EBRI

T-25

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

Hearing on

Health Care Cost Containment

October 26, 1983

Statement of

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* The views expressed in this statement are those of the author and do not necessarily reflect the views of the Employee Research Institute, its trustees, members or other staff.

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Mr. Chairman, I appreciate the opportunity to submit this statement for the record. The Employee Benefit Research Institute is a nonprofit, nonpartisan public policy research organization founded in 1978. EBRI sponsors research and educational programs in an effort to provide a sound information basis for public policy decisions. EBRI does not take positions on public policy issues. I am pleased to address the Committee concerning employer efforts to control the rising cost of health care in the United States.

Various measures taken by employers to contain the cost of providing health insurance benefits to employees and their dependents have been widely publicized over the last few years. These measures, while designed to serve the narrower goal of controlling employer costs, promise to also serve the broad goal of controlling aggregate health care costs. Neither the prevalence nor the effectiveness of alternative strategies adopted by employers in controlling the cost of their health insurance programs have been documented. No nationally representative data have been compiled that would track recent changes in the design of employer group plans to control plan costs. Nevertheless, we have some evidence that plan design changes as strategies to control plan costs are increasingly frequent; further, these changes may be at least moderately successful in stabilizing employer costs and raising employee awareness of the cost of their health care. Consumer awareness of their own health care costs has often been identified as a critical factor in containing aggregate health care cost inflation. Control of health care cost inflation, in turn, is an important factor in controlling the growing public burden of Medicare and Medicaid.

The variety of plan design changes that have been adopted by employers

can be grouped into three categories: (1) changes that are intended to redirect employee incentives to use health care in general, and hospital care in particular; (2) changes that specifically restrict the use of some services; and (3) changes that restructure the delivery of health care services to persons covered under the plan. Changes in the first group, those that redirect employee incentives to use health care services, include imposing higher deductibles and copayments for all or some services covered by the plan, as well as expansion of the scope of covered services to include substitutes for more costly inpatient hospital care. Changes in the second group, those that restrict the use of services covered by the plan, include requiring compliance with formal review of hospital utilization, as well as second-opinion surgery requirements and same-day surgery requirements. Changes in the last group, those that restructure service delivery to persons covered by the plan, include principally the establishment of a "preferrred provider" for services covered by the plan. The changes in plan design in each group are discussed in detail below.

In addition to these changes within the framework of existing employer health insurance plans, some employers have initiated a much more sweeping reorganization of their health insurance benefits. In some cases, this reorganization involves simply the offering of more than one health insurance plan option to employees with the same employer contribution to health insurance coverage under each plan option. Other employers have more fundamentally reorganized their health insurance plans within the framework of a flexible benefits program or "cafeteria plan." The incentives for employees to reduce health insurance coverage in favor of greater cost-sharing within the context of a flexible benefits program are

promising. Most employers who have adopted flexible benefits plans have done so to induce employees to share more of their health insurance costs and to take greater responsibility for controlling those costs. The emergence of flexible benefits plans, and the legal and regulatory impediments to their development, are described briefly below. The statement concludes with an examination of existing evidence on the success of alternative measures adopted by employers to control the cost of their own health insurance plans and, at the same time, the national cost of health care.

Changing Incentives

Plan design changes that redirect consumer incentives to use health care services include raising the level of cost-sharing required by the plan and changes in the scope of covered services. Increased cost-sharing under employer group plans may be achieved by raising deductibles and copayments for all or some services covered by the plan, as well as raising employee contributions for their own coverage or for dependents coverage under the plan. Because these changes reduce employees' real level of compensation by raising their out-of-pocket cost of health care, they have been generally resisted by employees, particularly by those with collectively bargained health insurance plans.

In spite of employee resistance to greater cost-sharing, many employers report having raised the deductible or copayment provisions of their group health plan coverage since 1980. One survey of 1420 employers throughout the United States indicated that approximately one-third (34 percent) had increased the copayment required for coverage of inpatient hospital care.1/

1/ The 1982 survey of health care cost containment efforts conducted by William M. Mercer, Inc. is an industry survey, and was not designed to be nationally representative. More than 55 percent of Mercer's respondents were employee groups of more than 1000 workers.

