T-99

Statement

Before the

House Ways and Means Committee
Subcommittee on Health

Hearing on

Experience in Controlling Costs & Improving Quality in Employer-Based Plans

by

Paul Fronstin, Research Associate
Employee Benefit Research Institute

Washington, D.C.

16 May 1995

Summary

- Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third party reimbursement, and technological advances. Responding to rising health care costs, employers have moved to managed care, which can be defined as any type of intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient setting.

- Firms have been increasingly requiring workers to contribute to health insurance premiums. In 1979, employers fully paid for single coverage health insurance for 73 percent of full-time workers employed in medium and large private establishments. By 1993, only 37 percent of workers had their coverage fully paid for.

- There has been an increase in the cost-sharing provisions of traditional fee-for-service health insurance. Between 1989 and 1992, more workers were subject to higher deductibles, higher coinsurance rates, and higher out-of-pocket maximums.

- Employers have increased their use of utilization review (UR) programs. These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis.

- The use of HMOs has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMOs, with 9.1 million enrollees. By 1994, there were 547 HMOs, with 43.4 million enrollees. Recently, the largest increase in enrollment occurred in mixed model HMOs and independent practice arrangements. Group-based plans, i.e., staff, group, and network model HMOs, experienced a decline in enrollment between 1993 and 1994.

- Preferred provider organizations and point-of-service plans have emerged as strong alternatives to fee-for-service plans and HMOs. The number of individuals enrolled in these plans increased significantly between the mid-1980s and today. Recently, the growth rate of enrollees in these plans has exceeded the growth rate of enrollees in HMOs because they allow greater choice of physician.

- Employers have formed health care coalitions to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

Committee on Ways and Means
Subcommittee on Health

Employer Experience at Managing Health Care Costs

Introduction

Mr. Chairman and members of the committee, I am pleased to appear before you this morning to discuss employer responses to rising health care costs. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions. I would ask that my full statement be placed in the record.

Currently a majority of workers receive health insurance through their employers.[1] In addition, over 60 percent of nonelderly Americans participate in an employment-based health plan. The employment-based health system has been evolving since World War II, with employers being very active in the development and implementation of cost management strategies.

Cost Management Strategies

Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third party reimbursement, and technological advances. Responding to rising health care costs, employers have moved to managed care, which can be defined as any type of intervention in the provision of health care services or reimbursement

of health care providers that is intended to provide health care services in the most efficient settings. These interventions not only include the movement of individuals into health maintenance organizations (HMOs) but also include increased employee contributions for health insurance premiums and increased cost sharing in traditional fee-for-service health insurance.

Premium and Cost Sharing

Firms have been increasingly requiring workers to contribute to health insurance premiums and subjecting them to direct out-of-pocket provisions. In 1979, employers fully paid for single coverage health insurance for 73 percent of full-time workers employed in medium and large private establishments. By 1993, only 37 percent of workers had their individual coverage fully paid for. In 1979, employers fully paid for family coverage health insurance for 54 percent of full-time workers employed in medium and large private establishments. By 1993, only 21 percent of workers had their family coverage fully paid for.[2]

There has also been a simultaneous increase in the cost-sharing provisions of traditional fee-for-service health insurance (table 1). In 1992, 26 percent of surveyed employers required a deductible of over $200, up from 11 percent in 1989. In 1992, 65 percent of employers required coinsurance of 20 percent for inpatient care, up from 62 percent in 1989. In 1992, 83 percent of employers required coinsurance of 20 percent for physician visits, up from 77 percent in 1989. In 1992, 26 percent of employers limited out-of-pocket expenses to between $1,500 and $2,499, an increase from 21 percent in 1989.

Evidence suggests that increased cost sharing does reduce health care costs and utilization. The RAND Health Insurance Experiment found that individuals enrolled in health plans with a 25 percent coinsurance rate had 15 percent lower per capita costs than individuals in plans with no coinsurance. The RAND study also

found that low-income individuals with lower coinsurance rates experienced health specific gains for high blood pressure, myopia, and dental problems—three prevalent chronic conditions that are relatively inexpensive to diagnose and treat. If individuals choose to forego preventive care and intervention services because of high cost sharing, they run the risk of necessitating more costly services in the future. This may have the effect of increasing total health care expenditures and utilization because individuals may be sicker once they seek treatment for a health problem.

