

## Health Care Cost Pressures and Financing Fundamentals

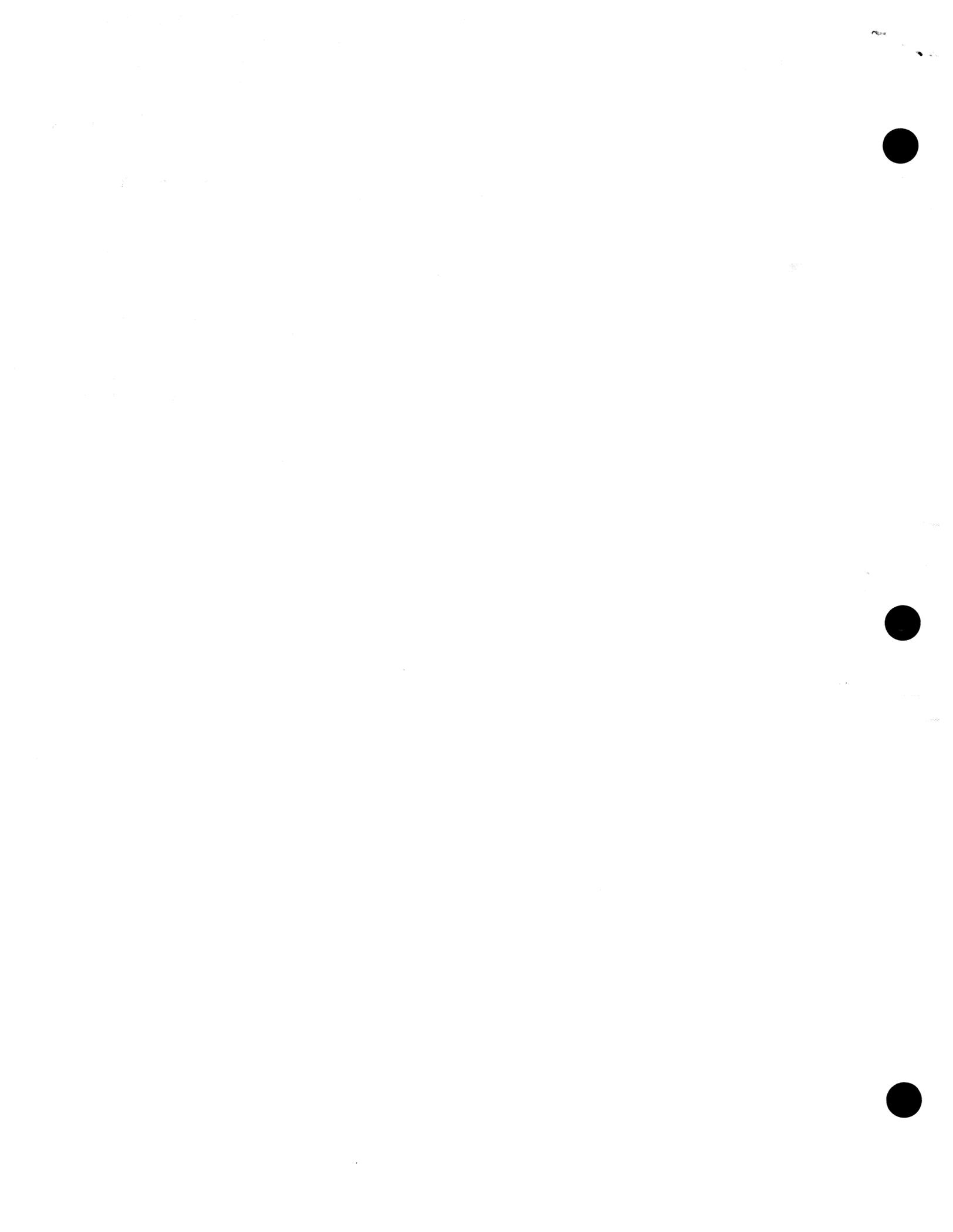
<b>Time:</b>	Thursday, January 9, 2003, 9:45 a.m. - 12:00 noon
<b>Format:</b>	Presentation and Discussion
<b>Presenter:</b>	Len Nichols, Ph.D. Vice President Center for Studying Health System Change Washington, DC
<b>Florida Panelists:</b>	Rhonda Medows, M.D. Secretary Florida Agency for Health Care Administration Tallahassee, FL  Rich Robleto, M.B.A., C.L.U., F.L.M.I. Chief Bureau of Life and Health Forms and Rates Florida Department of Insurance Tallahassee, FL
<b>Objectives:</b>	<ul style="list-style-type: none"><li>• Describe how health care services are financed.</li><li>• Identify the major components of health care spending and principal cost drives, and describe the major strategies for containing health care costs.</li><li>• Discuss the principles of health insurance market regulation and alternative means of spreading risk.</li></ul>



