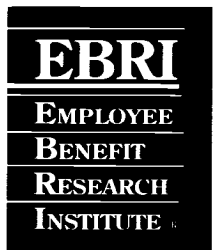


Edited by Dallas L. Salisbury

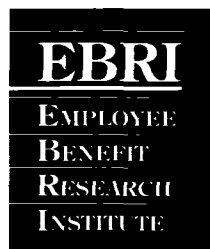


Education
& Research
Fund

The Future of Medical Benefits



An EBRI-ERF Policy Forum
Edited by Dallas L. Salisbury



Education
& Research
Fund

The Future of Medical Benefits

© 1998 Employee Benefit Research Institute
Education and Research Fund
2121 K Street, NW, Suite 600
Washington, DC 20037-1897
(202) 659-0670
Web site www.ebri.org www.asec.org

All rights reserved. No part of this publication may be used or reproduced in any manner whatsoever without permission in writing from the Employee Benefit Research Institute Education and Research Fund except in the case of brief quotations embodied in news articles, critical articles, or reviews. The views expressed in this publication should not be ascribed to the officers, trustees, members, or other sponsors of the Employee Benefit Research Institute, the EBRI Education and Research Fund, or their staffs. Nothing herein is to be construed as an attempt to aid or hinder the adoption of any pending legislation, regulation, or interpretative rule, or as legal, accounting, actuarial, or other such professional advice.

Library of Congress Cataloging-in-Publication Data

The future of medical benefits/edited by Dallas L. Salisbury.

p. cm.

ISBN 0-86643-091-1

1. Insurance, Health—United States. 2. Employee fringe benefits—United States. 3. Medical policy—United States. I. Salisbury, Dallas L.

HG9396.F88 1998

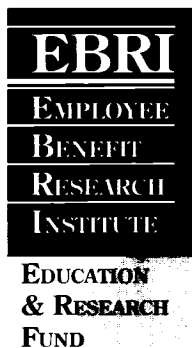
331.25'5—dc21

98-46026

CIP

The premier organization

for employee benefits research



Established in 1978, the Employee Benefit Research Institute (EBRI™) is the only nonprofit, nonpartisan organization in the United States totally committed to original public policy research and education on economic security and employee benefits.

EBRI's overall mission is to encourage, to contribute to, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI does not lobby or endorse specific approaches. Rather, it provides balanced and unbiased analysis of alternatives based on the facts. Through its activities, EBRI advances knowledge and understanding among the public, the news media, and government policymakers of how employee benefits function and why they are critically important to our nation's economy.

Since its inception two decades ago, EBRI has grown to include a cross section of the public and private sectors with an interest in economic security programs. EBRI is funded by membership dues, grants, and contributions from foundations; businesses; labor unions; trade associations; health care providers and insurers; government organizations; and service firms, including actuarial firms, employee benefit consulting firms, law firms, accounting firms, and investment management firms. International members look to EBRI's work to gain understanding of the U.S. economic and employee benefit systems.

Today, EBRI is recognized as one of the nation's most authoritative, objective, and reliable resources on the rapidly changing employee benefits sector—health, savings, investment, retirement, work/family issues, demographics, and economic security.



Table of Contents

About EBRI-ERF Policy Forums vii
Preface viii
About the Authors x

Introduction: The Future of Medical Benefits
Christopher R. Conte

Current Trends 1
Managed Care: Cost Control or
Quality? 2
Room for Improvement 3
Challenges for Employers 3
A Retail Market? 4
What's Next? 5
Where Do Employers Stand? 5

TRENDS IN EMPLOYMENT-BASED HEALTH BENEFITS

1. Features of Employment-Based Health
Plans
Paul Fronstin

Introduction 9
Health Plan Costs 10
Cost Sharing 12
Contributions to Premiums 12
Deductibles 14
Coinsurance 14
Out-of-Pocket Limits and Lifetime
Maximum Limits 14
Delivery Systems 16
Independent Practice Associations 16
Network Model HMO 17
Mixed Model HMO 17
Preferred Provider Organizations/
Point-of-Service Plans 17
Plan Prevalence 18
Coverage of Services 21

Coverage Limitations 21
Nontraditional Benefits 23
Retiree Health Benefits 24
Policy Implications 26
Conclusions 26
References 27

2. Projections of National Health
Expenditures: 1997–2008
Jeff Lemieux

Introduction 29
Strong Economic Growth Will Help
Boost Premiums in 1998 30
Projections of Private Health
Insurance Through 2008 34

MANAGED CARE: COST CONTROL OR QUALITY?

3. Behavior and Its Effect on Future Medical
Benefits
Jessie Gruman

Introduction 39
Defining Behaviors 39
Three Propositions 39
Distribution of Consumers 40
Applying Behavioral Data 40
Conclusion 40

4. Health Care Proposals: The Need for
a Balanced Discussion
Karen Ignagni

Introduction: Assessing the Proposals ... 43
Cost or Quality? 43
The Principle of Accountability 43
The Current Status 44
Conclusion 45

| | | |
|----|---|----|
| 5. | Putting the Patient in the Driver's Seat: A Four-Point Proposal for Change <i>Daniel H. Johnson</i> | |
| | Introduction | 47 |
| | Evidence of Patient Dissatisfaction | 47 |
| | Money, Power and Something for Nothing | 47 |
| | A Four-Point Proposal for Change | 48 |
| | Expanding Choices | 48 |
| | Motivation or Regulation? | 49 |
| | Conclusion | 49 |
| 6. | A Partnership for Quality and Customer Satisfaction <i>Susan C. Meholic</i> | |
| | Introduction | 51 |
| | Addressing the Backlash | 51 |
| | Evolution of Managed Care | 51 |
| | Health Plan Accountability | 52 |
| | Challenges | 52 |
| | The Shift in Focus to Self-Service | 52 |
| | Conclusion | 53 |
| 7. | Four Basic Challenges for Value-Based Purchasing <i>Meredith Miller</i> | |
| | Introduction | 55 |
| | Four Basic Challenges | 55 |
| | National Aims for Improvement | 56 |
| | Accountability and the Patients' Bill of Rights | 57 |
| | Gaps in ERISA | 57 |
| | Isolated Discussions | 58 |
| | Conclusion | 58 |
| 8. | Selling State-of-the-Art Medicine <i>Karen Williams</i> | |
| | Introduction | 59 |
| | An Integrated Approach to Care | 59 |
| | Closing the Practice Gap | 60 |
| | Conclusion | 62 |

CONSOLIDATION: WHAT DOES IT ALL MEAN?

| | | |
|-----|---|----|
| 9. | The Rationale for Health Care Consolidation <i>James D. Bentley</i> | |
| | Introduction | 65 |
| | Defining Consolidation | 65 |
| | Striving for Efficiencies | 65 |
| | Responding to the Shift in Risk | 65 |
| | Third-Party Payer Behavior | 66 |
| | Excess Capacity | 66 |
| | Reduction in Length of Stay | 66 |
| | The Desire for Market Domination | 67 |
| 10. | Building an HMO Without Walls <i>Charles Blanksteen</i> | |
| | Introduction | 69 |
| | Coalition Structures | 69 |
| | Buying Services as a Group | 70 |
| | Conclusion | 71 |
| 11. | A Partnership With HMOs <i>John B. Brence</i> | |
| | Introduction | 73 |
| | A Historical Perspective | 73 |
| | Coalition Guidelines | 73 |
| | Quality Initiatives | 74 |
| | Result Highlights | 75 |

LONG-TERM POLICY IMPLICATIONS FOR EMPLOYMENT-BASED HEALTH PLANS

| | | |
|-----|--|----|
| 12. | What Lies Ahead for Medical Benefits <i>William S. Custer</i> | |
| | Introduction | 79 |
| | Economic Growth | 79 |
| | Health Care Cost Inflation | 79 |
| | Market Segmentation | 80 |
| | Reform in Recession | 80 |

The Future of Medical Benefits

13. Confronting the Issue of Coverage

Paul C. Harrington

| | |
|--------------------------------|----|
| Introduction | 83 |
| Shifting Trends | 83 |
| Different Messages | 84 |
| Reflecting Social Values | 85 |
| Conclusion | 85 |

14. Providing Health Benefits: What Motivates Employers?

Richard Ostuw

| | |
|--|----|
| Introduction | 87 |
| The Business Purpose of Benefits | 87 |
| Changing Business Needs | 88 |
| A Shift in Employer Orientation | 88 |
| Reduced Emphasis on the Employer Role | 89 |
| The Prevalence of Cost Management | 89 |
| A Test for Employee Benefits | 89 |

Q & A

Dallas L. Salisbury

List of Policy Forum Attendees



About EBRI-ERF Policy Forums

The Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) holds two policy forums per year. The goal of the policy forums is to bring together a cross section of EBRI sponsors, congressional and executive branch staff, benefit experts, and representatives from academia, interest groups, and labor to examine public policy issues. It is a roundtable discussion featuring verbal and written exchange among speakers and participants. The roundtable format is designed to encourage discussion.

Past EBRI-ERF policy forums include:

- 12/03/97 “Do Employers/Employees Still Need Employee Benefits?”
- 04/30/97 “Retirement Prospects in a Defined Contribution World”
- 12/04/96 “Assessing Social Security Reform Alternatives”
- 04/30/96 “Comprehensive Tax Reform: Implications for Economic Security and Employee Benefits”
- 12/07/95 “The Changing World of Work and Employee Benefits”
- 05/11/95 “When Workers Call the Shots: Can They Achieve Retirement Security?”
- 10/26/94 “The Future of Employment-Based Health Benefits”
- 05/04/94 “Retirement in the 21st Century: Ready or Not?”
- 10/06/93 “The Changing Health Care Delivery System”
- 05/05/93 “Pension Funding and Taxation: Achieving Benefit Security”
- 12/01/92 “Rationing: Making Choices and Allocating Resources in the Health Care Delivery System—Implications for Access, Quality, and Costs”
- 04/29/92 “Paternalism vs. Empowerment: What Benefits Should/Will Employers Provide?”
- 09/25/91 “Retirement Security in a Post-FASB Environment”
- 05/02/91 “Pension Portability and Preservation: Assuring Adequate Retirement Income in the 21st Century”
- 10/04/90 “Winners & Losers in Reforming the U.S. Health Care System”
- 05/03/90 “Assessing the Implications of Proposals for Pension Fund Taxation”



Preface

Americans are spending an ever-increasing amount of money on health care. National health expenditures are estimated at \$1.035 trillion, representing 13.6 percent of Gross Domestic Product (GDP), in 1996, up from \$699.5 billion and 12.2 percent of GDP in 1990, as shown in chapter 1. Chapter 1 also shows that employer spending on private health insurance totaled \$262.7 billion in 1996, up from \$61 billion in 1980. Business health spending as a percentage of total compensation increased from 3.7 percent in 1980 to 5.9 percent in 1996 and reached a high of 6.6 percent in 1993. Private health plan costs per employee increased from an average of \$3,502 in 1992 to \$3,924 in 1997. For larger employers, average costs increased from \$3,775 in 1992 to \$4,369 in 1997.

Despite rising spending on health care, only 5 percent of Americans give an excellent rating to health care in America today, according to results from the 1998 Health Confidence Survey (HCS), co-sponsored by the Employee Benefit Research Institute (EBRI) and Mathew Greenwald & Associates. While just over one-half rate health care as excellent, very good, or good, almost one-half rate it as fair or poor. In fact, while health care is a very important issue to Americans, it is barely on the American public's radarscope when compared with other issues of national importance. When asked what they consider to be the most critical issue in America today, 15 percent of Americans cite health care, while 83 percent consider something else to be the most critical issue. This juxtaposition of health care with other national issues is important as policymakers debate legislation concerning consumer protection issues, mandated benefits, managed care, and health plan liability.

In order to explore the issues surrounding the future of health care, how managed care and consolidation in the health care industry affect that future, and the policy implications for employee health benefit programs, EBRI's Education and Research Fund (EBRI-ERF) sponsored a policy

forum in Washington, DC, on May 6, 1998, on the topic: "The Future of Medical Benefits." The policy forum brought together government officials, corporate executives, employee benefit professionals, and representatives from academia, research organizations, and media to discuss these issues. The papers included in this volume were originally prepared for the policy forum. The session included an active discussion among the authors and the more than 100 invited participants with an interest in the health care system and employee benefit issues.

This book integrates the papers and proceedings of the policy forum into a single work. The introduction written by Christopher Conte, a former *Wall Street Journal* reporter and editor who is now self-employed as a writer and an EBRI Fellow, sets the stage for the remaining sections of the publication. Conte highlights segments of the discussion, weaving them into an eloquent synopsis of the entire session.

The first section of the book provides background information on the current status of the health care system and outlines critical issues for the future. The first paper, written by Paul Fronstin of EBRI, provides data and statistics on health plan costs, cost sharing arrangements, the changing health care delivery system, trends in the range of benefits covered, and retiree health benefits. The second paper, written by Jeff Lemieux, of the National Bipartisan Commission on the Future of Medicare, and formerly of the United States Congressional Budget Office (CBO), discusses the CBO's past projections of the private health insurance premiums and how and why these estimates have changed recently.

The second section of the book examines the future of managed care, with many of the authors addressing the issue of accountability. In addition, Jessie Gruman, of the Center for the Advancement of Health, discusses the relationship between personal behavior and the future of health

benefits, while Karen Williams, of the National Pharmaceutical Council, discusses the role of prescription drugs in the future of managed care.

The third section of the book discusses the issue of consolidation in the health care industry. James Bentley of the American Hospital Association discusses consolidation from the hospital point of view. Charles Blansteeen of Merrill Lynch and John Brence of William M. Mercer both discuss consolidation among health plan sponsors.

The fourth section of the book deals with the long-term policy implications for employment-based health plans. William Custer of Georgia State University, an EBRI Fellow, shares his thoughts on the employment-based health system, rising health care costs, and the overall economy. Paul Harrington of the U.S. Senate Labor and Human Resources Committee adds his perspective on the future of employment-based health benefits as a policymaker. Finally, Richard Ostuw of Towers Perrin offers the employers' orientation on the future provision of employment-based health benefits.

The final section of the book presents highlights from the question and answer period

which followed each section of the policy forum. I thank the sponsors of EBRI for making this forum and book possible, while making it clear that any opinions, errors, or positions taken are those of the authors and not of EBRI, EBRI-ERF, its staff, Members, Trustees, or editors.

I want to thank Pamela Ostuw and Paul Fronstin for organizing the forum; Cindy O'Connor for the production of forum materials and the book; Steve Blakely, Deborah Holmes, and Lynn Miller for copy editing; and all of the forum authors and participants.

EBRI was founded in 1978 by leaders in the employee benefits field with a vision of building an objective research and education organization. Its mission is to encourage, to contribute to, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

This volume carries forward that mission of providing a basis for sound program design. It is dedicated to the founders of EBRI, in this our Twentieth Anniversary year.

Dallas L. Salisbury
November 1998



About the Authors

James D. Bentley is Senior Vice President for Strategic Policy Planning at the American Hospital Association (AHA). His responsibilities include developing AHA policy on long-term public policy issues, such as restructuring Medicare for the future and increasing the number of Americans with health care coverage; using policy development to promote unity among provider advocacy organizations; and the financing and accreditation of graduate medical and nursing education. Bentley joined the American Hospital Association in December 1991 as Senior Vice President for Policy. For the first six years, he was responsible for planning and directing the AHA's public policy analyses, its data analysis on trends impacting hospitals and health networks, and its involvement in medical education issues. Before joining AHA, Bentley spent 15 years with the Association of American Medical Colleges. Initially responsible for legislative and regulatory activities affecting teaching hospitals, he concluded his AAMC career as Vice President of Clinical Services with responsibility for the Association's program of services for teaching hospitals and faculty practice plans. Bentley spent five years in the U.S. Navy Medical Service Corps and has been on the faculty of George Washington University, where he taught medical sociology and health care administration. He has published in a wide variety of journals, including *Health Affairs*, *The New England Journal of Medicine*, and *The Journal of the American Medical Association*. He earned his B.A. in health facilities management from Michigan State University and his Ph.D. in medical care organization from the University of Michigan.

Charles Blanksteen is a health care and group benefits consultant in William M. Mercer's New York office. He specializes in creating, managing, and assessing health and disability delivery systems and their integration with benefit programs. His clients include American Express Company, Merrill Lynch & Co., Inc., Mobil Corpora-

tion, The New York/Cornell Medical Center, Sears Roebuck & Company, and the U.S. Department of Labor. Blanksteen has strategically designed, implemented, and maintained managed medical, dental, and disability benefit programs for several major public and privately held organizations. He has been a consultant to several employer and health care provider coalitions, including the National HMO Purchasing Coalition. He was a member of Mercer's National Health Care Practice Group and a member of the in-house data analysis faculty. Prior to joining Mercer in 1980, Blanksteen was a consultant at Johnson and Higgins and before that an underwriter at Metropolitan Life Insurance Company. He holds a B.A. in psychology from Connecticut College, an M.S. in economics from Polytechnic University, and advanced professional certification in organizational development from Columbia University.

John B. Brence is Vice President, Global Benefits, for Merrill Lynch, and has been with the company for eight years in corporate benefits and executive compensation roles. He is responsible for the design and management of all domestic health care, welfare, and workers' compensation programs. Merrill Lynch has over 60,000 active and retired employees and contracts with 180 health plans. Prior to joining Merrill Lynch, Brence held a variety of consulting and management positions with Sibson & Company, Goldman Sachs, and Carlson Companies. He earned a master of industrial relations degree from the University of Minnesota and a B.A. from the University of Notre Dame.

Christopher R. Conte is a freelance writer based in the Washington, DC, area. An EBRI fellow since 1995, he has written on a wide range of social policy issues, including Social Security, Medicare, and welfare reform, for such publications as *Governing Magazine*, *Congressional Quarterly*, and

the *AARP Bulletin*. He also has reported extensively on telecommunications policy and the social implications of new information technologies for the Benton Foundation. In addition, he has written major articles about journalism. From 1979 to 1995, Mr. Conte worked in the Washington bureau of the *Wall Street Journal*, where he covered economic policy, banking, and transportation and edited both foreign and domestic policy coverage. He also wrote the *Washington Wire*, a weekly column on government and politics, and the *Labor Letter*, a column on labor and work place issues. Earlier, he worked as a reporter for the *Congressional Quarterly* and the *Rutland Herald* in Vermont. He holds a B.A. from Harvard.

William S. Custer is an Associate Professor in the Department of Risk Management and Insurance at Georgia State University. Previously, he was the Director of Research at the Employee Benefit Research Institute (EBRI) in Washington, DC. Prior to joining EBRI, Custer was an economist in the Center for Health Policy Research at the American Medical Association, and served as Assistant Professor of Economics at Northern Illinois University. He has authored numerous articles and studies on the health care delivery system, health insurance, retirement income security, and employee benefits. He has served as a member of the Board of Directors, National Association of Health Data Organizations. A member of the National Academy of Social Insurance since 1992, Custer received his Ph.D. in economics from the University of Illinois.

Paul Fronstin is a Senior Research Associate with the Employee Benefit Research Institute (EBRI). He is also director of the Institute's Health Security and Quality Program. Fronstin's research interests include trends in health insurance coverage and the uninsured, the effectiveness of managed care, retiree health benefits, retirement transitions, employee benefits and taxation, the role of non-profit organizations in providing employee benefits, children's health insurance coverage, and public opinion about health care. His most recent publications include a chapter in *Driving Down Health Care Costs: Strategies and Solutions*, 1996, on health care cost management strategies and articles in *Inquiry* and *Social Science Quarterly*,

both explaining trends in health insurance coverage. Fronstin has appeared before many groups to share his expertise on employee benefits. He has also made numerous presentations for congressional staff and the media. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. from the University of Miami.

Jessie Gruman is Executive Director of the Center for the Advancement of Health, a Washington-based nonprofit organization that promotes research on the influence of psychological, social, behavioral, and environmental factors on health and illness and the translation of that research into practical, real-world applications in health care settings, work sites, schools, and communities. The Center's work is funded by the John D. and Catherine T. MacArthur Foundation, the Nathan Cummings Foundation, the Robert Wood Johnson Foundation, and others. Gruman's career has been devoted to expanding the traditional view of health from its predominantly biological focus to health care that recognizes and treats the complex network of interactions among mental states, emotions, behaviors, environment, and biology. The Center's mission is to integrate this expanded view into the national health research agenda and health care delivery. Before founding the Center in 1992, Gruman was with the National Cancer Institute, where she designed and directed the initial phases of the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST). Prior to her government service, she served as National Director for Public Education at the American Cancer Society and as manager of health promotion at AT&T corporate headquarters. She received her Ph.D. in social psychology from Columbia University in 1984.

Paul C. Harrington is Health Policy Director, Majority Staff, for the U.S. Senate Committee on Labor and Human Resources. He is responsible for working in all areas of health policy and legislation in order to assist Sen. James M. Jeffords (R-VT) in his capacity as the Chairman of the Labor and Human Resources Committee, as a member of the Finance Committee, and as a member of the Aging Committee. Prior to this position, he served as Deputy Commissioner for the Vermont Department of Labor and Industry. There, he carried out

The Future of Medical Benefits

administrative, operational, and policy development responsibilities in all areas of the department's jurisdiction. The department is responsible for enforcing Vermont's laws relating to workers' compensation, occupational safety and health, registered apprenticeship, wage and hour issues, and public building codes.

Karen Ignagni is President and CEO of the American Association of Health Plans (AAHP), the nation's largest trade association for HMOs and network-based health care systems. Named by *Washingtonian* magazine as one of the 50 best trade association heads in Washington, and voted one of the 100 most influential people in long-term care during 1996, Ignagni has been with AAHP (formerly Group Health Association of America) since 1993. Under her leadership, the 1,000-member trade association has been called "a force to be reckoned with on Capitol Hill" by the *National Journal*. Ignagni has had a long and active involvement in health care issues. Prior to joining AAHP, she directed the AFL-CIO Department of Employee Benefits. For four years, Ignagni served on the U.S. Senate Labor and Human Resources Committee staff. In the late 1970s, she was assistant executive director for the Committee for National Health Insurance, and prior to that, a research analyst for the Department of Health and Human Services. Ignagni is CEO of the AAHP Foundation, is on the boards of directors of the National Academy of Social Insurance, the Partnership for Prevention, and the Bryce Harlow Foundation and is a member of the Commonwealth Funds' Commission on Women's Health. Articles by Ignagni have appeared in numerous national publications. She holds an M.B.A. from Loyola University.

Daniel H. Johnson, a diagnostic radiologist, completed his year as President of the American Medical Association (AMA) in June 1997. Johnson, who was elected President-Elect in June 1995, served as Vice Speaker of the AMA House of Delegates from June 1987 to June 1991 and as Speaker from June 1991 to June 1995. He had served as a delegate from 1983 until he became President-Elect and as an alternate delegate from 1980 to 1982. Long active in organized medicine, Johnson chaired the Louisiana State Medical Society's (LSMS) committees on long-range plan-

ning, advertising and fee complaints, and alternative delivery systems. He was Speaker and Vice Speaker for the LSMS House of Delegates for 11 years, and is a past president of the society. He is a founding member of the Board of the Louisiana Medical Mutual Insurance Company (LAMMICO) and is active on its marketing committee. He is also a past chair and treasurer of the Louisiana Medical Political Action Committee (LAMPAC). Since the summer of 1992, he has represented the physicians of Louisiana on the Louisiana Health Care Commission. Johnson received his M.D. degree from the University of Texas at Galveston, where he interned in surgery. Currently, he is Clinical Professor of Radiology and Otolaryngology at Tulane University. He was Co-Founder and President of the American Society of Head and Neck Radiology. He is also a past president and past chair of the Board of the New Orleans Radiology Society.

Jeff Lemieux recently joined the staff of the National Bipartisan Commission on the Future of Medicare. Prior to that, he was a health economist with the Congressional Budget Office (CBO). At CBO, Lemieux formed CBO's projections of national health expenditures, which combine forecasts for Medicare and Medicaid with CBO's outlook for the private health market, and used those projections to estimate the costs of health reform plans. Subsequently, he helped develop CBO's estimating models for the Medicare budget plans of 1995 and the Balanced Budget Act of 1997. His most recent CBO publications are "Medicare Projections" and "Projections of National Health Expenditures, 1997-2008" in CBO's *Economic and Budget Outlook* (January 1998). Prior to joining CBO, Lemieux worked two years for the Office of the Actuary at the Health Care Financing Administration. Between 1986 and 1990, he was with DRI/McGraw-Hill, the macroeconomic forecasting firm.

Susan C. Meholic is District Manager for Health Plans Administration at AT&T. In this capacity, she has oversight responsibility for Plan Administration of AT&T's managed care and other health plans that provide benefits to 140,000 active employees and retirees. Meholic's responsibilities include developing partnerships with 14 vendors and 140 HMOs, assessing vendor performance, developing action plans for improvement and

communicating information to employees that allows them to make informed decisions about their health plan choices. Prior to joining AT&T, Meholic was a consultant with the Health and Welfare Consulting Group of Actuarial Sciences Associates (ASA), where her primary role was to assist similar corporations in managed care benefit and vendor evaluations, focusing on quality of care, customer satisfaction, and financial issues. Meholic began her employee benefits career with the Prudential Insurance Company of America, during which time she held a variety of positions in marketing, account management, claim operations, and customer service. She received a Bachelor of Science degree in chemistry from Cornell University, has completed numerous courses in the Master of Business Administration degree program at Boston University Graduate School of Management, and has completed several CEBS exams.

Meredith Miller, who has been involved for more than 14 years with on-the-job benefit programs for American workers, is serving in her fifth year as Deputy Assistant Secretary for Policy in the U.S. Department of Labor's Pension and Welfare Benefits Administration. Miller works closely with the agency's Assistant Secretary, Olena Berg, in guiding administration policy. Miller came to her federal assignment from the AFL-CIO, where her last position was assistant director of the employee benefits department. She had been with the AFL-CIO since 1988 and served in other roles involving employee benefits. From 1983 until 1988, Miller was assistant research director for employee benefits with the Service Employees International Union and taught at the college level for one year before that. Professional activities include serving on the Labor Department's ERISA Advisory Council, on the editorial board of *Business and Health Magazine*, and on the advisory boards of the Bureau of National Affairs' *Pension and Benefits Reporter* and the National Resource Center on Work Site Health Promotion of the Washington Business Group on Health. She holds memberships in several organizations, including the National Academy of Social Insurance and American Friends of the London School of Economics. Miller graduated from Hampshire College in Massachusetts in 1977, and earned her master's degree a year later in industrial and labor relations from the London

School of Economics in England, where she finished first in her class.

Richard Ostuw is a Principal of Towers Perrin and the firm's Chief Actuary. He is located in the Stamford office. As a consultant, he assists employers in all aspects of employee benefits, with emphasis on their design and financing. He has been a national leader in the design and financial management of retiree health care and flexible benefits programs. As Chief Actuary, Ostuw provides leadership for developing new approaches and consulting tools for the firm's employee benefits services (EBS) staff, the professional development of the staff, the efficient delivery of services, and continuous quality improvement. He serves as a resource to the staff on various technical and consulting issues. He also serves as a member of the Towers Perrin Quality Council, as chair of the EBS Professional Standards Committee, and as chair of the Promotions Committee. In addition, he chaired the Cost Audit Group for the President's health care reform task force, served on FASB's Advisory Committee and conducted research for the FASB and the U.S. Congress. Ostuw has a B.A. degree in mathematics from Rutgers University and an M.S. degree in actuarial science from Northeastern University. He is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Conference of Consulting Actuaries. He has been active in these organizations and has served on several committees. In addition, he has written numerous articles on employee benefits and has taught Certified Employee Benefits Specialist and actuarial courses.

Dallas L. Salisbury is President and CEO of the Employee Benefit Research Institute (EBRI), Washington, DC. He is also Chairman and CEO of the American Savings Education Council (ASEC), a partnership of public- and private-sector institutions that undertakes initiatives to raise public awareness about what is needed to ensure long-term personal financial independence. He is currently a member of the Board of Directors of the National Academy of Social Insurance, the Board of Directors of the Health Project, and the Advisory Board of the National Academy on Aging. He serves on many editorial advisory boards, including those

The Future of Medical Benefits

of *Employee Benefit News*, *Benefits Quarterly*, *Employee Benefits Journal*, and *Healthplan: The Magazine of Trends, Insights and Best Practices*. Salisbury has served on the Secretary of Labor's ERISA Advisory Council, on the presidentially appointed PBGC Advisory Committee, as a consultant to numerous government agencies and private organizations, and on committees of many professional organizations. He is a Fellow of the National Academy of Human Resources. He has written and lectured extensively on economic security topics. He holds a B.A. degree in finance from the University of Washington and an M.A. in public policy and administration from the Maxwell School at Syracuse University.

Karen Williams joined The National Pharmaceutical Council (NPC) as President in 1996. NPC is a research and education association supported by the leading research-based pharmaceutical companies. The council conducts research on the appropriate use of pharmaceuticals and prepares educational and information resources for public and

private payers and health care policymakers. Williams has more than 20 years of senior executive experience and accomplishments in public programs, private insurance, the pharmaceutical industry, and consulting. She was previously a principal with Medimetrix Group, a national consulting firm based in Cleveland, Ohio. She spent seven years as Vice President of the Pharmaceutical Research and Manufacturers of America, the industry trade association, where she directed the health care systems and policy analysis division. During her seven years with the Health Insurance Association of America (HIAA), she was responsible for strategic planning and policy development. She initiated and directed the development of the long-term care insurance market and led the industry's endorsement and design of insurance practice reforms. Williams spent eight years with the federal government, primarily with the Health Care Financing Administration (HCFA) as liaison for Medicare and Medicaid policy, where she was a major collaborator on the design of the Medicare prospective payment system for hospitals.



Introduction: The Future of Medical Benefits

by Christopher R. Conte

Americans have many conflicting views about our health care system, but most of us would agree on one point: whatever the situation is today, it almost certainly will be different tomorrow.

For many employers, the continued flux is perplexing. After all, the managed care revolution has halted the runaway inflation that helped create a health care “crisis” in the 1970s and 1980s. The erosion in health insurance coverage has largely come to a halt. And since the defeat of the Clinton health plan in 1994, calls for sweeping reform have largely disappeared.

Yet many Americans are dissatisfied with the current situation and worried about the future. Horror stories about people being denied benefits, combined with irritation at a confusing bureaucracy and a billing system that seems incomprehensible, have helped spawn a public backlash against managed care. The political system has responded with moves to create new consumer protections, expand legal rights for health plan participants, and mandate benefits.

How will employers react? Will they find ways to address public dissatisfaction within the context of the current managed care system? Or will they succumb to political forces and stand by while government redesigns the system of medical benefits?

Leaders from the health care industry pondered that question at the Employee Benefit Research Institute’s (EBRI’s) May 6, 1998, policy forum on the “Future of Medical Benefits.” Like many employee benefit issues, the topic lies squarely at the intersection of business management and public policy. As a result, even if business executives wanted to concentrate purely on their private concerns, they would ignore the broader social issues at their own peril.

As Georgia State University economist and

EBRI Fellow William Custer noted, “Employers thinking about the future are going to have to come to grips—very soon—with what they want their future to be, and how they want to fit into the health care delivery system.”

■ Current Trends

Custer’s warning comes against a backdrop of relative calm. After eroding substantially between 1987 and 1993, health insurance coverage has stabilized and actually increased slightly since 1994, noted Paul Fronstin, senior research associate at EBRI. Health costs, which had been rising at double-digit rates, also have slowed sharply and generally have been tracking the very modest overall rate of inflation.

Not coincidentally, these trends correspond to the dramatic growth of managed care. As recently as 1992, Fronstin noted, 60 percent of employers offered traditional fee-for-service health plans. But by 1997, only 30 percent did, and just 15 percent of employees actually participated in such plans. What’s more, the remaining traditional plans have managed care features. “Virtually the entire population is in a managed care plan,” Fronstin said.

While these trends may give employers some relief, many Americans are unhappy, or at least feel unsettled, by the changes in the health care system. According to Fronstin, just 5 percent of Americans surveyed by EBRI and Mathew Greenwald & Associates in the 1998 Health Confidence Survey rate the current system as excellent, and some 59 percent say it needs major changes. What’s more, 35 percent say the overall system has gotten worse, 57 percent say health insurance coverage has gotten worse, and 81 percent say health care costs have gotten worse.

Those figures appear to speak eloquently of a public that is dissatisfied with the health care system. But Americans are sending “mixed messages,” Fronstin noted. For instance, only 14 percent of those surveyed rate the nation’s health system as poor. More significantly, despite their belief that the system has gotten worse, only 10 percent say they are dissatisfied with the care they personally have received over the last two years, and the same low percentage voice displeasure with their health plans.

Many people say they are unhappy with plans that take away their ability to choose their own doctors, however. Almost one third—32 percent—say they are dissatisfied with the cost of health insurance, and 37 percent are displeased with the cost of treatments that are not covered by their health plans. When asked about their confidence in health care over the next 10 years, Americans express the least amount of confidence in their ability to afford coverage without suffering financial hardship, Fronstin said.

That particular concern may seem surprising considering how health care inflation has eased in recent years. Jeff Lemieux, a staff member for the National Bipartisan Commission on the Future of Medicare and former health economist for the Congressional Budget Office, said that managed health care plans have helped overcome “market failure”—that is, the lack of incentives for cost containment in a system where the availability of insurance prevents people from knowing the economic consequences of decisions they and their medical care providers make.

“Plans have gotten very good control over physician and other practitioner costs and hospital costs over the last five to eight years,” Lemieux said.

■ **Managed Care: Cost Control or Quality?**

Seeking to understand frustrations that have led to a public backlash against managed care in the face of such positive news on the cost front, forum participants debated whether the current system has sacrificed quality of care in the name of cost control.

Meredith Miller, deputy assistant secretary for policy in the U.S. Department of Labor’s Pen-

sion and Welfare Benefits Administration, cited surveys suggesting that people are unhappy with managed care plans mainly because they believe needed treatments are either being delayed or denied—with serious health consequences. She also said the employee share of health insurance premiums has grown. And she decried a lack of “accountability” on the part of managed care plans, whose decisions are not subject to external review.

“You can go purchase a toy at Toys “R” Us, rent a car, use your credit card, and should you be harmed you are better protected than when you purchase your health care,” Miller said.

Other forum participants suggested that health plans could go a long way toward assuaging a disgruntled public simply by improving “customer service.” Several speakers cited, in particular, the “hassle” of dealing with the health care bureaucracy. “Many, many consumers ... simply want us to get it done once, get it done right, not have rebillings, and not have hospitals and providers have money and think they don’t have it,” said William Young, head of operations for Aetna US Healthcare’s Northeast Region.

Poor customer service can have real health effects, noted Susan Meholic, district manager for health plans administration at AT&T. “Lack of convenience diminishes both perceived and real quality,” she said. “It discourages well people from getting important preventive care, and chronically ill people from getting ongoing needed support.”

Karen Ignagni, president and chief executive of the American Association of Health Plans (AAHP), offered a spirited defense of managed care. While managed care certainly took hold in large part as a means of controlling costs, she said, health plans have entered a new, evolutionary stage in which they are “bringing cost containment and quality assurance together.”

She noted, for instance, that the National Committee for Quality Assurance, a voluntary accreditation organization for health plans, is moving away from “process-oriented” to “outcomes-based” standards in accrediting health plans. As part of its efforts, NCQA has developed the Health Plan Employer Data and Information Set (HEDIS), a data system that will allow users to compare health plans on the effectiveness of their patient care in such areas as cancer screening, prenatal care, smoking cessation, heart disease, and eye exams.

“We have gotten the message, loud and clear, that we have to continue to be for continuous quality improvement,” Ignagni said. AAHP is the nation’s largest trade association for health maintenance organizations and networked-based health care systems.

■ Room for Improvement

While hailing the creation of HEDIS and similar moves toward “value-based purchasing,” Miller said substantial challenges must be met before consumers—employers and individuals alike—have the information they need to compare health plans on the basis of quality, rather than just price. Databases are not standardized, and much of the information on the quality of care isn’t in the public domain, making comparison shopping difficult, she noted. What’s more, she said, studies show that employers are still purchasing on the basis of cost, rather than quality. Recently, the Labor Department responded to this finding by issuing a letter of guidance informing employers that if workers have to help pay the premiums for their health insurance, employers have a fiduciary obligation to purchase coverage on the basis of quality as well as cost.

Other participants suggested that regardless of how one views managed care, there is plenty of room for improvement in the quality of care Americans currently are receiving. Karen Williams, president of the National Pharmaceutical Council, spoke of a “practice gap.” All too often, according to Williams, people get diseases that are not diagnosed. Or they get afflictions—especially hypertension, depression, and diabetes—that are diagnosed but are not actively treated. Or doctors prescribe treatment, but nobody follows up to determine whether patients actually get the medicine or treatment they need.

“We as health care people need to sell state-of-the-art medicine, and payers need to pay for it,” Williams said. “Anything else ... is going to wind up increasing regulation and public backlash.”

In a similar vein, Jessie Gruman, executive director of the nonprofit Center for the Advancement of Health, noted that Americans as a society still take a far too narrow view of what is required to stay healthy. She said a substantial body of

social science research has demonstrated that personal health is profoundly affected by personal behavior—a term encompassing everything from an individual’s socioeconomic status and community “embeddedness” to emotional variables such as self-image and specific activities such as smoking, diet, and exercise. But “we are using only 10 percent of what we know” in this area, she said.

To deliver real value to consumers, Gruman concluded, health care plans must not only pay for certain medical services, they also must give people information about when, how, and why to seek health services. And they must help people find a wide range of services that address the behavioral issues affecting health.

“I don’t think medical care and health care in general will ever be fully responsive unless it’s able to systematically take behavior into account,” Gruman said. “And that means to recognize, to address, and to treat the whole person.”

■ Challenges for Employers

Having vested considerable power in health plans, can employers help ensure that health plans meet employee concerns about the quality and convenience of their care?

It won’t be easy. In the face of a wave of consolidations among health care providers and insurers, some employers feel they have lost leverage in the health care market. The many companies that have moved away from directly delivering benefits toward using outside vendors have fewer—and in some cases, no—local benefit managers to which employees can turn, noted AT&T’s Meholic. Corporate consolidations, downsizing, and continued pressure to do more with less have created a “considerable challenge for the staff remaining to devote the time needed to improve performance and service, and endeavor to provide meaningful support for employees,” she added.

Some very large companies have banded together in an effort to counter such pressures and gain more leverage in the health care market. Charles Blanksteen, a health care and group benefits consultant with William M. Mercer Companies, described how some employers are pooling resources to provide “non-HMO (health maintenance organization) coverage” for employees. Six

Fortune 100 companies, for instance, have formed a “study group” that has designed a health plan with in- and out-of-network features, a shared resource center, specialty utilization review, and other features.

John Brence, vice president for global benefits at Merrill Lynch, described the National HMO Purchasing Coalition. Originally formed by Merrill Lynch and American Express, the coalition has grown to include 12 major corporations that collectively purchase health plan services for their employees.