Utilization Review

Employers have increased their use of utilization review (UR) programs (table 2). These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis. In 1992, 83 percent of surveyed employers required prior authorization for certain procedures, nonemergency hospital admissions, and elective surgery, up from 73 percent in 1989. In 1992, 66 percent of employers required health care to be monitored as it was provided and/or determined the length of a hospital stay and the scope of the treatment prior to treatment, up from 52 percent in 1989. Second surgical opinions were the only type of UR whose use decreased between 1989 and 1992. Studies have found that UR is an effective mechanism for controlling health care costs and utilization. One study found that UR lowered hospital expenditures by 11.9 percent, total medical expenditures by 8.3 percent, hospital admissions by 12.3 percent, and inpatient days by 8 percent.[3]

HMOs

The use of HMOs has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMOs, with 9.1

million enrollees.[4] By 1994, there were 547 HMOs, with 43.4 million enrollees.[5] These plans range from staff models where the HMO owns its health care facility and employs health care providers on a salaried basis, to independent practice arrangements (IPAs), where groups of physicians practicing independently contract with an HMO to provide health care services to the HMO enrollees. The recent movement of individuals into HMOs has not been into the more controlled staff or group model HMOs but into the IPAs, where patients have a greater choice of physician. Between 1993 and 1994 there was a 42.6 percent increase in enrollment in mixed models, followed by a 7.6 percent increase in enrollment in IPAs. Group-based plans, i.e., staff, group, and network models, experienced a decline in enrollment between 1993 and 1994. New evidence suggests that HMOs reduce use of health care services by an average of 8 percent, compared with services that similar patients would be expected to use in a traditional fee-for-service indemnity plan.[6] However, staff and group model HMOs were shown to reduce services by nearly 20 percent, and IPAs reduced use by an average of 0.8 percent.

Preferred Provider Organizations and Point-of-Service Plans

Preferred provider organizations (PPOs) and point-of-service (POS) plans have also emerged as strong alternatives to fee-for-service plans and HMOs. The number of individuals enrolled in these arrangements increased significantly between the mid-1980s and today. Recently, the growth rate of enrollees in these plans has exceeded the growth rate of enrollees in HMOs because they allow greater choice of physician. Evidence on the savings from these plans is largely lacking but does suggest there is a potential for savings. For example, AT&T was able to reduce its annual growth rates for medical expenses from 12.9 percent in 1991 to under 5 percent in 1992 because they moved their workers into POS plan. In 1991, the Pacific Telesis Group moved their fee-for-service enrollees in POS plans and reduced its

annual growth rate from 12 percent to 5 percent. Surveys of their employees found that they were generally satisfied with the system once they understood it.

Coalitions and Cooperatives

In 1991, Cincinnati Bell, General Electric Aircraft Engines, Proctor and Gamble, and the Kroger Company formed a health care coalition to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. Annual savings in the Cincinnati area have been estimated at $75 million for all private and public payers of health care because of a 5 percent decrease in the average charge per patient and a 10 percent decrease in the average hospital length of stay.[7]

Coalitions have also been formed in Denver, CO; Memphis, TN; Cedar Rapids, IA; Houston, TX; Minneapolis, MN; Kingsport, TN; and many other cities. The activities of these coalitions have varied greatly, including the selection of preferred providers on the basis of efficiency, assistance in the purchase of cardiovascular care, the provision of mental health and substance abuse programs at reduced rates, the enactment of healthy lifestyle programs for adults and children, and the provision of small business insurance options. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

States have responded to growing health care costs not only as government entities but also as employers. The California Public Employees' Retirement System (CalPERS) has had success with its own purchasing cooperative for health care services. CalPERS experienced premium decreases in both 1994 and 1995 by negotiating more aggressively with health care providers, asking HMOs to forego

rate increases, and the state introduced a standard benefits package in 1993, requiring copayments of its employees.

