforts to contain costs.

As a response to rising medical costs, managed care formulates a strategy of cost containment. This strategy includes:

- Attempts to ensure care is delivered in the appropriate setting---in or outpatient;
- Using the correct tests, in the correct sequence, rather than over-testing;
- Use of appropriate treatments---non-invasive or invasive, modern rather than outdated;
- Determine if charges are reasonable and comparable to others;
- Use the right kind of doctor, in the right kind of facility.

One problem with the current system is rationing. We have no acceptable mechanism in place to accomplish this. Americans are anti-rationing; our gut instinct tells us to spend the money if a life is at stake. This attitude can permit excesses. But all government systems make hard rationing decisions---why is the medical system immune?

Managed care is popular because it attacks excesses. Pre-certification allows employers and insurers to control costs up front, screening medical use before it is actually given. Managed care applies two standards to care---does it help, and is it cost efficient?

Managed care can also promote higher quality medical care. Outdated treatments are removed from reimbursement. Defensive medicine and over-testing can be stopped.

There are several specific kinds of managed care programs:

- Requiring a second surgical opinion.

- Hospital Utilization Review Programs (HURPs) such as pre-certification before hospitalization.

- Concurrent review---estimating how long a stay should take after patients are admitted;

- Discharge Planning, and aftercare programs;

- Diagnostic and Surgical procedure review---examine questionable procedures and require second opinions before they can be used;

- Catastrophic care management---intervene in costly cases, work with the family, assess the care from a medical standpoint;

- Contract for high cost procedures before they occur---contract for kidney transplants at a set price rather than an as-they-come basis;

- Network Development---preferred provider networks, HMOs, exclusive provider networks, other new provider arrangements that restrict patient choice of provider;

- Other price and service contracting methods.

One additional suggestion for cost containment is retention of an existing Minnesota law. Under Minnesota law, preferred providers can be reimbursed at a different rate than non-network providers. This is seen as a good idea, because it allows networks to provide cost savings and incentives to doctors who provide cost savings.

HEALTH INSURANCE: University of Minnesota

If health insurance has traditionally provided the wrong incentives for cost control, what are the right incentives? A list of suggestions was provided by Dr. John Kralewski of the University's Health Services Research and Policy Division.

- Re-think the level of mandated health coverage in Minnesota.

- Encourage employees to take a more aggressive role in controlling health care costs.

- Develop some form of planning for rural health services. Create an office of rural health to coordinate rural programs and initiatives.

- Expand the Medicaid program to include low-income families on a sliding scale basis.

- Reduce duplication of services between public programs paying for health services.

- Mandate cost control measures in health insurance plans, including deductibles and co-insurance.

- Link preventive health services to welfare payments.

- Provide incentives to health professionals to work in rural areas.

- Develop a no-fault liability plan to replace existing nurse and doctor malpractice coverage.

These ideas are aimed at pushing the health care system into cost-consciousness. They do not radically reform the system; instead they make the system aware of its own shortcomings.

COST CONTROL PROCEDURES: Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota (BCBSM) estimate that in 1988 alone their cost containment program saved $199.2 million. They use a variety of means of cost containment, attacking the problem on several fronts.

The major cost containment method of BCBSM is of course the establishment of provider networks. The BCBSM provider network is a series of contracts with all sorts of providers--physicians, hospitals, chiropractors, mental health specialists, and more. These contracts guarantee a level of patient usage in return for a rate of payment that controls costs.

Patients are limited to physicians and providers from the network, and cannot choose their own providers without paying extra. BCBSM describes its network as a partnership with providers to link effective services at a manageable cost.

BCBSM is also involved in trying new cost containment practices. BCBSM uses pretreatment appropriateness review to assess the need for treatment, especially with new technologies. Appropriateness criteria have been developed for over 200 different treatments. This is an attempt to control costs through an assessment of the treatment before it is used.

BCBSM has designed a "MedisGroups" program. This program has established a computer system in 40 hospitals which measures the severity of an illness and uses that measure as part of reimbursement to hospitals. A severe illness should yield longer stays and more intensive care, and therefore higher reimbursement. Less severe illness calls for less costly care and lower reimbursement. By measuring severity BCBSM is attempting to compensate according to the illness involved.

BCBSM attempts to link payments to patient outcomes. This is a method of combining both cost control and effective medicine. By providing financial incentives for providers to create positive outcomes, BCBSM will try to make healing patients pay better.

REFORMING MANAGED CARE: Minnesota Medical Association

The MMA is a critic of managed care as it is currently operated. The concept of managing costs through better information about medical practices may be a good one, but current containment practices are found to be costly in and of themselves.

The MMA would support a managed care that was based on sound medical principles, and that streamlined the data required from physicians. The MMA puts out a brief comparison of the top 16 managed care contracts, and rightly notes that their guide is but a brief overview of these lengthy requirements. Doctors are spending more and more time on forms, and less with patients.

The MMA contends that managed care needs to be reformed, to prevent it from becoming an obstacle itself.

TECHNOLOGY REVIEW: Metropolitan Health Planning Board

A suggestion of the Metropolitan Health Board is a set of regional technology review panels which would serve as a guide to the adoption of technology in the health care system.

Technology is one of the "cost drivers" of the health care system. Witnesses have spoken of an arms race between various providers, each having to have the latest machine. There have been hints that some machines are over-used, and some may not work at all.

There is no intent to impose some kind of state controlled technology rationing, or certificates of need for technology. Instead, a voluntary panel which discusses and studies new technologies might provide guidance that could be used by consumers, insurers, hospitals, and clinics.

The proposal has the following characteristics:

- Voluntary membership;
- Community forum, either state-wide or regional;
- Government operated, privately financed;
- Panel chooses half a dozen technologies per year, and studies them using secondary sources, data from participant companies, hospitals, etc;
- Panel recommends the pacing of implementation for a new technology;
- Anti-trust exemption allowed so that participants may use information from this group as a justification for technology decisions. Insurers would cite this as a reason for "experimental" rulings, hospitals as a reason to buy or not to buy a new machine;
- Clarification of tort status: could a study from this panel be used as a community standard in a tort-liability case?

For credibility reasons this panel would probably need a government actor to run it---perhaps the Department of Health. It might need seed money, but most expenses could be from private sector contributions. The panel would be phased into operation.

It is not a forced rationing of technology. Instead it is a careful look at new technologies, and a voluntary recommendation for a timetable for adoption. If some provider disagrees, such as the Mayo Clinic, they are free to go ahead with a technology without consulting this new review process.

CONTROLLING THE SYSTEM: Minnesota Hospital Association

The Minnesota Hospital Association suggested several ideas for cost containment.

- Expand public education efforts, and try and improve public health;
- Make the health-cost link clear to the public;
- Teach employees to stop thinking of health insurance as a free perquisite;
- Emphasize managed care---Minnesota is a leader in this;

- Increase the use of case managers in the MA program;

- Standardize utilization review procedures;

- Encourage prompt payment, within 30 days of billing;

- Clarify experimental v. medically necessary distinctions;

- Lower mandates for small business;

- Tort reform to lower malpractice costs;

- Anti-trust enforcement is too tight---it chills hospital joint ventures/consolidations;

- More transition grants to hospitals;

- Re-think our growing dependence on new technologies.

The Hospital Association feels that many hospitals are themselves subject to the rising costs of medical services and technology. They are interested in rational ways to control rising medical costs.