Brence said the coalition came together to ensure high-quality medical care as well as low costs. There really is no conflict between these goals, he argued. Noting that 1 percent of employees are responsible for 25 percent of health benefit costs, Brence said companies can both save money and improve health care at the same time by concentrating on finding individuals as early in the “illness cycle” as possible and providing them treatment that prevents them from getting seriously ill.

In pursuit of its goals, the coalition looks for health plans that have comprehensive medical management systems in place and that can use information from a variety of sources proactively to help doctors and hospitals improve the quality of the care they provide. When the coalition reviews health plans, he added, its members are mostly interested in meeting with the plans’ primary clinical staff, reviewing actual medical charts to see how they handle specific cases, and looking at how well the plans’ quality assurance committees function.

It’s no coincidence that the members of the coalition are all large corporations. Smaller employers often lack the resources needed to supervise health plans so rigorously.

Daniel Johnson, past president of the American Medical Association, offered what might appear to be a tempting alternative to some employers. He proposed transforming health benefits to the “defined contribution” model so popular in the field of retirement benefits. Under this approach, employers would provide the same financial support, but they would allow employees to select their own health plans. Employers would “get themselves out of the insurance business, out of the micromanagement of care ... [and give] the employee ... the opportunity and the responsibility

to choose his or her own insurance,” Johnson argued.

Johnson, who said managed care continues to cause physicians “a huge amount of anxiety,” said his proposal would address the primary cause of high health care costs—namely, “the fact that the person consuming the services is insulated from the cost of these services because somebody else is paying.”

■ A Retail Market?

Forum participants found a number of potential problems with the defined contribution approach. Perhaps most significantly, several argued, it would create a real danger of “adverse selection”—that is, insurers would lure people who are good risks and exclude those who aren’t. This would substantially increase the costs of covering people who are not considered good risks. According to the National Pharmaceutical Council’s Williams, 20 percent of people account for between 60 percent and 70 percent of all health costs. To the extent those 20 percent find themselves unable to obtain insurance or become saddled with unbearably high costs for their coverage, pressures for political intervention likely would become intense.

At the moment, consumer choice is fairly limited in the health arena. Only 20 percent of employers currently offer their workers more than one health plan. But employees are demanding more choice, and the system is moving toward accommodating them. This trend toward “self-service,” as Meholic put it, raises a concern, however: several forum participants argued that employees currently do not have the information they need to make the complex decisions involved in choosing health plans or individual service providers.

Meholic noted, for instance, that fewer than one-third of employers currently pass on to their employees any information they have on plan performance. And, she added, “For those employers who do provide quality information to their employees, employees don’t know how to use it.”

The Labor Department’s Miller agreed, noting that the health care sector has generated nothing comparable to the widespread partnerships in which employers, nonprofit groups, the financial industry, and government seek to educate the public about pension and retirement saving.

Predicting that the public will increasingly demand quality information on health care, she said the Clinton administration is establishing a blue ribbon panel to set up a private-sector entity to coordinate, standardize, and make available to the public health-related data being developed by disparate groups.

■ What's Next?

For employers, one of the most important questions today is whether political forces will give health plans time to address public concerns on their own without more aggressive government intervention. The indications are mixed.

EBRI Fellow Custer predicted that economic forces eventually will create pressures for sweeping change. While currently restrained, health care costs eventually will surge ahead of other prices, he said. He cited Lemieux's observation that the Congressional Budget Office currently projects that health insurance premiums will rise about 5½ percent next year, faster than the expected inflation rate.

The cost squeeze will intensify if the economy falls into a recession and family income drops, according to Custer. In this situation, some individuals and companies will stop buying health insurance. This will shrink the number of people in insurance risk pools, driving up the cost of insurance and further reducing the number of people covered by insurance. As a growing number of people come to feel vulnerable, pressures for government intervention will grow, Custer asserted.

"Comprehensive health reform is no farther away than the next recession," Custer said. "The health care reform debate is simply in a lull, and it's going to pop up again in a very large way."

At the moment, with the economy growing at a healthy clip and inflation seemingly tamed, Custer's scenario may seem a distant possibility. What's more, political forces do not seem aligned for comprehensive health care reform. "As long as we have an executive branch controlled by one party and a legislative branch controlled by another party, I think we're going to continue to be in a time of incremental reform," said Paul Harrington, health policy director for the Senate Labor and Human Resources Committee.

But Harrington acknowledged that some of

the incremental reforms favored by Congress do not seem to be winners with the public. Medical savings accounts, which allow individuals to hold their own health funds in tax-favored individual accounts under their personal control, have not caught on. In the current test program, Congress authorized the creation of up to 750,000 such accounts, but only 17,000 people had taken advantage of the option as of July 1997, Harrington noted.

"When Congress makes decisions based on an ideological perspective, sometimes the market and consumers' choices are completely out of sync with where Congress thinks the American people can and should go or want to go," he said.

Harrington said Congress is torn between conflicting views concerning the role of employers in the health benefits arena. Many members of Congress believe employment-based benefits prevent market forces from working. But when they consider the cost of having the government pick up more of the health care tab, many lawmakers are profoundly committed to preserving employment-based medical benefits, he said.

In the short term, Harrington suggested that Congress will continue to grapple with a number of proposals for incremental change, including mandated benefits and the possibility of allowing aggrieved plan participants to file law suits under Employee Retirement Income Security Act of 1974 (ERISA). But the "intractable" problem that awaits a solution is the 17.7 percent of nonelderly Americans who do not have health insurance—primarily low-income people who work for small employers. He said Congress will have to find ways to help smaller employers, especially smaller employers who have workers with preexisting medical conditions.

Both Custer and Harrington suggested that the answer lies in finding and preserving some mechanism for pooling risk broadly. "People want to have choice," Custer noted. "To have choice, you've got to have a risk pool large enough to sustain the insurance fundamentals. You can't have choice with a segmented insurance market."

■ Where Do Employers Stand?

Custer said the employment-based system is the most efficient way to provide health benefits in a voluntary, private system. But he said there are a potentially "infinite" number of other approaches

that wouldn't include employers. As a result, employers are going to have to consider carefully whether they want to preserve their central role in the system of medical benefits —and what steps they are willing to take to make sure they do.

"Employers, individually and as a group, are going to have to think through what the benefits of offering health insurance to their employees are, and what the costs are," he said.

Richard Ostuw, chief actuary for Towers Perrin, took up Custer's challenge, presenting a series of questions on which employers likely will decide whether to continue offering medical benefits.

First, he said, do employers add significant value in arranging coverage? As a general rule, the answer is yes, according to Ostuw. Individuals can get better coverage at a better price through employers than they can on their own. However, the advantages are less true for smaller employers than for large ones.

Is the cost of managing medical benefits modest and is the size of employer contributions acceptable? The jury is out on this point, according to Ostuw. He said the cost appears to be acceptable to many employers, but noted that employers are concerned about possible escalation in costs.

Is the employer contribution a reasonable allocation of the compensation dollar? Ostuw said employers are under a lot of pressure to spend more of their compensation dollars to reward employee performance. Medical benefits, which are provided on the basis of need rather than performance, are

inconsistent with that goal, he said.

Do medical benefits help attract and retain productive employees? Ostuw said they do. They are seen as a barometer of whether a company cares about its employees. He also argued that medical benefits directly increase employee productivity by reducing the time employers have to spend arranging their own coverage.

Do employment-based medical benefits improve employee health? On this question, the evidence is less clear, since employees likely would find coverage elsewhere if their employees stopped offering medical benefits.

Is the value of the program perceived by employees to be greater than the cost? This, Ostuw said, is the "ultimate test." So far, he said, the fact that companies keep offering benefits suggests that the answer is yes.

For the moment, at least, Ostuw said he doesn't expect employers to abandon the medical benefit business. But he acknowledged that many employers have started saying that "the system is so difficult to manage (that) we'll never satisfy employees and therefore, maybe we're better off not playing the game."

Ultimately, Ostuw concluded, preservation of the current employment-based system may depend on how effectively employers respond to employees' current concerns. "A critical issue is dealing with the underlying causes of employee dissatisfaction and managing expectations," he suggested.

TRENDS IN EMPLOYMENT- BASED HEALTH BENEFITS

Features of Employment-Based Health Plans

by Paul Fronstin

■ Introduction

Employment-based health plans are the most common source of health insurance among the nonelderly population in the United States, providing coverage to nearly two-thirds of the nonelderly population in 1996 (Fronstin, 1997c). In addition, 34 percent of individuals ages 65 and older had employment-based coverage in 1996, mainly as a supplement to Medicare (Fronstin, 1997b). Employers offer employment-based health benefits for the basic purpose of keeping workers healthy and providing workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. In addition, they offer health benefits as a form of compensation to recruit and retain qualified workers. Health benefits are probably the benefits that are most used and valued by workers and their families. Employment-based health insurance was cited as the most important benefit by 64 percent of respondents to a recent survey (Ostuw, 1996).

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with coverage increased. This increase occurred largely because wages were frozen during the war by the National War Labor Board, whereas health benefits were not restricted or subject to income or Social Security taxes as cash wages were. Twelve million people were covered by private health insurance in 1940 (less than 10 percent of the population). By 1945, 32 million people had private health insurance coverage, and by 1950, 77 million had such coverage (Health Insurance Association of America, 1996). In 1996, nearly 166 million nonelderly Americans were covered by private health insurance (71 percent of the U.S. population), and

150 million of them had employment-based plans (Fronstin, 1997c). Between 1987 and 1993, employment-based coverage of the nonelderly population fell from 69.2 percent to 63.5 percent. Employment-based coverage has been increasing since 1993, in part due to downsizing in the military and efforts to move individuals from welfare to work, and it now covers 64 percent of the nonelderly population.

As the number of persons covered by private health insurance grew, so too did the number of services and delivery systems available. In addition to the traditional hospital room, board, and ancillary services, many health care plans now offer such items as outpatient prescription drug benefits, vision care, and dental benefits. Moreover, one of the most significant changes in the health care financing and delivery system has been the increased use of managed care. The delivery system is now dominated by preferred provider organizations (PPOs), health maintenance organizations (HMOs), point-of-service (POS) plans, and managed indemnity plans. Services may also be offered in a variety of settings such as ambulatory care or birthing centers.

The cost of and access to these services and delivery systems is not equally distributed among all payers or participants. The cost of employment-based health insurance depends on the characteristics of an employer's work force, risk factors attributed to the type of employment, and the local health care service market. There are significant differences in average costs among industries and between large and small employers. In addition, individuals may lose employment-based health insurance coverage because of extended separation from the labor market or through job loss, divorce, or death of a parent or spouse. Furthermore, if workers with health insurance are reluctant to change jobs because of concerns about health

insurance, they may forgo opportunities that would increase their productivity. According to the results from the Employee Benefit Research Institute (EBRI)/Mathew Greenwald & Associates 1998 Health Confidence Survey, 27 percent of Americans surveyed in 1998 indicated that they or a family member had passed up a job opportunity solely because of health benefits. These considerations have led analysts to consider whether tying the provision of health care to employment results in an equitable distribution of benefits and costs (Custer and Foley, 1992).

From the 1970s to the early 1990s, escalating costs led to ongoing change in health care financing and in the design of employment-based health insurance benefits. In an attempt to control health care cost inflation, Congress changed the way that Medicare reimburses health care providers, which in turn resulted in changes in the design and cost of employment-based retiree health benefits (Fronstin, 1996a, and Fronstin and Copeland, 1997). Employers also changed active employees' health care benefits.

This discussion examines changes to the health care financing and delivery system as implemented by employers. It specifically focuses on cost management trends and other innovations in employment-based health benefit plans. Drawing on data from the Department of Labor (DOL), Bureau of Labor Statistics' (BLS) employee benefits surveys, and from surveys by private employee benefits consulting firms, it analyzes health plan costs, cost sharing, plan funding, health care delivery systems, services covered under various health plan types, coverage limitations, and retiree health coverage. It concludes with an overview of health care policy activity that promises to influence group health plans.

■ Health Plan Costs

National health expenditures are estimated at \$1.035 trillion, representing 13.6 percent of Gross Domestic Product (GDP) in 1996, up from \$699.5 billion and 12.2 percent in 1990 (Levit et al., 1998). Rising health care costs are also evident at the employer level. In 1996, employer spending on private health insurance totaled \$262.7 billion, up from \$61.0 billion in 1980 (table 1.1). Business health spending as a percentage of total compensation increased from 3.7 percent in 1980 to a high of

6.6 percent in 1993, and declined to 5.9 percent in 1996 (table 1.1). Among private employers surveyed in another study, health plan costs per employee increased from an average of \$3,502 in 1992 to \$3,924 in 1997 (table 1.2). For large employers, the average costs increased from \$3,775 in 1992 to \$4,369 in 1997.

While health care costs have continued to increase, the annual increases have been relatively small since 1991. For some large employer plans, costs have actually declined. Between 1994 and 1996, the average cost of an indemnity plan increased from \$3,497 to \$3,928, then declined to \$3,759 in 1997, while the average cost for an HMO declined from \$3,487 to \$3,307 (table 1.2). Indemnity plan costs increased 4.4 percent during 1995 and 2.4 percent during 1996, while HMO costs declined 3.8 percent in 1995 and 2.2 percent in 1996 (chart 1.1).

Most employers have covered employee health care costs by purchasing coverage, through insurance premiums, from commercial insurers, Blue Cross and Blue Shield plans, or other managed care plans. These plans are considered to be

Table 1.1
EMPLOYER SPENDING FOR HEALTH INSURANCE

Total Employer Outlays for Group Health Insurance and Employer Health Spending as a Percentage of Total Compensation and Gross Domestic Product (GDP), 1959-1994

| Year | Employer Spending on Private Health Insurance (\$ billions) | Employer Spending as a Percentage of Total Compensation | Employer Health Care Spending as a Percentage of GDP |
|------|---|---|--|
| 1959 | 3.0 | 1.1% | a |
| 1960 | 3.4 | 1.1 | 0.1% |
| 1970 | 12.1 | 2.0 | 0.3 |
| 1980 | 61.0 | 3.7 | 1.2 |
| 1990 | 188.6 | 6.2 | 2.8 |
| 1991 | 205.4 | 5.9 | 3.1 |
| 1992 | 228.8 | 6.3 | 3.4 |
| 1993 | 249.6 | 6.6 | 3.6 |
| 1994 | 259.8 | 6.5 | 3.6 |
| 1995 | 256.7 | 6.1 | 3.5 |
| 1996 | 262.7 | 5.9 | 3.4 |

Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, August 1997 (Washington, DC: U.S. Government Printing Office, 1996); and *The National Income and Product Accounts of the United States: Statistical Supplement 1929-1994* (Washington, DC: U.S. Government Printing Office, 1998).

^aNot available.

Table 1.2
AVERAGE ANNUAL HEALTH PLAN COST PER EMPLOYEE, BY PLAN TYPE, 1992-1997

| Plan Type | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|--|---------|---------|---------|---------|---------|---------|
| Total Cost per Employee ^a | \$3,502 | \$3,781 | \$3,741 | \$3,821 | \$3,915 | \$3,924 |
| Small employers (fewer than 500) ^b | 3,058 | 3,240 | 3,452 | 3,448 | 3,380 | 3,357 |
| Large employers (500 or more) ^b | 3,775 | 4,117 | 4,040 | 4,181 | 4,332 | 4,369 |
| Total Cost per Active Employee ^a | | | 3,644 | 3,653 | 3,703 | 3,594 |
| Small employers (fewer than 500 employees) | | | 3,448 | 3,467 | 3,405 | 3,280 |
| Large employers (500 or more employees) | | | 3,812 | 3,795 | 3,930 | 3,820 |
| Indemnity ^{c,d} | | | 3,497 | 3,686 | 3,928 | 3,759 |
| Average employee contribution | | | | | | |
| employee-only coverage | | 420 | 468 | 444 | 516 | 552 |
| family coverage | | 1,392 | 1,476 | 1,512 | 1,596 | 1,692 |
| Health Maintenance Organization (HMO) ^{c,d} | | | 3,487 | 3,410 | 3,350 | 3,307 |
| Average employee contribution | | | | | | |
| employee-only coverage | | 420 | 456 | 456 | 396 | 492 |
| family coverage | | 1,476 | 1,572 | 1,704 | 1,596 | 1,584 |
| Preferred Provider Organization (PPO) ^{c,d} | | | 3,334 | 3,242 | 3,434 | 3,518 |
| Average employee contribution | | | | | | |
| employee-only coverage | | 408 | 468 | 492 | 492 | 492 |
| family coverage | | 1,464 | 1,596 | 1,824 | 1,764 | 1,704 |
| Point-of-Service Plan (POS) ^{c,d} | | | 3,454 | 3,572 | 3,584 | 3,588 |
| Average employee contribution | | | | | | |
| employee-only coverage | | 420 | 468 | 432 | 504 | 504 |
| family coverage | | 1,476 | 1,608 | 1,572 | 1,704 | 1,692 |

Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).

^aFor all medical claims costs, including dental, vision, prescription drug costs, and other carve outs.

^bTotal health benefit cost for active and retired employees.

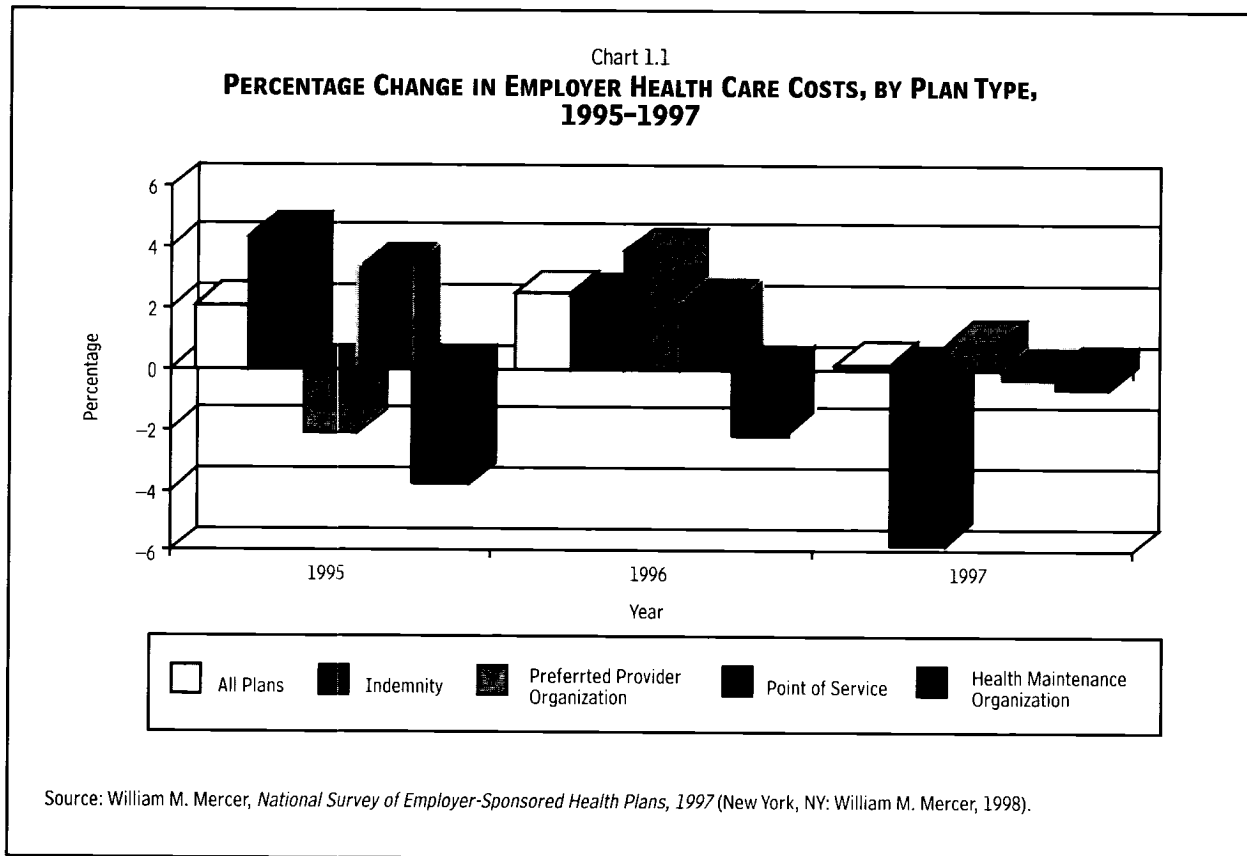
^cLarge employers.

^dDoes not include costs for benefit carve-outs and free-standing plans such as dental care.

fully insured. In a fully insured plan, all of the risk associated with health claims is borne by the insurance company. The insurance company generally sets premiums high enough to maintain some cash reserves, cover administrative costs, and cover state premium taxes. In an effort to reduce health care costs, some employers choose to self-fund, or self-insure, health care plans. This occurs particularly among large firms, which experience less volatility in total dollars spent on claims than smaller firms and are able to more effectively spread the risk of bearing their own health care costs. In a self-funded plan, the employer uses funds normally designated for premiums to pay employee health care claims. Thus the employer essentially acts as its own insurance company and bears the financial risk of making payments to providers. Firms began moving to self-funding to avoid state premium taxes and state-mandated benefits and to retain funds for investment or other

purposes. Self-funding also allows multi-state employers to offer the same health benefits to all workers in all states. Under fully insured plans, on the other hand, insurance companies are required to comply with individual state health mandates, pay state premium taxes, and maintain reserve funds to pay claims. Thus, firms acting independently can often finance benefits for less than insurance companies would charge them. The move to self-funding accelerated following passage of the Employee Retirement Income Security Act of 1974 (ERISA), which was enacted in response to continuing increases in health care premiums and the acceleration of state-mandated benefits for insured plans.¹ Recently, however, the move to self-funding has moderated with the growth of managed care.

¹ For a more detailed discussion about self-funded health plans, see Copeland and Pierron (1998).



■ Cost Sharing

As health care plan costs continue to rise, employers increasingly are changing the design of cost-sharing features. For example, employees are being required to contribute toward routine health care plan cost expenses such as premiums. By increasing employees' share of routine health care costs, or by imposing stricter coverage limitations, employers seek to lower their overall health care expenditures in two ways. First, their required short-term outlay of funds for employees' health care needs is reduced.² Second, cost sharing may lower health care expenditures by reducing the utilization of health care services. However, it has been argued that when cost sharing is increased, some of the care forgone by employees may include preventive or other necessary care, the lack of which may result in greater long-term costs. In addition, increased cost sharing may create negative feelings among

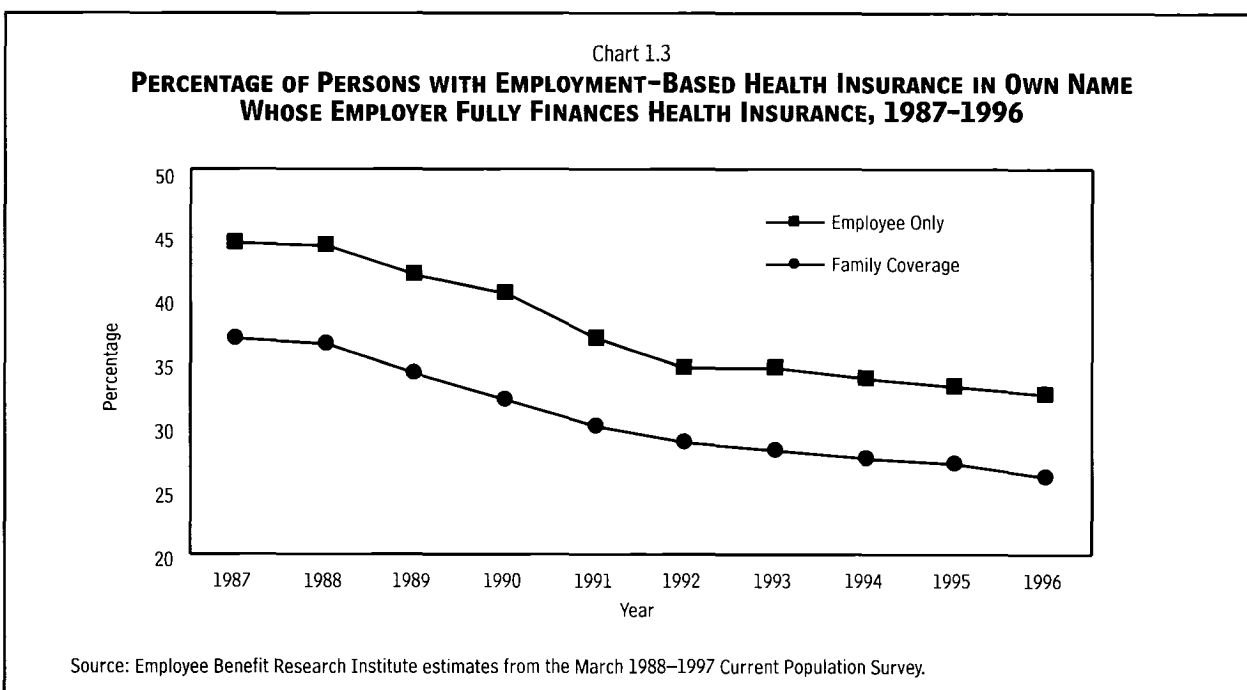
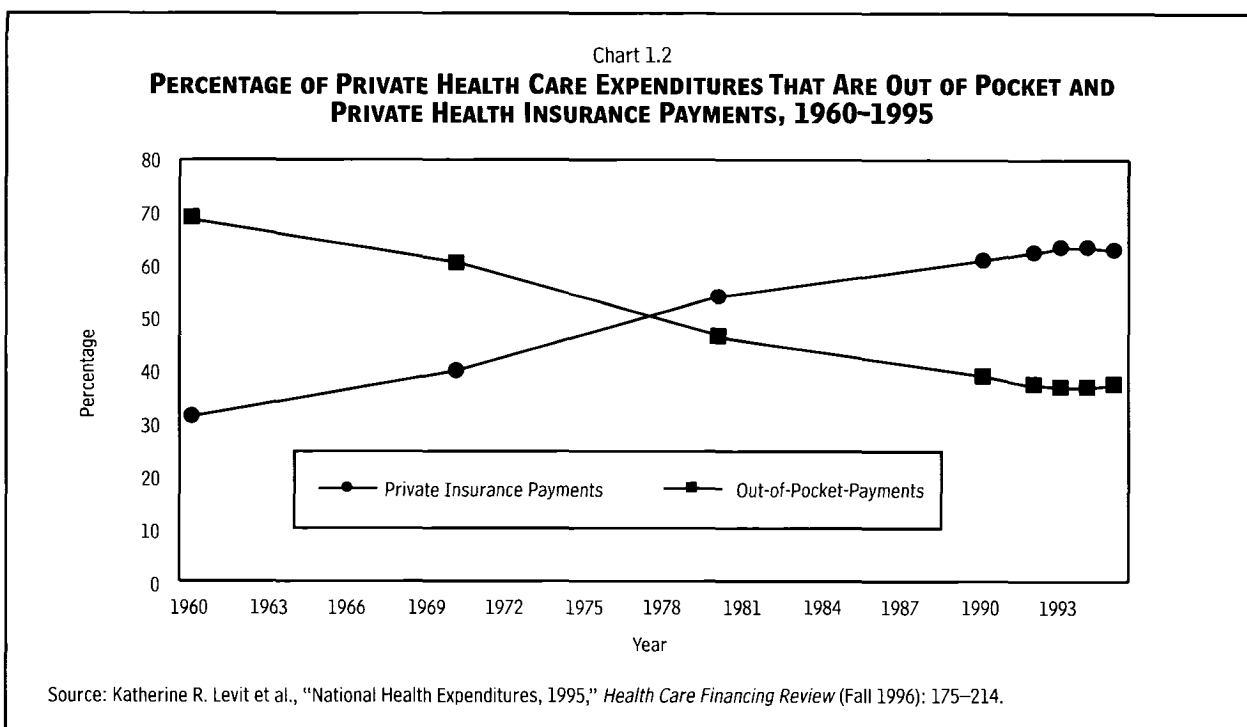
workers, leading to lower productivity.

Despite the growth of many cost-sharing provisions, studies indicate that, in the aggregate, individuals are paying a smaller *percentage* of total health care costs than in the past. In 1960, 69 percent of private health care expenditures were paid out of pocket, and 31 percent were paid by private insurance (chart 1.2). Between 1993 to 1996, only 37 percent of private health expenditures were paid out of pocket, compared with 63 percent paid by private insurance.

Contributions to Premiums

According to EBRI estimates from the March 1988–1997 Current Population Surveys, since at least 1987 employees have been increasingly likely to pay at least a portion of the cost of their health insurance coverage. In 1987, 44.2 percent of workers with employee-only coverage were in plans that were fully financed by their employer, compared with 32.5 percent in 1996 (chart 1.3). In addition, 36.7 percent of workers with family coverage had that coverage fully financed by their employer in 1987, compared with 25.9 percent in

² Although the employer's health care costs may increase relative to the prior year, the increase is less than if the employer absorbed the entire cost increase.



1996. In contrast, *average* employee contributions to various types of health plans, measured as a percentage of the premium, have shown no upward or downward trend (table 1.3). While overall costs increased and the percentage of workers whose employer fully financed coverage decreased, some employees experienced an increase in annual

health care plan costs and others experienced a decrease. For example, a recent survey shows that the average annual employee contribution toward health care for employee-only coverage increased in indemnity plans and PPOs between 1993 and 1997 (table 1.2). In contrast, the average annual employee contribution toward health care for em-

Table 1.3
**AVERAGE PERCENTAGE OF MEDICAL PLAN PREMIUM PAID BY EMPLOYEE
 IN FIRMS OF 500 OR MORE EMPLOYEES, BY PLAN TYPE, 1993-1997**

| Type of Plan | 1993 | 1994 | 1995 | 1996 | 1997 |
|--|------|------|------|------|------|
| Indemnity^a | | | | | |
| Employee-only coverage | 24% | 20% | 23% | 24% | 24% |
| Family coverage | 33 | 25 | 33 | 32 | 32 |
| Health Maintenance Organization (HMO)^a | | | | | |
| Employee-only coverage | 23 | 22 | 22 | 22 | 23 |
| Family coverage | 33 | 29 | 35 | 33 | 34 |
| Preferred Provider Organization (PPO)^a | | | | | |
| Employee-only coverage | 24 | 20 | 25 | 24 | 23 |
| Family coverage | 31 | 28 | 41 | 36 | 36 |
| Point-of-Service Plan (POS)^a | | | | | |
| Employee-only coverage | 19 | 20 | 20 | 22 | 22 |
| Family coverage | 35 | 29 | 32 | 34 | 31 |

Source: William M. Mercer, *National Survey of Employer-Sponsored Health Plans, 1997* (New York, NY: William M. Mercer, 1998).
^aLarge employers.

Employee-only HMO coverage increased between 1993 and 1994, stayed constant between 1994 and 1995, declined between 1995 and 1996, and increased between 1996 and 1997. Similarly, employee contributions for a POS plan increased between 1993 and 1994, declined between 1994 and 1995, and increased between 1995 and 1996.

Deductibles

Over the past decade, the percentage of employees participating in non-HMO plans who are subject to a deductible has steadily decreased. Forty-nine percent of full-time participants in non-HMO plans sponsored by medium and large private establishments had deductibles of more than \$150 in 1995, compared with 53 percent in 1989 (table 1.4). In contrast, 23 percent had no deductible in 1995, compared with 5 percent in 1989. As HMOs compete with non-HMOs (traditional insurance plans and other managed care plans), it appears that non-HMOs have begun to offer plans without deductibles. While these plans are more likely to provide "first-dollar" (no deductible) coverage, premiums are typically higher.

Coinsurance

Plan participants are often required to pay a portion of their medical expenses up to a maximum annual limit. Commonly, the plan pays 80 percent

of recognized charges, and the employee pays the remaining 20 percent.³ Among full-time employees participating in non-HMO plans sponsored by medium and large private establishments, 60 percent were in plans with an 80 percent coinsurance rate in 1995, compared with 79 percent in 1989 (table 1.4). While the percentage of workers with a 90 percent coinsurance rate increased from 8 percent to 16 percent between 1989 and 1995, the percentage with no coinsurance also increased from 3 percent to 16 percent. As mentioned above, as HMOs compete with non-HMOs, it appears that non-HMOs have begun to offer plans without coinsurance.

Out-of-Pocket Limits and Lifetime Maximum Limits

Most major medical plans impose a maximum dollar limit on the amount of health insurance

³ The 80 percent coinsurance is often based on usual, customary, and reasonable (UCR) charges. UCR charges are defined as follows: The covered amount is the provider's usual fee for the service, the customary or prevailing fee for the service or product in that geographic region, and a reasonable amount based on the circumstances involved. Hence, the plan will pay 80 percent of the UCR, not of the total charge, and the employee will pay any disallowed charge in addition to 20 percent of the UCR.

Table 1.4
PERCENTAGE OF FULL-TIME EMPLOYEES PARTICIPATING IN NON-HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS,^a BY TYPE OF COST SHARING PROVISION, SELECTED YEARS

| | Medium and Large Private Establishments | | | | State and Local Governments | | | Small Private Establishments | | |
|--|---|---------|---------|---------|-----------------------------|---------|---------|------------------------------|---------|------|
| | 1989 | 1991 | 1993 | 1995 | 1990 | 1992 | 1994 | 1990 | 1992 | 1994 |
| Deductible | | | | | | | | | | |
| Under \$100 | 6% | 4% | 3% | 2% | 11% | 9% | 5% | 2% | 1% | 1% |
| \$100-\$149 | 35 | 28 | 22 | 17 | 41 | 37 | 33 | 35 | 29 | 17 |
| \$150 or higher | 53 | 53 | 54 | 49 | 38 | 37 | 46 | 56 | 60 | 66 |
| None | 5 | 9 | 12 | 23 | 9 | 15 | 16 | 6 | 9 | 14 |
| Based on earnings | 2 | 5 | 6 | 8 | b | b | b | b | b | 1 |
| Coinsurance | | | | | | | | | | |
| 80 percent | 79 | 74 | 71 | 60 | 71 | 82 | 64 | 80 | 90 | 72 |
| 85 percent | 4 | 3 | 3 | 4 | 2 | 2 | 3 | 2 | 1 | 2 |
| 90 percent | 8 | 11 | 12 | 16 | 14 | 10 | 17 | 10 | 2 | 13 |
| Other | 4 | 5 | 3 | 3 | 4 | 3 | 3 | 4 | 5 | 7 |
| None | 3 | 7 | 10 | 16 | 8 | 3 | 13 | 4 | 2 | 7 |
| Lifetime Maximum Limits | | | | | | | | | | |
| Less than \$250,000 | 5 | 4 | 3 | 2 | 3 | b | 2 | 2 | 2 | 1 |
| \$250,000 | 6 | 7 | 7 | 4 | 8 | 4 | 2 | 7 | 6 | 3 |
| \$250,001-\$499,999 | 3 | 2 | 1 | 1 | 1 | b | b | b | b | 1 |
| \$500,000 | 12 | 11 | 12 | 6 | 10 | 4 | 5 | 4 | 3 | 3 |
| \$500,001-\$999,999 | 3 | 2 | 1 | 1 | 2 | 1 | b | 1 | 1 | 1 |
| \$1 million | 40 | 43 | 46 | 47 | 51 | 53 | 57 | 50 | 51 | 49 |
| More than \$1 million | 2 | 2 | 6 | 9 | 2 | 4 | 6 | 5 | 8 | 14 |
| Other maximum | 8 | 3 | 5 | 1 | 4 | 1 | 2 | 3 | 4 | 3 |
| No maximum | 21 | 24 | 20 | 27 | 20 | 30 | 24 | 27 | 26 | 24 |
| Out-of-Pocket Limits | | | | | | | | | | |
| Percentage with limit | 83 | 83 | 83 | 83 | 88 | 83 | 92 | 89 | 88 | 87 |
| Average dollar maximum on individual out-of-pocket expense | \$1,077 | \$1,170 | \$1,319 | \$1,358 | \$992 | \$908 | \$941 | \$934 | \$1,108 | c |
| Average dollar maximum on family out-of-pocket expense | \$2,298 | \$2,326 | \$2,642 | \$2,858 | \$1,859 | \$1,856 | \$1,947 | \$2,054 | \$2,262 | c |

Source: U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1989 (Washington, DC: U.S. Government Printing Office, 1990); Employee Benefits in Medium and Large Private Establishments, 1991, 1993, and 1995 (Washington, DC: U.S. Government Printing Office, 1993, 1995, 1997); Employee Benefits in State and Local Governments, 1990, 1992, 1994 (Washington, DC: U.S. Government Printing Office, 1992, 1994, 1996); Employee Benefits in Small Private Establishments, 1990 and 1992 (Washington, DC: U.S. Government Printing Office, 1991 and 1994).

Note: Details may not sum to 100 percent due to rounding.

^a1993 data include only non-HMO medical plan participants. Prior years include participants in nonqualified HMOs but exclude participants in federally qualified HMOs. In federally qualified HMOs, allowable cost-sharing provisions are limited.

^bLess than 0.5 percent.

^cData not available.

coverage provided. Plans that impose limits may do so on a per episode basis, such as per hospital admission or per disability, or they may impose an annual and/or lifetime maximum on payments for all covered services. Individual lifetime maximums are generally set between \$250,000 and \$1 million. The percentage of full-time employees in medium and large private establishments participating in

medical plans with lifetime maximums has fallen over the last decade. In 1995, 71 percent of full-time employees in medium and large private establishments who participated in non-HMO plans had a maximum lifetime benefit, compared with 79 percent in 1989 (table 1.4). For those with a maximum lifetime benefit, the level has increased. Forty-seven percent of those in non-HMO plans had

lifetime benefits of \$1 million in 1995, compared with 40 percent in 1989.

Because 20 percent of a large medical claim may pose a significant burden for many individuals and families, most plans limit participants' out-of-pocket expenditures for covered services. After a certain level of spending is reached, coinsurance reverts to 100 percent, meaning that the insurance company will pay all covered costs above a certain threshold. The percentage of full-time employees participating in medical plans in medium and large private establishments with out-of-pocket maximums remained fairly steady over the last decade. Between 1989 and 1995, the percentage of employees with an out-of-pocket maximum remained at 83 percent. In 1995, the annual maximum for out-of-pocket expenses averaged \$1,358 for individuals and \$2,858 for families.

■ Delivery Systems

Health care delivery systems can be arranged in a spectrum according to the degree of financial control the employer or payer has over such plans and to the degree of control such plans have over patient choice. At opposite ends of the spectrum are the traditional fee-for-service indemnity plan, with no managed care elements, and the staff model HMO. Between these two extremes lie fee-for-service plans with managed care features (known as managed indemnity plans), PPOs, and HMOs with greater choice of physicians. Finally, as health care delivery systems evolved and employers became more involved in the design of corporate benefit plans, hybrid plans (known as point-of-service or POS plans) were developed that combine elements of the HMO and PPO in an attempt to balance freedom of choice for the employee and financial control for the employer.

Traditional fee-for-service plans reimburse insured persons for covered charges they incur, using various methods to calculate provider payments.⁴ When a person covered by a traditional fee-for-service health plan needs medical care, he or she seeks the services of a physician, who attempts to diagnose the illness and choose the appropriate course of treatment. The physician decides whether surgery or drug therapy is needed and whether the illness should be treated in a hospital or in an outpatient setting. The traditional insurance

system finances the cost of treatment choices without attempting to influence the treatment setting. Thus, there are generally no outside incentives for providers or patients to pursue the most cost-effective treatment or setting.