Conclusion

The health care delivery and financing system is evolving rapidly. There have been changes in the way health care is financed, the types of treatments available, the sites of care, and the physician-patient relationship. These changes have resulted primarily from reactions to health care cost inflation, and employers' experiences in managing health care costs have varied with the methods chosen. We can expect to observe a continued increase in cost-sharing responsibilities of workers, the monitoring of care, the movement of workers and their dependents into managed care arrangements, especially those that offer greater choice of physician, such as IPAs, PPOs, and POS plans, and the formation of employer coalitions to negotiate for volume discounts for health care services.

Thank you for the opportunity to testify this morning. I'll be glad to answer any questions you may have.

---

[1] In 1993, 54.2 percent of workers aged 18-64 received health insurance coverage from their employer. See Sarah Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

[2] U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms,* 1979–1989 (Washington, DC: U.S. Government Printing Office, selected years); *Employee Benefits in Medium and Large Private Establishments,* 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995).

[3] Paul J. Feldstein, Thomas M. Wickizer, and John R.C. Wheeler, "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures," *New England Journal of Medicine* (May 1988): 1310-1314.

[4] Nancy Kraus, Michelle Porter, and Patricia Ball, *Managed Care: A Decade in Review 1980-1990,* (Excelsior, MN: The InterStudy Edge, 1991).

[5] The InterStudy *Competitive Edge,* 5.1 (Minneapolis, MN: Interstudy, 1995).

[6]U.S. Congressional Budget Office, "The Effects of Managed Care and Managed Competition," CBO Memorandum, February 1995.

[7]Danae A. Manus, Robert J. Strub, and Thomas R. Werner, "The Cincinnati Initiative," *Managed Care Quarterly* (Winter 1994): 20-26.

Related EBRI Publications

"The Future of Employment-Based Health Benefits." *EBRI Issue Brief* no. 161 (Employee Benefit Research Institute, May 1995).

Sarah Snider, and Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no.158 (Employee Benefit Research Institute, February 1995).

Paul Fronstin. "The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence." *EBRI Issue Brief* no. 154 (Employee Benefit Research Institute, October 1994).

Paul Yakoboski, et al. "Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey." *EBRI Issue Brief* no. 152 (Employee Benefit Research Institute, August 1994).

"The Changing Health Care Delivery System: An EBRI/ERF Policy Forum." *EBRI Issue Brief* no. 148 (Employee Benefit Research Institute, April 1994).

William Custer. "Health Care Reform: Examining the Alternatives." *EBRI Issue Brief* no. 147 (Employee Benefit Research Institute, March 1994).

Table 1

Percentage of Employers With Cost-Sharing Provisions, by Level of Cost Sharing and Year for Traditional Indemnity Plans, 1989–1992

Individual Deductible Amount	1989	1990	1991	1992
$100 or less	40%	38%	34%	29%
$150	15	15	15	13
$200	29	27	28	28
Over $200	11	18	23	26

Coinsurance Rate for Inpatient Care	1989	1990	1991	1992
0%	23%	25%	27%	25%
10	7	5	4	4
15	2	2	2	2
20	62	65	63	65
25	a	2	1	1

Coinsurance Rate for Physician Visits	1989	1990	1991	1992
0%	8%	6%	6%	5%
10	6	5	4	4
15	2	2	2	2
20	77	84	82	83
25	a	2	1	1

Employee Out-of-Pocket Maximums	1989	1990	1991	1992
<$1,000	35%	37%	30%	28%
$1,000-$1,499	38	37	39	38
$1,500-$2,499	21	20	24	26
$2,500-$4,999	4	5	6	6
$5,000+	2	2	2	2

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, Report 1: Indemnity Plans: Cost, Design and Funding* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990-1993).

[a]Data not available.

Table 2

Percentage of Surveyed Employers with Utilization Review Programs for Traditional Indemnity Plans, 1989–1992

Type of Program	1989	1990	1991	1992
Precertification of Elective Admissions	73%	81%	81%	83%
Concurrent Review	52	65	65	66
Catastrophic Case Management	55	65	67	69
Outpatient Utilization Review	19	20	19	22
Second Surgical Opinion	89	88	82	71
Mandatory[a]	59	55	49	45
Voluntary[b]	30	33	33	26
None of These	9	7	8	7

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990–1993).

[a]For specific procedures.

[b]For all procedures.