Another survey of 308 large employers indicated that more than half (53 percent) had increased their plan's deductible; 25 percent had increased the copayments required by the plan. In addition, nearly one third (31 percent) had raised the employee contribution for either their own coverage or dependents coverage under the plan.2/

A corrollary of increased deductibles and copayment provisions for hospital care has been the reduction of "first-dollar" coverage for inpatient hospital expenses. An annual survey of new comprehensive major medical plans underwritten by 33 major insurers in the United States indicated a sharp reduction in the proportion of new plans that cover initial expenses for inpatient hospital or surgical care.3/ In 1982, only 7 percent of all new plans (weighted by plan size) provided first-dollar hospital/surgical coverage. This rate represents an 81-percent drop since 1980 in the (weighted) number of new plans that provide first-dollar coverage for inpatient hospital or surgical care. The annual change in the proportion of new plans providing first-dollar hospital/surgical coverage since 1980 is presented in Table 1.

Changes in the scope of services covered by the plan are often designed to redirect patient use of health services toward less expensive substitutes

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2/National Association of Employers for Health Care Alternatives (NAEHCA), Survey of National Corporations on Health Care Cost Containment (1982). This survey, like the Mercer survey, is a specialized survey of large firms and was not designed to be nationally representative. The average size of firms that responded to NAEHCA's survey was about 30,000 employees; the smallest respondent employed 100 workers. 1979 information from NAEHCA is obtained from their 1979 Survey of National Corporations on Health Care Costs and Health Maintenance Organizations. The 1979 survey included 251 large employers.

3/Health Insurance Association of America (HIAA), New Group Health Insurance Policies Issued in 1982 (Complete Tables), Mimeo (1983).

TABLE 1

DISTRIBUTION OF EMPLOYEES BY FIRST-DOLLAR COVERAGE OF HOSPITAL/ SURGICAL EXPENSES, NEW COMPREHENSIVE MAJOR MEDICAL PLANS, 1980-1982 (in percents) 1/

Level of Coverage	1980	1981	1982	Percentage Change, 1980-1982
All Employees	100.0	100.0	100.0	--
First-Dollar Coverage 2/	36.4	24.4	6.6	-81.0
Deductible or First-Dollar Copayment	63.6	75.6	93.4	+46.9

SOURCE: Health Insurance Institute, New Group Health Insurance Policies Issued in 1980 (Complete Tables), Mimeo, Table 45; Health Insurance Association of America, New Group Health Insurance Policies Issued in 1981 (Complete Tables, Mimeo, Table 49; Health Insurance Association of America, New Group Health Insurance Policies Issued in 1982 (Complete Tables), Mimeo, Table 50.

1/ Includes new comprehensive major medical plans with hospital room and board coverage only, ancillary hospital service coverage only, all hospital service coverage only, surgical coverage only or all hospital plus surgical coverage. Surgical coverage may include coverage of either schedule or actual charges.

2/ Plans that provide first-dollar hospital-surgical coverage require no deductible for coverage of hospital or surgical care and no copayment on initial expenses for these services.

for inpatient hospital care. Consistent with this goal, employers are increasingly expanding the scope of group health plans to include coverage of home health care services, hospice services and outpatient hospital services. Outpatient hospital services covered by employer group plans often include preadmission testing, outpatient surgery or surgery performed in free-standing surgical centers. These services are often intended to discourage the use of inpatient hospital care or to discourage protracted hospital stays by equalizing insurance incentives between inpatient and outpatient care.

The HIAA survey of new comprehensive major medical coverage described above indicates emerging coverage of services that substitute for inpatient hospital care. In 1982, 89 percent of all new major medical plans (weighted by plan size) covered preadmission testing; 81 percent covered home health care services. Coverage of paramedical testing and hospice care was somewhat less common (44 percent and 13 percent, respectively). Evidence from other surveys of employers (in particular, the 1980 and 1982 surveys conducted by NAEHCA) indicate that these coverages have become much more common features of employer group plans since 1979.

Restricting Service Use

Restrictions on benefits for the purpose of controlling health plans costs most often apply to the use of inpatient hospital care by plan participants. Restrictions on benefits covered by the plan may include (1) compliance with hospital utilization review, (2) requirement of a second or third physician opinion before undergoing elective surgery, or (3) same-day surgery provisions. Although many employers have adopted these restrictions, restricting the use of benefits covered by the plan appears to be less

popular than increased cost-sharing as a method of controlling plan costs.