Until the mid-1980s, the typical HMO model was a fairly homogeneous staff or group model. In a staff model, the HMO owns its health care facility and employs health care providers on a salaried basis. Patient choice is limited: enrollees are restricted to network providers and are required to see a primary care physician first, who then refers them to specialists within the HMO when this is considered medically necessary and appropriate. A group model HMO is similar to a staff model HMO, except that it contracts with a single physician group to provide services to the HMO participants. The physician group is managed independently and is usually paid on a capitated basis.⁵ Group model HMO providers of health care usually spend most of their time serving HMO patients, but they may devote some time to private practice.

The recent expansion of HMOs has been dominated by heterogeneous network model HMOs. Currently, there are five different HMO models: staff model, group model, independent practice association (IPA), network model, and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs.

Independent Practice Associations

IPAs are groups of physicians in private practice who provide some services to HMO participants, but they primarily provide services to patients not

⁴ *Payments may be based on usual, customary, and reasonable (UCR) charges; a fixed schedule of fees; or a combination of these methods. Fee schedules, also called a "table of allowances" recognize charges for covered services only up to a fixed dollar amount for the specified medical procedure. This limit can take many forms. For example, a plan may limit hospital benefits to a fixed dollar amount per day and reimburse surgical charges according to a schedule of payments by procedure.*

⁵ *Providers that are reimbursed on a capitated basis are reimbursed at a fixed rate per HMO patient.*

enrolled in an HMO. The non-HMO patients are treated on a fee-for-service basis. Providers working with HMOs are generally paid on a fee-for-service basis; therefore, they do not have strong incentives to provide cost-effective care. However, there has been a movement toward reimbursing IPAs on a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers employees more choice among providers.

Network Model HMO

In the network model, HMOs contract with two or more independent physician groups that often provide specialty services as well as general services. The HMO typically pays these groups on a capitated basis, but the groups also spend some time in private practice, operating on a fee-for-service basis.

Mixed Model HMO

A mixed model HMO will initially adapt one type of model, such as a staff model, and then expand either its capacity and/or its geographic region at a later date by adding another type of model, such as an IPA.

The financial incentives within a health plan can affect physicians' decision-making process and how that process ultimately affects patients, as well as the cost of providing health care. Within the network-based models mentioned above, reimbursement schemes have evolved from a salaried or capitated basis to one in which physicians share less of the risk associated with treating patients. In addition, some HMOs use withholding accounts⁶ and bonus programs based on productivity to reimburse providers. Research on the effectiveness of the various financial incentive models has recently become available.

Preferred Provider Organizations/ Point-of-Service Plans

PPOs and POS plans have emerged as strong alternatives to fee-for-service plans and HMOs. A PPO is a panel of health care providers who individually contract with insurance companies

and/or employers to offer health care benefits to their members. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. They usually choose their providers on the basis of their performance, but many plans choose physicians to fit geographic and specialty areas, often in response to employer requests. Enrollees can receive health care services from PPO providers or non-PPO providers, but they usually face higher cost-sharing requirements when receiving care from a non-PPO provider. While the PPO structure differs greatly from the HMO structure, they both combine three broad cost-management strategies: a limited provider panel, negotiated fee schedules, and utilization review (UR).⁷ In addition, some PPOs have a physician who acts as a gatekeeper to the system.

Until 1988, a traditional feature of HMOs was a requirement that employees use network providers. POS plans are essentially HMOs that allow participants to choose a provider from outside the list of network providers. Enrollees are required to select a primary care physician, who then acts as a gatekeeper, essentially controlling referrals to specialists. The enrollee's cost-sharing responsibilities vary with the choice of provider—the highest cost sharing is associated with the use of nonnetwork providers. The single major difference between POS plans and HMOs is that POS participants can seek nonnetwork treatment and receive benefits just as they would under a fee-for-service plan, with higher cost sharing.

One of the distinguishing features of a

⁶ In a withholding account arrangement, a percentage of the payment is withheld until the end of the year. Premiums are set aside in a referral fund which is used to pay for the services of primary care physicians, specialists, hospitals, and outpatient testing. If the referral fund runs a surplus, then physicians receive the amount that accumulated in the withholding account. If the referral fund runs a deficit, nothing is returned to the provider.

⁷ UR is a process of systematically reviewing care to determine its necessity and appropriateness. There are three general types of UR: prospective review, concurrent review, and retrospective review. UR is discussed in more detail later in the paper.

network of providers is the way the plan selects its providers. Some plans evaluate candidates against a set of predetermined selection criteria. Providers must be able to achieve the network's goals for cost control and quality improvement by successfully managing health care delivery. Candidates can also be chosen according to their location. Providers must be able to provide health services to an adequate geographic area. Networks must be available where employees live and work. In addition, most networks require providers to agree to accept UR procedures, refer patients only to other providers in the network, and accept the network's reimbursement procedures. Many networks also monitor their providers' practice patterns in order to identify unjustifiably high costs, and then alter these patterns through education and financial incentives.

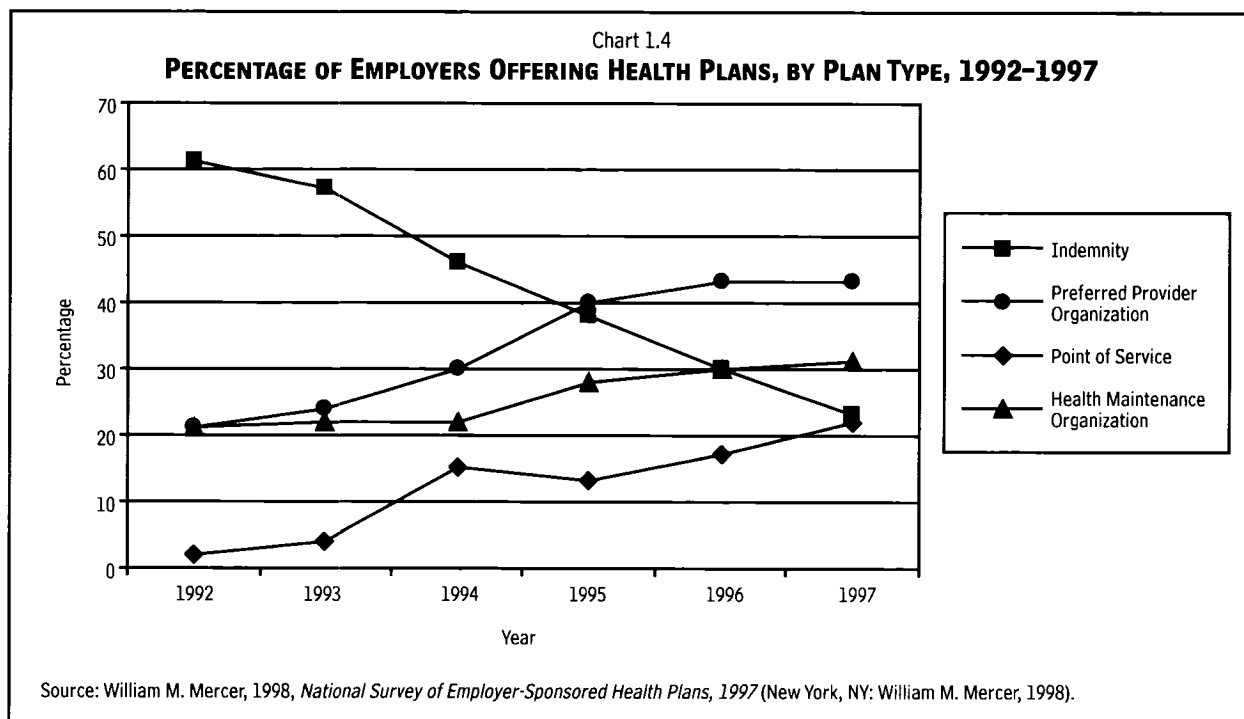
Some employment-based plans use objective information on the quality of care to identify potential providers for their network. Employers contract with specific networks of health care facilities for high-cost procedures such as open-heart surgeries and transplants. These facilities, known as centers of excellence, are selected according to a number of criteria, including experience; efficiency; effectiveness; and outcomes, such as mortality (death) and morbidity (disease) rates. In

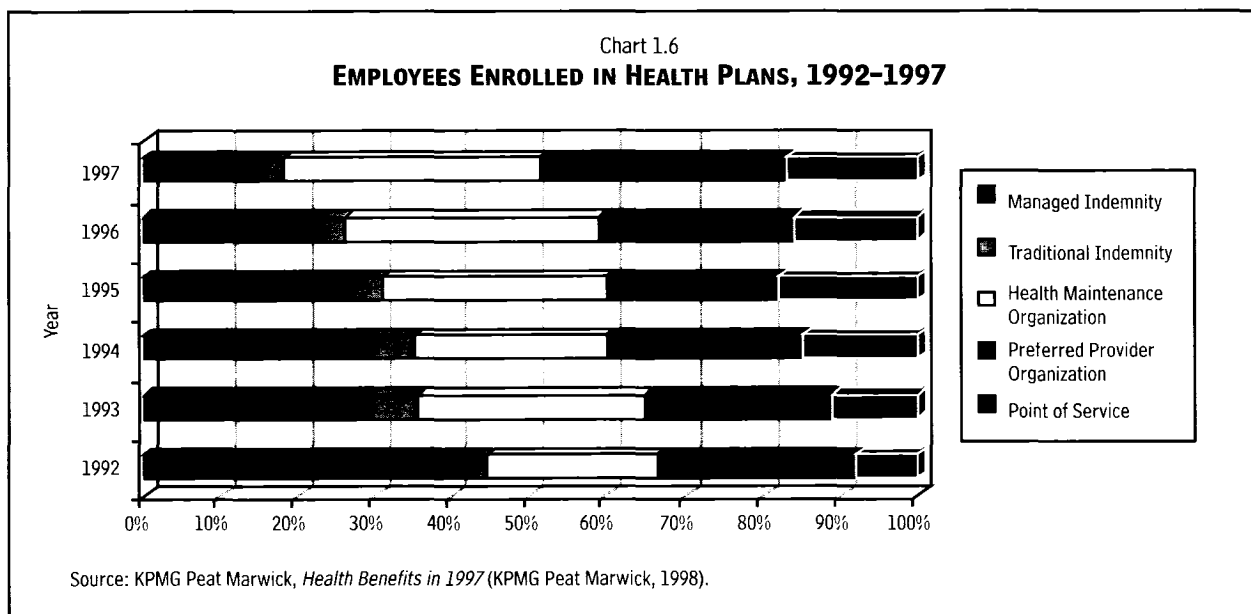
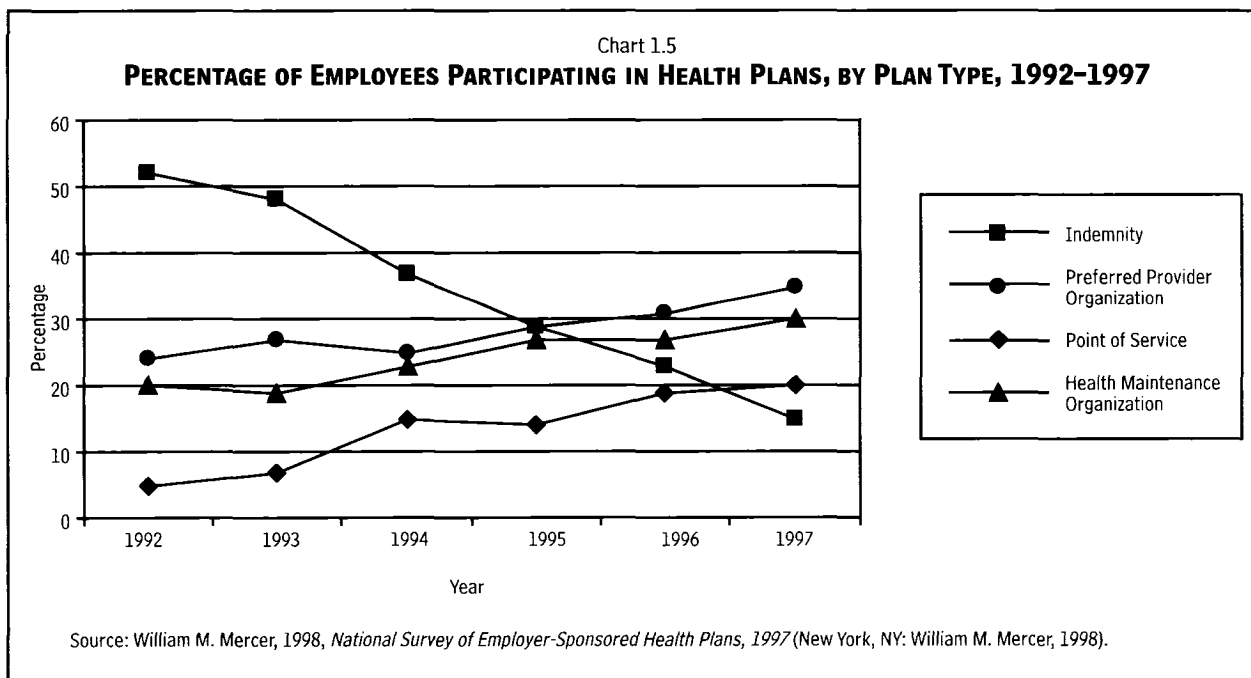
selectively contracting on the basis of these criteria, employment-based plans are explicitly using outcome measures for determining reimbursement.

Providers have challenged the use of unadjusted outcome measures as criteria for selection because providers with sicker patients will appear to be of poorer quality. In response, health care organizations have developed systems to analyze medical records that adjust for the severity of the case mix. The outcomes achieved by physicians and hospitals can potentially allow health plans and plan sponsors to objectively compare and assess the quality and cost effectiveness of care. Selectively contracting with providers using objective criteria such as these begins for the first time to directly reward providers for low-cost, high-quality health care.

Plan Prevalence

One of the most significant developments of the 1980s, which has continued throughout the 1990s, is the growth of managed care plans. As recently as 1994, traditional indemnity plans were the most commonly offered health plan among employers that offered health plans (chart 1.4). As fewer employers offered traditional indemnity plans, participation in these plans declined and participation in managed care plans increased. In 1997,

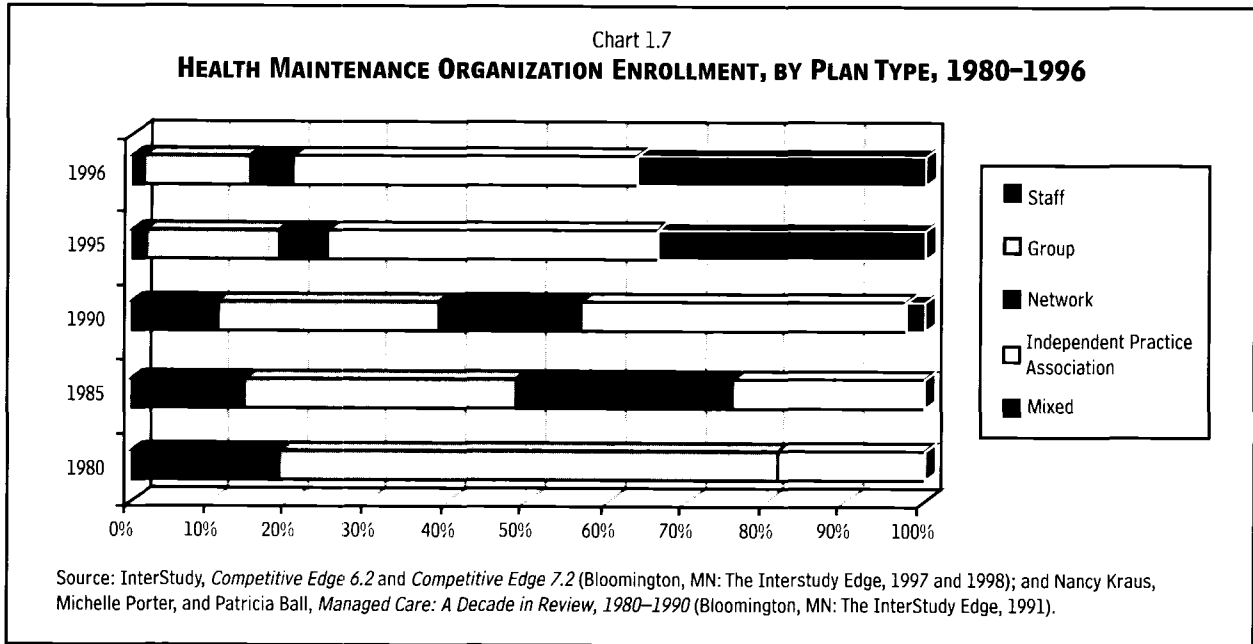




15 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 52 percent in 1992 (chart 1.5). During the same period, enrollment in managed care plans increased from 48 percent to 85 percent. Enrollment in PPOs increased from 24 percent to 35 percent. Enrollment in HMOs increased from 20 percent to 30 percent, and enrollment in POS plans increased from 5 percent to 20 percent.

In addition to the decline in participation in fee-for-service indemnity plans, the structure of

these plans has changed as employers and insurers have added managed care features to them. In 1997, only 2 percent of employees were enrolled in traditional indemnity plans, compared with 6 percent in 1993 (chart 1.6). In contrast, 16 percent of employees were enrolled in managed indemnity plans in 1997, compared with 26 percent in 1993. A similar survey found that 92 percent of employees in traditional fee-for-service plans were in plans with UR in 1990, compared with 44 percent in 1987 (Hoy et al., 1991).



Enrollment in HMOs grew from 9.1 million in 1980 to 33.6 million in 1990, a 26.9 percent increase (Interstudy, 1997). Yet, overall HMO growth between 1990 and 1996 was 88 percent. In addition, the number of enrollees in staff and group model HMOs has fallen as a percentage of all HMO enrollees. In 1996, staff and group model HMO enrollees accounted for 15 percent of all HMOs, compared with 82 percent in 1980 (chart 1.7). Similarly, the percentage of HMO enrollees in IPA and mixed-model HMOs increased from 19 percent in 1980 to 79 percent in 1996.

One reason for the decline in staff and group model HMO enrollment may be the lack of flexibility afforded the employee. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees. Locking employees into a plan that limits their choice and perhaps reduces their satisfaction may be less costly but may not be cost-effective in terms of an employer's recruitment and retention costs. If employees could enroll in a plan with greater flexibility, in many cases they could retain their family physician or specialist (Gabel, 1997). A second reason for the steady decline in staff and group model HMO enrollment may be that employers' disappointment with expected cost savings has caused them to experiment with other plan types. Another reason may be that staff and group model HMOs were not as aggressive as IPAs and network plans at increasing market share because they

Table 1.5
PERCENTAGE OF FULL-TIME EMPLOYEES PARTICIPATING IN HEALTH CARE PLANS, BY TYPE OF PLAN AND COVERAGE FOR SELECTED SERVICES AND PREVENTIVE BENEFITS, MEDIUM AND LARGE PRIVATE ESTABLISHMENTS, 1995

| Benefit Item | All Plans | HMO ^a Plans | Non-HMO ^a Plans |
|-----------------------------------|-----------|------------------------|----------------------------|
| Hospital Room and Board | 100% | 100% | 100% |
| Inpatient Surgery | 100 | 100 | 100 |
| Outpatient Surgery | 100 | 100 | 100 |
| Inpatient Physician Visits | 100 | 100 | 100 |
| Office Physician Visits | 100 | 100 | 100 |
| Diagnostic X-ray and Laboratory | 100 | 100 | 100 |
| Extended Care | 73 | 80 | 71 |
| Home Health Care | 78 | 91 | 73 |
| Hospice Care | 56 | 44 | 61 |
| Inpatient Mental Health | 97 | 94 | 98 |
| Outpatient Mental Health | 91 | 95 | 90 |
| Inpatient Alcohol Detoxification | 98 | 100 | 97 |
| Inpatient Alcohol Rehabilitation | 77 | 66 | 81 |
| Outpatient Alcohol Rehabilitation | 81 | 80 | 81 |
| Inpatient Drug Detoxification | 97 | 98 | 97 |
| Inpatient Drug Rehabilitation | 76 | 65 | 80 |
| Outpatient Drug Rehabilitation | 80 | 80 | 81 |
| Hearing Care | 33 | 87 | 12 |
| Physical Exam | 56 | 98 | 40 |
| Well-Baby Care | 60 | 97 | 46 |
| Immunization and Inoculation | 47 | 91 | 31 |

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1995* (Washington, DC: U.S. Government Printing Office, 1997).
^aHealth maintenance organization.

were more likely to be owned by less aggressive nonprofit organizations (Gabel, 1997).

■ Coverage of Services

Both indemnity plans and managed care plans generally include coverage for care associated with an episode of hospital care, including hospitalization, in-hospital professional care, surgery, and many outpatient services. However, these plans sometimes have coverage limitations, such as preexisting condition clauses and service requirements. In addition, non-HMO plans are less likely than HMO plans to offer preventive services and services that are predictable or not considered medically necessary, such as immunizations or physical exams (table 1.5). This is partly due to requirements that federally qualified HMOs offer such services.⁸ Some argue that this focus on preventive care by the HMO encourages patients to receive such care and potentially avoids costly medical conditions, although the evidence on savings is not clear-cut.

⁸ To be federally qualified under the HMO Act of 1973, the HMO plan must include physician and physician referral services; outpatient and inpatient hospital services; medically necessary emergency health services; 20 outpatient mental health visits; treatment and referral services for alcohol and drug addiction or abuse; diagnostic laboratory and diagnostic and therapeutic radiological services; home health services; and preventive health services, including well-child care, children's eye and ear examinations, immunizations, infertility services, and adult periodic health evaluations.

Coverage Limitations

Coverage limitations include provisions that effectively shorten coverage periods or narrow coverage for individuals. Companies may limit employee coverage based on a previous medical condition or length of service with the company. Companies have also instituted UR programs to review the necessity and appropriateness of care, sometimes with the result of limiting coverage.

Preexisting Conditions—Many health insurance programs will not pay for health services related to conditions that were known to exist at the time the employee joined the plan. However, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) effectively limits an employer's ability to exclude preexisting conditions from coverage. HIPAA prohibits a group health plan from applying preexisting condition limits for periods greater than 12 months (18 months for late enrollees). Furthermore, cases involving pregnancy, newborns, or newly adopted children who become covered under the plan within 30 days of birth or placement for adoption are not subject to preexisting condition limits. HIPAA also prevents group health plans from imposing preexisting condition limits on individuals with a history of prior health insurance coverage. Health plans must reduce the duration of their preexisting condition limits by one month for each month of prior creditable coverage, so long as the individual did not have a break in coverage exceeding 63 days. Waiting periods related to service requirements cannot be counted toward the break in coverage.

Table 1.6
PERCENTAGE OF EMPLOYERS WITH UTILIZATION REVIEW PROGRAMS, AMONG EMPLOYERS OFFERING AN INDEMNITY PLAN, 1993–1996

| Type of Program | 1993 | 1994 | 1995 | 1996 |
|---|------|------|------|------|
| Precertification of Elective Admissions | 52% | 64% | 70% | 73% |
| Concurrent Review | 37 | 31 | 41 | a |
| Catastrophic Case Management | 40 | 23 | 32 | 34 |
| Outpatient Utilization Review | 28 | 23 | 32 | 39 |
| Second Surgical Opinion | 84 | 92 | 84 | 85 |
| Mandatory | 43 | 51 | 45 | 44 |
| Voluntary | 41 | 41 | 39 | 41 |
| None of These | 27 | 14 | 13 | 10 |

Source: A. Foster Higgins & Co., Inc., Tables: National Survey of Employer-Sponsored Health Plans, 1993–1996 (Princeton, NJ: A. Foster Higgins & Co., Inc., 1994–1997).

^aData for concurrent review are combined with precertification of elective admissions.

The Future of Medical Benefits

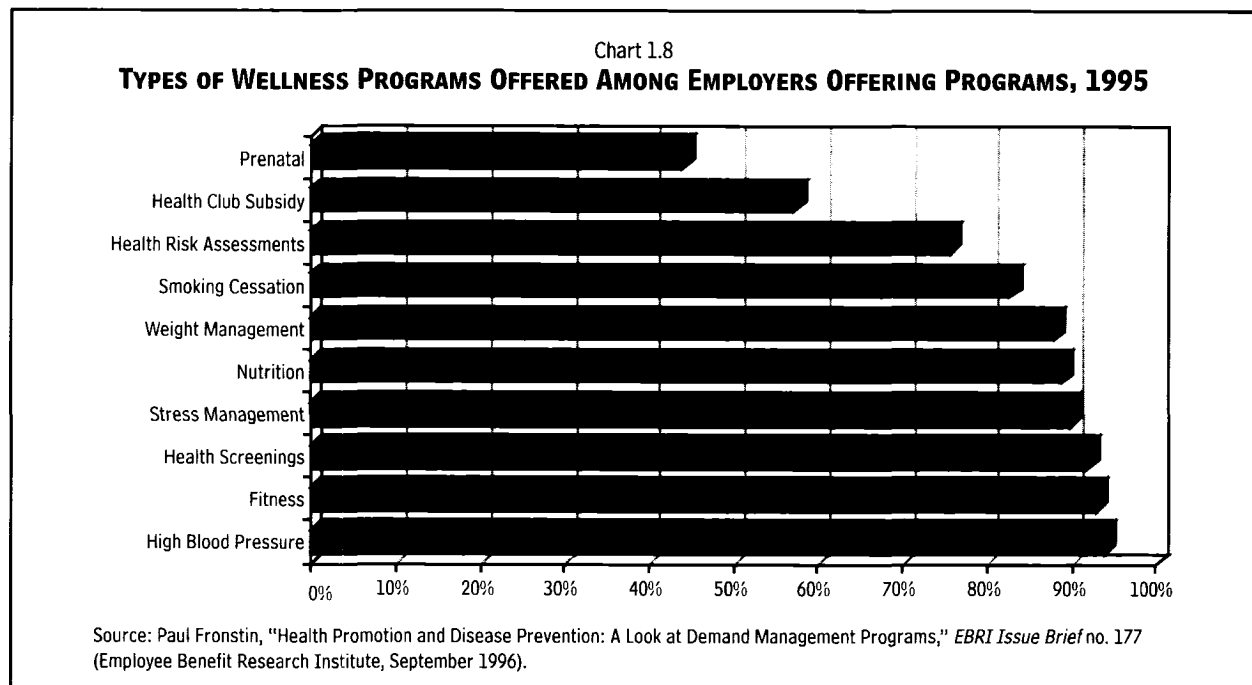
Service Requirements—Many employers require employees to satisfy a waiting period on being hired before becoming eligible for health care coverage. Data from the U.S. Department of Labor indicate that at least 64 percent of full-time employees in medium and large private establishments had minimum service requirements for participation in 1995, and 31 percent did not have a service requirement (U.S. Department of Labor, 1998).⁹ Fifty-eight percent of those workers with a service requirement were required to work for at least three months before becoming eligible for health benefits. Only 4 percent of participants with service requirements were required to wait more than six months.

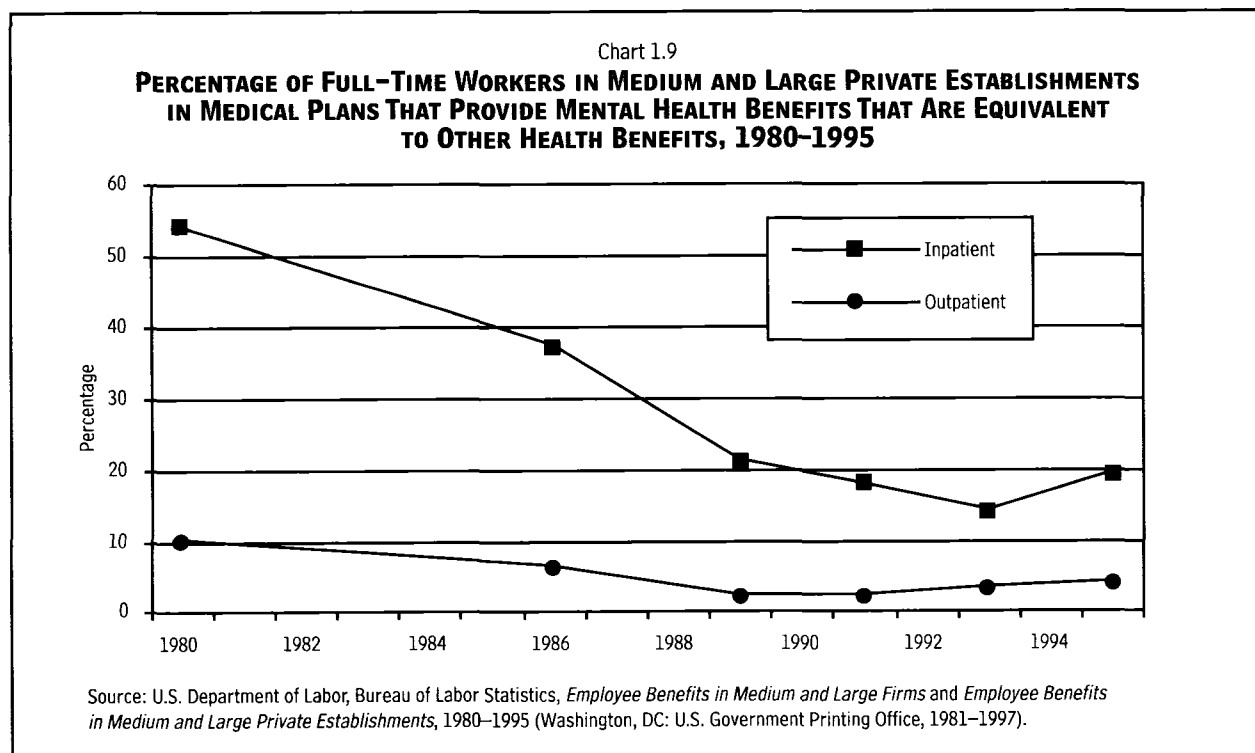
Utilization Review—UR programs are used on a case-by-case basis to monitor the progress and appropriateness of care and limit the volume of unnecessary health care services. As mentioned previously, even traditional indemnity plans are using UR. UR strategies include prospective review, concurrent review, retrospective review, and mandatory second opinion. Prospective review includes evaluation of the appropriateness of an

inpatient stay before the individual is admitted. An example of prospective review is hospital preadmission certification, which requires that patients receive prior authorization for certain procedures, nonemergency hospital admissions, and elective surgery, or the insurer may not pay for the full cost of care. Concurrent review monitors care as it is provided. It may include the prior determination of the length of hospital stays and the scope of the treatment during the stay. Under retrospective review, care is reviewed after it is given. Insurers use this strategy primarily to apply what they learn from past experience when implementing UR in future cases. It is also used to give providers an incentive to exercise self-restraint to avoid the potential of a retroactive denial. Under mandatory second opinion, the patient must receive a second opinion about the appropriateness of a proposed treatment from a health care provider other than the one making the original recommendation.

Employers have been increasingly using UR programs. In 1996, 90 percent of surveyed employers used some type of UR program, compared with 73 percent in 1993 (table 1.6). Second surgical opinion and precertification of elective hospital admissions are by far the most often used UR strategies.

⁹ The service requirement was not determinable for 5 percent of the sample.





Nontraditional Benefits

As competition among health care plans and market demand increases, separate services are developing to supplement benefits already offered. For example, many employers and insurers have developed stand-alone plans that cover outpatient prescription drugs, dental care, and vision care services. In addition, in order to offset increases in health care costs, many employers have modified their plan design to expand coverage for health promotion and disease prevention programs. Between 1988 and 1993, the percentage of full-time employees in medium and large private establishments with access to wellness programs increased from 17 percent to 37 percent (U.S. Department of Labor, 1990, 1995).¹⁰ Screening for high blood pressure, physical fitness centers, weight management, and smoking cessation programs are among the programs employers most frequently offer (chart 1.8).

While employers have been expanding

¹⁰ Between 1993 and 1995, the percentage of full-time workers employed in medium and large private establishments with access to a wellness program declined slightly, from 37 percent to 34 percent (U.S. Department of Labor, 1998).

some of the benefits they offer, they have also been cutting back on others. For example, in 1980, 54 percent of full-time workers in medium and large private establishments had the same coverage for inpatient mental health benefits as they did for other health care services, compared with 19 percent in 1995 (chart 1.9). A similar trend has occurred with outpatient mental health benefits as compared with other health care services.

The Mental Health Parity Act of 1996 requires employers with more than 50 employees to offer identical annual and lifetime dollar limits for mental and physical health care services. However, employers are still allowed to offer health plans with fewer covered inpatient days for mental illness than for other illnesses. In addition, employers are allowed to offer plans that do not provide any benefits for mental illness. A recent survey found that employers have begun to change mental health care provisions in response to this legislation (William M. Mercer, 1998). The survey found that the use of limits on covered inpatient days has increased. For example, in traditional indemnity plans, the use of limits on covered inpatient days increased from 27 percent of plans to 30 percent. At the same time, the use of annual dollar limits fell from 31 percent to 28 percent, and the use of

lifetime dollar limits fell from 36 percent to 28 percent.

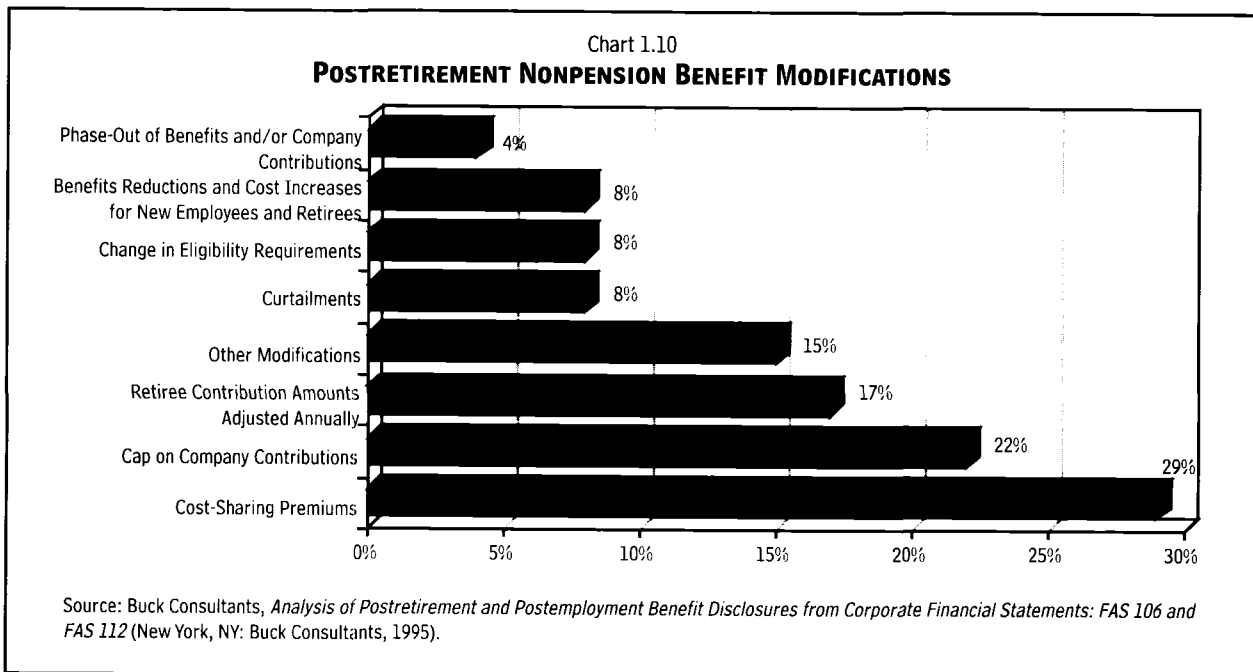
■ Retiree Health Benefits

Retiree health benefits were originally offered in the late 1940s and the 1950s, when business was booming as a result of post-war economic expansion and there were very few retirees in relation to the number of active workers. Retiree health benefits were simple to provide. These benefits emerged as part of collective bargaining agreements, and employers were more than willing to provide them because the cost was such a small proportion of total compensation. With the enactment of Medicare in 1965, the employer obligation became even less significant, and costs declined even further because employers were able to integrate their retiree health benefit programs with Medicare. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, in more recent years, the changing demographics of the work force, combined with increasing life spans, rising health care costs, downsizing, and early retirement, have left many employers with higher retiree-to-active worker ratios. As a result, employers' retirement liabilities have grown.

In December 1990, the Financial Accounting Standards Board (FASB) approved Financial

Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions." FAS 106 requires companies to record unfunded retiree health benefit liabilities on their financial statements in order to comply with generally accepted accounting standards, beginning with fiscal years after December 15, 1992. As a result, the retiree health care liabilities required to be listed on a balance sheet in accordance with FAS 106 far exceed the costs that appeared prior to this standard.