**Materials:**

- Nichols presentation
- Strunk BC, Ginsburg PB, Gabel JR. Trends- Tracking Health Care Costs: Growth Accelerates Again in 2001. Web Exclusive. Health Affairs. September 25, 2002.
- Nichols LM. Can Defined Contribution Health Insurance Reduce Cost Growth? Issue Brief. Employee Benefit Research Institute. No. 246. June, 2002.
- Health Insurance: States' Protections and Programs Benefit Some Unemployed Individuals. United States General Accounting Office. Washington DC: October, 2002. (summary page)
- Medows presentation
- Robleto presentation





OVERHEADS

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*Len Nichols, Ph.D.*

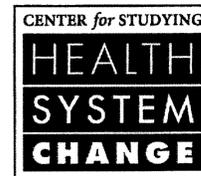


# Health Care Cost and Financing Fundamentals

The 2003 Florida Health Care  
Summit

Len M. Nichols, Ph.D.  
Vice President

January 9, 2003



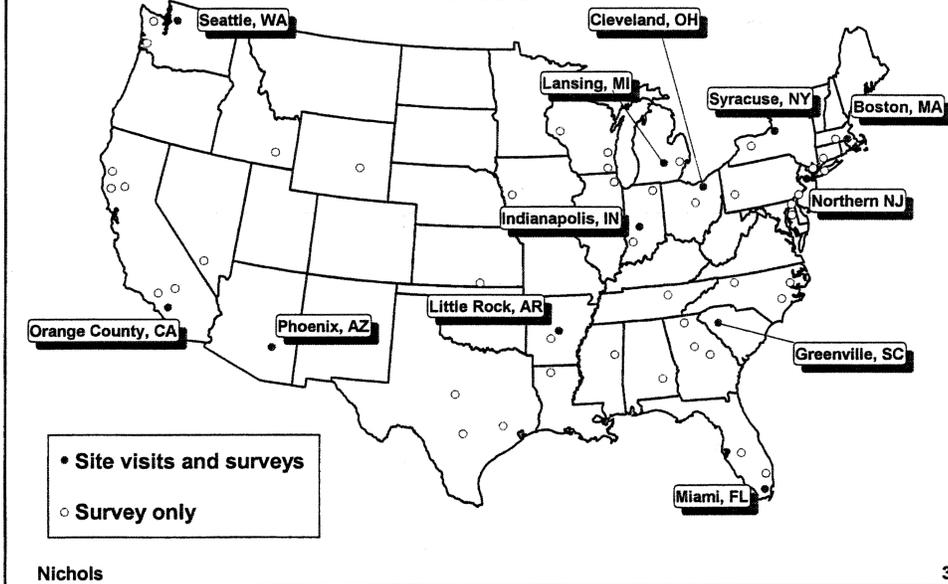
Providing Insights  
that Contribute to  
Better Health Policy

## About HSC

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- Objective research on changes in the organization and delivery of care – and their impact on people
- Emphasis on market dynamics
- Combination of data collection and research strategies
- [www.hschange.org](http://www.hschange.org)