Hospital utilization review involves assessing the appropriateness of hospital admission, inpatient hospital services and hospital discharge. Individual employers or insurers may contract with professional service review organizations (PSROs) or with peer review organizations (PROs) to evaluate hospital use. Hospital utilization review may be conducted prospectively (before hospital admission), concurrently (during the patient's hospital stay), or retrospectively (after hospital discharge). Because prospective and concurrent review are highly labor intensive and, therefore, costly to produce, review organizations often delegate prospective and concurrent review to the admitting hospital on a subcontract basis. Critics of the utilization review process, however, have charged that the practice of delegating review to the hospitals significantly compromises its effectiveness. As a result, employers who use utilization review most often use retrospective review. Although retrospective review itself does not limit benefits covered by the plan, it may enable the plan to enforce other plan restrictions on coverage prior to payment. Retrospective review probably also exerts a "sentinel" effect on plan participants, physicians and hospitals, particularly when the employer or insurer is large and well known to local health care providers. The 1982 NAEHCA survey of employers indicated that 35 percent of the surveyed employers used utilization review; this rate was 10 percent greater than the 1979 rate reported in NAEHCA's earlier survey.

Plan provisions that require a second or third medical opinion before elective surgery are often enforced either by refusing payment for failure by plan participants to comply, or by imposing a separate deductible or higher

copayment for expenses related to the surgery. Same-day surgery provisions are intended to eliminate unnecessarily early hospital admissions and the subsequent higher cost of hospital room and board. This provision may uniformly exclude coverage of hospital room and board charges for weekend admissions unless surgery is scheduled for the following morning. To date, no survey information has tracked the emergence of same-day surgery provisions in employer group health plans. Second- or third-opinion surgery provisions, however, have become quite common. The 1982 HIAA survey of new comprehensive major medical plans underwritten by major insurers indicated that 84 percent of plans (weighted by plan size) included a second-opinion surgery provision.

Restructuring Service Delivery

The emergence of contractual arrangements between individual providers or provider groups and some employers or insurers is an important development in the effort to control health care costs. These arrangements have come to be known generically as "preferred provider organizations" (PPOs). A PPO is a contractual arrangement between providers and purchasers of health care services. Under the arrangement, providers may agree to discount charges in return for guaranteed prompt payment. In addition, providers may cooperate in utilization review that would monitor and contain the growth of health service use and plan costs. As an incentive for plan participants to use the services of the PPO, plan coverage is often better for PPO services than for services delivered by other providers. Greater coverage for PPO services might be achieved by waiving the deductibles, copayments, or limits on coverage for services delivered by the PPO.

The legal status of preferred provider organizations has been an

important obstacle to their development. Several forms of these arrangements have been found in violation of antitrust laws as horizontal price-fixing arrangements (Arizona v. Maricopa County Medical Society, 1982) or as arrangements potentially in restraint of trade (Group Life and Health Insurance Company v. Royal Drug Company, 1979). In general, a PPO is open to legal review; nevertheless, these arrangements have been pursued aggressively by some employers and insurers in an effort to control the cost of their group health insurance plans.

The Emergence of Flexible Benefit Plans

A flexible benefit or "cafeteria" plan is an employer benefits plan which gives employees some choice among types of benefits or relative amounts of benefits provided by the employer. Plans established under Internal Revenue Service Code Section 125 may not contain a pension plan or other deferred income plan other than an employee profit-sharing plan. To the extent that a "typical" flexible benefits plan exists, these plans typically include two or more health insurance plans. They may also include a dental insurance plan, group life and disability insurance, dependent-care benefits, group legal services, vacation and sick-leave time and a cash account--sometimes called a "reimbursement account"--from which employees may reimburse themselves for out-of-pocket health care expenditures, or contribute to a savings plan on a pre-tax basis. IRS Code Section 125 was legislated in 1978; implementing regulations, however, have not been issued by the Department of the Treasury. Despite the resulting atmosphere of uncertainty, the popularity of flexible benefits programs among both employers and employees has generated apparently significant growth of these plans during the last five years.

Employer goals in implementing a flexible benefits program are complex.

Often they include:

- o containing the cost of group health insurance benefits by inducing employees to share more of the health care costs covered by the plan;
- o offering employees new, specialized benefits tailored to the needs of a demographically changing workforce without substantially raising total benefits costs; and
- o encouraging employees to elect higher levels of saving, anticipating the need for greater reliance on personal savings for retirement income.