In response to FAS 106 and increases in health care costs, some firms have dropped retiree health benefits, while others still have no plans to change their existing benefit provisions. However, the vast majority of companies have made numerous modifications to their retiree health benefits programs. For example, one study found that 51 percent of responding employers have modified or are considering modifications to their post-retirement nonpension benefit programs (Buck Consultants, 1995). This survey studied the year-end 1993 and 1994 annual reports of 489 Fortune 1000 companies that adopted FAS 106. Of those companies indicating that they had modified or were considering modifying their plans, the most common modification was a change in cost-sharing provisions, followed by a cap on company contributions (chart 1.10). Only 4 percent of surveyed employers had made or were considering making



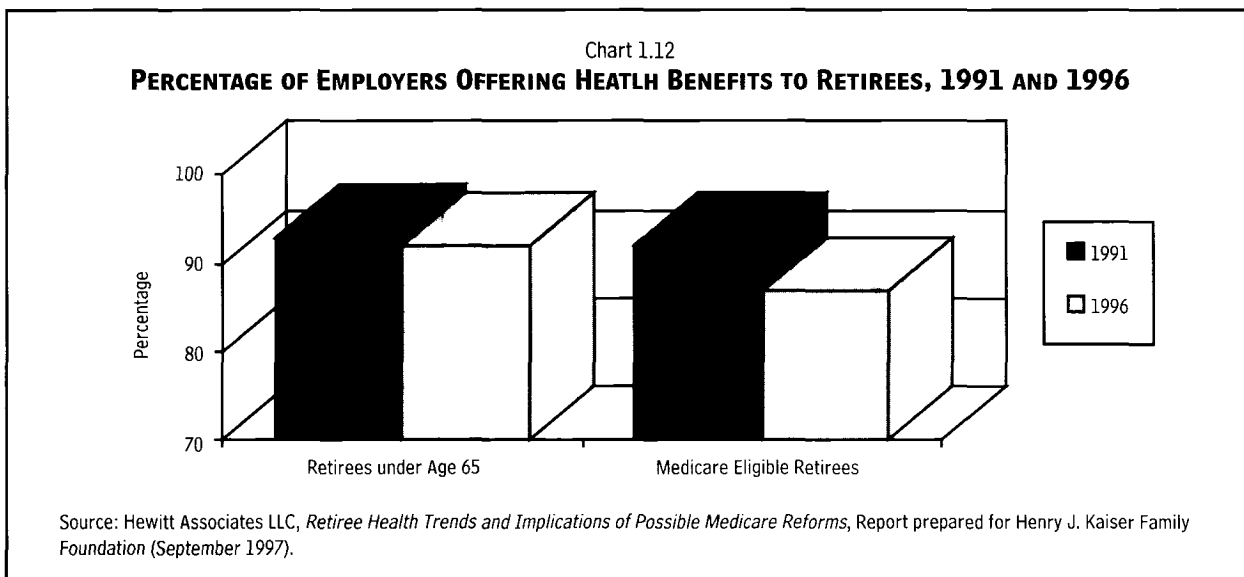
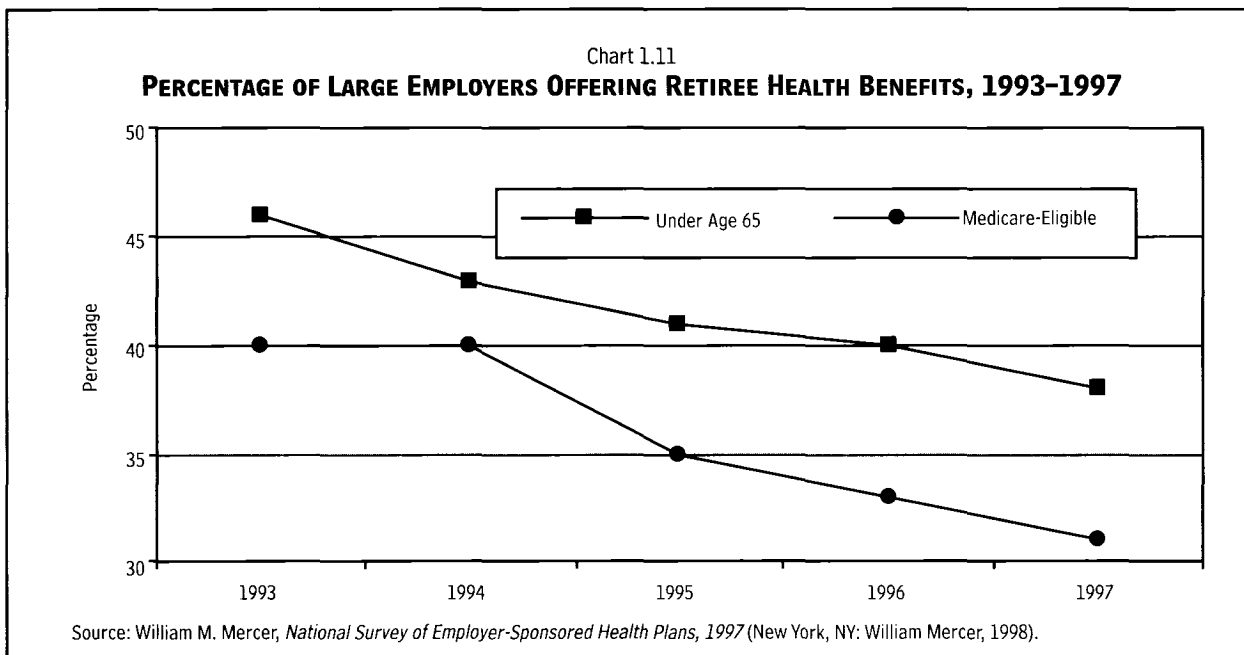
modifications that would entirely phase out retiree health benefits and/or company contributions.

Some employers have completely eliminated retiree health benefits. A recent survey of employers with 500 or more workers found that 38 percent offered retiree health benefits to retirees under age 65 in 1997, compared with 46 percent in 1993 (chart 1.11). The survey also found that 31 percent of employers offered retiree health benefits to Medicare-eligible retirees in 1997, compared with 40 percent in 1993.

Trends in retiree health benefits can also be measured by looking at a constant sample of

employers instead of a random sample. A recent study of the same large employers in 1991 and 1996 found that virtually none of the employers had eliminated retiree health benefits for retirees under age 65 (chart 1.12). In contrast, employers were found to eliminate retiree health benefits for Medicare-eligible retirees.

Any change in plan design alters an employer's obligation to employees. While reduced or changed benefits may be beneficial from a bottom-line standpoint, this action may lower employee morale and reduce a firm's ability to recruit and retain employees. In addition, reducing



or eliminating retiree health benefits affects employees' retirement decisions (Fronstin, 1997a). Thus, changes in retiree health care plans may hinder employers' attempts to reduce their work force by offering early retirement incentives in lieu of layoffs.¹¹

■ Policy Implications

The ongoing rise in enrollment of insured individuals in managed care plans—the direct result of increasing health care costs during the late 1980s and early 1990s—continues to focus policymakers' attention on the issue of access to health care for individuals without coverage and health care quality issues for the insured population. Policy initiatives at the state and federal levels may affect the design and availability of employment-based group health insurance plans.

Since insurance is regulated primarily at the state level, the states have been actively pursuing health care reform issues. By mid-1997 in the legislative year, state legislatures had debated approximately 1,000 bills concerning issues of health care and managed care regulation, and had enacted almost 20 percent of them (*Healthcare Trends Report*, 1998). Each of these proposals will have a significant impact on employment-based health plans, especially among nonexempt small employers. Furthermore, many of the health care mandate initiatives being debated at the state level are also being debated at the national level.

Quality of health care and consumer protections have been key concerns among policymakers, and a number of bills have been introduced to address these issues. President Clinton's Consumer Bill of Rights and the bipartisan Patient Access to Responsible Health Care Act (PARCA) (S. 644/ H.R. 1415), co-sponsored by Rep. Norwood (R-GA) and Sen. D'Amato (R-NY), are just two examples of the types of legislation that policymakers are considering. The Consumer Bill of Rights, for example, includes provisions on information disclosure, choice of health care providers and health plans, access to emergency care, patient participation in treatment decisions, medical records privacy, and a complaints and appeals process that includes an independent system of external review. PARCA includes many of the same provisions as the Consumer Bill of Rights. The legislation would prohibit: (a) all employment-

based health plans from limiting discussion of patient options, (b) requiring preliminary authorization for emergency treatment, and (c) giving incentives to physicians and other providers to limit necessary care or access to specialists when recommended by health care professionals. All plans would also be required to offer point-of-service options for patients who want to go off-network. In addition, PARCA would allow health plans now preempted by ERISA to be liable for compensatory and punitive damages under state tort laws.

These proposed reforms could have a significant impact on employment-based health plans, if enacted. For example, one recent analysis of PARCA finds that health care costs could increase between 7 percent and 39 percent, depending on which provisions of the legislation are passed and various other assumptions (Lee et al., 1997). In addition, the U.S. Congressional Budget Office (CBO) predictions of modest increases in health care costs assume that federal laws on health care remained unchanged (U.S. Congressional Budget Office, 1998). However, another recent study estimates that insurance premiums would increase between 0.7 percent and 2.6 percent (Nystrom et al., 1998).¹²

■ Conclusions

Between 1993 and 1997, employment-based health benefit cost increases have been virtually nonexistent. Employers have kept cost increases low by using managed care and making other changes. For example, fewer employees with health insurance coverage are in plans that are fully financed by their employer. Workers have been shifted to, have been induced to choose, or have voluntarily selected managed care health plans, with the result that PPO and POS plans have experienced relatively strong gains in enrollment. Employers have increased the use of UR for active workers and cut back on health benefits for retirees. These changes

¹¹ For a more complete discussion of retiree health benefits, see Fronstin, 1996a.

¹² For an examination of the differences behind these studies, see Paul Fronstin, "The Patient Access to Responsible Care Act of 1997: How Much Will It Cost?" EBRI Notes, no. 6 (June 1998): 1-6.

are in stark contrast to the pre-1993 period, which saw even faster change (Snider, 1992). During that time, health care costs increased rapidly, and deductibles and coinsurance for workers in non-HMOs also increased, as compared with the declines experienced in the post-1993 period.

There are strong signals that health care cost inflation is increasing in 1998. For example, the Federal Employees Health Benefits Program announced in the Fall 1997 that premiums would increase, on average, 8.5 percent in 1998 if worker enrollment selections remained unchanged from 1997. The California Public Employees Retirement System, CalPERS, also announced a relatively large increase in premiums for 1998: After four years of declining premiums, 1998 premiums will increase 3 percent. While William M. Mercer found that overall cost increases in 1997 were less than 1 percent for employers, this was in large part due to the increased use of managed care. For employers with the same health plan in 1996 and 1997, average costs increased 4 percent (William M. Mercer, 1998). In addition, the survey found that 67 percent of surveyed employers expect health care costs to increase in 1998, and are budgeting for an average increase of 7 percent.

It is too early to predict whether these increased costs represent a one-time change or a return to sustained high health care cost inflation. The CBO predicts that the cost of employment-based health plans will increase 5.6 percent in 1998, but also that health care cost inflation will once again decline in the following few years (U.S. Congressional Budget Office, 1998). In 1999, costs are expected to increase 5.2 percent, and in 2000 they are expected to increase 4.9 percent. In addition, health care costs are not expected to increase by more than 6 percent until at least 2008. The CBO analysis attributes future cost increases to an emphasis on quality, a strong economy, and a short-term profit cycle in the health insurance industry. The CBO analysis also assumes that current federal laws concerning health care will remain unchanged. The projections do not account for the effects that future passage of legislation mandating health care quality, consumer protections, and provider protections might have on the cost of employment-based health plans. While the CBO predicts that the percentage of the nonelderly population with employment-based health benefits

will continue to decline over the next 10 years, we can also expect that workers with health insurance will experience a continuing trend in higher premium contribution requirements, an increased use of flexible managed care arrangements, and other plan design changes.

■ References

- Buck Consultants. *Analysis of Postretirement and Postemployment Benefit Disclosures from Corporate Financial Statements: FAS No. 106 and FAS No. 112*. New York, NY: Buck Consultants, 1995.
- Copeland, Craig, and William Pierron. "Implications of ERISA for Health Benefits and the Number of Self-Funded ERISA Plans." *EBRI Issue Brief* no. 193 (Employee Benefit Research Institute, January 1998).
- Custer, William, and Jill Foley. "Health Care Reform: Tradeoffs and Implications." *EBRI Issue Brief* no. 125 (Employee Benefit Research Institute: Washington, DC, April 1992).
- Fronstin, Paul. "Retiree Health Benefits: What the Changes May Mean for Future Benefits." *EBRI Issue Brief* no. 175 (Employee Benefit Research Institute, July 1996a).
- _____. "Health Promotion and Disease Prevention: A Look at Demand Management Programs." *EBRI Issue Brief* no. 177 (Employee Benefit Research Institute, September 1996b).
- _____. "Employee Benefits, Retirement Patterns, and Implications for Increased Work Life." *EBRI Issue Brief* no. 184 (Employee Benefit Research Institute, April 1997a).
- _____. "Over 149 Million Nonelderly Americans Have Employment-Based Health Insurance, 41.4 Million Uninsured, According to March 1997 CPS." *EBRI Notes*, no. 11 (November 1997b).
- _____. "The Patient Access to Responsible Care Act of 1997: How Much Will It Cost?" *EBRI Notes* no. 6 (June 1998): 1-6.
- _____. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 Current Population Survey." *EBRI Issue Brief* no. 192 (Employee Benefit Research Institute, December 1997c).
- Fronstin, Paul, and Craig Copeland. "Medicare on Life Support: Can It Survive?" *EBRI Issue Brief* no. 189 (Employee Benefit Research Institute, September 1997).

The Future of Medical Benefits

- Gabel, Jon. "Ten Ways HMOs Have Changed During the 1990s." *Health Affairs* (May/June 1997): 134–145.
- Health Insurance Association of America. *Source Book of Health Insurance Data, 1996*. Washington, DC: Health Insurance Association of America, 1996.
- Healthcare Trends Report* (January 1998).
- Hewitt Associate LLC. *Retiree Health Trends and Implications of Possible Medicare Reforms*. Report prepared for The Henry J. Kaiser Family Foundation, September 1997.
- Hoy, Elizabeth W., Richard E. Curtis, and Thomas Rice. "Change and Growth in Managed Care." *Health Affairs* (Winter 1991): 18–36.
- Interstudy. *Competitive Edge 6.2*. Bloomington, NM: InterStudy, 1996.
- _____. *Competitive Edge 7.2*. Bloomington, MN: InterStudy, 1997.
- KPMG Peat Marwick. *Health Benefits in 1996*. Peat Marwick, 1997.
- _____. *Health Benefits in 1997*. KPMG Peat Marwick, 1998.
- Kraus, Nancy, Michelle Porter, and Patricia Ball. *Managed Care: A Decade in Review, 1980–1990*. Bloomington, MN, The InterStudy Edge, 1998.
- Lee, Timothy, Mark Litow, Richard Hauboldt, and Michael Strum. *Actuarial Analysis of the Patient Access to Responsible Care Act*. Report by Milliman and Robertson. Minneapolis, MN: November 7, 1997.
- Levit, Katharine R., Helen C. Lazenby, Bradley R. Braden, and the National Health Accounts Team. "National Health Spending Trends in 1996." *Health Affairs* (January/February 1998): 35–51.
- Nystrom, Scott V., Donald N. Muse, David Goldenberg, and Gregory Portner. "The Health Premium Impact of H.R. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA). Washington, DC: Muse & Associates, January 29, 1998.
- Ostuw, Pamela. "Health Insurance Continues to Be Most Valued Benefit According to Recent EBRI/Gallup Survey." *EBRI Notes*, no. 11 (November 1996).
- Snider, Sarah. "Features of Employer-Sponsored Health Plans." *EBRI Issue Brief* no. 128 (Employee Benefit Research Institute, August 1992).
- U.S. Congressional Budget Office. *The Economic and Budget Outlook for Fiscal Years 1999–2008: A Preliminary Report*. Washington, DC: U.S. Government Printing Office, January 1998.
- U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1988 and 1989*. Washington, DC: U.S. Government Printing Office, 1990 and 1990.
- _____. *Employee Benefits in Medium and Large Private Establishments, 1995*. Washington, DC: U.S. Government Printing Office, 1998.
- William M. Mercer. *National Survey of Employer-Sponsored Health Plans, 1997*. New York, NY: William M. Mercer, 1998.

Projections of National Health Expenditures: 1997–2008

by Jeff Lemieux

■ Introduction

The Congressional Budget Office (CBO) estimates that calendar year 1997 will mark the fourth consecutive year in which national health spending grew no faster than the nation's Gross Domestic Product (GDP).¹ By contrast, health spending's share of the economy grew from 9 percent to more than 12 percent between 1980 and 1990, and by another 1.5 percentage points between 1990 and 1993. Since 1993, however, health spending has stabilized at about 13.5 percent of GDP (see table 2.1). That is the longest period in which the health sector has grown no faster than the rest of the economy in at least 30 years.

The slowdown in the growth of health spending has been caused largely by changes in the nature and purchasing of private health insurance. Before the 1990s, health insurance was dominated by fee-for-service plans, which had only a limited ability to control health costs. In the mid-1990s, a wide variety of managed care plans, with greater potential to control costs, led a surge of competition in the marketplace. Managed care plans can reduce costs both by negotiating favorable prices with health providers and by controlling the volume of services provided. The new plans allow employers to search aggressively for lower premiums and richer benefit packages. Managed care plans and the competition they have spawned are helping to offset (rather than eliminate) some of the root problems that have historically weakened price competition in the health sector.²

CBO projects that the growth in health spending will soon accelerate, and that national health expenditures will reach 15.5 percent of GDP by 2008 (see chart 2.1 and table 2.1). That percentage is slightly lower than CBO's 1997 projection of 16 percent of GDP (in 2007). The downward revision

stems from reductions in Medicare outlays resulting from the Balanced Budget Act of 1997 and lowered projections of Medicaid spending.

CBO's current projections of private health spending are generally similar to those described last year in *The Economic and Budget Outlook: Fiscal Years 1998–2007* (January 1997). The current projections reflect updated figures on historical health spending through 1996 from the Health Care Financing Administration and an updated economic forecast (described in Chapter 1). Chart 2.2 shows CBO's current and previous projections of the growth in private health insurance premiums and the excess of that growth over the growth of GDP.

Last year, CBO projected that the annual growth rate of private health insurance premiums would stabilize at about 1 percentage point higher than the rate of GDP growth—considerably faster than the rates observed in the mid-1990s, but well below the historical average of about 4 percentage points more than the GDP growth rate. CBO assumed that as the economy maintained full employment, workers and the employers that purchase health insurance on their behalf would focus less on costs and more on quality, resulting in higher growth in premiums. At the same time, CBO assumed that the new plans and competition in the 1990s were permanent features of the health

¹ *The appropriate benchmark for comparisons between health spending and the economy is nominal GDP. Growth in nominal GDP includes both price change and growth in real output.*

² *CBO described some of the reasons for such a rapid change in the environment for health care purchases in U.S. Congressional Budget Office, *The Economic and Budget Outlook: An Update* (Washington, DC: U.S. Government Printing Office, August 1995).*

Table 2.1
NATIONAL HEALTH EXPENDITURES FOR SELECTED CALENDAR YEARS, BY SOURCE OF FUNDS

| Source of Funds | Actual | | | | | | Projected | | | |
|--|--------|---------|---------|---------|---------|---------|-----------|---------|---------|----------|
| | 1965 | 1980 | 1990 | 1993 | 1995 | 1996 | 1997 | 1998 | 2000 | 2008 |
| (\$ billions) | | | | | | | | | | |
| Private | \$31 | \$142 | \$415 | \$506 | \$536 | \$ 552 | \$ 573 | \$ 600 | \$ 659 | \$1,026 |
| Public | 5 | 72 | 196 | 280 | 329 | 351 | 374 | 392 | 439 | 773 |
| Federal | | | | | | | | | | |
| State and local | 5 | 33 | 89 | 109 | 126 | 132 | 138 | 145 | 161 | 255 |
| Total | 41 | 247 | 700 | 895 | 991 | 1,035 | 1,085 | 1,138 | 1,259 | 2,055 |
| As a percentage of total expenditures | | | | | | | | | | |
| Private | 75% | 58% | 59% | 57% | 54% | 53% | 53% | 53% | 52% | 50% |
| Public | | | | | | | | | | |
| Federal | 12 | 9 | 28 | 31 | 33 | 34 | 34 | 34 | 35 | 38 |
| State and local | 13 | 13 | 13 | 12 | 13 | 13 | 13 | 13 | 13 | 12 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Average annual growth of Gross Domestic Product (GDP) (percentage change from previous year shown) | | | | | | | | | | |
| Private | | 10.7% | 11.3% | 6.8% | 2.9% | 3.0% | 3.8% | 4.7% | 4.8% | 5.7% |
| Public | | 19.7 | 10.5 | 12.6 | 8.4 | 6.7 | 6.5 | 5.0 | 5.8 | 7.3 |
| Federal | | | | | | | | | | |
| State and local | | 12.7 | 10.4 | 7.3 | 7.6 | 4.5 | 4.6 | 5.0 | 5.3 | 5.9 |
| All National Health Expenditures | | 12.7 | 11.0 | 8.6 | 5.2 | 4.4 | 4.8 | 4.9 | 5.2 | 6.3 |
| Memorandum: Gross Domestic Product (billions of dollars) | \$719 | \$2,784 | \$5,744 | \$6,558 | \$7,265 | \$7,636 | \$8,081 | \$8,461 | \$9,195 | \$13,280 |
| Average Annual Growth of GDP (Percentage change from previous year shown) | | 9.4% | 7.5% | 4.5% | 5.3% | 5.1% | 5.8% | 4.7% | 4.2% | 4.7% |
| Ratio of National Health Expenditures to GDP (percent) | 5.7 | 8.9 | 12.2 | 13.6 | 13.6 | 13.6 | 13.4 | 13.4 | 13.7 | 15.5 |

Source: Congressional Budget Office.

market and that future growth in premiums was unlikely to return to its historical average.

Both assumptions still appear valid. CBO projects that the growth in health premiums will be 5.5 percent in 1998, up from 3.8 percent in 1997. That increase will stem from the predicted emphasis on quality, an economy that has been even stronger than expected, and a short-term profit cycle in the health insurance industry. CBO continues to project that premiums will grow about 1 percentage point faster than GDP in the longer run as pressures to restrain cost increases balance pressures for more services and higher quality.

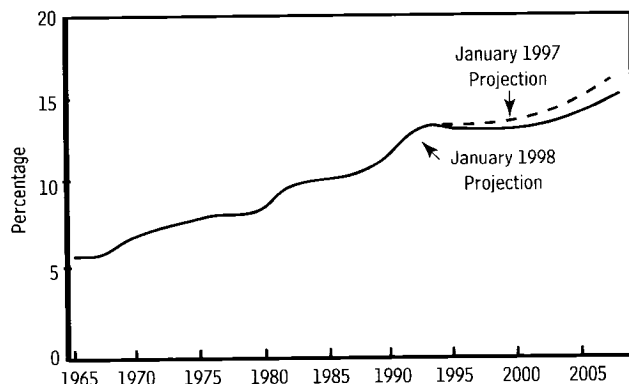
CBO's health projections assume that current federal laws and key regulations continue

unchanged. However, proposed changes in federal law could change private health spending. Laws to protect health consumers could raise private premiums. Laws intended to aid health providers in their dealings with insurance plans could raise the growth of health costs as well. Medicare expansions or other laws that would extend public coverage could substitute for private insurance, reducing private health spending.

■ Strong Economic Growth Will Help Boost Premiums in 1998

Pressures for more and higher quality health services are always strong. In the current health

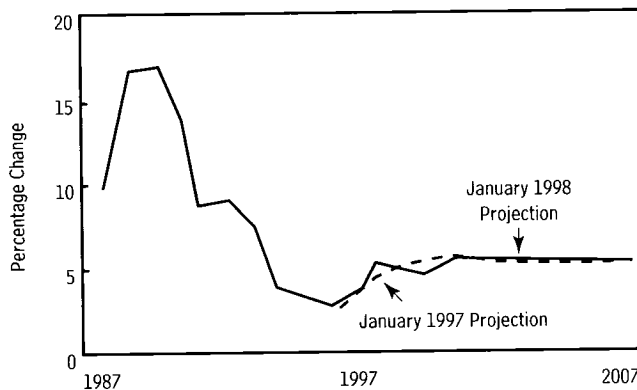
Chart 2.1
NATIONAL HEALTH SPENDING AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT (BY CALENDAR YEAR)



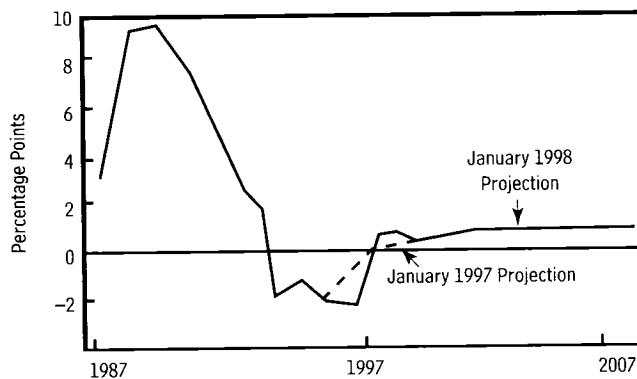
Source: Congressional Budget Office.

Chart 2.2
PRIVATE HEALTH INSURANCE PREMIUMS (BY CALENDAR YEAR)

GROWTH IN PREMIUMS



EXCESS OF GROWTH IN PREMIUMS OVER GROSS DOMESTIC PRODUCT



Source: Congressional Budget Office.

Table 2.2
**PROJECTIONS OF NATIONAL HEALTH EXPENDITURES THROUGH 2008, BY SOURCE OF FUNDS
 (BY CALENDAR YEAR)**

| Source of Funds | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| (\$ billions) | | | | | | | | | | | | |
| Private | | | | | | | | | | | | |
| Private health insurance | \$350 | \$369 | \$389 | \$407 | \$428 | \$453 | \$479 | \$507 | \$537 | \$568 | \$601 | \$636 |
| Out of pocket | 178 | 184 | 192 | 201 | 212 | 224 | 237 | 251 | 265 | 281 | 297 | 314 |
| Other | 45 | 46 | 48 | 50 | 53 | 56 | 59 | 62 | 65 | 69 | 72 | 76 |
| Subtotal | 573 | 600 | 629 | 659 | 693 | 732 | 775 | 820 | 868 | 918 | 970 | 1,026 |
| Federal | | | | | | | | | | | | |
| Medicare | 219 | 230 | 244 | 259 | 278 | 299 | 324 | 350 | 379 | 409 | 440 | 473 |
| Medicaid | 96 | 101 | 109 | 116 | 123 | 132 | 142 | 154 | 167 | 181 | 196 | 212 |
| Other | 59 | 61 | 63 | 65 | 67 | 70 | 72 | 75 | 78 | 81 | 84 | 88 |
| Subtotal | 374 | 392 | 415 | 439 | 468 | 501 | 538 | 579 | 623 | 670 | 720 | 773 |
| State and Local | | | | | | | | | | | | |
| Medicaid ^a | 58 | 62 | 66 | 70 | 75 | 80 | 87 | 94 | 102 | 110 | 119 | 129 |
| Other | 80 | 83 | 87 | 91 | 95 | 99 | 103 | 108 | 112 | 117 | 121 | 126 |
| Subtotal | 138 | 145 | 153 | 161 | 170 | 179 | 190 | 201 | 214 | 227 | 241 | 255 |
| All National Health Expenditures | 1,085 | 1,138 | 1,197 | 1,259 | 1,332 | 1,412 | 1,503 | 1,601 | 1,705 | 1,815 | 1,931 | 2,055 |
| Annual percentage change | | | | | | | | | | | | |
| Private | | | | | | | | | | | | |
| Private health insurance | 3.8% | 5.5% | 5.2% | 4.8% | 5.2% | 5.6% | 5.9% | 5.9% | 5.9% | 5.8% | 5.8% | 5.8% |
| Out of pocket | 3.8 | 3.7 | 4.2 | 4.8 | 5.5 | 5.6 | 5.8 | 5.8 | 5.8 | 5.7 | 5.7 | 5.7 |
| Other | 3.2 | 3.3 | 3.9 | 4.4 | 4.9 | 5.2 | 5.4 | 5.4 | 5.4 | 5.4 | 5.4 | 5.4 |
| all private | 3.8 | 4.7 | 4.8 | 4.8 | 5.3 | 5.6 | 5.8 | 5.8 | 5.8 | 5.8 | 5.7 | 5.7 |
| Federal | | | | | | | | | | | | |
| Medicare | 8.0 | 4.9 | 5.9 | 6.2 | 7.4 | 7.6 | 8.3 | 8.2 | 8.1 | 7.9 | 7.8 | 7.5 |
| Medicaid | 4.2 | 5.9 | 7.4 | 6.2 | 6.6 | 7.0 | 7.7 | 8.3 | 8.4 | 8.4 | 8.4 | 8.4 |
| Other | 4.6 | 3.7 | 3.4 | 3.4 | 3.6 | 3.7 | 3.9 | 3.9 | 3.9 | 3.8 | 3.8 | 3.8 |
| all federal | 6.5 | 5.0 | 5.9 | 5.8 | 6.6 | 6.9 | 7.5 | 7.6 | 7.6 | 7.5 | 7.5 | 7.3 |
| State and Local | | | | | | | | | | | | |
| Medicaid ^a | 4.3 | 6.0 | 7.5 | 6.2 | 6.6 | 6.9 | 7.7 | 8.3 | 8.4 | 8.4 | 8.4 | 8.4 |
| Other | 4.9 | 4.3 | 4.2 | 4.2 | 4.3 | 4.4 | 4.4 | 4.3 | 4.2 | 4.1 | 4.0 | 3.9 |
| all state and local | 4.6 | 5.0 | 5.6 | 5.1 | 5.3 | 5.5 | 5.9 | 6.1 | 6.2 | 6.1 | 6.1 | 6.2 |
| All National Health Expenditures | 4.8 | 4.9 | 5.3 | 5.2 | 5.8 | 6.0 | 6.4 | 6.5 | 6.5 | 6.5 | 6.4 | 6.4 |

Source: Congressional Budget Office.

^aThe national health expenditures data use a different definition of state and local Medicaid spending than that used for budgetary purposes.

market, however, pressure to restrain premium increases is determined mostly by the strength of the economy. In a period of strong growth and low unemployment, employers and employees may hesitate to switch to lower-cost health plans. In a weak economy, when the trade-off between health costs and wages is more apparent, low-cost health plans have more appeal.

The economy surged in 1997, with unemployment likely to average only 4.9 percent for the year. CBO estimates that nominal GDP grew by 5.8

percent, about 1.2 percentage points higher than projected last January. CBO currently expects GDP growth of 4.7 percent in 1998.

CBO's projection of health insurance premiums reflects adjustments in CBO's forecast of GDP growth, with faster GDP growth in 1997 leading to more rapid growth in premiums in 1998.

After several years of restraint, some large purchasing groups have announced increases in health premiums for 1998. The Federal Employees Health Benefits program, for example, which had

Table 2.3
**ANNUAL GROWTH OF PREMIUMS OR COSTS FOR HEALTH INSURANCE,
 CALENDAR YEARS 1990-1997 (PERCENTAGE)**

| | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|------|------|------|------|------|------|------|------|
| FEHB ^a | 9% | 6% | 7% | 10% | 2% | -4% | 0% | 2% |
| CalPERS ^b | 17 | 11 | 6 | 1 | -1 | n.a. | -4 | -1 |
| HayGroup ^c | 17 | 13 | 11 | 8 | 3 | 2 | -2 | -1 |
| Foster Higgins ^d | 17 | 12 | 10 | 8 | -1 | 2 | 2 | n.a. |
| KPMG Peat Marwick ^e | n.a. | 12 | 11 | 8 | 5 | 2 | 0 | 2 |
| Bureau of Labor Statistics ^f | 12 | 11 | 10 | 8 | 6 | 2 | 0 | 0 |

Source: Congressional Budget Office based on the sources below.

Notes: Zero growth in the table means an increase or decline of less than 0.5 percent.

^aFederal Employees Health Benefits program, Office of Personnel Management.

^bCalifornia Public Employees Retirement System (CalPERS), Health Plan Administration Division. Data for 1995 are unavailable because CalPERS changed the definition of its contract year. Before 1995, the CalPERS contract year ran from August 1 to July 31. In 1995, CalPERS began to switch its contract year to a calendar year basis. The 1994 data are for the contract year starting on August 1, 1994, and ending on July 21, 1995. The 1996 data are for the contract year starting on August 1, 1995, and ending December 31, 1996. Data underlying calculations for 1997 correspond to calendar year premium costs.

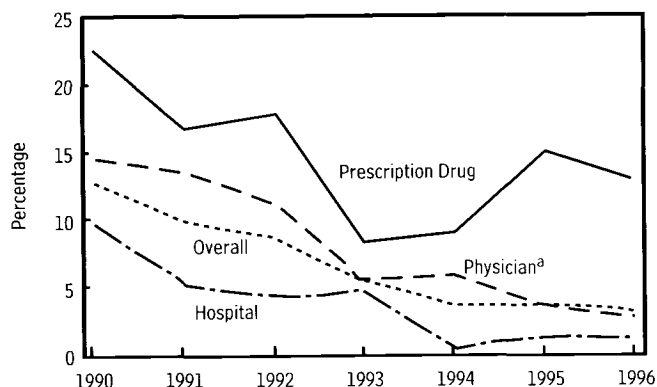
^cHayGroup, Hay Benefits Report (Washington, DC: HayGroup, 1990 through 1996). The surveys use average premiums for all employers on a "same company" basis for the most prevalent plan, based on a sample of public and private employers that generally have at least 100 employees.

^dFoster Higgins, *National Survey of Employer-Sponsored Health Plans* (New York: Foster Higgins, 1990 through 1996). The surveys are based on a sample of private and public employers with 10 or more employees.

^eKPMG Peat Marwick, Health Benefits (Tysons Corner, VA., and San Francisco: KPMG Peat Marwick, 1990 through 1997). The surveys are based on a sample of private and public employers with 200 or more employees.

^fDepartment of Labor, Bureau of Labor Statistics, employment cost index. The index covers only the employer's share of premiums or costs. Growth rates measure changes in cost over a 12-month period from March to March.

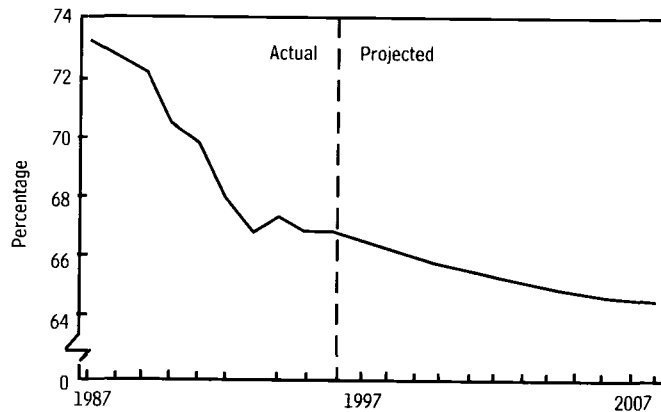
Chart 2.3
**GROWTH IN SPENDING FOR PRIVATE HEALTH INSURANCE BENEFITS
 (BY CALENDAR YEAR)**



Source: Congressional Budget Office.

^aIncludes the services of dentists and other health professionals.

Chart 2.4
**NUMBER OF PEOPLE WITH EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE
 AS A PERCENTAGE OF THE POPULATION UNDER AGE 65 (BY CALENDAR YEAR)**



Source: Congressional Budget Office.
 Note: Historical figures based on tabulations of the Current Population Surveys done by the Employee Benefit Research Institute. Data for 1996 are from the March 1997 Current Population Survey.

held premiums virtually steady since 1993, announced that premiums would increase by about 8.5 percent in 1998 if enrollment selections were unchanged from 1997. Enrollees of Minnesota's state employees health plan face similar increases. CalPERS, a large California purchasing group, announced a 3 percent increase for 1998, after four years of declining premiums. Table 2.3 shows premium trends for FEHB and CalPERS and other indicators of the growth in costs or premiums for health insurance over the past several years.

In part, the 1998 premium increases signal a profit cycle in the industry rather than a dramatic change in the costs of insurance. Historically, health premiums offered by competing plans have tended to grow in tandem. The industry as a whole has had years of high profits, when premiums collected exceeded benefits paid, and years of poor profitability, when the gap between premiums and costs diminished.

Based on recent data from the American Hospital Association and other sources, CBO estimates that the costs of health insurance will continue to grow quite slowly, with the exception of benefits for prescription drugs. Many managed care plans offer generous prescription drug benefits, and while the growth in spending for hospital care and professional services has fallen significantly in

recent years, drug expenditures have resumed a double-digit pace (see chart 2.3).

CBO expects that growth in spending for benefits will lag the premium increases achieved by plans in 1998, improving health plans' profit margins in 1998 after two years of relatively weak profits. The profits of some large network plans, many of which had bid aggressively for market share in recent years, have faltered in 1996 and 1997. Pullbacks by those plans, which had formed networks quickly and had often led price wars, will probably yield higher 1998 premiums in some areas.

■ Projections of Private Health Insurance Through 2008

CBO's long-run projection for health insurance premiums is based on underlying growth in benefit costs and an assumption that profit and administration rates remain constant. Because benefit costs remain likely to grow at moderate rates, CBO has not changed its long-run projection for growth in premiums: about 1 percent above GDP growth.

CBO projects that the growth of nominal GDP will fall to 4.2 percent in 1999 and will average about 4.5 percent over the next 10 years. Therefore, CBO's projection of the rate of growth in

Table 2.4
PROJECTIONS OF PRIVATE INSURANCE PREMIUMS (BY CALENDAR YEAR)

| Type of Insurance | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---------------------------------|--------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| | (\$ billions) | | | | | | | | | | | |
| Employment-Based Insurance | | | | | | | | | | | | |
| Employer contributions | \$274 | \$288 | \$303 | \$317 | \$333 | \$351 | \$371 | \$392 | \$415 | \$438 | \$463 | \$489 |
| Employee/retiree contributions | 55 | 59 | 63 | 67 | 71 | 76 | 81 | 87 | 93 | 100 | 107 | 115 |
| Subtotal | 329 | 347 | 366 | 383 | 404 | 427 | 453 | 480 | 508 | 538 | 570 | 604 |
| Individual Insurance | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 33 |
| Total, Private Health Insurance | 350 | 369 | 389 | 407 | 428 | 453 | 479 | 507 | 537 | 568 | 601 | 636 |
| | Annual Percentage Change | | | | | | | | | | | |
| Employment-Based Insurance | | | | | | | | | | | | |
| Employer contributions | 3.7% | 5.4% | 5.0% | 4.6% | 5.0% | 5.5% | 5.7% | 5.8% | 5.7% | 5.7% | 5.6% | 5.6% |
| Employee/retiree contributions | 5.2 | 6.9 | 6.5 | 6.1 | 6.5 | 7.0 | 7.2 | 7.2 | 7.1 | 7.1 | 7.0 | 7.0 |
| all employment-based insurance | 4.0 | 5.6 | 5.2 | 4.9 | 5.3 | 5.7 | 6.0 | 6.0 | 6.0 | 5.9 | 5.9 | 5.9 |
| Individual Insurance | 2.0 | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| All Private Health Insurance | 3.8 | 5.5 | 5.2 | 4.8 | 5.2 | 5.6 | 5.9 | 5.9 | 5.9 | 5.8 | 5.8 | 5.8 |

Source: Congressional Budget Office.

private health insurance premiums averages about 5.5 percent a year.

The share of the under-65 population covered by employment-based health plans fell rapidly in the late 1980s and early 1990s, but then stabilized at about two-thirds after 1992 (see chart 2.4). The total number of people with employer plans actually began to rise in 1994. The combination of the solid economic growth and slowly growing premiums no doubt helped break the downward trend. CBO projects that with slower economic growth and faster growth in health premiums over the next 10 years, the share of people covered by employment-based plans will resume its downward drift, although at slower rates than were seen in the early 1990s.

Table 2.4 details CBO's projections of private health insurance spending in the 1997–2008 period. Those projections reflect the assumptions discussed above and also the impact of the State Children's Health Insurance Program enacted under the Balanced Budget Act of 1997. That program will fund state initiatives to provide health insurance for children. Because some children who are newly insured under the state programs would have been covered by private health insurance in the absence of those programs, CBO estimates that

enactment of the Balanced Budget Act will slightly reduce spending on private health insurance and the number of people privately covered.

Future legislation, in states and the federal government, could affect the course of private health spending. CBO's health projections explicitly assume that current federal laws and key regulations continue unchanged. In addition, the current projections assume that there will be no major changes in state laws affecting private health spending.

Proposed consumer protection laws involving disclosure of information, appeals and grievances, and so on, could boost health spending slightly, but probably would not alter any longer-term trends. Similarly, most benefit or coverage mandates would cause a one-time jump in costs, but would not in most cases alter the trajectory of private spending growth.

Provider protection laws have greater potential to raise the growth of health spending in the long run. Laws that would mandate coverage of the services of certain providers or change the financial relationships between health providers and plans could dull some of the tools that plans now use to hold down costs in a competitive market.