## The Community Tracking Study (CTS) Sites



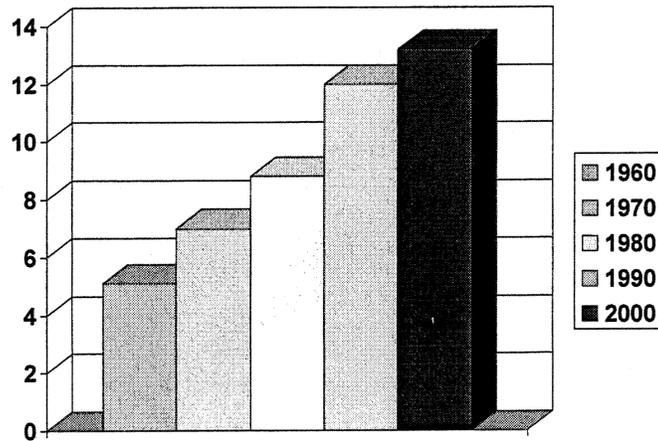
## Overview

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- Cost of health care cost growth
- What we buy
- Federalism and health care finance
- Medicaid budget pressures
- Why health care costs are growing now
- How we finance care for the uninsured now

## The “Real” Cost of Health Care Cost Growth

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National Health Spending as a share of Gross Domestic Product

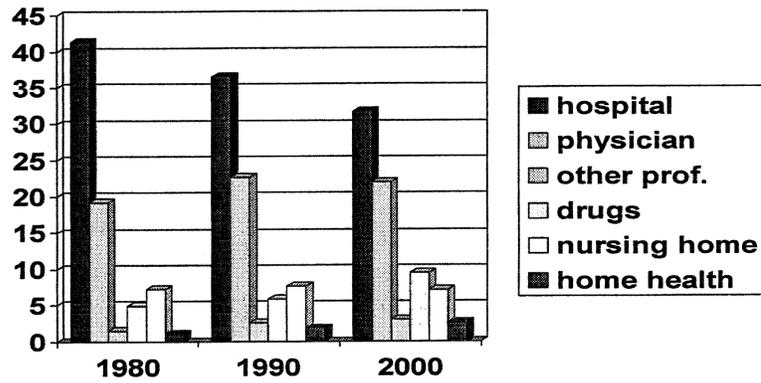
Source: CMS, National Health Accounts Data

## Implications of “Real Cost”...

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- Opportunity cost of health care services is rising
- Hidden cross-subsidies are more expensive and harder to hide
- Increasing fraction of our work force cannot afford US health care

## Trends in Expenditure Shares by Health Service

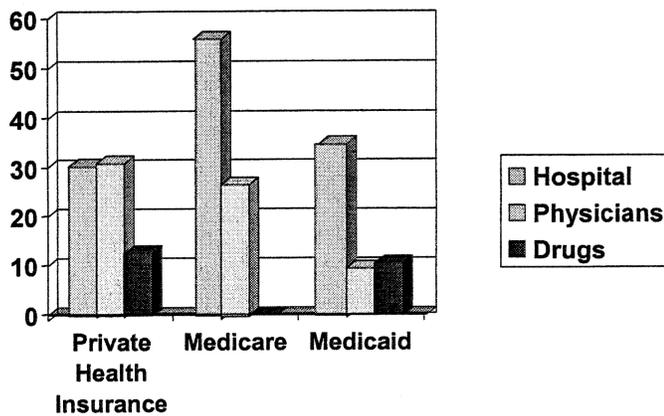


Source: CMS, National Health Expenditure Tables, 2002.