The inclusion of a cash reimbursement account in these plans is often, in the employer's mind, critical to the success of the program in reducing health plan costs. Employers anticipate that employees would resist "trading down" to a less generous health insurance plan option in the absence of an ability to, in effect, insure against unanticipated out-of-pocket expenses. A reimbursement account enables employees to self-insure against higher health insurance costs; the employee can designate residual balances in the reimbursement account to pre-tax saving (possibly in a 401(k) account), or cash the account out as taxable earnings.

Employers anticipate reducing their health insurance benefits costs, and reducing total employee health care expenses, by fixing their contribution to health insurance benefits. Employer contributions can be fixed either absolutely or as a percentage of the cost of the lowest-cost health insurance plan. Employees have an incentive to use fewer health care services, even with a cash reimbursement account. Dollars taken to reimburse employees for the initial costs of their health care--those not covered by the less generous health insurance plan they have elected--reduce their ability to purchase other benefit options, contribute to pre-tax savings, or receive additional cash income.

The repricing of alternative health insurance plan options in a flexible benefits program--consistent with the cost experience of the plans--is important to the program's potential success in containing health insurance costs and health care costs aggregately. Employers who provide more than one health insurance plan option anticipate "adverse selection" by employees. That is, employees who expect to have lower health care expenditures over the year are most likely to elect a low-cost, less generous health insurance plan. As a result of this adverse selection behavior, employees remaining in the most generous--and most costly--health insurance plan option are likely to represent greater health care costs, on average, than employees who elect a less generous health plan. As a result, the average cost of the most generous plan option is likely to rise significantly faster than the average cost of the least generous plan option. Repricing plan options according to experience will, subsequently, result in the prices of the plans diverging over time.

Employers are concerned that the tax code that now governs flexible benefits plans will ultimately limit the repricing of health insurance options according to experience. That is, the non-discrimination rules that govern flexible benefits under the IRS code --Section 125(g)(2)-- require employers to contribute not less than 75 percent of the cost of the most expensive health plan to the health plans of all employees. The purpose of this restriction is to prevent employers from offering "luxury" plans to highly compensated employees that are not accessable to lower-paid employees. Employers who seek to reduce their health plan costs--and health care costs aggregately--through a flexible benefits program, however, are concerned that this section of the tax code restricts their ability to induce

employees away from generous health insurance coverage. This concern persists in spite of general employer agreement that the intent of the code with respect to nondiscriminatory benefits is worthy.

The Effectiveness of Plan Redesign

Evidence of the effectiveness of alternative plan design changes is scarce. Most research that has been conducted has examined the effect of greater cost-sharing on health service utilization and, subsequently, on hospital costs. This research has uniformly concluded that higher cost-sharing by insured consumers reduces the use of health care services, including the use of inpatient hospital care. It appears that reduced use of hospital care, and lower hospital costs, result from significantly lower rates of hospital admission among persons with insurance that requires greater cost-sharing for hospital expenses.4/ Whether increased cost-sharing is more effective in containing health plan costs than alternative plan design strategies, however, has received little attention.

The data collected in the 1982 NAEHCA survey of employers allow a preliminary assessment of the relative effectiveness of alternative changes in plan design intended to control health care costs. By inference, strategies that are effective in reducing employers' costs of providing health insurance benefits are also effective in reducing aggregate health care utilization and cost. The magnitude of that saving, however, cannot be measured with available survey data.

The information provided by the NAEHCA survey, moreover, must be considered with caution. These data provide the only published assessment of

4/See, for example, the results reported by J.P. Newhouse et. al, "Some Interim Results from a Controlled Trial of Cost-Sharing in Health Insurance," The New England Journal of Medicine 305, no. 25: 1501-1507.

the relative effectiveness of the various cost-control strategies that have been adopted by employers. Nevertheless, the published distributions provide no information about the combinations of strategies used by employers. The particularly good cost experience associated with any particular strategy, therefore, may reflect the usual adoption of that strategy in combination with other measures to control health care costs.

Despite this problem, the results reported in the NAEHCA survey are reasonable. These results are summarized in Table 2. Among respondents that had added or increased the copayments required by the plan, 70 percent had experienced cost increases that were less than the median cost increase reported by all respondents. Similarly, coverage of hospice benefits was associated with good cost experience; the narrow margin between the cost experience of employers whose health insurance plans covered hospice care and those whose plan did not probably reflects the low frequency of terminal illness and hospice use even among plans that continue health insurance coverage to retirees.