**MANAGED CARE: COST
CONTROL OR QUALITY?**

Behavior and Its Effect on Future Medical Benefits

by Jessie Gruman

■ Introduction

I agree with the proposition that the idea of behavior is going to make a difference in terms of the way medical benefits change and grow in the future. First, I would like to discuss what we mean when we use the word “behavior.” I would propose three different ideas about how this might affect medical benefits in the long term.

■ Defining Behaviors

If we look at the most distal determinants of behavior, especially behavior that influences health, we see factors such as socioeconomic status, culture, social support, and embeddedness in communities. If we look at behavior from the perspective of an individual, we see factors such as anxiety, depression, and traits, such as locus of control and self-efficacy. If we look at specific behaviors that we know increase risk, we see factors such as smoking, diet, exercise, sexual practices, use of seat belts, helmets, immunizations, clinical preventive services, etc. If we talk about characteristics more related to disease management, we are talking about being able to provide a competent history, manage symptoms, identify symptoms, monitor symptoms, take medication, use medical devices, seek care appropriately, etc.

Then there is a whole series of items that we can talk about as medical decisions that have to do with pre- and post-surgery behavior, self-care generally, decisions at the beginning of life, genetic testing, decisions at the end of life, palliative care, hospice, etc. And finally, we have a number of things that are currently being called consumer behavior: choice of plans, choice of physicians, choice of benefits, etc.

When I go through this list, I have three

responses. The first is, “Oy.” Medical care is nothing compared with addressing behavior systematically. The second response is that we will never be able to take full advantage of the promise of medical technology unless we somehow figure out how to address behavior systematically. And the third relates to using 90 percent of our brain. We are using only 10 percent of what we know in terms of shaping health and social policy in response to what we know about behavior. So we have great promise, but we have yet to realize it.

■ Three Propositions

There are three propositions about the future of medical benefits through the lens of behavior. The first is that we have yet to develop a full understanding of what it is to be a medical consumer, or a consumer of health care. The second is that we have yet to fully utilize the behavioral data in personnel practices generally and in the design of medical benefits in particular. And the third is that we have yet to realize the value offered by a long tradition of behavioral and social science research in designing health care and medical benefits to truly improve the health of employees and people in general.

So starting with consumers, I am concerned that consumers may not be an appropriate metaphor for what we are seeking from individuals in a changed health care system. When we talk about developing people who are good consumers of medical care, we are talking about developing people who are informed, educated, engaged, and who are making rational decisions. If we were all informed, educated, engaged, and rational decision-making consumers, we would all own and drive Toyota Camrys because Consumer Reports says, in fact, that they have the best repair record, they are

the cheapest, they give you the most value for the money, etc. I do not believe that we are going to achieve a point where all of us are Camry-buying automobile shoppers and consumers, and I do not believe that we are ever going to reach a point where consumers are making decisions based on a kind of idealized model that we are imposing on them.

■ Distribution of Consumers

In fact, it is likely that, over time, if we continue in this vein, we will realize a kind of bimodal distribution of consumers. There will be many who really respond to the challenge of the health care marketplace, and they will become informed and engaged, and they will make decisions, and they will drive their physicians nuts for awhile. And they will drive their employers nuts, too. But there will be a group of people who are able to competently make decisions about their medical care.

Simultaneously, though, there will be a group of people who are unable to engage in that kind of behavior relative to their medical care, and I am concerned about those consequences. If you think about what will be the determinants of being in one mode or the other, they are influenced by factors such as education, access to information, a sense of empowerment, sense of efficacy. You can go down the list and think of what those are. Any change in any one of those variables can stick someone over in the other distribution.

The consequences of not buying a Camry are relatively trivial. You can get a cheap Cherokee. You can get a Hyundai. You walk. The consequences of not being a good health care consumer are unknown to us, but we can imagine them. And some real exploration of the metaphor needs to be done because in a sense, we may be setting people up to do less well than they are able to do.

■ Applying Behavioral Data

The second proposition is that we know we have yet to fully utilize behavioral data in personnel practices generally, and in medical benefit design in particular. This has variable consequences. Michael Scofield's work, the linking of databases—productivity, workman's comp, absenteeism, health care utilization—has shown that the best predictor of

future behavior is past behavior.

Use of this kind of information is going to become more and more prevalent in hiring decisions, in maintaining employees, in compensation decisions. It also will, unavoidably, become a part of the design of medical benefits. The idea of staged, or graded, medical benefits relates to issues such as, "Who are you willing to invest in in the long term?" and "Who should get one kind of medical benefits versus another?" These issues are going to move onto the table as this information is collected more systematically and used more systematically.

And finally, we have yet to fully realize the value offered by a long tradition of research on computer and social sciences relative to health and behavior. Often when I talk to health plans, I go through this list of what we are talking about, unpack the word "behavior." They say, "Well, you know, it's not the responsibility of medical care to address all these issues." I basically agree with that. But I do not think that medical care and that health care in general ever will be able to be fully responsive unless it is able to systematically take behavior into account. And that means to recognize, to address, and to treat the whole person.

■ Conclusion

Here are four things that I think that health plans ultimately will need to do to be able to deliver real value in their health care.

- They need to make available to individuals information about when, how, and why to access services.
- They need to offer effective screening, diagnosis, and triage to appropriate services, whether those services have to do with direct medical services, self-management support training, behavior change training, or referral to appropriate community agencies for other kinds of support.
- They need to systematically provide services to address behavioral needs, such as smoking, diet, exercise, and self-management of chronic conditions.
- They need to develop an ongoing, collaborative relationship among individual physicians and, more largely, health plans and individuals. That requires all sorts of public information marketing training, as well as individual behavior on the parts of physicians and other providers.

Generally, I cannot predict how either the employer world or health plans is going to systematically address these items. Attention to behavior is growing. We need to look at the people available if we are going to be able to address this responsibly.

Health Care Proposals: The Need for a Balanced Discussion

by Karen Ignagni

■ Introduction: Assessing the Proposals

As we deal with the issues of cost and quality, we need to analyze thoughtfully, out of the glare of the public spotlight, the issue of a number of proposals that are on the political table, at the federal level as well as the state level, and whether these proposals take us on the wrong road or the right road.

It is incumbent upon all of us to analyze whether so-called “consumer protection” bills would achieve that goal or impose new costly layers of regulation with little benefit to consumers. While it is not politically correct, yet, to have that discussion, we need to begin a national conversation if we are to improve the delivery system, continue to establish the benchmarks, and develop the critical path toward quality care.

As resources are always finite, whether they be from public- or private-sector purchasers, anything we are talking about in the federal, state, or legislative regulatory arena does come directly from patient care, and we need to evaluate it. That is not to prejudge where we end up, but we need to evaluate it. For our part, we are looking forward to a more balanced discussion about the impact. As we see more proposals and we move away from politics to substance, we will see some policy discussions that will be more in balance.

■ Cost or Quality?

The title of this session could be summarized as cost or quality. It is probably predictable to say that they are not mutually exclusive. The overriding question, in both the public and the private sector, is, that given finite resources, how do we provide high quality care that is affordable?

To wrestle with these issues, and to deal with some of the questions that we were prompted to address, we need to step back and consider the evolution of where we are today and how we got there. From a health plan perspective, there have been three phases. In Phase 1, around the passage of the Health Maintenance Organization Act of 1973, we were “alternative delivery systems.” We were a small presence in the delivery system.

In Phase 2, when costs went up dramatically, we began to be looked upon as the “alternative” to fee for service, particularly because of our cost-cutting potential. Without a doubt, the focus was definitely on cost containment within the health plan community, within the employer community, and in the public sector. This was in the 1980s, when we were seeing double-digit rates of inflation, hitting 17 percent or 18 percent.

At the same time during that period, although it was not perhaps recognized or discussed publicly very much, we were laying down some important principles that guide us into the next phase and actually offer a good deal of promise in terms of changing relationships between physicians and health plans, and in terms of the long-term potential to increase the quality and improvement of activities.

■ The Principle of Accountability

First is the principle of accountability, the principle of measurement. We never were able to do that in the past, and while we have not yet arrived at where we want to be in terms of measurement, performance, and outcomes analysis, we are on that path. Those principles were laid down as reliance on managed care expanded, and, in those days particularly, health maintenance organizations (HMOs), and then the development of PPOs, of

course, exploded in the late 1980s and 1990s, and now we see an amalgam of the two systems. What we are seeing now, in Phase 3, are evolutionary changes in that we have traditional health plans on the HMO side, for example, offering direct access to specialists. A number of plans allow consumers to decide for themselves whether they want to have a gatekeeper or not, particularly when they have chronic illnesses, etc.

We are seeing PPOs that have led the way in quality assurance activities, credentialing, laying down the principles of quality assurance, etc. And we are seeing much more convergence, as well as diversity, in the market for consumers and employers to take advantage of. We think that is positive.

We are doing better on the issues of measurement and accountability. If you think of the first wave of managed care as a cost containment phase, the real activity was focused on discounting. To our peril, we focused on discounting to explain how plans achieved savings. This focus has led legions of very smart people to conclude that we were one-shot deals, one-time savings. If you are not in the arena, if you are not sitting at the employee benefits table, you are not likely to know that what now is going on in the industry is a whole new wave of cost containment, bringing the cost containment and the quality assurance together in the area of disease management.

We can call it case management, which is probably a more comprehensive term for it, but, nonetheless, it relies on physicians and plans working together, relying on information systems, feeding back information on performance, and partnering to ensure that the people with chronic illnesses are treated better. That allows us to maintain all of the advantages on the side of early intervention and prevention.

■ The Current Status

How are we doing? We looked at a recent study quite thoroughly because it confirmed many of our medical directors' anecdotal reports about whether they were denying coverage for particular procedures that physicians wanted to do.

Inquiry published an article by a very solid panel of investigators, including George Lundberg, editor of *Journal of the American Medical Association*,

indicating that coverage denial in eight categories of care was, at most, 3 percent. This means that 97 percent of what physicians wanted to do was approved.¹

That should give us all pause at a time when we are having a major national debate. Although there has been a backlash, it is attributable, on the physicians' side as well as on the consumers' side, to this dramatic change we have had in going from one system to another.

Some other useful statistics show that we in the health plan arena spend too little time communicating outcomes. You may be quite surprised to find that diabetics are 3 times more likely to undergo follow-up retinal screens in our plans; heart-attack victims are 2½ times more likely to be prescribed data blockers; and patients are 2 times more likely to be counseled to quit smoking, 1¼ times as likely to undergo screening for cervical cancer; and 1½ times as likely to be screened for breast cancer.

We know that HMO patients—and this was a study particularly on HMOs, not on PPOs—in intensive care units have a significantly lower level of mortality.

This is not an exercise in selective reporting or highlighting research that is favorable to us. We are now seeing strong research accumulating in peer review journals on the track record of what health plans have contributed. It is relevant, as we talk about cost containment and quality, for us in the industry to actually talk much more straightforwardly about what we have accomplished. With the new National Committee on Quality Assurance (NCQA) guidelines, NCQA has made a major transition that is very relevant to where the industry is today. The new 1999 accreditation standards move away from a more process-oriented measurement to a much more outcomes-based measurement.

The Health Plan Employer Data and Information Set (HEDIS), the data system under which plans report, will be part of the accreditation process. It will be looking at effectiveness of care in the areas of cancer screening, prenatal care, smoking cessation, heart disease, diabetes, and eye

¹ *Dahlia K. Remler et al.*, "What Do Managed Care Plans Do to Affect Care?" *Inquiry* (Fall 1997): 196–204.

exams. And so for the first time, health plans will be benchmarked against others on their outcomes, with respect to particular goals and objectives. What all of this says is that there has been quite a lot going on in the health plan arena with respect to quality performance and quality assurance. It also suggests that we have to do a much better job of bringing that information to the table, in both the public sector and the private sector.

The business sector has launched new activities to ensure that employees get more information about their health care coverage, their choices. It is quite significant that the Business Roundtable, National Association of Manufacturers, National Federation of Independent Business, the Chamber of Commerce, Association of Private Pension and Welfare Plans, the ERISA Industry Committee (ERIC), and a number of others have collaborated on this initiative, and that points strongly to the commitment to do a better job.

Those of us in the health plan arena have received the message, loud and clear, that we have to continue to be on the side of continuous quality improvement, which means stating very straightforwardly that we do not do it correctly 100 percent of the time and engaging in dialogue about what people can expect with respect to our ethical code, our code of conduct. With respect to the standards that all members of our association have agreed to uphold, we are going to be reporting how we are doing on those particular fronts very soon.

There are a number of initiatives in the private sector. That is not to say that there are not a number of things going on in the public sector, but on balance, with respect to quality, you have to conclude that the private sector has led the way.

■ Conclusion

As we come to a strategic crossroads in the political arena, the question is, how do you encourage the development of these activities, not discourage their development? How do we have a more balanced discussion about what has contributed to the track record with respect to health plan performance? How do we ensure that as we now have become the dominant force in the delivery system, we continue to get better and to meet the goals that consumers and that physicians and that the public sector expect from us?

There is no simple formula, and what we are going to see very soon, in the political arena, as well as at the bargaining table, and during employer discussions in communities, is much more participation from health plans in discussions about the problems we are wrestling with, how we are trying to do it better, where we are hitting the mark, and where we are falling short. That is a very positive development and a good step forward, but it must be done in the context of a much more balanced discussion.

Putting the Patient in the Driver's Seat: A Four-Point Proposal for Change

by Daniel H. Johnson

■ Introduction

It certainly is a pleasure for our American Medical Association, and for me personally, to participate in this forum and address an area that is very important to us.

I would like to approach this forum from a slightly different point of view and look at the current situation with perhaps a less rosy scenario. Having had the opportunity that I have had as a physician to travel the country and talk to my colleagues, I find a huge amount of anxiety among physicians continuing today. These are people who care very much about what happens—not only to themselves but to their constituents, who are their patients.

■ Evidence of Patient Dissatisfaction

Despite the confusing data, there is clear evidence, over and over again, at least in certain sectors, that people who get sick are not happy. There is not a great deal of satisfaction among that population, the people who actually access the services. For most of them, happily, it is similar to how they feel about their member of Congress. They are happy with their own individual situation, but they are not real thrilled with the overall system.

These anxieties do exist, and I do not think it is any miracle that they exist. I would like to offer a pejorative comment—and I want to be up front that it is pejorative—on how we got into this situation.

The reasons were very important and very legitimate. Both employers in the private sector and government in the public sector were faced with double-digit escalation of costs. They, in effect, were writing blank checks, the resources were

finite, and that simply could not be allowed to continue. Employers—and I think that the employers have taken the lead here, not government—turned to the markets to solve the problem. This was logical; the problem is that the kind of markets that the employers turned to unleashed some unfortunate circumstances.

■ Money, Power, and Something for Nothing

There are three potential seductive forces in health system reform: money, power, and something for nothing. I would argue that what the employers unleashed, in at least segments of these, was all three of those forces. If you wanted to figure out a way where you could suck money out of the system and divert it from patient care to profit, the mechanism that employers turned to is ideal for that purpose. That is not meant to criticize the mechanism. It just happens to be a fact that there were disingenuous people who were able to do that. They did this to the disadvantage of patients and the people who care for them, whether it's hospitals, or physicians, or whoever. And frankly, we have been upset about that, and so have the patients.

If you look among those three, who is to say which is the most important? But if you can tell me that you're going to give me an opportunity to tell you what to do, that may be more important to me than any amount of money that you can give. The notion of power, frankly, brought out the worst in some of our physician community and others. The ability of physicians to sock it to other physicians dawned on some of my colleagues, and this occurred. That is just an example of human behavior bringing out the worst.

The force that may be the most important is the something-for-nothing situation. The cost

dilemma that we have experienced is not a function of technology; it is not a function of an aging population; it is not a function of the professional liability dilemma we had. It derives from the fact that the person consuming the services is insulated from the cost of these services because somebody else is paying for it.

If you agree with that premise, then you buy into the something-for-nothing dilemma, the belief that there is, in fact, a free lunch. Consequently, we seized on a mechanism that has another term, which is prepaid care. And prepaid care, by definition, is first-dollar coverage. I have never met an employer who thought that first-dollar coverage made sense. And yet employers turned to a mechanism of first-dollar coverage. What you end up with is the situation that we have now.

While I agree very much with other forum participants that we have made tremendous progress on all these fronts—and we are getting to the place where I think we ought to be in spite of ourselves—it has been very painful to get there, and there are still barriers in place.

■ A Four-Point Proposal for Change

I'm a radiologist. We deal with images. And I have to say, is there something wrong with this picture? Is there not a way that we could do this better? I do not want anyone who cares anything about what the AMA thinks to think that we are either defenders of the status quo or want to go back to where we were, because it did not make any sense. Our problem is with where we are and how we got there, and we think that maybe it ought to be time to consider a different way of looking at this. We have a four-point proposal for a different kind of vision that is not pejorative in any way and that takes advantage of the diversity that exists out there. The fact is that there is more than one way to look at some of these ideas, and to take advantage of what the employers tried to do at the outset, which was to use the market concept. But our plan looks at markets in a different way.

First, our proposal would expand the choices. At the outset, we had a limitation of choice, and then we had a change in the kind of choices, and now we begin to see this opening back up as a

natural evolution. I very much agree with the third evolutionary phase, but we would like to be a little more proactive than that. We would like to be a little more forceful. By expanding the choices, I am talking about not just choosing one's own physician, but choosing the financing and delivery mechanism as well.

There is no one correct way to do this. There are multiple different imperfect ways to do it. So what we would like to do is take advantage of human behavior and expand the choices. Have health maintenance organizations, preferred provider organizations, and traditional insurance, benefit payment schedules, medical savings accounts, mixtures of all those, and who knows what else, in a much more complex and diverse marketplace.

The second point we would like to see is something the U.S. Chamber of Commerce has threatened. I would like to see it make good on that threat: Have employers put up the same amount of money, the same defined contribution, no matter which choice the person makes. Get the employers out of the insurance business, out of the micro-management of care, and, third point, give the employee the opportunity and the responsibility to choose and own his or her own insurance with the periodic right to change if dissatisfied with the previous choice. That requires some changes in the tax laws. They are not major changes, but they are important changes for individuals to be able to do that. And, it does not require reinventing the wheel.

The fourth point is to create some way for that to happen. Nine million federal employees and retirees get their insurance through a similar mechanism in the federal employee health benefit program. We have suggested that there be formed what we have termed voluntary choice cooperatives—not purchasing cooperatives, but choice cooperatives. These would be mechanisms where people can go and select that insurance.

■ Expanding Choices

My medical practice is a small business by any definition. I have 10 full-time employees. How in the world could I offer my 10 employees some different way of getting their insurance, a variety of different plans? It is impossible. But if I live in

Louisiana, if the Louisiana Association of Business and Industry, or the local Chamber of Commerce, or someone, would set up a voluntary choice cooperative where I could send my 10 employees with a check or a letter of credit, or a voucher, or some kind of instrument that says I am good for the money, they could pick whatever they want. And if they do not like it, next year they could change to a different mechanism. That would force the accountability to flow to the person who is being served by the system. We talk about accountability. We are entirely in favor of that kind of accountability and willing to live by that.

■ Motivation or Regulation?

Basically, there are questions that I want to pose, particularly with respect to human behavior. Is it better to motivate or to regulate? We end up coming down on the side of regulating things that we really are not very enthusiastic about. Doctors hate regulation. But if we do not have a different kind of system, we do not feel that we have any choice but to do that.

So is it better to motivate or regulate? Is it better to entice or coerce? Is it better to reward someone for using the system in a cost-effective way or punish them for not doing so? While I am fascinated with the human-behavior notions, I believe that people do respond to positive incentives, that they can—and do—respond to better ideas, and I think that we have put that on the table. But we have to take advantage of the lessons learned. As Karen Ignagni points out, the data have been available, but we are getting much smarter about knowing how to use these data.¹

¹ See Karen Ignagni, “Health Care Proposals: The Need for a Balanced Discussion,” in this volume.

There was a time when insurance companies gathered data, but they would not tell anybody what the data were.

Let me tell you something about physicians that you may not realize. Physicians respond to good data. That is what we are trained to do. But do not hide the data from us, and then expect us to come up with the response that you would like to see from us. We are not clairvoyant.

We have to take advantage of the process that we have had—and good processes work, no matter what kind of financing or delivery mechanism you have—but to suggest that they would become proprietary to one kind of delivery mechanism, one financing mechanism, is invalid.

With respect to the linkage of quality and cost, we could not agree more. Brent James of Inter-Mountain Health Care in Salt Lake City makes the point: It costs less to do something right the first time. That is common sense. So we would agree that cost and quality are intimately connected and should remain so. And if we could get a handle on both of those, the access problem has the potential to solve itself.

■ Conclusion

In summary, what we would like is to see employers, and government for that matter, move to an entirely different kind of marketplace than the one we see now, at least in the private sector. It would expand the choices, have a defined contribution, get the employer out of the insurance business—not out of providing the benefit but by providing that benefit through a defined contribution—have the individual be given the opportunity and the responsibility to choose his or her own insurance, with a periodic right to change, and create some way for that to happen.

A Partnership for Quality and Customer Satisfaction

by Susan C. Meholic

■ Introduction

Rather than attempting to educate you on the various nuances of managed care or employment-based health plans, I'd like to share with you my perspective as a manager of health plan benefits for a large, national corporation. I would like to begin by describing where we are today.

You cannot hide from the issue of managed care. You cannot pick up a newspaper, watch a TV program, or go to the movies and not see some issue related to the industry, in terms of new drugs and treatment protocols, industry consolidation, and legislation. Indeed, managed care continues to be seriously challenged, despite the recognized progress that has been made in the cost, delivery, and the outcome of medical care.

In terms of cost, suffice it to say that while it certainly deserves our attention in terms of the size and the predicted uptick in premium costs, the dynamics of health care costs are something that we do understand and have some parameters within which to work. Likewise, access is a continuing priority of managed care that we seem to understand and can measure. In addition, it has been a topic of discussion for some time, and many of those same tightly managed health plans of yesterday are expanding the size of their networks and making it easier to get referrals.

However, there are two areas where a solid understanding of the issues and mechanics eludes us, notably quality and customer satisfaction. I use the word "customer" here broadly, to include members, providers, and employers alike, as all parties have their brand of frustrations. We seem to know better what quality and customer satisfaction are not than what they are.

Our experience, and the experience of those that we have benchmarked against, show that the

less-restrictive point-of-service (POS) plans continue to lag measurably in satisfaction behind their health maintenance organization (HMO) counterparts. Employees seem to resist the notion of steorage, and yet the point-of-service, out-of-network benefit is seen as punishment for bad behavior instead of an option for freedom of choice. In response, we point to quality-of-care issues as a source of our frustration, but is quality of care really the issue? We need to better understand how quality measurements work.

■ Addressing the Backlash

Given this state, where do we need to go? First of all, we must address the backlash. Headlines tell the story clearly: Increasingly, employees and providers are rejecting the notion of steorage and the perceived hassle factor. We must fix the process before this hassle factor overrides the success of the most firmly established benefits of managed care. We must improve the ease of getting care and the ease of giving care.

Additionally, we must continue to educate employees on the issues of quality and the benefits of managed care without losing sight of the employees' definition of quality. We have seen the statistics. We can point to the Health Plan Employer Data and Information Set (HEDIS). Employers may know what that means, but do we know how to communicate it?

■ Evolution of Managed Care

We also must recognize and encourage the evolution of managed care. The question for us should not be, "Has managed care done all it can do?" but "How will it evolve?" New medication, new technology, and the use of outcomes data in making

treatment decisions make this evolution natural. Consider the use of data in promoting patient-specific programs for diabetes, depression, and heart disease, just to name a few.

■ Health Plan Accountability

We have, indeed, come a long way in the collection of data regarding health plan performance, the publication of these data against standards, and the existence of accrediting organizations. We must persist in holding the health plans and, for that matter, all the participating parties, accountable. And we, the employers, the medical community, and health plans, must operate in partnership for the development of meaningful and nationally accepted standards.

■ Challenges

This certainly is not going to be an easy thing to do. There are a few challenges ahead of us. Employees are a highly mobile group, with more information available to them from more sources than ever before. They are not confined to a home base. They telecommute. They travel, and they change jobs more frequently. At the same time, technology has brought information to their fingertips. People are more willing to look things up and to become more knowledgeable.

As a result, however, we, as employers, have no control over the quality, the quantity, or the accuracy of the information to which they have access, while health plans and other educators have no guarantee as to how their information will be received. Employees risk getting lost in the morass, challenging their ability to choose wisely, among all the other medical plan options available to them—HMOs, preferred provider organizations (PPOs), POS plans, and all the other acronyms.

■ The Shift in Focus to Self-Service

On the other hand, there are a few things that employees do not have. Many companies have moved from the delivery of benefits to strategic oversight of benefit programs. The result is fewer and, in some cases, no local benefits managers on whom employees can depend. The focus is clearly

on self-service. In addition, employees, like the rest of us, have no time. They work long hours and are more frequently than not part of two-career families or single heads of families.

To paraphrase Regina Hertzlinger, being busy has translated into a demand for convenience, and the lack of convenience diminishes both perceived and real quality. It discourages well people from getting important preventive care, and it discourages chronically ill people from getting ongoing needed support. Being busy has reduced the tolerance of the hassle factor to a bare minimum.

Let us not forget employers. Despite the progress mentioned earlier, there continues to be ever-present pressure to provide cost-effective, quality health care to employees and enhance employee satisfaction and productivity while they are working all those long hours. In terms of consolidations and downsizing, the message is to do more with less. This results in a considerable challenge for the staff remaining to devote the time needed to improve performance and service and endeavor to provide meaningful support for employees.

This brings us to the evolution of managed care. The rapidly changing world is both a boon and a challenge to the evolution of managed care. As programs evolve, health plans must constantly monitor and react to this change. Consider the following dynamic factors. We have advances in technology, such as insurance swipe cards that instantly provide patient information and simplify the process. We have changes in behavior, as employees become better educated and informed consumers rather than patients. We have changing demographics, multicareer families, and the impending retirement of the baby boom population. Purchasing patterns are changing, both in the development of integrated systems of delivery and in the shift in purchase of coverage decisions from employers to employees. And last, of course, employee perception, as a negative perception, or lack of understanding can be a significant barrier to the evolution of these new programs.

And finally, there are the challenges to health plan accountability. We spend a considerable amount of time getting the carriers to focus on what we consider to be crucial. AT&T, for example, has in excess of 100 performance specifications to

which its plans must adhere. Other large corporations similarly impose their own standards and requirements. In the ideal world, all those company-specific standards would be unnecessary. However, this is challenged as companies buy, sell, and reorganize, and the collection of this data is severely hindered.

On the other hand, the pendulum is swinging back from an approach of local administration to national standards with room for local flavor. The key is to master best practices and create efficiencies, not a rigid structure. The challenge is that a merger or restructure is not a guarantee of synergy.

Converting data into usable information is a sizable challenge and a critical need. What we, as employers, seem to need is the quality and performance equivalent of *Cliff's Notes*. Like employees, we have access to more data than ever before, but, according to researchers at the University of Oregon, the majority of employers, even large ones, do not know how to sort through and use these data when making decisions. Take that one step further, and you see why only 31 percent of employers provide any kind of performance information to employees. Again, in establishing measurements and standards, we must come to agreement on how to measure these standards and how to communicate them, how to understand them, and how to tie all the factors together.

■ Conclusion

We have made strides in empowering employees to be prudent consumers. Today, one-third of employers pass on performance information, which never used to be available. Continued work in the development of meaningful information regarding quality will allow us to continue that trend. We have increased the use of technology and streamlined the referral process and, in addition, the use of specialists in certain cases for special needs patients is developing. Likewise, through the implementation of disease-management programs, we are identifying chronically ill patients and getting them into a regime of appropriate and timely care. And, lastly, there has been a significant amount of discussion of national standards, focusing on how to measure quality, how to understand it, and how to communicate it.

These are just examples of the progress we have made. The important thing in all of this is that the execution needs to be personalized to be effective. We need to recognize the value of intervention as promoting, not restricting, care. We need meaningful information we can use, and we must continue to work in the spirit of partnership.

Four Basic Challenges for Value-Based Purchasing

by Meredith Miller

■ Introduction

I have this very “scientific” way of figuring out whether a paradigm has really hit Washington. I go to a number of meetings and try to figure out whether the quality people and the people associated with the Employee Retirement Income Security Act of 1974 (ERISA) are in the same room talking to each other. That really has not happened all that often. Having spent the last year on the Health Care Quality Commission that the President appointed, I realize that we have come so far in terms of the quality data and development. However, I also realize that people who are developing the quality data, the experts in this area, are very unfamiliar with some of ERISA’s reporting and disclosure requirements and the workings of employment-based plans covered by ERISA. Likewise, the people in the ERISA universe tend to know very little about the Health Plan Employer Data and Information Set (HEDIS). And the broad spectrum of medium- and small-sized employers in this country is not as up to speed as most of those who are attending these meetings.

The Department of Labor’s ERISA Advisory Council has a working group that is looking at what data on the quality of health care plans should be disclosed to workers. And just the other day we faced this dilemma, which is how to teach ERISA folks “Quality 101” on performance measurement data. So our worlds have not joined. We need to figure out a way to get that going. One reason this has not occurred is that the quality movement has been going slowly. We want to take our hats off to the Fortune 500 companies that started HEDIS and gave us the impetus for what we call value-based purchasing, which is what a lot of companies do these days. They use accreditation data and performance quality data to make deci-

sions about how to purchase quality care. We have to continue to move in that direction.

■ Four Basic Challenges

We have four basic challenges in the quality data area for companies or organizations that want to do value-based purchasing. First, we need to figure out how to deal with the Balkanization of databases. We have data by one organization on physicians. We have data by others on hospitals, and others on health maintenance organizations (HMOs) and preferred provider organizations (PPOs). We need to figure out a way to standardize and combine all these data so that purchasers, unions, and employers actually can figure out and rationalize the system. Otherwise, it is very difficult to access all of this and to figure out how to compare across plans.

Second, we need to deal with the stratification of data since we now have data that report on outcomes or the new amalgam of outcomes, as well as performance measures and customer satisfaction.

The third issue, which is critical, is that this whole quality-measurement movement is still developing. That is, we have not brought the data down to the provider level. We can look at data at the local level that compares plans, but so many providers and hospitals participate in each plan that it is becoming an overlapping data collection. It is very difficult to compare your doctor and your hospital with another doctor and another hospital. As Janet Corrigan, executive director of the President’s Advisory Commission, would say, we need to figure out how to roll it down to the community level and to the provider level.

Our fourth challenge is how to put these data in the public domain. Whether we like it or

not, there is going to have to be some kind of intervention to get it into the public domain. It is going to be very important for employers of all sizes who cannot afford access to these data—as well as consumers—to be able to have the data available.

One of the reasons why I am so passionate about moving this agenda is that workers now are going to be demanding this kind of data. In many ways, it is the source of the confusion we are experiencing. We now have workers who are in 401(k) plans who are downloading data on mutual funds and making incredible investment decisions. They can see that the financial institutions in this country can produce, download, and give them that kind of comparison. It is only a nanosecond away from when they will be demanding the same thing from the health care industry.

Additionally, workers are very diverse. We are finding that only 20 percent of private employers offer workers health insurance choices of two or more plans. So we have workers who are really stuck in only one plan, making one choice. We have to consider that with the Health Insurance Portability and Accountability Act (HIPAA) and other types of health care reform, workers are now moving between plans in ways they had not done before. So they are going to be making more choices over their lifetime.

Second, more workers will be making health plan choices due to the cost shifting that has occurred over the past decade. I would take issue with some of the data that we have seen and point out that employees' share of premiums actually has escalated, with family contributions growing 146 percent and single contributions growing 284 percent between 1988 and 1996.

Many of us know a family member who is facing a fairly high deductible. My sister was just telling me about her \$800 deductible in a managed care system and the number of health care choices and decisions she would have to make over one year to meet the deductible. So she is making a number of important decisions that are not related to choice between plans, yet being able to access quality data would be very helpful in making her decisions.

We also have a lot of challenges for plan sponsors, for unions, and for employers as large purchasers. Large employers now have multiple data needs. We know that many large employers,

those with more than 5,000 employees, offer more than one plan. And it turns out that, according to some data, they have workers who now are covered by HMOs and PPOs.

The statistics that we were looking at indicate that employers with 5,000 or more workers now have one-third of their workers in fully insured state-regulated HMOs. And so we are faced with the challenge of having to provide data on a whole array of plans. As was pointed out, there are many pieces of legislation that, if passed, would require the disclosure of data and performance measures on all of the plans that are offered.

Some of the large purchasers are the models for best practices in value-based purchasing. A survey by the Washington Business Group on Health found that out of 527 employers, 50 percent had established long-term partnerships with providers to improve value; 57 percent had considered HMO accreditation status; and 37 percent used HEDIS.

Still, we have a lot of work to do. A study by the Agency for Health Care Policy and Research¹ and other studies have shown that employers are still purchasing on the basis of cost instead of quality. We at the Department of Labor and the Pension and Welfare Benefits Administration recently issued a letter of guidance to trustees, saying that if plan assets are involved—which is sort of a code word for saying if workers make contributions to the health plan—that it is actually a fiduciary obligation to purchase on the basis of quality as well as cost.

So we are trying to move this agenda along as well, in recognition that both quality and cost are integrated and very, very important linkages.

■ National Aims for Improvement

In terms of the Clinton Administration, we are doing our level best to coordinate and bring groups together. When he received the last report from the Quality Commission, the President charged the federal agencies to get together and look at national aims for improvement and to coordinate data

¹ See *Agency for Health Care Policy and Research, Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers (Rockville, MD: Agency for Health Care Policy and Research, 1997)*.

and performance measurement across the federal government programs. These, combined with my program, hit almost all insured workers in America. We all gathered at the first meeting of what was called the Quality Interagency Coordination Task Force (QUIC), and I am very encouraged that these efforts, combined with the efforts of the Employee Benefit Research Institute policy forum on the Future of Medical Benefits, will begin to move us forward on the national level.

In June, Vice President Gore announced the establishment of a Blue Ribbon planning group that will set up the Forum for Health Care Quality Measurement and Reporting—a private-sector entity that will begin to coordinate and make attempts to standardize the data gathering that all these different accreditation organizations and similar kinds of groups are conducting. The forum will not compete with them, but will help disseminate the data in the public domain.

■ Accountability and the Patients' Bill of Rights

My agency, which is responsible for the enforcement of ERISA-based plans, reported back to the President that the standards in ERISA were so minimal in terms of reporting, disclosure, and fiduciary responsibility that out of the seven rights and the one responsibility in the Bill of Rights, we could only do regs in two areas: reporting and disclosure and claims processing. It would take legislation to comply with the President's request that we implement the rest of the Bill of Rights right away.

One of the issues that was not in the Bill of Rights, but one that we, in the Administration, had been urging, is some way that we could provide consumers with legal enforcement of the Bill of Rights, some way that we could make sure that those rights are legally enforceable and real. In my agency, that issue is the one of which we are most fond. With all the options that are out there for trying to achieve effective enforcement, it should be no surprise to anyone that we believe ERISA lacks a meaningful remedy when a patient is inappropriately denied medical care through the benefit claims process.

This issue is a little bit more complicated because it is not just denied coverage, it is a

delayed denial, or determination, stemming from medical necessity. When ERISA was passed, it was mostly targeted toward pension abuses. At the time, only 4 percent of workers were covered by self-insured plans, and Congress anticipated that workers would be under state regulation and be protected by the whole array of provisions that were there at the time, in 1974. Also at the time, there was a legal interpretation and ambiguity about workers' ability to avail themselves of remedies, which meant that if they were harmed, they would get more than just the benefit. They would be able to get the cost of additional medical costs, or attorney fees, or back wages. In 1987, a critical Supreme Court case called *Pilot Life* overturned that assumption. It said that because ERISA speaks specifically to the area of claims regulation, and of remedies, it occupies the field. So that all workers who thought of themselves as being able to go through the system and avail themselves of state remedies were now only under ERISA remedies.

■ Gaps in ERISA

To make that story a little bit clearer in terms of what happens, we often refer to a case about a newborn called Madison Scott who required a critical eye test. There was some indication that she might be blind, and the managed care organization delayed that test for eight weeks. It ended up that there was irreparable harm. I point that out because, under ERISA, the only thing that she could have gotten was the cost of the eye test. The family could not get additional medical costs or any other care that they might need to bring up that baby.

Joe Piacentini and I have developed this little template called Bob and Mary to bring this home. We refer to Bob as the individual policyholder, who many may think of as either a state employee or someone in a state who is just an individual holder of a policy. If he was inappropriately denied coverage, he could go to state court right now to receive remedies, which would include uncovered additional care, attorney fees, and other lost costs, lost wages, and other financial losses, compensation for injury or wrongful death, compensation for pain and suffering, and possibly punitive damages.

Mary, his neighbor in the same state, is under an ERISA plan that preempts state remedies. Should she be injured by exactly the same condition, she can sue only in federal court, and the only thing that she could recover is the benefit that should have been paid to begin with. And, as we know, there are 122 million Marys in this country and 60 million Bobs.

There has been some thinking on our part about what it means to have delayed denial and inappropriate denial due to medical necessity. We looked at a Kaiser survey of managed care enrollees who reported that their biggest problem with managed care was delay or denial of treatment.² When we looked at the numbers, they said that there were real costs, both physical and financial costs, associated with delay or denial. Of the 11 percent reporting, 24 percent were physically injured; 37 percent permanently disabled; 26 percent lost school or work time; 9 percent lost more than 10 days; and 41 percent suffered financial losses.

As we think about what we consider to be an anomaly in contract law here in America, it is important to point out that we have a weird situation where you can purchase a toy at Toys 'R' Us, rent a car, use your credit card, and, should you be harmed, you are better protected than when purchasing your own health care.

I am advised by the lawyers who surround me in the Department of Labor that tort law and the ability to sue historically have been an issue of civil unrest. So if I were walking down the street and someone bopped me right in the face, while I would not hit him back, I would have an ability to deal with him in some other way. Right now, the people who are harmed in these situations have no ability to fight back.

² See *Sierra Health Foundation, Kaiser Family Foundation, and the California Wellness Foundation, Survey of Consumer Experiences in Managed Care (November 19, 1997)*.

■ Isolated Discussions

It is also important for people to remember that we cannot discuss remedies in isolation. All of the legislative proposals and many of the policy proposals that deal with this issue are not isolated. They deal with it within what I call an infrastructure. That is, they deal with it with the knowledge that the Department of Labor is going to issue a regulation in June that is going to expedite internal claims processes, knowing that no bill is going to pass, at least in my personal opinion, with remedies without the existence of an independent external review. And that if you combine all those pieces—expedited claims, external review, and remedies—the number of cases that would rise through that process will be very small.

It is the right thing to deal with the problems of quality of care up front. That is the reason why we are doing the reg. That is the reason why we need independent, external review, and that still, those procedural changes are going to be no substitute for those egregious cases, bad patterns of practice, or things that just slip through the system. And there is no way some of the people in the cases that we are looking at could have been compensated, or bad quality of care been avoided, even with all those three pieces in place.