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## What Specific Payers Buy



Source: CMS national health account data, 2000

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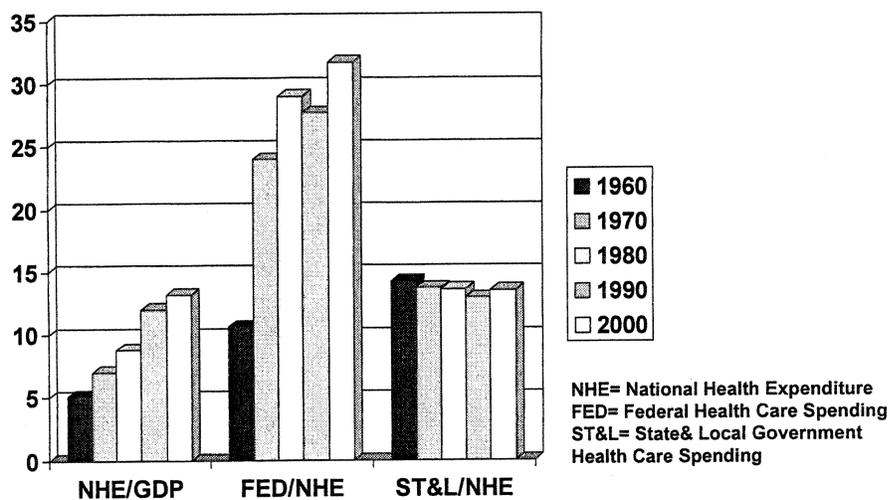
## Federalism and Health Care Finance

- Theory
  - Government “should” do only what the market cannot
  - Redistribute wealth at the national level
  - Tailor programs to fit local needs vs. national standards
- Medicare
  - Too great a burden for individual states
  - Financed by payroll and income taxes, premiums
- Medicaid
  - Federal requirements and matching payments
  - Most spending is “optional”

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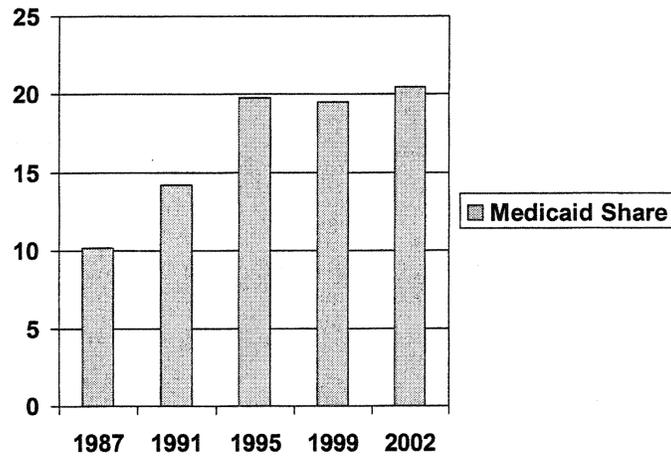
## Federalism, Financing, and Cost Growth



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## History of Medicaid and State Budgets

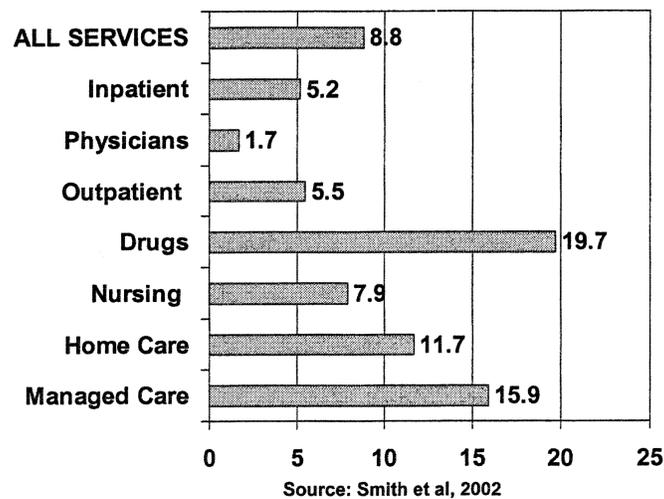


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Source: Smith et al 2002.

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## Average Annual Growth in Medicaid Components, 1998-2000



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Source: Smith et al, 2002

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## Medicaid-specific cost growth factors

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- Enrollment
  - Aged, blind, and disabled (60% of costs, and growth in enrollment)
  - Children and families (recession-induced)
- General system cost pressures
  - use (roughly 60-40)
  - prices
  - drugs
- Overall: 40% enrollment, 60% services/prices

Source: Smith et al, 2002; Urban Institute 2002.