Raising deductibles or the level of employee contribution to the plan have apparently been less successful strategies for controlling health plan costs. The lack of success in achieving lower plan costs through higher deductibles or employee contributions may reflect increases that have been minor relative to either the rising cost of the health plan or to general rates of inflation. Alternatively, employers who have raised deductibles or employee contributions may have done so in order to avoid implementing other plan changes that would reduce health service utilization or redirect patient care to less expensive forms or sources of care. The poor cost experience of employers who adopted optional low-benefit plans may reflect adverse

TABLE 2

PROPORTION OF RESPONDENTS WHO EXPERIENCED COST INCREASES BELOW THE SURVEY MEDIAN INCREASE IN 1981 BY WHETHER THEY IMPLEMENTED A SPECIFIC PLAN FEATURE

Program	Have Implemented (Percent)	Have Not Implemmented (Percent)	Difference
Added or Increased Amount of Co-Insurance	70.0	32.1	37.9
Covered Hospice Benefits	60.0	54.4	5.6
Used Outpatient Review	58.3	46.2	12.1
Covered Outpatient Surgery or Surgical Centers	52.5	27.3	25.2
Covered Home Health Care	52.2	38.5	13.7
Used Inpatient Review	50.8	45.5	5.3
Implemented a Health Promotion Program	50.7	47.3	3.4
Required a Second Surgical Opinion	50.4	47.2	3.2
Used Coordination of Benefits	49.3	40.0	9.3
Used Claims Review	49.1	47.9	1.2
Covered Pre-admission Testing	48.3	42.1	6.2
Covered Extended Care Facilities	47.7	39.3	8.4
Increased Deductibles	40.1	44.9	-4.8
Increased Amount Employee Pays of Premium	26.1	49.0	-22.0
Added an Optional Low Benefit Plan	12.5	48.4	-35.9

SOURCE: W. Pollock and R. H. Stack, 1982 Survey of National Corporations on National Corporations on Health Care Cost Containment, National Association of Employers on Health Care Alternatives (1983): pp.29-31.

selection and a rapid increase in the cost of the more generous plan; the data do not indicate whether the multiple plans were offered in the context of a flexible benefits program, or whether other incentives were provided for employees to elect less generous health insurance coverage.

Summary

Although changes initiated in employer group health plan design over the last few years have received considerable media attention, no nationally representative data have been collected to document those changes. We have no good evidence, moreover, that the changes that employers have initiated in the design of their health insurance plans have been effective--alone or in combination with other efforts--in controlling either plan costs, or the total cost of health care among employees. In general, the changes that have occurred are too new to evaluate their effectiveness. Nevertheless, preliminary evidence has begun to emerge; this statement provides a summary of available evidence regarding the effectiveness of alternative employer strategies to control health care costs.

The changes initiated by employers include (1) changes intended to encourage employees to use less health care and to use less expensive forms of health care; (2) changes that restrict the use of health care services covered by the plan; and (3) changes that encourage employees to obtain services from providers that have contracted to provide a discount from normal charges, or more importantly, to cooperate with utilization review. Although the prevalence of these changes has been documented only by industry survey data --none of which were intended to be nationally representative-- these surveys suggest that employers have been aggressive in their pursuit of strategies to control the cost of their health plans by inducing employees to be more aware of their own health care costs. Many who would reform the

health care delivery system in the United States see the lack of consumer awareness of health care costs as a critical source of health care cost inflation. Survey evidence suggests that health care cost inflation itself has forced employers to consider dramatic changes in their health insurance benefits. These changes may be the single most promising avenue for controlling the rising cost of health care for all payers.

The changes initiated by employers are notable for two reasons. First, they have occurred in a relatively undramatic, incremental fashion -- and without legislation that would either encourage or require change. In fact, employers have implemented both preferred provider organizations (PPOs) and flexible benefits programs in spite of potential conflicts with existing law.

Second, these changes reflect the real options available to employers and private insurers in controlling health care costs. Other potential strategies -- such as the implementation of prospective pricing for services delivered to plan participants -- are often unfeasible in a competitive environment. It is likely that prospective pricing by a single small plan would merely lower the value of health insurance coverage to plan participants and restrict their access to health care. Neither employers nor insurers are able to require providers to accept prospective payment as payment in full, as does both Medicare and Medicaid. It is important that employer actions to control health care costs be evaluated in the context of the competitive environment in which employee health benefits and health insurance contracts are bargained.

I thank you for the opportunity to submit this statement, and stand ready to assist the Committee in further consideration of measures to control the rising cost of health care.