■ Conclusion

We have been very sensitive to the projected and potential costs related to remedies and external review. It is something that we are very much aware of and struggling with, and I know that it will play itself out in the public debate. There are as many studies on one side as there are on the other. In terms of the Administration position, we are open to discussions of options in terms of how we can deal with making the Bill of Rights legally enforceable and dealing with the issues I have discussed. There are a number of ways to go about doing this, and I do not know that we have any one best answer. There are pros and cons to all of them, but we would really like to continue the discussion.

Selling State-of-the-Art Medicine

by Karen Williams

■ Introduction

Like other participants in this forum, I believe that affordability and quality are compatible but that costs are likely to go up. The next round of solutions will be more complex because most of the simpler solutions have already been implemented. Some of these solutions have netted meaningful savings; some of these savings will be retained in the baseline of health care budgets but others may not. I hope that the next round of solutions can be developed cooperatively. If the components of health care do not work together, we are all going to be on the receiving end of more extensive regulations—and my industry, the pharmaceutical industry, already has its share of regulations.

Even as we try to work together on more complex solutions, it is tempting to give short shrift to the other players' issues and even to shift blame. So one of the obstacles to working together is that we sometimes find ourselves put in a defensive posture by other stakeholders. Especially in public forums, the representatives of different stakeholders alternate between taking a jab at each other and trying to figure out some new, mutually workable solutions. Perhaps the themes derived from the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry can point to a cooperative path of progress.

■ An Integrated Approach to Care

One of the themes from the President's Quality Commission is the value of an integrated approach to care. The commission found that there is an unacceptably high level of errors in the health care system and that the errors are, in theory, largely avoidable. The unhappy result is that there is a gap between what we know should be done and the care that patients actually receive. The commission was

quick to say that the errors are systemic, occurring as often in health maintenance organizations (HMOs) as in fee-for-service settings and associated as much with specialty care as with primary care. The errors appear to be the result of a lack of integration among the many entities involved in delivering care. Even if the latest scientific evidence is disseminated and the right patient information is initially collected, system disconnects can occur when the patient has a change in condition, location, or caregivers.

What we need to have is an integrated approach to thinking about each other's contributions and ways of coordinating how each component of our health care system is delivered and rewarded. If we fail to take an integrated approach, we will continue to have higher overall costs, patients will remain at risk for suboptimal care and employers will continue to face increased premiums and reduced productivity. The opposite of an integrated approach is component management—evaluating each of the treatment modalities individually, controlling each of them individually. Component management hampers appropriate and cost-effective shifts in health care delivery. As technology improves, the site for care delivery moves into lower cost settings. As a result, some modalities, like ambulatory surgery and pharmaceuticals, increase in volume while others decrease. Sometimes increases in one type of care are offset by savings in other types of care, as when increases in drug expenditures substitute for services that are more expensive.

Component management (and component evaluation of costs) are often reinforced by misaligned incentives in payment policies and fragmented contracting. Fragmented, inconsistent payment bases that reward component management are more rigid in the public sector but are also highly prevalent in the private sector. So, even

when there is agreement on a better way to treat patients, such as when a medical society embraces a practice guideline, individual physicians and plans may find themselves in conflict with the incentives contained in the contract language of several payers.

When I was in managed care consulting, I met with a plan where the medical director had shown wonderful leadership in improving quality. Despite being in a relatively secure market, he was very motivated, really enthusiastic about guidelines and disease-state management. With his medical teams, he developed 56 different disease-management type protocols. He was understandably proud of their efforts and thought they were going to improve quality of care. Before implementation, however, he had the presence of mind to examine how the new protocols would change service utilization patterns and therefore the plan's revenues. For half of the 56 new guidelines, full implementation would have so reversed the revenue stream that he would likely have bankrupted his otherwise very secure plan. So doing the right thing in the absence of having the right payment is nothing trivial. A practice or health plan could literally jeopardize its existence due to the misalignment between payment incentives and best medical practice.

Most managed care plans live with a mixture of payment scenarios. It is estimated that over 80 percent of Americans are treated by a managed care plan but that only 8 percent of Americans are covered on a capitated basis. So the vast majority of plans have to deal with inconsistent and potentially misaligned incentives embodied in a variety of coverage and payment rules. Paying plans on wildly different bases for treating similar patients encourages practice variation that could in turn raise medical malpractice issues. Payers—and all of us who work with reimbursement—need to realign payment incentives to reflect and reward desirable shifts in patterns of care and to develop a means to rationally make the transition from payment methods that conflict with best care to methods that are more consistent across sites and payers.

■ Closing the Practice Gap

The second major theme derived from the

President's Quality Commission is the "practice gap" that exists between best medical practice and actual practice. The commission found that the growth of medical science has been exponential, making it increasingly difficult for physicians to keep up with new medical findings. The number of peer reviewed journals increased from 500 a year in the late 1970s to well over 8,000 a year in the early 1990s. Trying to keep current with the latest medical information is a major challenge for physicians and for payers.

Although it is tough, we have to find a way to meet the challenge of providing patients with state-of-the-art medicine. People can hope for miracles, and they may be disappointed. But if they do not have confidence that they and their families will receive state-of-the-art medicine, they will react. Patients will sue and regulations will increase. Although patients cannot insist on miracles, they do expect the most appropriate medical care based on the latest medical knowledge. It is what each of us expects when faced with illness or injury. And it is essential to maintaining the public trust.

We need to work together to close several types of practice gaps. There is a gap between the high incidence of chronic diseases and the number of patients who are diagnosed. In America, there are over 15 million diabetics—over 5 million of whom have not been diagnosed. After patients are diagnosed, they do not always remain in active treatment, especially for chronic diseases like hypertension, depression, and diabetes. Many health care systems, particularly fee-for-service, fail to notice when the patient is no longer actively engaged in treatment, for example, failing to refill prescriptions for chronic diseases. Some patients get treatment but not state-of-the-art treatment. That is a practice gap. And, far too often, patients are prescribed state-of-the-art care but do not follow their physician's advice regarding medication compliance.

Probably the biggest source of waste in the pharmaceutical budget is attributable to those patients who are prescribed needed medications and do not take them properly. Patients frequently self-ration their medicines. They break the pills in half. They take them fewer times a day than required or take medicines intended to manage a chronic condition only after acute symptoms have reappeared. Meanwhile, pharmaceutical companies

must submit randomized controlled clinical trials to the FDA in order to establish exactly what medication level is both safe and effective. The value of that data, as well as the value of the physician's diagnosis and counsel, is likely lost if the patients cut their medications in half or do not take them consistently.

Compliance is an issue for life-threatening conditions as well as chronic ones. Studies suggest that cutting back on chemotherapy dosages, due to nausea, pain, etc., by as little as 15 percent to 25 percent may render the chemotherapy ineffective in tumor reduction. Likewise, a high percentage of transplant patients fail to comply with immunosuppressive therapy and lose the transplanted organ. So we have to start dealing with the question of compliance, not because it sells more pills but because noncompliance is a costly waste of health and resources.

Where are the greatest opportunities for cost and quality improvement? According to the National Chronic Care Consortium, a research group of leading integrated delivery systems, 70 percent of acute care costs are due to chronic illness. That is where we are going to have the most impact. And, based on some of the studies we have seen, managed care plans seem to be as good as, if not better than, fee-for-service, in diagnosing and treating some chronic illnesses. Unless we as patients change our health-related behaviors, payers and health plans are going to need more pharmaceuticals to deal with our chronic diseases and to restrain the related acute care costs that are driving the system. So, it is logical, unavoidable, and arguably desirable that the drugs increase as a portion of total health care costs.

Finally, I feel compelled to challenge earlier presentations that focused on the increased rate of drug expenditures and implied that drug costs are largely responsible for recent premium increases. Payers simply cannot get 10 pounds of savings out of a one-pound sack. The pharmaceutical budget is not big enough to account for large premium increases, nor is it big enough to generate major savings. Pharmaceutical costs are approximately 10 percent of the health care dollar. The most recent estimate shows drug expenditures increasing approximately 11 percent. This would mean an increase in total costs of only 1.1 percent—not enough to explain the total premium increases. And

of the 11 percent increase in drug expenditures, only 2 percent to 3 percent is the manufacturers' price. The rest of the increase is volume.

There are some things we can examine to see if the increased drug volume makes clinical sense. If we are talking primarily about managed care premiums, remember that managed care plans are arguably doing a better job of finding chronic illness because of the National Committee on Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS) measures. If a plan diagnoses more cancer, the plan is going to use more chemotherapy. If the plan uses more chemotherapy, it is likely to use more pain and nausea drugs in order for cancer patients to tolerate an adequate dosage of chemotherapy. Examples abound for chronic conditions as well. Between 1993 and 1996, use of antihypertensives in managed care plans increased by 16 percent. Cholesterol-lowering drugs were up 15 percent, and antidepressant drug use increased by 52 percent. So, in addition to price inflation of no more than 3 percent, you also have more patients in HMOs taking drugs. Patients who have any prescriptions have more of them (8.3 prescriptions per person in 1996, compared with 8 prescriptions per person in 1995).

Another driver of volume is that appropriate treatment of chronic conditions means taking drugs for a longer time. Over time, patients may be taking drugs for one or two chronic conditions and occasionally a drug for an acute illness as well. And when new medications are ordered, the existing medications may need to be changed for compatibility. So there are many clinically sound reasons why drug volume should be going up. I would also argue that increased use of drugs could have a substantial fiscal offset on the other more expensive types of health care. A congestive heart failure program in Evanston, Illinois, reduced direct treatment costs by 60 percent by maintaining patients outside the hospital and compliant with their therapy, including drug therapy. According to a study in the *New England Journal of Medicine*, the use of an ACE inhibitor for such patients can avoid \$9,000 in hospital costs per patient. A partnership program in Virginia Medicaid has used disease management techniques to reduce expected emergency services for asthma by 42 percent. According to a report in *Business and Health*, some HMOs have seen a

30 percent increase in asthma drug costs, but a 50 percent reduction in hospital costs for asthma.

Total costs and service substitutions may not be easily recognized if plans or employers carve out and look at drug benefits separately. This is not to disparage pharmacy benefit managers. But, when a product, service, or condition is under a separate management contract, the employer and plan need to keep the integrated approach in mind and put all the pieces back together again. Otherwise, we are not going to get the state-of-the-art care that our customers demand or the levels of quality and cost we expect from our management decisions.

I believe that providers of health care services and products need to validate and then provide state-of-the-art medicine, and payers need to pay for it. Anything less is going to generate a public backlash and increase regulation on providers, plans, and employers. That requires all of us to forge ahead, to share our databases and methods, and to continue to work with NCQA and others to figure out what state-of-the-art medicine is and how we can best recognize and reward its delivery. Payers need to get better at contracting for state-of-the-art medicine in a way that breaks down, rather than reinforces, component management. Payment

policies need to consider the total costs of caring for the whole patient over time, not lock in fragmented episodes and encourage cost shifting from one type of care or provider to another regardless of best practice.

■ Conclusion

We need to avoid blame and to seek partnerships that will produce mutually workable solutions. If we don't, we will all be burdened with additional, and probably ineffective, regulation. The way to produce mutually workable solutions is to continually validate the care we should provide and then work together to remove the barriers—in information, infrastructure and payment—to getting it done. There is a temptation among legislators to respond to public frustration with increased regulation because it sounds like taking action, and it makes a nice media sound bite. But regulation alone is not going to assure quality. It diverts the money, resources, and goodwill needed to identify state-of-the-art medicine, recognize when it is being delivered, and properly pay for it. We look forward to working with patients, practitioners, plans, and payers. Together we can improve quality of care while restraining overall health care costs.

**CONSOLIDATION: WHAT
DOES IT ALL MEAN?**

The Rationale for Health Care Consolidation

by James D. Bentley

■ Introduction

This discussion is designed to take a look at the consolidation in the health area that I know best as a Senior Vice President of the American Hospital Association. We watch hospitals and health networks in terms of their behavior and listen to them a lot.

■ Defining Consolidation

To define the issue, a series of consolidations is going on, and sometimes people are using the same terms and sometimes they are using the terms differently. For the past 20 years, there clearly has been what I will call horizontal consolidation—hospitals coming together with other hospitals. They may have similar capabilities or complementary capabilities.

The second kind of consolidation we have observed is consolidation in a vertical sense, where we have a hospital consolidating with either ambulatory care or with post-acute care, be that a nursing home, a home health agency, or something else. We also see a third kind of consolidation in terms of some combination of the provider capability with an insurance capability. These different forms of consolidation tend to get mixed up, although there is a fairly common basis for why they are occurring—what is driving them to consolidate. A friend of mine who looks at American business as an analyst says we are basically a nation of lumpers and splitters. For a while, we go through lumping companies together to make big companies, and then we decide, “No, that wasn’t the value added.” So we become splitters. And, at least in the health care system on the provider’s side, we are doing both at the same time.

■ Striving for Efficiencies

One factor that is motivating people is the attempt to achieve efficiencies in terms of the provider capacity. They are putting organizations together to achieve economies of scale or economies of scope. Economies of scale mean that if you can put several similar organizations together, you only need one chief nurse, one chief financial officer, one chief executive officer, or one chief operating officer. That is a low-level example, but you may well have saved the expense of those jobs. It also works on the medical side. For example, when you consolidate in a community that may have two hospitals, you may combine two small transplant programs or two small open-heart surgery programs. Bringing them together may well achieve economies of scale. Economies of scope occur when you begin to bring more complementary things together. You may not be building a bigger scale, but if you have a neonatal ICU with specialized capability in pediatrics and you can bring it together with other pediatrics capabilities, you may be able to produce the services at less cost because you are able to use the specialized resources—either equipment or personnel—more consistently.

There is very little literature in the economics field about the economies of scale or scope. Some of the literature suggests that this is a U-shaped distribution, where there is a period of time in which you achieve economies of scale or scope, but you may also go backward if you get beyond that.

■ Responding to the Shift in Risk

The second factor contributing to provider consolidation is clearly the movement—whether in

Medicare, Medicaid, or private insurance coverage—to shift the risk, of both price and now increasingly of utilization, to providers. Our members try to deal with that by putting together larger organizations for a couple of reasons. It enables them to have a broader part of the process. If you are unable to make money or perform successfully in one part, you have an opportunity to recover that elsewhere in the production stream.

Second, it is done to reduce the suboptimization. Lots of our members who tried virtual networks found that each part of the stream wants to optimize its own behavior, although the sum of all the efforts of individual components may not add up to the best overall organization.

Last, how many times is there a stream of profits in the delivery system? People are trying to put together larger organizations so that as they have to work within the risk that is being shifted; they are in a position to take that profit only once in the system.

■ Third-Party Payer Behavior

Another factor contributing to consolidation is the behavior of at least some third-party payers, be they private or public, who want to sign a contract with a provider that has something approaching a full-spectrum capability. This is not present in some markets.

If you look at the California marketplace, where the plans seem increasingly to want to sign up with all physicians and all hospitals, then this factor is not as salient. But if you are in a part of the country where the marketplace behavior of either the Medicaid program, in particular, or private insurance companies, is to sign up with some limited number of providers, then you are more successful with them if you can offer a broad array of products.

Going back to the earlier point, an increasing number of our members would like to be in the position to take a broader array of risk. So, they enter into agreements for a percentage of premium. If you are in an agreement for a percentage of premium, at least as I am observing the market wisdom now, people want to have a broader share of that premium rather than less. They are worried that the more that is carved out, the more difficulty they will have managing a successful organization.

■ Excess Capacity

Excess capacity also is an influence. On any given night in the United States, if we asked our members how many beds they have set up and staffed, they have about 900,000. We use about 600,000, and if we were to use beds at the rate that, say, Portland, OR, or Minneapolis, MN, use beds, we would need about 400,000 in this country. Now, I say that with one caveat. Every physician and every hospital I have seen in the past couple of months adds a note of caution to these projections because of the flu season. We have had a very large number of admissions for the complications of flu in 1998. And they say, “You know, if the efficiency experts, or the people pushing us for efficiency, had achieved the downsizing potential, we would have had a bad year.”

Excess capacity has a couple of heritages. As a cynic has said, “We built the interstate highway system and the Hill-Burton hospital construction program in the wrong order. First, we decided to build hospitals after World War II. And then we decided to put in interstate highway systems that allowed people to drive by those small community hospitals, especially in rural areas that adjoin urban areas.”

If you look at suburban Massachusetts or suburban Nebraska, a large number of people want to have a hospital that they do not want to use. They want to go to the large urban center. So we have excess capacity.

■ Reduction in Length of Stay

The changes in clinical medicine, whether they be in anesthesia, surgery techniques, or the use of pharmaceutical products, have dramatically reduced the length of stay. This has taken bed days off faster than our members have taken beds out of the inventory. When we survey the public, we do not meet many people for whom a night's stay in the hospital ranks as a positive. If they can go home earlier, they say, “Thank you.”

There are stories about drive-through deliveries and the 24-hour maternity stay, and a few things that have been a part of the managed care backlash or folklore; but we see lots of patients who, when given the choice of having a roommate, being wakened up at night, having somebody

interfere with them, say, “No, thank you. If I can manage, I’d just as soon go home or go to a nonhospital kind of setting that’s less intensive.” So, we are seeing utilization fall because of that. I have been watching the electric power literature. There is a lot of “stranded capacity” out there in the health care field, and a question for those of you who are either employers or insurers is, if there are costs to pay that off, who is going to wind up doing that?

■ The Desire for Market Domination

To be frank, some people are putting together a larger organization because they either want market dominance or have an edifice complex, or however you want to describe it. They want a larger market share simply because when they went to management school, they read the “Jack Welsh rule”: If you are not number one or two of your market, you ought to get out of it. So, they are determined to put together an organization that is number one or number two.

As the payers have consolidated and as payment programs have consolidated, our members say, “I don’t have any leverage in this marketplace. If there are only going to be two or three payers, I need a balance at the negotiating side.” And, “I need to do that for the third reason. I have become a price taker. I want to enter into a price negotiation, or even a price-setting, role. I need to have the market share to be able to do that.” These are a set of pretty straightforward business reasons as

opposed to health or other reasons for doing that. About 1,000 hospitals have closed in the United States in the past dozen years, most without any great impact on the community or access to care. And we are going to see a lot more consolidation within the hospital field and between hospitals and other providers.

But there is a contrary trend in the increase of niche providers who want to profit from taking some of the services out of the hospital. Our members are having a lot of angst about that right now. To create a niche provider, you want to pull services out of the hospital. One of the things you tend not to want to take with you is some burden of uncompensated care that the hospital was trying to cross-subsidize.

Whether it is a hospital service or an ambulatory care service, there are people who argue that the system would be better, in an overall efficiency sense, if you optimized the parts and let each of those parts pursue its own advantage, rather than if you created large organizations that are able to make internal decisions about how to build an optimum system.

In conclusion, as we watch developments, we need to keep straight the difference between the costs of a unit and the costs of a system. I have seen some communities in which the pursuit of more niche providers certainly has allowed service X to be provided at a lower cost. In effect, though, it has resulted in increasing the total community cost because there was no one who could take out much capacity in terms of the rest of the community.

Building an HMO Without Walls

by Charles Blanksteen

■ Introduction

One of the interesting aspects of the consolidation of providers in the health care industry is that this consolidation had a ripple effect. All of the participants (doctors, hospitals, managed care companies, payors) had to do something in response, as a defensive posture. I have been involved with two defensive reactions from the employer/payer perspective. The first is the National HMO Purchasing Coalition and the second is called the Study Group. The National HMO Purchasing Coalition has been together since 1994 while the Study Group has come together in the last 12 months. This article discusses the development, structure, and purpose of the Study Group.

■ Coalition Structures

Most of the major employer purchasing coalitions are involved in collectively buying HMO coverage. The Study Group is different because it is a non-HMO based combination of employers. People have asked me a lot about this, and they keep saying, "How are these coalitions exactly structured?" The answer is they are structured in every possible way you can imagine. Structuring around a geographical area is typical. For example, many coalitions are in Texas because of the ongoing problems with health care purchasing in Texas. Other times, they are structured around a specific managed care organization. Other times, they are structured around a key mission, such as quality of care over cost. The issue of quality of care has taken on more and more momentum. If we just keep tracking the price side of health care, we neglect to focus on the most important part of the process, which is the outcome for patients.

The primary reason for coalitions is, of course, defensive. Many large employers were used to controlling the relationship with their health

care vendors. Those relationships took a downward turn as employers began purchasing health care locally (i.e., HMOs) all over the country. The result was that a very large employer would have very little clout in a city where they had even 1,000 employees, as opposed to the clout they were used to having when they had 10,000, 20,000 or 100,000 employees across the country. Many large employers found this situation unsettling, unproductive, and expensive to administer.

The other issue facing employers is that there are fewer and fewer alternatives available in the marketplace. We have seen situations where managed care organizations are, in effect, dictating to employers how to offer coverage. We had situations where large managed care organizations have told employers, "Here is what your contribution strategy will be. Otherwise, we will not offer you coverage." Employers may have no recourse, unless they can position themselves with 10 allies right behind them, to help by saying, "Wait a minute. We are not going to accept that."

The Study Group is a group of six large national employers that have banded together to purchase non-HMO coverage. The reason they banded together is painfully obvious. The members have between 70 percent and 80 percent of their employees in HMOs. Defensively, they ended up saying, "We only have a few thousand employees left in non-HMO serviced areas, we are paying huge amounts of money in administrative costs, we have absolutely no clout at all with the vendors, and we do not get good data that we can use to monitor the program because we are too small." As a result, they banded together to establish what is, effectively, a very large employer. Now, combined, they can become the large employer they once were.

Surprisingly, we also found that the solutions the members were seeking regarding plan administration, design, and cost were not very different. There were differences in plan designs

and administrative requirements. When you boiled it down, the non-HMO plan needs of each member, and what they actually end up offering employees, are not very different, market by market by market. As a result, we found a third-party claims administrator who had access to managed care networks and discounts (because, of course, you shouldn't buy retail any more) and created new plans.

Requirements of participation were interesting because when you put together groups like this, such things as bylaws and rules initially are what people discuss. In reality, you have to have a set of rules and practices that you can live by, but they must not be too cumbersome.

■ **Buying Services as a Group**

In the early stages of the Study Group, we listed the services that members liked in their non-HMO plans. We then determined if these services could be effectively be bought together as a group. The first service desired was a dedicated shared resource service center. That was the key for all of the members. Second was a national PPO network which allowed a plan design with in- and out-of-network features that would allow people to have choices and, at the same time, receive in-network care as much as possible. There was one overriding rule: "never buy retail if you can avoid it." The overall intent of the new program was to attempt to mimic the best features of an HMO, from the standpoint of discounts and utilization of care monitoring, yet retain the freedom of choice from the traditional indemnity plans.

Other services desired by members were more company specific. Such as wanting dedicated claim processing, dedicated customer service, fee negotiation on every out-of-network claim over \$500 and post-hospital claims service. The post-hospital claims services, in many ways, mirror HMO services to make sure that when someone leaves the hospital, they have help in sorting through all the bills, all the details, and wending their way through the system.

Next, to truly create an HMO without walls, as well as control cost and utilization, a specialty utilization review and management system vendor was hired to mirror what the best HMOs did. The vendors system copies systems

from some of the staff model HMOs on the West Coast and tries to provide patient information for physicians at the point of service, across the country. To maximize the "never pay retail concept," we also included dedicated lab contracts and dedicated pharmacy contracts. A critical feature was electronic data feeds (all operating on a real time basis) channeling claims information back into the specialty utilization review and management system. This allows the vendor to assess the data, identify potential issues, and feed information back to the attending physicians.

From a plan design perspective, an in-and-out of network PPO structure, as an alternative to lock up HMOs, was the initial decision made by the members. To arrive at this structure, the first studies we did compared POS, PPO, and HMO prices market by market, with demographic adjustments. We found, in our case, that a PPO structure produced what we consider an "optimal balance" among those types of programs. We also wanted to be able to accommodate as many ancillary carve-out program feeds as possible, so that each one of the members could customize or allow for existing carve-out mental health or pharmacy programs.

With regard to the third party administrator, we established a common renewal date so that the financial negotiations with the vendors occurs once with multiple year fee guarantees. Given the size of the group, we are staggering the implementation into the new system over the period of a year. Also, we negotiated a dedicated team at the administrator to handle all aspects of claims and customer service.

The members found that items such as plan oversight, which in the old days were relatively easy to do because you had enough people in one common program, could be done collectively when you put a group like this together. That meant we could do plan performance and monitoring audits of a different level and different depth than we had ever done. The kinds of monitoring studies that are being done now, area by area, and the numbers of employees that we have in any geographical area, can allow us to have customized negotiations with providers and all kinds of interesting semi HMO-like arrangements, if we want them.

As a result of the size of the combined

members, we were able to consider performance guarantees that go beyond the usual limitations of phone-answering times and claim accuracy measurement and actually look at performance. For example, we would ask, "How many large claims did you find before they became large?" So, if the answer was 1,000 large claims and you did not find them until it was too late, that would be a failure of the system.

The size of the group also dictated that we have back-up disaster plans. With a group this size, we are able to have an entire unit that is ready to go at a moment's notice should the main service body have a problem, whether it is mechanical, a business problem or anything else.

The fee negotiations were all done en masse, which makes it, at one level, much easier. At another level, it makes it much more difficult, but it does make it very effective. The prices members are getting now are probably 30 percent to 50 percent less than the individual members were able to obtain on their own, with discounts that are probably 10 percent and 30 percent greater than they were getting through the rates that they had before. So the difference in cost is rather staggering.

An additional benefit of the size of the coalition structure is that we are able to have features such as executive claim handling, so the executives would be taken care of in a preferred way. Some of the employers do not want that; others do. It is based on each company's philosophical position toward its benefits programs.

There also are members who are putting third country nationals into this program. They are coming into this country and using the system, and we find this trend is happening more and more. As companies become more global, their employees are coming back to the United States, or foreigners are coming to the United States for the first time to get health care. They are coming into a system like this rather than going into a fee-for-service system.

Overall, our results are quite straightforward. We have leverage, with the marketplace and with the vendors. In some cases, we have negoti-

ated directly with providers where our volume is sufficient. The coalition structure helps maintain a market-share relationship so that we can have a viable alternative in markets where HMO costs may spike in a given year. We have found that, in some markets, this program, demographically adjusted, is more effective than many of the HMOs in the same market. That was a big surprise for all of us.

Part of the reason for the Study Group was to see if we could build an HMO without walls that would be effective in markets where the HMO choices either had gotten out of hand or were getting out of hand. Lastly, the goal was to increase the price competition in the marketplace.

■ Conclusion

The results are coming in through some of the members and they demonstrate that there is a way to solidify the market price and the market fluctuations we have been seeing. This occurs, for example, if you have an alternative to three or four HMOs in a market where prices are rising very rapidly and the underlying costs really are not. To measure the actual costs in a market, we collect data for some of the Study Group members on the underlying HMO costs, either from published data from the state insurance departments or from direct claims activity data we get from the HMOs.

In our experience, we do not always find that they are changing rates to match the underlying costs that they are experiencing. We have found that having an alternative, a managed care, HMO-like program without walls, run by multiple employers, is an effective ballast against that kind of price increase.

Finally, it is a way for managed care companies to increase volume without having the expense, necessarily, either of acquisition of the employees or of building new networks by using existing PPO networks. Overall, we have found the coalition format and the development of a managed care alternative to HMOs to be a very, very effective tool.

A Partnership with HMOs

by John B. Brence

■ Introduction

The National HMO Purchasing Coalition companies came together to collectively select and partner with locally competitive health maintenance organizations (HMOs), to promote a high degree of clinical quality, member access, and patient satisfaction. While all the coalition companies have other medical programs, including point-of-service and indemnity plans, the coalition was formed solely to focus on evaluating and selecting HMOs.

The coalition has two objectives. The first was to ensure that the health plans were focusing on quality, as defined from the clinical perspective. The second was to leverage our group purchasing power to lower the costs that our companies and employees pay for health care. One of the driving forces that brought the coalition companies together was a common belief that good quality costs less. Getting things done right the first time has always been the most cost-effective solution for all of us.

■ A Historical Perspective

The coalition was founded by Merrill Lynch and American Express in 1992. Initially we tested the concept in one market location. The results were promising, so the next year, we expanded it to six locations, including markets in California, Florida, and New York. In 1995, the coalition expanded to include nine Fortune 100 companies, and most recently, we have expanded to 12 companies in 1998. Participating companies include American Express, AMOCO, BP America, Gannett, The Hartford, IBM, Lockheed Martin, Marriott, Merrill Lynch, Mobil, Pfizer, and Sears.

One of the factors that led these companies to pursue this joint effort was that, although each company has a large employee base, with many companies having over 50,000 employees, our

employees are scattered throughout the U.S. For example, while Merrill Lynch has close to 50,000 U.S. employees, we are in all 50 states with over 650 sales offices, as well as various operations locations.

Additionally, the coalition companies all employed evaluation and selection methods focused on selecting health plans on a market-by-market basis. This, again, highlights the benefit of coming together with other purchasers to increase our leverage in the local marketplace.

■ Coalition Guidelines

We tried to keep the guidelines of the coalition simple. We selected three different plan designs to meet the diverse needs of all member companies. We all agree to offer the same two to four HMOs in each marketplace and to drop or freeze enrollment in any currently offered HMOs that are not selected by the group.

In developing this model, we met with Alain Enthovan to discuss the concept of managed competition. We believe our market-based approach, which directs volume to a limited number of plans, is one of the primary reasons for our successful results. It is a different approach than most other coalitions, where the emphasis typically is on evaluating plans and allowing each company to select any or all plans that meet the group's standards.

Using this approach has helped us, in terms of both partnering with the plans in quality initiatives and in helping from an economic perspective. Table 11.1 provides a brief summary of the standard plan designs. The major difference is that there is some variation in terms of the copayments, but all the plans offer the same scope of services and coverage.

In defining a "market," we try to make it as large as possible, while recognizing the standard

Table 11.1
STANDARD PLAN DESIGN

| Benefits | Plan 1 | Plan 2 | Plan 3 |
|--------------------------|------------------------|-------------------------|---------------------------|
| Physician Copayment | \$10 | \$15 | \$15 |
| Hospital Copayment | \$0 | \$0 | \$500 |
| Emergency Room Copayment | \$50 | \$50 | \$100 |
| Inpatient MH/SA | 30 Days at 100% | 30 Days at 100% | 30 Days After \$500 Copay |
| Outpatient MH/SA | 40 Visits; \$10 Copay | 40 Visits; \$15 Copay | 40 Visits; \$25 Copay |
| Prescription Drugs | \$5 Generic, \$5 Brand | \$5 Generic, \$10 Brand | \$10 Generic, \$10 Brand |

service areas of the local HMOs. As a result, a market could be defined as narrowly as a city, such as Cleveland, Detroit, or New York; part of a state, such as northern California or southern California; or as broadly as an entire state, such as Alabama, Tennessee, or Oregon.

Over time the coalition has expanded the number of markets we cover. In 1996, the group worked together in 27 markets, and expanded to 44 market locations in 1998. For each market, we send a joint request for proposal (RFP) and ask the plans to quote one rate, which will be used by all the member companies for that location.

Not all companies participate in every location. This provides flexibility to recognize the differing priorities of member companies in different locations. For example, one company may have a small population in a location where other coalition members have a sizable presence. This approach prevents a company from being required to offer more HMOs than warranted.

■ Quality Initiatives

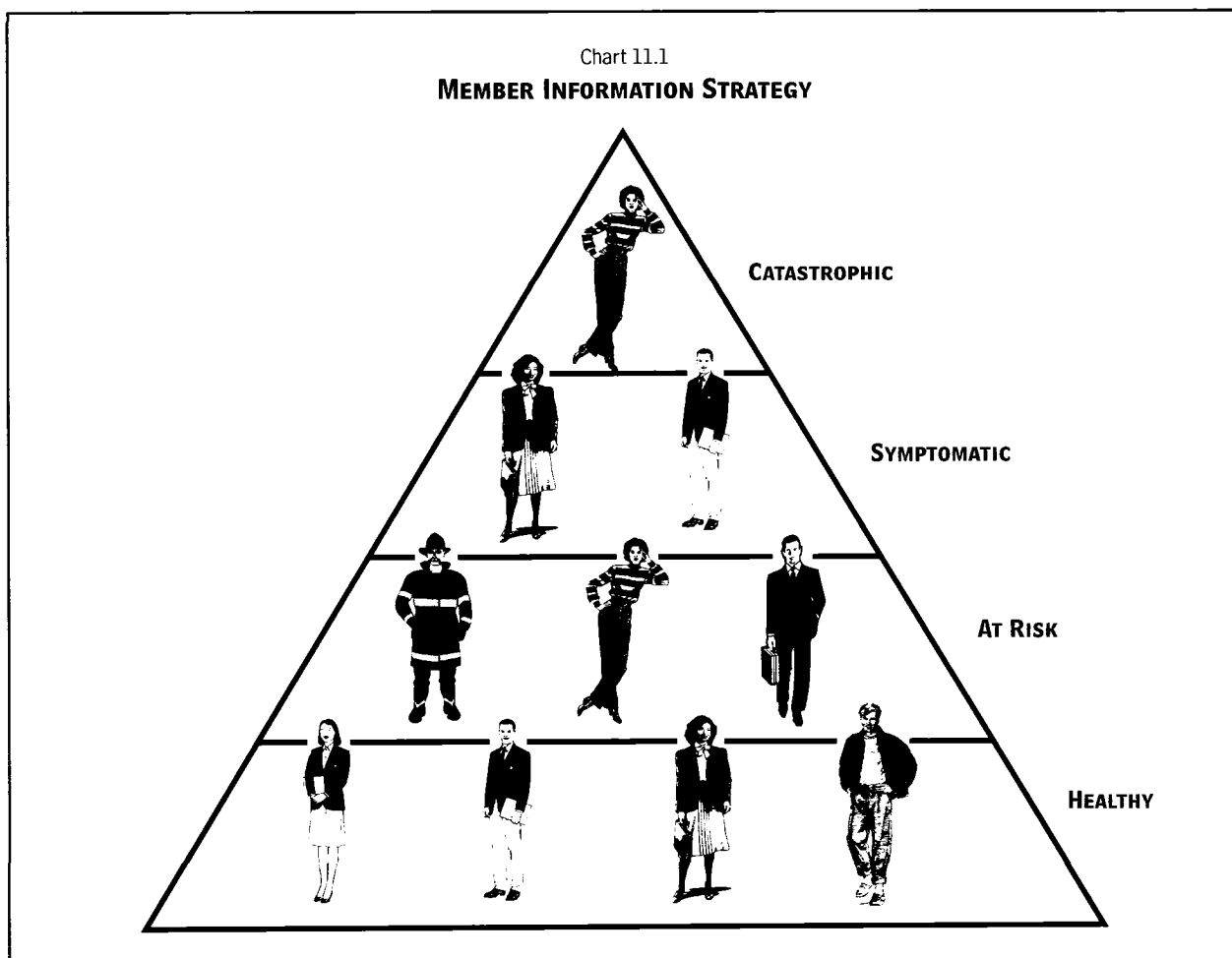
The coalition's quality-review process has focused on the quality of care from a clinical perspective. Specifically, our approach builds upon the efforts of National Council on Quality Assurance (NCQA) and the Health Plan Employer Data and Information Set (HEDIS) measures and expands the scope to focus on the systems an HMO has in place to ensure sick members get appropriate care. We look for plans to have a comprehensive medical management program that oversees all services, including office visits, hospitalizations, test results, and prescription drugs. We try to assess the capability of plans to integrate data from disparate sources and then use that data in a proactive way to provide a clinical support system to help the

doctors and hospitals in the network to improve the health status and outcomes for their members.

We have been traveling the country for the last several years conducting site visits in a number of different markets. At this point we understand the administrative aspects of many plans. When we meet with HMOs, we want to spend time with the primary clinical staff responsible for medical management. As part of the review, we ask them to bring in the sanitized medical charts of actual cases. The most important member of the review team is a consulting physician, who reviews the medical charts to ascertain how the plan's medical management program supported the optimal treatment of its members. One component of the process includes reviewing the quality-assurance committees' activities and meeting minutes and examining the documentation for the cases brought before the Quality Assurance committee in an effort to evaluate the committee's effectiveness.

We also look at what the plans do in terms of profiling doctors and hospitals. What kind of feedback do they give them? We also want to see the range of data that is gathered, especially any information that goes beyond the typical data items that focus on utilization, per capita cost, access, and customer service satisfaction issues.

Chart 11.2 illustrates our focus on measures plans take to try to get members the best care as early in the illness cycle as possible. What we have learned from our experience in analyzing the data for our indemnity programs is that a very small number of cases, typically less than 1 percent of the population, is generally responsible for about 25 percent of costs. As a result, our approach to reviewing quality has emphasized working with HMOs to try to get optimal care for the very small number of individuals who are at the greatest risk



of becoming catastrophically ill. It is hoped that through the use of data integration and bringing to bear a plan's medical expertise, the HMO can intervene in time to prevent individuals from moving from the at-risk category to the catastrophic category.

In terms of the actual plan selection, we consider a broad range of measures. The most heavily weighted are the quality components—all the facts that we collect from our on-site visits, as well as HEDIS and NCQA accreditation results. We look at factors such as employee satisfaction and employer satisfaction, as well as access measures. Compliance with the coalition's plan designs is also considered because one of the goals of all coalition companies is to try to have the homogenous benefits design across the country. The cost of a plan relative to local competitors is evaluated as well.

We conduct a joint employee-satisfaction survey. The results are then compiled for all of the member companies, and that also is considered in

the selection process as well as giving the feedback to the plans. Currently we are working with some of the national managed care companies to conduct clinical audits to ensure a continued focus on quality initiatives.

■ Results Highlights

We have seen some positive results in the form of quality initiatives that have been adopted by the plans with which we have been working. A number of these changes may have been adopted independently of our efforts, but we believe we have acted as a catalyst to implementing new initiatives.

We continue to work with some HMOs where the coalition has a large enrollment to conduct pilot programs to test the efficacy of existing medical management systems. The goal is to take what we learn in the pilots and introduce new programs in a number of locations.

By coming together as a group, we have

The Future of Medical Benefits

been able to streamline the evaluation, selection and negotiation process. An HMO can now complete a single RFP rather than developing 12 separate responses. The group approach has enabled each company to reduce the cost of the administrative process because we can divide the cost among member companies. This has enabled coalition companies to participate in initiatives that

we may not be able to undertake on our own.

Going forward, we hope to move toward a stronger emphasis on multiple year arrangements and, with select plans, a more open sharing of information, in terms of both the data that the plans collect and any feedback we receive from our employees.

**LONG-TERM POLICY
IMPLICATIONS FOR
EMPLOYMENT-BASED
HEALTH PLANS**

What Lies Ahead for Medical Benefits

by William S. Custer

■ Introduction

It was a decade ago this spring when Dallas Salisbury hired me at the Employee Benefit Research Institute (EBRI), and I'd like to thank him for that opportunity. Of course, I think I was a lot smarter a decade ago. Then, when somebody would ask me about health care reform, I would shake my head and say it is not going to happen. Today I'm going to try to persuade you that it is as close as the next recession.