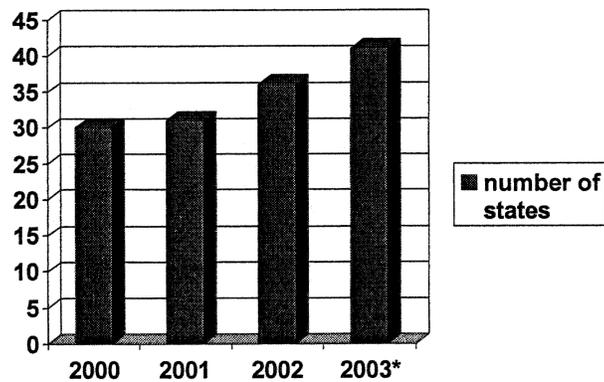
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## Medicaid Budget Shortfalls

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- Driven by entitlement vs. appropriations



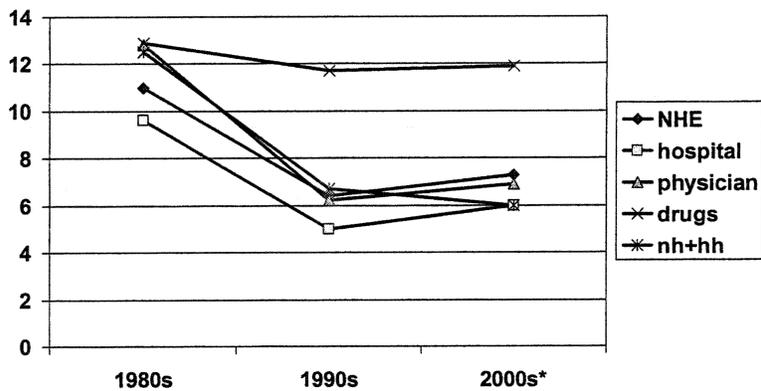
Source: Smith et al, 2002.

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## Growth of Health Service Expenditure Categories

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Source: Author's calculations, annual compound growth rate by decade, using CMS National Health Account data, 2002.

## What's Driving Cost Growth Now?

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- Managed care loosening
- Provider capacity constraints
- Provider consolidation and push-back
- Information-fueled consumer demand

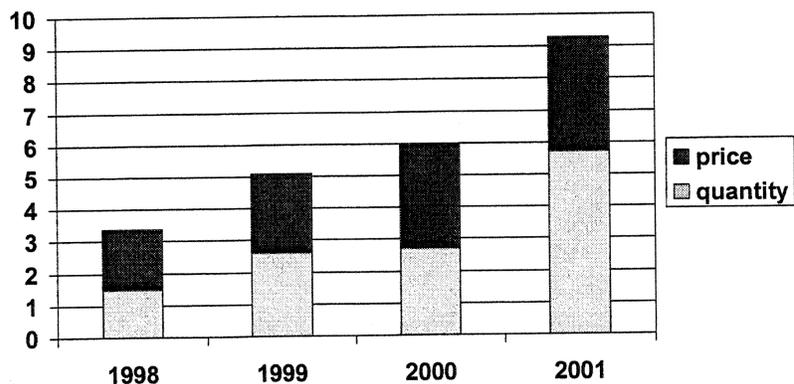
## Evidence of Capacity Constraints

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- Patients reporting more delays, unmet need
- Physicians working longer hours
- ER overflow, patient diversion
- Shortages of nurses and staffed hospital beds

## Evidence on growth in hospital use vs. price

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Source: Strunk, Ginsburg, and Gabel, Health Affairs, 2002.