A decade ago I would argue that it was too difficult to identify the winners in any health care reform plan and very easy to identify the losers. There was no single reform proposal that a majority of stakeholders could agree was better than the status quo. Public opinion polls indicated that the voting public was concerned about health care, but it was a relatively low priority issue. Without broad-based support from an important segment of the voting public, I argued that comprehensive health reform just could not happen.

Then the recession of 1990 occurred. As a result of that economic downturn, 2 million Americans lost employment-based health insurance coverage. Health care, as a political issue, surged in importance. It was the deciding factor in the special election for the Senate in Pennsylvania, and by the 1992 presidential election was the number two issue in the voters' minds after the economy. The time for health reform was at hand.

But of course it did not happen. There have been so many postmortems on the health reform that never was it seems pointless to rehash them here. But the simplest explanation is that by the time the Clinton plan was unveiled it was too late—in the voting public's mind the crisis had passed. The economy was growing strong—people were back at work—health care cost inflation was moderating, and the number of Americans with insurance was no longer falling. Health care reform

had moved significantly down the ladder of importance in the minds of the electorate.

■ Economic Growth

Over the last five years we have enjoyed an unprecedented period of economic growth. This growth has been characterized by both high employment and low inflation. There is a debate among economists as to whether this growth results from a fundamental change in the economy or from a series of fortunate supply shocks such as falling energy prices.

One of the beneficial supply shocks at least some economists have identified is a moderation in the growth of health care costs—especially as a component of compensation. There is also a debate among health care analysts as to whether the moderation in health care costs is due to a fundamental change in the way health care is delivered or to a series of one-time cost savings.

■ Health Care Cost Inflation

The health care delivery system has undergone a rapid evolution during the past decade, both in terms of technological innovation and in the organization and financing of the delivery of health care services. The efficiencies achieved by integration and consolidation, by changing provider incentives, and by changing practice patterns have resulted in significantly lower costs, but they are one-time savings.

History shows that health care cost inflation lags behind the business cycle by several years. The primary drivers of health care inflation are the adoption of new technology, changes in patient demographics, and the fact that health care services are labor intensive. There is some evidence that managed care plans are slower to adopt new technology, but the evidence is mixed. The popula-

tion is aging, and as a result the demand for health care services is likely to increase. Finally, the fact that health care services are labor intensive means that, as workers become more productive in other sectors of the economy, they drive up wages, increasing the costs of labor in the health care delivery system. As a result, it seems likely that we will see a return to health care cost inflation that is greater than the growth rate of income.

What that means is that, in the event of a recession, health care costs will increase as a percentage of national income—they will increase as a percentage of the federal budget, as a percentage of state and local budgets, as percentage of compensation, and as a percentage of families' incomes.

When health care costs rise faster than incomes, the result is more Americans without health insurance. As the cost of health insurance becomes a larger part of family budgets, people begin to more closely assess their own risk of needing health care services against the cost of health insurance. Those most likely to elect not to purchase health insurance are the best risks. The two groups most likely to reduce their purchase of health insurance are therefore those whose family incomes are low and those whose risks of needing health care services are low. In the labor market, those workers will seek out jobs where compensation is weighted toward cash and not health benefits.

■ Market Segmentation

Risk selection is an important issue in any insurance market, but it has become more important as the health insurance market has become increasingly segmented. State insurance mandates have increased the costs of coverage, driving small and medium firms to self-insure. Small employers have chosen not to offer expensive coverage, hiring spouses of workers with coverage. With small risk pools, it only takes a few good risks making a personally rational decision to leave the pool to make coverage unaffordable for poorer risks. Employers seeking to manage their health care costs have increased the share of the premium paid by employees, resulting in 6 million workers declining health insurance coverage offered to them by their employers.

Congress has moved recently to further segment the health insurance market by extending the tax treatment of health insurance as an employee benefit to the self-employed (many of whom purchase health insurance in the individual market). As appealing as this and other proposals to extend a tax deduction to individuals might be in terms of equity, they have a detrimental effect on health insurance coverage.

Health insurance coverage tied to employment is the most efficient way to provide health insurance in a voluntary market. This is because individuals choose health insurance at the same time they choose a job. By bundling the health insurance purchase with all the other factors that go into a job decision, the individual's own assessment of his or her risk of needing health care is reduced in importance. Employment-based health insurance thus reduces adverse risk selection and allows health insurance to be purchased a lower rate.

Equalizing the tax treatment between individual and employment-based health insurance would allow the best risks to leave the employer group—but poorer risks would not leave. Thus, the per employee cost of health insurance would increase, leading some employers to drop coverage altogether. The result of these policies might be a decrease in health insurance coverage.

■ Reform in Recession

So if the economy plunges into a recession, the result is likely to be a rapid increase in the number of Americans without health insurance. Health care will return to the number two issue in the minds of the voters, behind the economy, and politicians will scramble for a solution to the newly rediscovered health care crisis.

Having told you that there is going to be health care reform, I might as well crawl out to the tip of the branch and describe what that reform will look like. A crisis is no time for the creation of new ideas. It is likely that the reform that will be enacted will be one of the proposals already under discussion.

It is important to recognize two very important facts about the American health care system. The first is that Americans view health care as a right. That is not a pejorative statement;

it is an observational statement. No matter how much we talk about individual responsibility, we as a country do not allow people to bleed to death on the street regardless of the cause of their injury or their ability to pay. Everybody in America gets some level of care. Studies have found that the uninsured spend about 60 cents for every dollar spent by those privately insured. Those billions of dollars come from state and local governments, providers, and paying patients.

The second important fact is that health care is financed through an insurance mechanism. You can never forget the fundamentals of the insurance market in designing a health care financing system. The twin problems of moral hazard and adverse selection must be accounted for in any reform.

It seems unlikely, for example, that medical savings accounts (MSAs) will play a large part in this reform for two reasons. First, offered as a choice, MSAs further segment the market because they are most attractive to the best risks. Second, and more importantly, in the midst of a recession and health care crisis, voters are unlikely to endorse a plan that appears to put more of their own money at risk.

It seems even less likely that we would adopt a national health care system patterned after Canada or Northern Europe. Our national aversion to government-run industries makes that unlikely. What seems most likely is some form of managed competition. Managed competition covers such a wide range of proposals that the term has even less meaning than managed care. The fundamental aspect of managed care is a large well-defined risk pool, where the individuals are presented with a set of health plans that compete for enrollment on the basis of price and quality.

There is an infinite range of managed competition proposals that varies in terms of the composition of the risk pool (i.e., it can be a whole

state, a metropolitan area, employees of a large firm, etc.), the regulation of the market (private purchasing cooperatives or public regulatory entities), and operation of the market (no constraints to price regulation).

And of course the appeal of these proposals will depend on the details. But, as a political issue, managed competition is appealing because it can be attractive across the political spectrum. It has the virtue of creating a market where individuals make choices, and it can be designed to maximize coverage. It is this style of proposal that formed the basis of President Bush's health reform proposal in the spring of 1992, and it was the basis of candidate Clinton's campaign reform proposal in the fall of that year.

For employers, the range of forms of managed competition presents a challenge and an opportunity. Many employers have complained of the costs and time involved in providing health benefits. In a policy forum not long ago an individual speaker suggested that employers would be better off "cashing out" employees and dropping health insurance benefits. At the time, I told him he was dreaming because individual employers could not drop those benefits without reducing their ability to attract and retain workers. However, in the coming health care crisis employers could support reforms that would remove them from the health care financing system. Or they could support reforms that provide a base level of coverage for Americans but allow large employers to retain their competitive edge in the labor market.

Now is the time for employers to have an introspective discussion, both internally and within the employer community, about their future role in the health care delivery system. That discussion should occur now, in the absence of a health care crisis, so that employers will be ready when the inevitable crisis occurs.

Confronting the Issue of Coverage

by Paul C. Harrington

■ Introduction

As the health policy director for the Senate Labor and Human Resources Committee, I work for the Chairman, Sen. James Jeffords (R-VA.) This paper represents solely my viewpoints, unless I attribute them to Sen. Jeffords.

I owned a small business for about 15 years and was unable to afford health insurance for my employees or myself. I have served three terms in the Vermont House of Representatives, and sponsored small group and individual market reform that provides for guaranteed issuance of community rating. The last time I looked, we had 10 participants in the individual market, and about 15 in the small group market. I held two positions in the state government, one as an insurance regulator. I worked for universal coverage in Vermont and then helped administer workers' compensation in Vermont. I bring all these perspectives to my work on federal health care policy for Sen. Jeffords.

Any conversation we have will always be on the periphery, unless we somehow confront the issue of coverage at some point in our country's future; however, I do not think this will be soon. As long as we have an executive branch controlled by one party and a legislative branch controlled by another party, we will continue to be in a time of incremental reform. More importantly, as long as we have a strong economy and the low inflation that we are currently enjoying, there will be strong entropy to the steady state as far as our health care system is concerned. But that could change very quickly. The next presidential campaign could provide both the timing and the forum for revisiting this debate.

■ Shifting Trends

From my perspective, my outlook has been affected

by three recent events. First, an Employee Benefit Research Institute report in April 1997 indicated that in 1995, 65 percent of men ages 55 to 64 were in the work force. In 1965, that percentage was 85 percent. Over a span of 30 years, we have seen a 20 percent drop in the percentage of men in the work force who are older than age 55 and younger than age 65. That will have profound implications for any future discussion of either social insurance type of health care coverage or employment-based coverage. Whether this is a plateau that has been reached or a slope that will continue, we obviously have some future problems that we have not fully grasped.

Second, we went to the northern California area in February to try to understand the changes in the health care marketplace there. The newest and most surprising information is that the medical group practices that are forming there—which represent the most effective level of accountability and quality improvement—where the providers are on a fee schedule, they are typically being paid 80 percent of Medicare's fee schedule. That floored me because, especially when I was in state government, the common wisdom was that Medicare pays below cost. In California, the private sector is discounting Medicare. Medicare is cross-subsidizing the private sector.

If California is a harbinger of where we are going, this experience overturned a lot of my prior assumptions, given that, at least on the public sector side, we tend to get involved in rate setting as opposed to some sort of negotiation, or competitive pricing based on supply and demand.

Third, one of the questions asked in connection with the future of medical benefits is whether medical savings accounts (MSAs) will play an even larger role in health care. The Health Insurance Portability and Accountability Act capped the number of accounts at 750,000. There was a lot of debate as to whether that cap would be

reached early, and there would be pent-up demand. I am not going to argue about the benefits or problems of MSAs. However, I do believe they are an example of Congress making a decision based on an ideological perspective, and finding that sometimes the market and consumers are completely out of sync with where it thinks the American people can and should go, or wants to go.

For any policymaker at the federal level, especially one who is trying to achieve behavioral change, that is a very humbling kind of experience and a signal that the American people may not want to go where Congress thinks it should be headed.

Another factor that is shaping my thought is that although we have a very difficult access system to explain, it is also a system that seems to work. As long as you are employed and you have a high income, or if you are unemployed and still have high income, you are probably going to be covered in this country.

The intractable problem we seem to be unable to resolve is that 60 percent of Americans who are working, or may not be working, have low incomes. The current congressional debate focuses on tax code changes to address coverage problems of low-income Americans, but we are probably not going to be able to change their situation through tax code changes. There is not a lot of interest at this point in focusing on the spending side, which is probably where we could actually have an impact on the 16 percent of Americans who lack health insurance.

Another factor is that, while individuals who work for firms that employ 50 or more employees probably have health coverage available to them, smaller firms are less likely to offer coverage. If a very small firm has an employee, or an employee's family member, with a preexisting, high-cost medical condition, the premium perhaps will be unaffordable. So the notion that President Bush alluded to—providing some pooling mechanism—will continue to be the focus of congressional attention, in terms of the needs of smaller employers and particularly smaller employers who have an employee with a preexisting medical condition living in a state that has not taken action to provide for some risk-spreading mechanism.

■ Different Messages

In terms of the broad theme of long-term policy

implications for employee-based health plans, we are probably going to hear different messages at different times, based on whether the federal government is trying to influence private-sector behavior or it is actually in the business of paying bills.

Concerning the latter, when we passed the children's health insurance program during the last Congress, giving the states \$24 billion over five years with the option of either expanding Medicaid or creating a private-sector response to cover children under age 18, there was enormous concern about crowd out. It was stipulated that if a state either raised its Medicaid eligibility levels beyond a certain amount or embraced an alternative to Medicaid, it has to explicitly tell the Health Care Financing Agency how it is going to prevent crowd out.

In that instance, there was a profound assumption on the part of Congress that the employment-based access system is a good thing, and that we do not want federal dollars to displace the contributions that employers are making. This assumption is in contrast to other opinions voiced in current discussions that the marketplace does not work because we have an employment-based system and we need to move more toward a system of individual choice. I am not sure that you can reconcile these two positions. Either the federal government is thought of as a payer or as a policymaker.

As chair of both the Labor Committee and the Finance Committee, Sen. Jeffords has advanced three principles to guide the work he is trying to achieve in this Congress. The first principle is that the federal government has a fiduciary responsibility to meet the needs of vulnerable populations, which he defines as the very young, the very old, and the disabled population. We believe we have done a good job in trying to meet the needs of the very young. There will be ongoing efforts to meet the needs of the disabled population, and certainly the current Medicare commission, which will report in March 1999, is an attempt to continue to ensure that those older than age 65 will have health insurance available to them.

The second principle is ensuring nondiscrimination in this country, and the Kassebaum-Kennedy legislation, the Health Insurance Portability and Accountability Act, was a good first start by Congress in that area. While I am not sure

what subsequent steps will be taken; that is an appropriate role for Congress.

■ Reflecting Social Values

The third principle is one that is probably guiding this Congress to pursue policy that reflects our social values, i.e., market-based health care reform. That is a debate in which we probably will be engaged under the broad heading of managed care quality. How is the marketplace evolving, and does that evolution fundamentally reflect our societal values?

How this will be played out is unclear. We may have some early indications fairly quickly, however. Sen. D'Amato (R-NY) offered, as an amendment to the Internal Revenue Service restructuring bill, a bill that has been characterized as requiring in-patient mastectomy length of stay as a national bill. He has since amended it so that it does not require 24 hours of in-patient mastectomy care, but rather has the provider, the physician, in consultation with the patient, determine if, on the basis of medical necessity, there should be in-patient care for the person undergoing the mastectomy. Secondly, the proposal has a broad, federal preemption of state law. All state laws relating to mastectomy length of stay would be preempted, and there would be a single federal standard.

Sen. Jeffords does not believe that Congress should be in the business of passing medical practice guidelines on the Senate floor. But he is particularly concerned that the bill would basically negate health plans' utilization review processes, and he is troubled by this issue of whether we should move toward federal regulation of insurance with complete preemption of state insurance law.

How we resolve the tension between national carriers and state-based carriers, preemptive standards and deference to the states, is a bit of the same debate we have had about the Employee Retirement Income Security Act of 1974 (ERISA). At issue is whether ERISA is truly tailored to the large, multi-state single employers, or, as another proposal advocates, it should be opened up and small employers should be allowed basically to band together and create national health care purchasing cooperatives or national purchasing associations that follow national standards.

There are five working groups at play. Both the House and Senate Republicans have task forces. Certainly the Democratic caucus is in both bodies, and then there is a bicameral bipartisan task force of Sens Jeffords, Joseph Lieberman (D-CT), and John Chaffee (R-RI) and Congresswoman Johnson (R-CT). This group could provide the bridge between the various partisan efforts.

The real wild card in this whole debate, and the action members of Congress could take that could have profound implications for the employment-based access system, is whether they started to breach the ERISA liability issue and provide for a state tort access through ERISA. Sen. Jeffords has argued strongly against this happening and has promoted an external grievance repeal process as an alternative to it. And there is consensus around that.

■ Conclusion

What is guiding our work is a profound sense of humility in view of the fact that there are always unintended consequences when you enact legislation. One of the liabilities of working in health care policy too long is that you come to appreciate these unintended consequences more and more. It is hoped that this awareness will guide Congress's behavior. We need a thoughtful debate about an evolving federalism. What are the appropriate responsibilities for the federal government? What are the appropriate responsibilities for the state? I am not optimistic that we will have this level of discussion because I am afraid that each discrete issue will somehow shape the nature of this relationship.

If I had to design a coverage system at this point, it would probably be based on an individual mandate that could be satisfied through proof of coverage. Individuals would satisfy the mandate and fulfill their responsibility if they had employment-sponsored coverage, if they had Medicaid and Medicare, or perhaps even if they belonged to a community that agreed to collectively meet the health care needs of its indigent members. But until we finally come to grips with that as a country, we will continue to try to deal with costs and quality issues absent our ability to fundamentally get at the heart of this problem, which has to do with the coverage issue.

Providing Health Benefits: What Motivates Employers?

by Richard Ostuw

■ Introduction

I primarily see the world through the eyes of large employers, and one of the things I have found so interesting is that we all see a lot of the same issues very differently—or at least we see the same developments very differently. That is why I want to address this topic from the perspective of the large employers. What is motivating them to do different things, and how can we look at those motivations to anticipate what they may do differently in the future? Certainly, everyone will do different things in the future. We live in a very dynamic world, and health care is an extraordinarily dynamic segment.

■ The Business Purpose of Benefits

What is the business purpose of health care benefits? In a sense, we could view it as the business purpose of anything else that employers do that relates to their employees. And the simple thing that we have heard for probably our lifetime is that the purpose is to attract, retain, and motivate employees. (See chart 14.1.) We know people pay salaries on that basis.

You could ask, why do companies pay

people salaries? Other than meeting minimum wage requirements, they do it because they need to attract, retain, and motivate people who are going to be productive in meeting their business needs. That relates to delivering products to customers in whatever form and to other purposes. To the extent that health care benefits help them meet that goal in a cost-competitive way, then health care benefits satisfy the business purpose of that employer. If health care benefits get in the way, then there is a better way to spend that money.

There is a natural tension in any element of compensation, whether it is health care benefits, salaries, or whatever, in that the more the company provides, the better it is in terms of attracting, retaining, and motivating employees. But the more money the company spends on compensation costs, the harder it is to develop competitive products to sell to the marketplace. That is the natural tension that employers face every day. And it changes almost every day.

We have very complex issues, but employers can be divided into those who have an employee-needs orientation and those who have a compensation orientation to health care benefits. (See chart 14.2) Employers have moved a great deal along that continuum over the last 20 years. While

Chart 14.1
EMPLOYER ROLE

- Business purpose: attract, retain and motivate employees
- Continuum of employer goals
 - employee needs orientation
 - compensation orientation
- Complexity of issue
 - changing and diverse business needs and philosophy
 - changing and diverse employee needs and expectations
 - changing health care environment

Chart 14.2
CHANGE IN EMPLOYER ORIENTATION

- Employers will continue to shift
 - from a benefit needs orientation
 - to a compensation orientation
- Implications include:
 - meaningful choice in number/type of plan options
 - reduced employer contribution for dependent costs
 - reduced emphasis on employer role in plan design and administration
 - increased emphasis on employee appreciation (relative to cost)
 - continue emphasis on cost management

there have always been some employers at all points in that continuum over time, there has definitely been a shift in the mainstream.

Employers once had a primary focus on employee needs. We provide health care benefits because employees need them. From a compensation perspective, perhaps the way to look at that rationally is that, for the aggregate compensation to the aggregate employee group, the most cost-efficient method of compensating employees is to address their needs. Because some employees need a lot of money to fund their health care costs, and some need none, if you give everybody the same amount, it is less efficient in meeting those employee needs. And in the aggregate, employees need to come up with that money.

The system is more efficient when you direct the money to those who need it most. That is the old school; we used to call that paternalism. The trend clearly has been toward more of a compensation-oriented structure. There have been discussions about moving to a mechanism of defined contribution. Probably everyone who says that has a different definition of a defined contribution mechanism. In the extreme, a more accurate term would be a voucher system, where a company says, "You go do whatever you want. We'll give you money."

Few large employers would seriously think about that today. But definitely they want to have their benefits be more compensation oriented than they have been in the past. But it is worth a reminder that this is a very complex issue. There are not two simple categories that define each issue. There is a continuum dealing with everything. There are certain mainstream areas where, instead of homogeneity, large blocks of people or companies have similar views, but they change.

■ **Changing Business Needs**

Therefore, the first issue, in terms of complexity, is that business needs and philosophy have been changing tremendously and are very diverse. And they are diverse among industries. So, if it is fast food or automotive manufacturing, it is easy to understand very, very different needs, very different philosophies, very different business pressures in those industries. But the differences within an industry are almost as great.

And things change. The nature of international competition is not like it was 10 years ago. It is continually changing. Much greater pressures exist now because the movement of jobs, movement of product purchase, movement of everything is so much faster, and cost competition is enormous. Additionally, employee needs and expectations vary a lot and change a lot over time. So part of the complexity is that, for a given employer, there is diversity of need and expectation within the work force. And, among employers, there is diversity to an even greater degree. And it all changed over time.

One of the things I have enjoyed in consulting about health care plans over the last 20 years is that the product cycle only lasts about a year or two or three because everything changes so dynamically. There is always something new, always a different pressure. Who would have predicted five years ago that hospitals would be buying up physician practices, or that the physicians who still go to their offices and look like they are independent practitioners are actually employees of hospitals? We probably have not yet seen the beginning of the implications of that.

■ **A Shift in Employer Orientation**

We have seen a tremendous shift from a benefits-needs orientation to a compensation orientation. We saw a fairly significant shift in the visible signs of that in the early 1980s, and then through the 1980s as companies moved to flexible benefit programs. That was a very explicit statement about changing health care from a paternalistic thing that companies did to help employees meet a need, toward something that said, "We, as an employer, have a certain role in health care, in identifying what plans to make available, and contributing toward the cost. And you, the employee, have certain responsibilities in deciding on what's appropriate for you and paying whatever additional cost is necessary."

Today, we see a further extension of that, with increases in the share of the cost the employee picks up and a shift between how much the company pays for employee coverage and dependent coverage. This means we see movement of some employers who commonly—certainly not universally—view their role as providing meaningful

choice in the number and type of plans. So, we still see some employers that offer employees 8 or 10 options in a given marketplace.

By and large, however, those companies have said, “It’s more trouble than it’s worth. It’s too expensive to maintain that many choices, and it’s confusing to employees.” They believe this is an example of where less might be more, that if employees can better understand the choices available to them, they might actually make better choices. If they are overwhelmed with information, they may make worse choices. On the other side, companies that used to think one plan is enough increasingly feel that it is not enough. But the differences ought to be meaningful differences, not cosmetic differences.

Reduced contributions for dependent coverage is a clear part of that. Clearly, in the single-worker family, or for the children in a two-worker family, there is an issue of who pays for dependent coverage. At least among large employers, employers pay the bulk of that cost. But from the pure point of view of compensation, it is not equitable when you have two workers who do the same job and one gets more money from the employer than the other. But companies do not say, “Well, if you have a large family, your food bill is probably larger, and so we’re going to give you more compensation to cover that cost.” Nobody would think about it. But if we separate the emotion from the substance of the health care issues, it is really the same.

■ Reduced Emphasis on the Employer Role

Similarly, there is reduced emphasis on the employer role in plan design and administration. We definitely are moving from what I sometimes refer to as a wholesale market to a retail market. Employers definitely are more interested in saying, “We’re going to make some plans available to you, but they’re going to be standard product kind of offerings from the plans. We’re not going to worry so much about what the dollar limits are for some particular procedure. We’re not going to worry so much about which things are viewed and defined as experimental and which are accepted. We’re not going to worry about some issues such as new medication or in vitro fertilization, or other things

like that.” In short, they are saying, “We’re not going to micromanage those things. We’re going to view our dollar contribution towards the premium as the compensation element.”

There also is increased emphasis on employee appreciation. Almost all of the backlash to managed care is not really about outcomes. It is really about the quality of service. It is about the satisfaction with the process. It is similar to the attitude about customer service or member service: It is more than how someone answers the phone when you call member services; it is the entire experience. We have seen a lot of change in a lot of industries, and particularly a lot more focus on customer service. Health care probably has more opportunity for improvement than most industries, in truly being oriented to the customer in all respects.

■ The Prevalence of Cost Management

Continued emphasis on cost management is a given. Early in the 1990s, when there were dramatic changes in what companies did, it was because cost was a survival issue. And although it may not be quite the survival issue that it was a few years ago, there is no question that it is an absolute. Companies do not have a choice about whether to manage their costs. Companies have to manage their costs. Enlightened employers realize that cost is not everything, but there are not any employers that really can get by without paying attention to cost control.

■ A Test for Employee Benefits

Chart 14.3 displays a test that I use to identify some of the criteria that employers use to answer the question, “Should we provide health care benefits, and, if so, in what form?” This list of nine questions in the chart does not represent the entire set of criteria for every employer; they probably are not the entire set of criteria for any employer. But it gives some clues about the implicit or explicit process that companies go through in saying, “We should do this or we shouldn’t,” or “This is how we should change.”

First, does the employer add significant value in arranging for coverage? And for health

Chart 14.3

A TEST FOR EMPLOYEE BENEFITS

| | Yes | No |
|---|-------|-------|
| 1. The employer adds significant value arranging for coverage. | _____ | _____ |
| 2. The cost of managing the arrangement is modest. | _____ | _____ |
| 3. The employer contribution toward the cost is acceptable. | _____ | _____ |
| 4. The employer contribution toward the cost is a reasonable allocation of the compensation dollar. | _____ | _____ |
| 5. The arrangement helps attract and retain productive employees. | _____ | _____ |
| 6. The presence of the arrangement enhances employee productivity by reducing the time spend by employees on non-productive activities. | _____ | _____ |
| 7. The arrangement enhances employee productivity by enhancing employee health. | _____ | _____ |
| 8. The value of the program (after-tax) as perceived by employees exceeds the employer cost. | _____ | _____ |
| 9. Employee expectations can be managed, to avoid employee dissatisfaction. | _____ | _____ |

care benefits, there is no question that this is true for large employers. The smaller the organization, the less it is true. Generally, individuals can get better coverage at a better price through an employer than they can on their own. As long as that is true, the employer provides value to the employee—even if the employer does not contribute to the cost—merely by arranging for coverage. If the employer can provide value to the employee without spending money, then it definitely helps in attracting, retaining, and motivating employees without increasing its product costs. To the extent that health care meets this goal, that is one factor on the side of continuing to offer health care coverage.

Is there a modest cost associated with managing the arrangement? The jury may be out right now because it is expensive for employers to maintain this coverage—and not just the employer contribution. When selecting providers, dealing with the problems, a lot of the employers, in my experience say, “I wish we could get out of this.” It is not so much because of the money they are spending but because of the hassle that they are going through and the lack of employee satisfaction. This is a critical issue for a lot of companies, and it is why a lot of companies are reducing the number of options they offer.

Is the employer contribution acceptable? By and large, today it is. Five years ago, eight years ago, by and large it was not. And that is why over about five years, corporate America basically moved from an indemnity-based delivery system to a managed care-based delivery system: the view was that cost was not acceptable. Today, the cost is acceptable, but there is concern about escalation in costs. So, we will see a lot of attention to dealing

with increases. And we probably will start seeing more increases, and this will be put to the test.

Is the employer contribution a reasonable allocation of the compensation dollar? That question receives a lot of pressure today. Many employers today are saying, “We need to move to more of a performance-oriented culture. We need to have people be motivated and rewarded based on their individual performance and company performance.” Spending a lot of the compensation dollar on medical benefits is inconsistent with that. It is not based on company performance; it is not based on individual performance. And that is one of the issues that will cause continued movement: shrinkage of the employer money spent on medical benefits and the use of that money elsewhere in the compensation program.

Does the arrangement help attract and retain productive employees? How many people would work for the company they do if it did not offer medical coverage? To some degree, it is a barometer for the overall environment, a statement of, does the company care about employees? But it is also a broader question, and definitely, in today’s environment, it is a necessary part of the program.

The sixth question has to do with the presence of the arrangement. It enhances employee productivity by reducing nonproductive time spent by employees. If the company did not provide coverage, how much time would employees waste by running around, either finding coverage or dealing with problems on their own, or changing coverage when they found that they had to? That definitely is one of the factors.

Does it improve employee health? That is tougher to answer because, to a large degree, if the employer did not provide coverage, most employees

Chart 14.4

FORCES SUPPORTING CONTINUED EMPLOYER ROLE

- The employer adds significant value arranging for coverage
- The employer contribution toward the cost is acceptable
- The arrangement helps attract and retain productive employees
- The presence of the arrangement enhances employee productivity by reducing the time spent by employees on non-productive activities
- The arrangement enhances employee productivity by enhancing employee health
- The value of the program (after-tax) as perceived by employees exceeds the employer cost

Chart 14.5

FORCES CONFLICTING WITH EMPLOYER ROLE

- The cost of managing the arrangement is modest
- The employer contribution toward the cost is a reasonable allocation of the compensation dollar
- Employee expectations can be managed, to avoid employee dissatisfaction

would find a way to buy it someplace and have it anyway. But it probably would be less liberal, and there may be other complications. Perhaps employees would not deal with chronic health problems. They might be out on disability longer. We definitely are seeing a movement toward more focus not just on containing the money spent on health care but also what that means in terms of disability costs.

Is the value of the program perceived by employees greater than the cost? Personally, I think that is the ultimate test. If employees perceive the value to be less than the cost, then the employer ought to take the money out of the program and give it to people in cash. Why go through all this trouble if employees think the dollars spent are worth more than what they are getting? The fact that the companies keep doing it says something about this relationship between perceived value and actual cost.

And last, can employee expectations be managed? That is one of the biggest issues, and a lot of companies are thinking about getting out of the business one way or another. It may be more of an issue with postretirement coverage than active coverage. It represents the feeling that, "The

system is so difficult to manage, we'll never satisfy employees' expectations, and therefore, maybe we're better off not playing in the game." We are a long way from that. But it is why, if you look at what companies are trying to do, you need to ask what are they working on. What are their concerns? Employee satisfaction is such a big part of that because we are in a tight labor market. It is hard to find the skilled workers that we need. And so dealing with the underlying causes of employee dissatisfaction and managing expectations is a critical issue.

If I look at those nine items, what are the things that say companies will continue to provide medical coverage? Charts 14.4 and 14.5 show that there are criteria that support continued health coverage, some more so than others, but there also are some that say it conflicts with our objectives.

In conclusion, a well-designed health care benefits program that operates effectively helps employers succeed. As long as that is true, employers will continue to provide these benefits. If employers do not feel the plans are contributing, we will see a widespread withdrawal from sponsorship of health benefits.

Questions and Answers

Dallas L. Salisbury

■ Session I

Q. Paul Fronstin's chart 1.4 in "Features of Employment-Based Health Plans showed employer coverage rebounding after 1992. That was connected to the slowdown in costs, which Jessie Gruman discussed. Is some of this attributable to employment growth? Is the rebound in employment after the recession a possible factor as well?

A. Absolutely. It is not necessarily a rebound, but the erosion has stopped. The year-to-year increases are really small—less than 0.5 percent. There has been a downsizing of CHAMPUS—fewer people coming out of the military, fewer people coming out of the Medicaid program. We believe these people are moving into private-sector jobs or public-sector jobs, and some of them are picking up coverage; others are not. So, we still have an increase in the uninsured, but we are starting to see an increase in employer-based coverage. This might reflect a redistribution of the population in various programs.

Q. One of the things that struck me during the presentations is the mention of state-of-the-art care, which requires research. And research requires the sharing of information. Yet, a lot of us are involved in the privacy debate. In fact, many proposed legislative initiatives would impede that sharing of information. Could anyone address the seeming dichotomy between the need to share information and the privacy legislation that may, in fact, prevent that sharing of the information?

A. On balance, there has been entirely too little public attention to this issue, even though there has been quite a lot of private attention and

activity, and a coalition is working on this very productively. On the one hand, everyone supports the principle of confidentiality, meaning that no individual patient's records or information should be disclosed inappropriately. On the other hand, we need to have access to information with respect to quality-assurance activities, best practices, and state-of-the-art therapies and pharmaceuticals.

A. broad coalition of stakeholders, representing many different perspectives, is beginning to come together—at least philosophically—on this issue. We need to have the data to do what we want and to achieve our expectations. But in particular, the European Union activities, which begin at the end of October this year, run counter to this principle of getting information with respect to quality assurance. This is probably because their delivery systems have not yet reached the state of our delivery systems, where we are engaging in disease management and case management and beginning to get outcome information.

Q. I was intrigued by the idea of employers moving to a defined contribution approach to health care. The Medicare commission also has been talking about this as an alternative way to finance Medicare. At the same time, you've mentioned the increasing share that employees have had to pay for family coverage. Would moving to a defined contribution approach lead to behavior that would lower cost plans and further erode family coverage?

A. It would definitely lead to a lot of risk stratification. If we do not find some way of solving the risk-adjustment problem, it generates such political backlash that even if it makes rational sense, and even if you believe people are willing to live with their choices, we do not know how to

pull it off mechanically in a halfway equitable way.

The second issue concerning defined contribution is, how confident can employees and Medicare patients be that a defined contribution is going to keep pace with costs? If it is a capped contribution, without an index based on what is happening in the market, reaction would be fast and furious. So you first have the issue of whether the defined cap contribution keeps pace. Then, even if you move to risk stratification where you have a defined cap, you run into the issue of whether it is fair, in our culture, to charge me more if my family is sicker, even if I had no control over the fact that my family is sicker and has higher costs.

The enemy of simplicity is equity. You get into equity issues for the employer payer, equity issues for the average enrollee, and equity issues for the sicker enrollee.

- A.** Along with a defined contribution approach, employee report cards would seem to go hand-in-hand with giving employees those kinds of choices. There was some discussion that employers continue to use costs, and not quality, as their primary factor in making decisions. Likewise, in situations where employers do provide quality information to their employees, employees do not know how to use that information. And the majority of those employees still made the decision based on the contribution and whether their doctor is in the network. So we have to get better at providing the information that will allow them to make a decision based on factors other than contributions.
- A.** Probably more employers than you think use some form of equal contribution. But there also is this issue of risk segmentation. It is possible to have equivalent contributions that get around the problems of risk segmentation, but it is not simple. The simple methods tend to exacerbate the problems. So while it is possible, it may seem inequitable to do it that way. But it is really the practical way to do it and the way that preserves the system and avoids the penalty for people who are sicker than the average, or are in a cohort, whether it's by age or location, that would cause them to pay substantially more than would otherwise be equitable.

Generally, employers that offer multiple plans do have some degree of equivalent contributions for people selecting different plans. And, generally, their objective is for employees to have financial incentives to choose more cost-effective plans.

- Q.** I would put the risk situation under the rubric of "adverse selection." The potential for adverse selection is very significant any time you have choices. It does not make any difference whether you are talking about buying automobiles or health plans. That is a reality of marketplaces.

The alternative to adverse selection is to eliminate choice. So, for example, you could force all employees to choose a medical savings account. That would be the only way that you could provide insurance and have no adverse selection. It would all be done the same way.

We believe we should confront adverse selection and figure out what behavioral changes and what regulatory changes, if any, make sense. That acknowledges that adverse selection is a downside of choice, regardless of the arena in which you make the choice.

With respect to accountability and the size of the contribution, the government could establish the size of the contribution; that would be no different than any other price control. The marketplace would assist in the size of the contribution, just as it does in the type of benefit provided now.

If we were to have a defined contribution system and I decided to low-ball the size of the contribution, how would that affect my employees? All it takes is for one of my competitors to offer a higher defined contribution, and I lose that valued person and my investment in that person. So, I am directly accountable under such a system.

Then there is the huge employer that decides on the size of that contribution through negotiation with a labor union, or perhaps with several unions. The negotiation actually becomes much simpler. Accountability remains, but instead of arguing over all the different benefits to include, the argument would be over one number.

The employees' representatives would like the number to be higher. The employers are apt

to want the number to be lower. Somewhere in there will be the common ground, but the negotiation would be over one point. So we believe this mechanism deserves significant attention, particularly in contrast to our current dilemma, where accountability can be very painful for employers and is apt to become more so.

- Q.** If you go back to 1983 or 1984, when the 401(k) first came in, people said individuals were too dumb to invest their own money. If you allow people to make decisions and provide a contribution on their behalf, in 15 years we will not have the problem of information being shared because the people who are making a marketplace decision will demand the kind of information that Fidelity and other vendors are giving them today on the 401(k).

Why not give people the opportunity to make decisions? They are doing a good job in investing their retirement money. They will do the same thing if you let them have the opportunity to make the decisions on health care.

- A.** While workers see that the financial industry is capable of providing that information, EBRI has published a Retirement Confidence Survey, similar to the survey in the health care area, which shows that, unfortunately, a lot of people still do not know how to invest their dollars correctly to provide for adequate retirement. We still are a long way in the pension education area from where we started in 1985. We have made tremendous inroads, so this is not a black-and-white issue. And, it is true: workers have demanded that information, and a good number are getting up to speed.

People who have pension education do better in investing. But in health care, we do not have the same partnering in the public and private sector that we have in pension and retirement education—the massive coordination among the employer community, the nonprofits, the financial industry, and the government. And we do not have the same grassroots, public education campaign in health that we have in the retirement area. That would make the situation for workers devastating. They do not have the information. The issue of their leverage in the market right now is very questionable.

We are missing this middle effort, where there are public/private activities that are not regulated, not mandated by Congress, and not totally initiated by the government. But, similar to the retirement savings education, teaching individuals and employers about how to purchase on the basis of quality and teaching workers how to make decisions can only be accomplished through the power of the market and the initiatives and guidance of people who have a national perspective.

- A.** Even if people make rational choices based on their health status, 80 percent of them are healthy, and they are going to consume far less than the amount of their defined contribution. Then there is the rational decision on health care and the amenities they could buy, such as health clubs. We literally do not have enough money to pay for the costs, via insurance, of the people who incur 60 percent to 70 percent of the costs. So the market does not work in a sense, partly because of the insurance functions. It is not the same as investing one's individual savings.
- A.** While a great deal of savings and investment education is going on, there is not nearly as much education on what you should do with your money if you leave your job and get your lump sum. The EBRI Retirement Confidence Survey pointed out that, in fact, about 20 percent of the people who get a lump sum roll it over or keep it in the retirement savings area. And there is no particular incentive for employers to educate people about what to do with that lump sum because these are people who are leaving them.

However, close to 70 percent or 80 percent of the money that is distributed in lump sums is rolled over. What that shows on the retirement side—where the information is much simpler and professionals have a pretty good grasp of how to make the judgments—is that we do not yet know the perfect way to choose among health plans.

In the retirement plan situation, wealthy people with a lot of money at stake are providing for themselves, and low-income people with small balances, who are getting small distributions, are spending it on their immediate needs,

which may be an immediate rational decision for them. They may need that money to pay the rent or pay for their kid to go to school. They may not be able to put it away for retirement.

The discussions about empowering people to make choices and negotiate their own way through the provider community, and health care, are much more complex. The stratification is not just one of risk, it is one of confidence, of capability, of actually splitting the country into various economic classifications, in terms of who can, in fact, take advantage of what is made available to them. This is a very long-term issue, and it needs some sensitivity about the people who are able to make these judgments.

- Q.** Virtually every news magazine now has its own separate survey of health plans. We have to respond to these very different methodologies. In principle, this is not a bad trend, but if you think about the infrastructure demands and the lack of uniformity, there has to be a better way for us to get our hands around the question of how are people doing. How do they compare with their colleagues in giving consumers the kind of information they need to have?
- A.** One important issue is to figure out how to restore the trust that the American people have in managed care, which they need to have in health care. In terms of the perspective from the U.S. Department of Labor, it would be probably more in the area of consumer protection. Trust and accountability are important. We have to start, in a very fundamental way, to get back to where we were in the 1980s.
- A.** The top issue for health plans is customer service. Many of the issues that are discussed in the political arena, in either the federal or state venue, from the perspective of the provider or a consumer, relate to customer service. We need to give a great deal of thought to the training of customer service representatives and the challenges they are being asked to take on in terms of information dissemination, evaluating options for individuals who are calling them and asking opinions, etc. This is causing a number of individuals within the health plan arena to go back and think about the new challenges that are faced by those at the first point of entry.

The frustration here is that, as that gets played out in a political arena, we see a number of the legislative proposals aimed directly at responding to some of the customer service challenges. You cannot use government regulation to deal with these issues.

That is not to say that we are putting our heads in the sand and ignoring challenges and issues; and we need to continue to improve performance in that arena. I suspect that in two years, in terms of the key issue, there is going to be even greater demand for customer service across the board. This won't simply be demand placed on those who are answering the phones or providing information for prospective health plan members, but it will be very broad demand in terms of interacting with physicians, the whole clinical side, providing information, decision support, etc.

- A.** Value is determined by the person who is served by the system, or the patient. I always have approached reform of the health care system with the rubric, "Put the patient in the driver's seat." When I was a teenager, the automotive industry told us that what we wanted to drive around were big boats that were expensive, unreliable, and uneconomical. But some competitors came along and said, "We think maybe Americans would like automobiles that are less expensive, more comfortable, smaller, more reliable, and more economical." And they almost blew our automotive industry out of the water. But if you go shopping for an automobile today, you will find American vehicles that are smaller, more reliable, more economical, more comfortable, and less expensive.
- To design a system, we have to learn from all the lessons, learn from the imperfections of what we have done before, and see if we can bring value to patients or prospective patients.
- A.** We have to make sure that customer service ultimately comes down to quality of care and state-of-the-art medicine, along with dealing with the scary anecdotes, such as the baby who did not get treatment for her potential blindness. If we do not make that the highest priority, then all the great telephone response times, friendly receptionists, and nice sofas in the waiting room will not save the health care

delivery system. We have to give people good quality care.

- Q.** At the end of the 1980s, a lot of insured plans ran to ERISA, not just to managed care because of the number of state mandates. People went to their legislators and said, “Pay for this. Pay for that. We want the plan to pay for this, that, or the other.”

How can any of these systems, be they defined contribution or whatever, respond responsibly to demand? We have finite resources; we cannot pay for everything. To some patients, value and quality also mean the equivalent of, “I got what I wanted.” Having access to brand-new procedures, as soon as they are announced, is the definition of quality care and of value.

How would these various systems, be they defined contribution or the evolution of managed care, respond to that? And, does value also mean that I can sue if I did not get what I wanted?

- A.** It is a very confusing area. One study showed that, although plans left the fully insured market and went to self-insured, it turns out that self-insured and fully insured plans have similar benefit structures. So, what is going on has become mystifying to us. Then, we looked at bare-bones plans and found out that, indeed, workers and employers rejected less costly plans that offered fewer benefits. So the tension between costs and the array of benefits and the demand is a very difficult issue, and surveys and trends do not seem to provide answers.

With respect to demand and the issue of suing plans—the fundamental issue is, how do you restore accountability in our health care system? What about the issue of quality, of assurance that, at the end of the day, there is some way you can pay for additional medical costs?

When you ask people what would make a health care system accountable, there is linkage through a financial incentive for providers and plans to do the right thing up front. If we in the health care system make the cost of doing nothing “nothing”—if you can deny benefits and never pay anything—then we have not given anyone the financial incentive to do the right thing, to do quality care, as the first thing they do.

- A.** The issue of value really does turn on customer service, and it is not about sofas. It is about people being able to get answers to their questions when they are confused, when they are ill, when they are frightened, or when a member of their family has some potentially dreaded disease. It is about physicians not being able to give a rapid response sometimes. It is not necessarily about being able to best present what we have contributed to the delivery system so people can react to it and can evaluate it. This whole area of value and customer service should be thought of very broadly.

Second is the issue of expectations. Viagra is a good case in point because it should turn all of our attention to, “What are we prepared to support? What are we prepared to fund?” There had been some discussion about whether Viagra should be covered because birth control pills were not necessarily or always covered. ACOG, the group that represents obstetricians and gynecologists, has called for mandatory coverage of birth control pills. We will see quite a lot of that. The question could just as well have been tied to experimental procedures, new therapies, or new technology. We are going to have to confront all of these issues. Those who are sitting at the employee benefits table have to do it implicitly every day.

Our society is not evaluating these issues and those trade-offs. And, yes, there are trade-offs. That probably is one of the reasons behind the current high-tempered debate. There is no process in our society for technology assessment in any one place, so we see quite a lot of extraordinary efforts going on, by plans and hospitals.

Physicians in this country have made some of the most provocative arguments about why the current tort system does not work. They have said that it encourages defensive medicine and encourages people to sweep things under the carpet, instead of learning from their mistakes, getting better, and improving quality. We are hitting the mark and beginning to know not only how to measure quality but to drive home better quality. The question is, do we take a flawed system and extend it more broadly? There should be a reasoned and rational debate about that.

And, we have to do a better job of evaluat-

ing how to handle things when they go wrong. Early intervention and whatever we can do on infrastructure are terribly important. For my family, I want to make sure that things are solved and detected at the earliest stage, before they go wrong. It gives me little comfort to be able to sue if someone has a tragic experience.

Many physicians have made the points about the tort system: It is flawed, ineffective, and it is not going to yield continuous quality improvement. We are going to get a lot of defensive utilization review, which is probably moving us in the wrong direction in terms of the micromanagement that we want to get around.

A. In terms of “expectations,” the job of the markets is to align the expectations and to let people understand the basis for their expectations—to let them know what they are getting. That is what information is all about. Let them decide what to expect, based on what they choose to expect from the system.

Q. About 10 years ago, we had a great debate about what we had to do to rein in costs. One group said the government would need to get more active in this, we would have to pass a whole bunch of laws, and we would rein in costs because the markets were in market failure. Other people said, “No. There are these different ways of doing it, and we’re experimenting with it.” And finally, the employer community said, “We’ve had enough of this.” They went to companies like CIGNA and said, “Find a different way of doing it, or we will find other people to deliver those services that we want.”

Lo and behold, the system changed, and today costs, while a concern, are not the overriding concern that they were. There were estimates that this year we would be spending 17 percent of Gross Domestic Product (GDP), and for the last three years, the percentage of GDP devoted to health care has remained relatively stable.

With the past as prologue for teaching us something about the future, one reason why costs were out of control was a misalignment of incentives. So my question to those who advocate for increased government intervention to correct misalignments of incentives is why do you believe the government would be more

successful than the marketplace? Why do we need it to intervene at this point?

A. There are many answers. One is that those involved have been ahead of the curve. They may have already implemented many aspects of the consumer bill of rights in their plans. The reason for proposed legislation and a call for government intervention is that a number of studies have indicated that employers who have done well in the cost area are still purchasing on the basis of costs. That, combined with the fact that the law that oversees the plans has minimal standards for information disclosure and claims review, means there is no external review. We cannot expect all actors in the system to voluntarily adopt all of the things that we believe we need to go forward.

The consumer bill of rights lined up against many plans would not significantly alter delivery of health care. That shows that a lot of these efforts can be done, but that we cannot count on everyone to do them. We have talked a lot about how workers cannot navigate their way through the system. Many workers do not believe they have access to adequate services, or they do not have the information to make decisions. From the administration’s perspective, we are not just going forward in terms of government intervention.

What we need are some ideas on public/private partnerships and collaborative efforts. But we are at a crossroads now where it is very difficult for any one of us to proceed alone. We are trying to push on some of the legislative fronts because these are minimal basic consumer protections that would mirror what many employers already have in their plans.

We do not want to live in a country where we have medicine scouts running around or people who have been damaged irreparably in some way. We have to figure out fundamentally how to deal with this issue, and it does not have to be the same old tort system and tort proposals of the past.

There is nothing in ERISA that prohibits employers from providing the information that we have been talking about today. We may not have done a great job at sort of clarifying what information can be disclosed, but none of our regulations would do that. They really serve as a

minimal floor. Many employers are way beyond them now.

■ Session II

Q. One of the things we talk about in terms of consolidation, and mergers particularly, is that access to capital is a major impetus. In a sense, that is counterintuitive because people access capital to grow, and then, they end up having duplicated services. But it seems that has always been the way the markets have evolved. The need for capital has been the chief driver, not only among hospitals, but among other providers as well.

A. You are correct in the hospital field; it is one of the things you get with an economy of scale. If you look at the capital markets for hospitals, most independent community hospitals do not have good access to capital. They are not big enough; they do not have a rating from one of the national rating firms; and they often are viewed by those who might want to place capital, particularly loan capital, as too dependent on a single marketplace.

So as people begin to create organizations that are in multiple markets, have larger scale, and begin to resemble what major capital markets are accustomed to dealing with on the commercial industrial side, it opens up the ability to have access to capital at a substantially lower price or with fewer restrictions and codes.

Q. There are differences in the liability exposure associated with claims handling, whether you are under ERISA or not. A lot of insurance carriers cover people who are under ERISA and people who are not under ERISA therefore have different liability exposure for their claims handling. Are those claims handled any differently? Is the utilization review handled any differently? Are appeals handled any differently for businesses within ERISA versus businesses that are not? Are claims handled any differently for state and local government employees that you cover than they are for private-sector employees?

A. Practices vary widely. Generally speaking, the utilization review process, the denials, and the claim exceptions are all the same for everybody. Many employees work very hard to make sure that is the case. But that is not to say that in the entire industry, public and private, things are not done differently.

A. For our company, the funding arrangement, whether it is a self-insured group or it is an at-risk group, does not affect how one would handle claim policy, or anything like that. It is driven more by questions such as, "Do you have state differences that you have to deal with? Do you have plan or benefit differences?" But the funding arrangement per se does not drive the claim policy.

A. In terms of state versus federal regulation, there is a lot of discussion at the federal level as to whether or not that is an appropriate area for the insurance regulation. When states have made decisions, they made some very unwise choices with regard to health insurance coverage. For example, in Kentucky, one of the ramifications of those choices is that the state legislatures are looking at repealing some of those laws.

There are 50 state insurance commissioners who have 100 years of insurance law on the books. They understand how the market operates. The state legislatures are better able to react to poor decisions they made because there is an immediate response. In Kentucky, when every single insurer left the state, they realized that they had made a bad choice.

At the federal level, sometimes our legislators do not react as quickly to some of the laws that they have passed and the changes that they have made. So in terms of state versus federal, from the perspective of the insured marketplace, we would prefer a state regulatory environment rather than a federal one.

■ Session III

Q. I was struck by the comment that an employer could not walk away from a plan, and I wonder if that means that no large employer will, in the foreseeable future, walk away? Or does it imply that there ought to be a government standard,

or some industry practice, that would give people an opportunity to do that, if that were what ought to happen?

- A. As a practical matter, large employers cannot walk away from health benefits for their overall population for a number of reasons. First, it is a competitive marketplace; health benefits are viewed as a very, very important benefit. One of the implications of the managed care backlash and all of the other horror stories printed and reported is that people are probably more concerned with health care, assured access, and portability than they used to be.

But that is not to say that there are not population segments among large employers about which they say, “For this population segment, it is more a transactional labor force. We need them for something for awhile. Skills are not that critical. Maybe there is not much value in retention.” And then there are populations about which they say, “We’ll get whatever labor we can get at the lowest price we can, and we can eliminate health care benefits as a way to save money.”

Any one employer can do that for a certain segment. And small employers can do it because they can live on the niche. But by and large, it is a limited segment of the population that is either willing to go without health coverage or that has health coverage through another family member.

- A. Large employers do not want to walk away from health care because of the labor market. They also get a definite advantage: They can supply these benefits at a lower cost than medium and small employers. But as medium and small employers become threatened, the problem is that the political process is going to take over. If large employers want to maintain a competitive advantage, they have to make sure that their competitors in the labor market still have some floor, that they do not drop completely out, and cause a political crisis that will yield a system in which your competitive advantage is gone.
- A. If employees realize that they need health coverage, then the question is, “Am I better off getting it by going to work for an employer who provides health coverage, or am I better off by going to one that has higher direct pay but

doesn’t have health coverage?” And that gets back to the efficiency of the delivery system. If the employer can do it better than the employee can, then there is a competitive advantage to the employer who provides the benefit directly, as long as the employees understand the value.

- A. The recession point is probably where this becomes an unanswerable, or an imponderable, prospect. In the current state of the economy, unemployment rates in multiple areas of the country are down at 1.5 percent and 2 percent, and in some areas, lots of jobs posted are unfillable. In areas such as Raleigh-Durham, NC, they are reporting negative unemployment rates because they do not have anyone on the unemployment roll.

In companies like Starbucks and others, which are not small companies by any definition, with 35,000 employees plus now—but with largely part-time employees and delimited turnover—extending longevity of employment from three months to six months or nine months or a year is deemed to be sufficiently valuable for them to provide health benefits and a 401(k) plan. And they try and get people to stay beyond that one year.

So you have a dynamic in the labor market today that even with cost pressures and managed care concerns, one wants to keep people around rather than face high turnover. And if one wants to recruit knowledge workers, provision of health benefits seems to be almost mandatory.

When do we hit the magic point that the year 2000 computer problem combines with a recession, a 50 percent drop in the equity markets, and four or five other things? At which point do we have a health insurance coverage problem?

- Q. So often in benefits, we are designing for our past problems and never looking forward enough to what we are facing in the future. Many of us have been in industries where we have been downsizing. We have put our people through a lot of agony with managed care and different programs, and now we are in situations where, for the first time, we are doing significant recruiting. We have a great medical plan, but I certainly cannot say that it is a competi-

tive advantage for us. So, when I look at all the money we are spending in the area, I wonder if we should not be taking a different look at it, thinking about the knowledge worker, the Generation X kind of population, and turning it more to our advantage?

We have come to the conclusion that we are wasting productive time in our work force with many of our plans today that are administratively burdensome. We have to move to ways that delight our people, rather than provide a minimum level of benefits. There are only so many ways that you can stretch yourself in terms of managing all the different vendors that you deal with. So I am in a situation where, if we are going to spend all this money on health care, I want to make it more valuable to people, to have them find value in getting it from the company they work for, rather than from some other company. And I would like to see it meet the needs of the people who are coming into the labor market, instead of the people who are sitting in the executive suites, perhaps.

- A. Defined contributions would give them the chance to make the choices themselves and eliminate the competitive angle. But there is another way to reward people, whether or not you use defined contribution—with medical savings accounts. These accounts reward people for using the system in a cost-effective way.
- A. We have looked into this to a great extent because it is a competitive issue, and the answers are rather disturbing. It is true: big employers cannot exactly walk away from medical benefits. That is not to say a lot of people would not try, but the average salary in this country borders on \$30,000 now. So, obviously, there is a work force out there that you are benefiting in a way that no law would require.

Having said that, however, there are pockets of the economy, such as restaurants, where we as a society have said it is totally acceptable to provide no benefits, and in fact, one of the largest restaurant employers in the country has a reverse insurance plan, in which they give you only the first \$500.

There are two highly socially acceptable ways to walk away from medical coverage. One is to send the job overseas, where you drop not

only medical coverage but everything else. The second way is to go to contingent-employment arrangements. Manpower is now the largest private employer in the United States. That is not because it got so good over the last 10 years. It has a lot more flexibility.

- A. To some degree, companies have segmented their work force by identifying which core jobs require continuity, or at least jobs in which continuity is highly desirable. We want these people to stay, as long as we can keep them and they are productive and adapt to change.

The rest are various forms of temporary labor. Some may be expensive because they have certain skills, but there is not the same kind of commitment on either side as to how long that relationship is expected to last. And so those jobs become more oriented to cash compensation, while for the more permanent employees, other elements of compensation are more highly valued.

- A. If there were a viable individual product marketplace, where people could go out on the street and buy meaningful coverage at a competitive price—competitive, as in as good as employers could do—then a lot of employers would say, “We’ll give you cash. Go take care of it yourself.”

To some degree, that explains why group auto and group homeowners insurance have not caught on. The advantage that the employer provides by doing centralized purchasing is not enough to make it worth the trouble. The current reality in the health care marketplace is that the advantage that the employer provides is substantial.

We cannot easily get to a health care marketplace that is like the auto insurance marketplace. As long as there are for-profit companies trying to maximize their individual profits—and it is hard to imagine that not being a significant factor in the marketplace—then there is going to be a degree of risk segmentation.

Companies are going to look for ways to make profit by attracting better risks. The retiree medical marketplace gives some clues about these issues. Companies are afraid to offer liberal benefits because they attract less healthy than average risks. In the over age 65 marketplace, as an example, only one-third has em-

ployer-sponsored coverage, and two-thirds either rely on Medicare or buy individual supplements. But that risk factor is very, very important. It is easy to say that it would be more of an issue if we were not dealing with just the Medicare supplement but the entire package.

In a theoretical world, where the individual marketplace provided the same value as the group marketplace, we would have a significant shift. There is little chance that we will see that world within any reasonable period of time.

A. That world cannot develop without changes in the tax laws. The difference between automobile insurance and health insurance is the way that the tax laws treat them. In the case of the employer segment, it is tax free to the employee, whereas the automobile insurance is not. Individual acquisition is with after-tax dollars. If you had tax equity, you would have the situation just described.

A. Does the question have to be framed as if it is either employer-provided group coverage, where the employer is paying a huge portion of it, or individual coverage, where people are out buying it on their own and are completely on their own? There may be some kind of middle ground, or a whole array of potential products, that we have yet to see from the insurance industry. We would like to see a way for employers to create a group and then either get an insured product or a self-insured product with group rates that could conceivably be employee-pay-all or retiree-pay-all. We would like to do this for our retirees.

Towers Perrin, for example, has created a coalition for Medicare HMOs which, in some instances, does not have employer contributions. But by creating the group, you are able to negotiate and bargain.

A. For the retiree marketplace, it is more practical to have employee-pay-all coverage. For active employees, it is harder to support a system that is truly employee-pay-all and get the level of participation needed to make it viable. There are purchasing coalitions in various locations, and they may be a viable means for that kind of arrangement.

Q. A number of studies indicate that more of the increases in the cost of coverage, or regulation, are being moved to employees. And we have a growing number of uninsured, many of whom have access to employer-based coverage. What will be the impact of that, and the fact that most of the companies that are being formed are small employers?

A. The ever-increasing amount actually stopped in 1993, according to the data we have seen, in terms of a consistent time series. There are two exceptions. One is with respect to small employers. Fewer employees of small employers are required to pay anything, whether for single or family coverage. The ones that are still required to pay something are paying significantly more, especially for fee-for-service plans. It is not really true for the managed care plans.

The other exception is a recent study that took different surveys and different time periods to piece together a time trend. It showed that the share and the amount have been rising. There is no doubt that the amount has gone up, but it was really hard to understand why they took these two different surveys to have a time series. It was inconsistent.

The consistent surveys we have seen show that, at least since 1993, the average share of the premium that employees are paying for both single and family coverage has been pretty much flat.

A. There has been a shift, within the last year or two. Companies are reducing their percentage of the health care dollar to redirect that money to other parts of the compensation system. It is put directly to the bottom line; it is not done to reduce employees' total compensation. Rather, it is a move from basically fixed cost to variable profit-sharing kind of plans and other incentive kinds of plans, rather than to contributions to health care.

List of Policy Forum Attendees

Peg Alzamora
SmithKline Beecham Corporation

Nisha Anthony
Office of Senator Jay Rockefeller

Joseph Antos
Congressional Budget Office

Geri Aston
American Medical News

James Bentley
American Hospital Association

Linda Bilheimer
Congressional Budget Office

Phillip Blando
American Association of Health Plans

Charles Blanksteen
William M. Mercer

John B. Brence
Merrill Lynch

Jeff Bringardner
Humana, Inc.

Sally Canfield
Mutual of Omaha

William Carroll
AT&T

Nancy Chockley
NIHCM

David Colby
Robert Wood Johnson Foundation

Christopher R. Conte
EBRI Fellow

Philip Cooper
Agency for Health Care Policy and Research

Craig Copeland
EBRI

Cathy Cowan
Health Care Financing Administration

Martha Craver
Kiplinger Letter

William Custer
Georgia State University and EBRI Fellow

Diana Dennett
American Association of Health Plans

Daniel Devine
EBRI/ASEC

Jane Dillon
American International Group

Laura Dummit
General Accounting Office

Richard Dunn
General Electric

Burton Edelstein
American Academy of Pediatrics

Cathie Eitelberg
The Segal Company

Bernadette Fernandez
House Commerce Committee

The Future of Medical Benefits

Steven Findlay
National Coalition on Health Care

Howard Fluhr
The Segal Company

Richard Froh
Kaiser Permanente

Paul Fronstin
EBRI

Steve Fussell
Abbott Laboratories

Jane Galvin
Health Insurance Association of America

Bob Green
Swiss Re Life and Health America, Inc.

Jessie Gruman
Center for the Advancement of Health

Paige Hansen
Lehman Brothers

Paul Harrington
Senate Labor and Human Resources Committee

Scott Harrison
BlueCross BlueShield Association

Gary Hart
Carter-Wallace, Inc.

Peter Hasselbacher
Senate Finance Committee, Majority Staff

Cameron Hayes
The Timken Company

Marcia Hayes
Barclays Global Investors

Ed Howard
Alliance for Health Reform

Burkett Huey
PepsiCo, Inc.

Tony Iallonardo
Towers Perrin

Karen Ignagni
American Association of Health Plans

Louise Ionescu
American Express

Daniel Johnson
American Medical Association

Nora Super Jones
GWU National Health Policy Forum

Michael Kahn
National Education Association

Lana Keelty
National Rural Electric Cooperative Association

Carol Kelly
Premier

Ralph Kimmich
Southwest Airlines

Jane Lassner
J.P. Morgan and Company, Inc.

Wayne Lednar
Eastman Kodak

Jeff Lemieux
National Bipartisan Commission on the Future of Medicare

Katharine Levit
Health Care Financing Administration

Arthur Lifson
CIGNA Corporation

Gerald Lindrew
U.S. Department of Labor
Pension and Welfare Benefits Administration

John MacDonald
The Hartford Courant

Joe Marlowe
Aon Consulting

Gerry Martens
Southern New England Telephone

William Mattox
Mutual of Omaha

Judy Mazo
The Segal Company

Peter McCauley
Pharmacia/Upjohn

Edward McGann
The Chase Manhattan Bank

Thomas McMahon
Pacific Maritime Association

Peter McMenammin
American Medical Association

Susan C. Meholic
AT&T

Carolyn Merck
Congressional Research Service

Meredith Miller
U.S. Department of Labor
Pension and Welfare Benefits Administration

Robert Miller
DuPont Company

Alan Monheit
Agency for Health Care Policy and Research

Thuhang Nguyen
Buck Consultants

Pamela Ostuw
EBRI

Richard Ostuw
Towers Perrin

Kathy Ott
TRW

Bettye Page-Wilson
Pacific Maritime Association

Joe Piacentini
U.S. Department of Labor
Pension and Welfare Benefits Administration

Bill Pierron
EBRI

Karl Polzer
GWU National Health Policy Forum

Richard Prey
The Principal Financial Group

Michael Pruschowsky
Kaiser Permanente

Carol Quick
EBRI

Edward Scott Ray
SBC Communications Inc.

Kenneth Reifert
Merrill Lynch & Co., Inc.

R. Lucia Riddle
The Principal Financial Group

Carmen Rivera-Lowitt
U.S. General Accounting Office

Jack Rodgers
Price Waterhouse

James Rodgers
American Medical Association

Melvyn Rodrigues
EBRI Fellow

Maria Saavedra
Buck Consultants, Inc.

The Future of Medical Benefits

Dallas Salisbury
EBRI

Donald Sauvigné
IBM

Wilma Schopp
Monsanto Company

David Shactman
Brandeis University

Lawrence Sharrod
Thompson Publishing

Elisabeth Shuba
American Academy of Pediatrics

Robert Sollmann, Jr.
Metropolitan Life Insurance Co.

Lisa Sprague
GWU National Health Policy Forum

Libby Terry
Hewitt Associates

Jack VanDerhei
Temple University and EBRI Fellow

Karen Williams
National Pharmaceutical Council

Alicia Willis
EBRI

Stan Wisniewski
National Education Association

William Young
Aetna US Healthcare

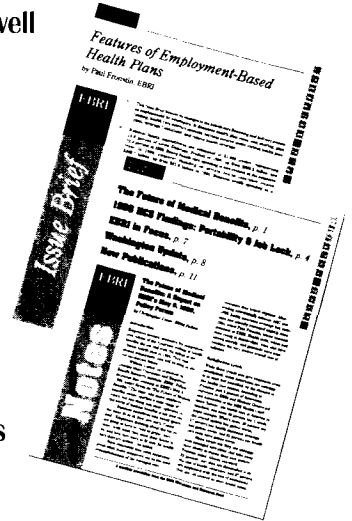
Richard Zimmerman
State Teachers Retirement System of Ohio

Now

you have more ways to subscribe to **EBRI Issue Briefs** and **EBRI Notes** — two monthly publications that go beyond the headlines to examine, analyze, and interpret the vital issues in employee benefits.

EBRI Issue Briefs—provide expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. Each issue, ranging in length from 16–28 pages, thoroughly explores one topic. Recent topics include: Health Insurance Portability, ERISA, Sources of Health Insurance & Characteristics of the Uninsured, Results of the 1997 Retirement Confidence Survey, Defined Contribution Pension Plans, Medicare, Lump-Sum Rollovers & Cashouts, Trends in Health Insurance Coverage, Analyzing & Comparing Social Security Policies, and more.

EBRI Notes—provide up-to-date information on a variety of employee benefit topics. Each issue includes a feature article on an important benefit topic; a statistical article highlighting new benefits data; highlights of legislative, regulatory, and judicial activities; research and activities taking place at EBRI; and a list of new benefit-related publications and internet sites.



➤ Subscription Options:

You can subscribe to both *Issue Briefs & Notes*, *Issue Briefs* only, or *Notes* only.

➤ Delivery Options:

Choose to receive your publications either in printed format—mailed to you each month, or in pdf format—e-mailed to you each month. You must provide an e-mail address for delivery of pdf files (pdf format requires the free Adobe Acrobat viewer software to read the files. This software can be downloaded from EBRI's web site or directly from Adobe's web site).

➤ Subscription Rates:

| | | | | |
|---------------------------------|---|-------------------------------|---|----------------------------|
| <i>Issue Briefs & Notes</i> | ➤ | printed & mailed = \$199/year | ➤ | pdf & e-mailed = \$89/year |
| <i>Issue Briefs</i> only | ➤ | printed & mailed = \$99/year | ➤ | pdf & e-mailed = \$49/year |
| <i>Notes</i> only | ➤ | printed & mailed = \$99/year | ➤ | pdf & e-mailed = \$49/year |

ORDER FORM

ISSUE BRIEF/NOTES SUBSCRIPTION

- Printed/mailed—\$199/year
 Pdf/e-mailed—\$89/year

ISSUE BRIEF ONLY SUBSCRIPTION

- Printed/mailed—\$99/year
 Pdf/e-mailed—\$49/year

NOTES ONLY SUBSCRIPTION

- Printed/mailed—\$99/year
 Pdf/e-mailed—\$49/year

Name _____ Title _____
 Company _____ Phone # _____
 Address _____
 City/State/ZIP _____
 E-Mail Address (required for pdf subscribers) _____
 Check enclosed Please charge my VISA MasterCard Amex Card # _____
 Exp. Date _____ Signature _____

Fax to: (202) 775-6312

Order Online: www.ebri.org/ebri-sub.htm

Mail to: EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037-1896

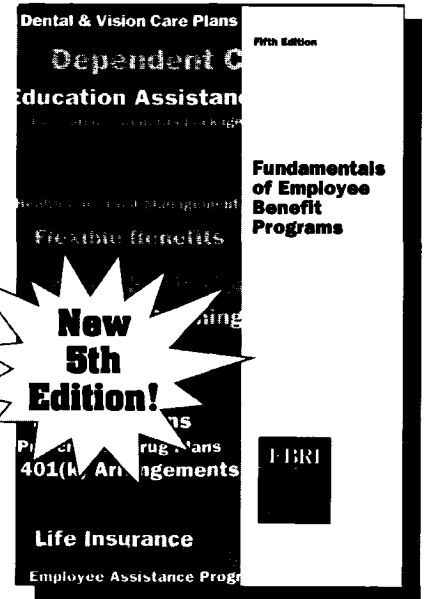
Fundamentals provides a straightforward, basic explanation of employee benefit programs in the private and public sectors, all in one book!

It is used by employers, employees, human resource managers, and consumers.

Each chapter focuses on a particular benefit plan or issue, offers an historical perspective on plan development, describes plan characteristics, and explains the tax implications of the benefits.

Key Chapters Include:

Social Security • ERISA • Pension Plans • Profit-Sharing Plans • 401(k) Plans • ESOPs • IRAs • Planning for Retirement • Health Insurance • Prescription Drug Plans • Managing Health Care Costs • HMOs • Employee Assistance and Health Promotion Programs • Group Life Insurance • Dependent Care • Flexible Benefit Plans • Guidance on Evaluating an Employee Benefit Package • Public-Sector Benefit Programs • AND MORE!



New 5th Edition!

New Chapters

Long-Term Care Insurance, Retiree Health Benefits, and Flat and Consumption Tax Reform Proposals and Implications for Employee Benefits.

Expanded Discussion

An expanded discussion of employee assistance programs and health promotion programs.

New Discussion

Discussion of the Federal Employees Retirement System.

Updates

All chapters have been updated with the latest tax changes, including the Health Insurance Portability and Accountability Act of 1996 and the Small Business Job Protection Act of 1996.

Order Your Copies Today!

Name _____ Title _____

Company _____

Address _____

City/State/9-digit ZIP _____

Phone _____ FAX _____ E-Mail _____

Prepayment Required—Charge to: American Express VISA MasterCard Check Enclosed

Name on Card _____ Exp. Date _____

Account # _____ Signature _____

_____ Fundamentals x \$49.95 _____

Shipping/Handling **\$4.95** _____

Total _____

**Fax to EBRI Publications at (410) 516-6998
or Mail to EBRI Publications
P.O. Box 4866 Hampden Station
Baltimore, MD 21211**



EBRI Databook on Employee Benefits

4th edition

EBRI
EMPLOYEE
BENEFIT
RESEARCH
INSTITUTE®

st, NW

The *EBRI Databook on Employee Benefits* is a statistical reference volume on private and public employee benefits programs and work force related issues. The data are compiled from multiple authoritative sources in table and chart form, supplemented with brief explanations of the information. The book, which is over 500 pages long and contains more than 400 tables and charts, is organized into five sections—overview, retirement programs, health programs, other employee benefits, and appendices.

The *Databook's* appendices cover general economic and demographic statistics, explanations of the source material, and a selected legislative history.

Also included are: a glossary, a source organizations list, a federal and congressional agencies contact list, and an index.

ISBN 0-86643-089-X

\$99.00*

*EBRI Members receive 55% off the regular price. Please indicate if you are a member when placing an order.

Order Form

Name _____

Title _____

Company _____

Address _____

City/State/ZIP _____

Phone _____

_____ copies x \$99.00 + \$4.95 (shipping) = \$_____

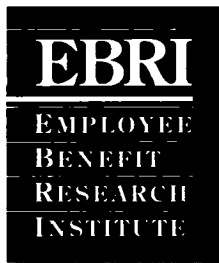
Check Enclosed Charge to: Visa MasterCard Amex

Card # _____

Exp. Date _____

Signature _____

Send to EBRI Publications, P.O. Box 4866,
Hampden Station, Baltimore, MD 21211
or Fax to (410) 516-6998



The Advantages of Membership

EBRI provides members with objective, top-quality analysis of public policy proposals, decisions, and future directions needed for both strategy and action.

- The bi-weekly *Washington Bulletin* provides a concise one-sheet picture of significant policy developments.
- The EBRI site on the World Wide Web (<http://www.ebri.org>) provides on-line access to EBRI publications, an e-mail link to the EBRI team, extensive library resources, and a password-protected "members only" section.

EBRI keeps member organizations one step ahead by providing timely updates on what is happening in areas of human resources, pensions, and health care—highlighting planning issues and opportunities.

- Monthly *EBRI Issue Briefs*, *EBRI Notes*, and *Facts from EBRI* provide an ongoing flow of research results, with an e-mail or a phone call making more information available.
- EBRI member meetings provide a means of analysis delivery and the opportunity to explore issues and implications with others.

EBRI saves members time and money; when they need information **immediately**, they can call on EBRI's professional team.

- EBRI undertakes over \$3 million in research annually that is available to members as it is produced. Members have the opportunity to directly participate in data collection and study efforts.

EBRI saves members money by providing top notch research on a variety of topics of value to multiple departments within organizations—from employee benefits to legal, to finance, to human resources, to marketing, to government relations, to strategic planning.

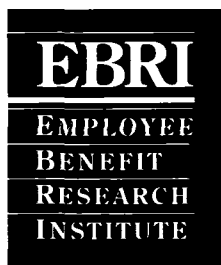
EBRI is the **best** "insurance" that organizations can have for staying ahead of public policy initiatives and for understanding policy process dynamics. EBRI members get an objective assessment from EBRI.

EBRI's long-standing reputation in Washington, DC, and with media across the nation, as the **objective** employee benefits data and education resource is the critical factor to being **heard by all parties**.

- EBRI's work is at the center of the policy process. EBRI provides regular briefings for government staff and the media. EBRI is the most widely cited source in the nation of diverse employee benefits data. EBRI staff regularly appear on CNN, CNBC, NPR, and other major outlets and are in the print media daily, providing objective data and education on employee benefits and the implications of public policy proposals.

EBRI: simply the most authoritative and objective public policy research resource in the nation on employee benefits.

For additional information, call EBRI at (202) 659-0670 or e-mail at info@ebri.org



The mission of the Employee Benefit Research Institute (EBRI) is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

WHAT IS EBRI?

- EBRI provides credible, reliable, and objective research, data, and analysis. The belief: neither public nor private policy or initiatives, whether institutional or individual, can be successful unless they are founded on sound, objective, relevant information.
- EBRI is funded by membership dues, grants, and contributions. EBRI's financial base includes a cross section of pension funds; businesses; associations; labor unions; health care providers; insurers; banks; mutual funds; government organizations; and service firms, including actuarial firms, employee benefit consulting firms, law firms, accounting firms, and investment management firms.
- EBRI does not take advocacy positions on policy proposals, lobby for or against proposals, or recommend specific approaches/prescriptions. EBRI does provide objective data on and analysis of the range of identified options in order to provide others the opportunity to make more informed decisions than might otherwise be possible.
- EBRI is a nonprofit, nonpartisan organization established in 1978. EBRI's Education and Research Fund (ERF), which performs the charitable, educational, and scientific functions of the Institute, is a tax-exempt 501(c)(3) organization supported by contributions and grants (it is not a foundation).

THE CHALLENGE

- As employee benefit costs—already in the hundreds of billions of dollars—continue to escalate, as public policy continues to evolve, as the design of employee benefit plans becomes more complex, and as employers change their views of benefits, the need for data and analysis is greater than ever.

EBRI PROGRAMS TO MEET THE CHALLENGE

- EBRI's comprehensive program of research and dissemination covers health, retirement, and related economic security topics. This program includes policy forums, round tables, briefings, testimony, interviews, and speeches. Major studies in process include Social Security reform, individual investment education and results, health insurance coverage, health policy reform, and pension design and investment trends. Major surveys include the annual Retirement Confidence Survey and the Health Confidence Survey.
- The *EBRI Databook on Employee Benefits* and *Fundamentals of Employee Benefit Programs* are regularly updated as resources. They are augmented by monthly *EBRI Issue Brief* studies and monthly *EBRI Notes* (which summarize major data releases, public policy activity, and new studies). Special initiatives for public education include EBRI's World Wide Web site <<http://www.ebri.org>> and the EBRI-ERF American Savings Education Council (ASEC) <<http://www.asec.org>>.
- EBRI's Fellows program allows individuals from the private sector, government, foundations, academia, and the media to undertake studies of economic security issues and work with EBRI teams on major projects.
- The EBRI-ERF American Savings Education Council undertakes initiatives to raise public awareness about what is needed to ensure long-term personal financial independence. ASEC's goal is to make saving and planning a vital concern of all Americans and in the economic interest of employers.

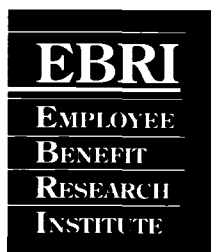
Dallas L. Salisbury is President and CEO. He can be reached at (202) 775-6322 or by e-mail at salisbury@ebri.org.

Employment-based health benefits currently enhance the economic security of over 150 million Americans. Approximately 85 percent of workers receive health benefits from a managed care plan.

The rate of change in the health care industry has been confusing for both casual observers of the industry and those directly involved in it. While the last few years have seen modest health care cost increases and subsequent increases in employment-based health insurance coverage, the re-emergence of cost pressures is resulting in both higher health care cost inflation and benefit package redesigns. With most insured workers now enrolled in managed care plans, a natural question to ask is how managed care will continue to control health care costs. Is the move to managed care a one-time savings? Are rising health care costs inevitable? What are the implications for improving health care quality? What are the implications if ERISA pre-emption continues to be narrowed?

The growth of managed care has also placed considerable pressure on providers of health care services and has stimulated responses by both providers and third-party payers. One of the most important responses has been consolidation both within sectors and across sectors. Hospitals have merged, physician groups have merged, and hospital and physicians have formed organizations. Employer groups have also formed coalitions. At the same time, the medical industry is undergoing a slow but steady transformation from not-for-profit dominance to for-profit dominance.

The papers contained in *The Future of Medical Benefits* explore these questions and issues. They reflect multiple perspectives, including employer, health insurer, health care provider, policymaker, employee benefit consultant, and academic. The authors review the current status of the health care system and explore the issues of managed care and accountability. The ever-continuing cycle of consolidation in the health care industry is discussed not only from the health care provider point of view but also from the point of view of the employer and the health insurer. The authors make many points that will be controversial, but they agree on one point overall: managed care and employment-based health benefits will look different in the future than they do today.



Education
& Research
Fund

Suite 600, 2121 K Street, NW, Washington, DC 20037-1896
(202) 659-0670 Fax (202) 775-6312

web sites www.ebri.org www.asec.org www.choosetosave.org

\$29.95

ISBN 0-86643-091-1

ISBN 0-86643-091-1



9 780866 430913