## Other Potential Sources of Cost Growth

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- Technology
- Aging
- Transactions Costs
- Mandates
- Inappropriate care

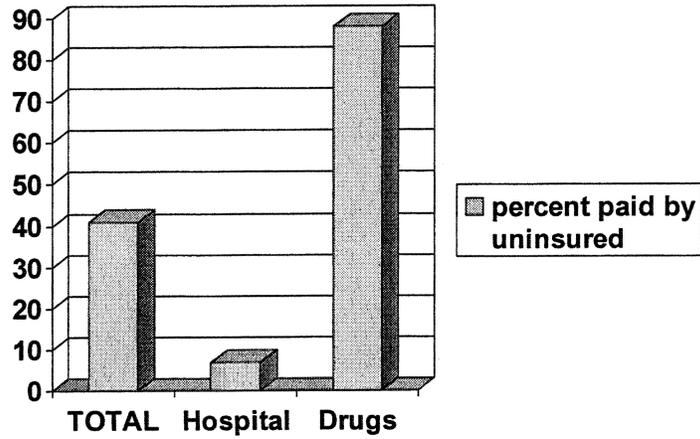
## How Risks and Costs are Spread

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- Private insurance pools
  - Large groups, self-insured
  - Small groups, commercial risk pools
  - Individuals in the non-group market
  - State high-risk pools
- What about the uninsured?

## Who Pays for the Uninsured?

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## Who Helps Pay for the Uninsured?

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- Taxpayers
  - Medicaid and Medicare
  - Direct subsidies to safety net providers
- Providers
- Privately insured

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BACKGROUND MATERIALS

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**BACKGROUND MATERIALS**

*Len Nichols, Ph.D.*



## TRENDS

## Tracking Health Care Costs: Growth Accelerates Again In 2001

Hospital costs have secured their place as the leading driver of health care cost increases, for the second straight year.

by **Bradley C. Strunk, Paul B. Ginsburg, and Jon R. Gabel**

**ABSTRACT:** For the first time in more than a decade, health care spending per capita rose at a double-digit rate in 2001, growing 10 percent. Spending on hospital services (both inpatient and outpatient) surged by 12 percent in 2001, reflecting increases in both hospital payment rates and use of hospital services. Hospital spending was the key driver of overall cost growth, accounting for more than half of the total increase. Prescription drug spending growth declined for the second straight year and was overtaken by spending on outpatient hospital services as the fastest-growing component of total spending. Driven by these cost trends and other factors, premiums for employment-based health insurance increased 12.7 percent in 2002—the largest increase since 1990. But taking account of the sizable amount of “benefit buy-down” in 2002, the true increase in the cost of health insurance for employers and employees was about 15 percent. Early evidence from 2002 suggests that health care cost trends are now beginning to slow, possibly setting the stage for more moderate premium growth in the future.

TRENDS in health care spending returned to the national spotlight during the past year. One year ago in this journal, we reported that growth in health care costs underlying private health insurance reached its highest level in a decade in 2000, driving rising premiums.<sup>1</sup> The effect of rapidly rising costs on premiums was exemplified more recently by the announcement of the California Public Employees Retirement System (CalPERS)—the nation's second-largest purchaser of health insurance after the federal government—that premiums for its health maintenance organization (HMO) and two preferred provider organization (PPO) offer-

ings would rise by 25 percent, 22 percent, and 19 percent, respectively, in 2003.<sup>2</sup> As other employers across the country face large premium increases, cost control has become the top priority of employee benefit managers.<sup>3</sup> Meanwhile, health care affordability has quickly become one of the top health issues on the minds of the nation's voters.<sup>4</sup>

Health care cost trends not only drive long-term premium trends but also influence the types of health insurance products employers offer their employees, benefit design, and workers' out-of-pocket costs. Cost trends also affect employers' decisions to offer any insurance at all and employees' decisions to take up

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*Bradley Strunk is a health research analyst at the Center for Studying Health System Change in Washington, D.C.; Paul Ginsburg is its president. Jon Gabel is vice-president, health system studies, at the Health Research and Educational Trust, also in Washington.*

coverage. For these reasons, rapid growth in health care costs threatens to undercut health coverage in America from a number of fronts.

The problem of rising costs intensified in 2001. Using the most recent cost trend data available, we report that annual growth in health care spending accelerated yet again, reaching double digits for the first time in more than a decade. Growth in spending on hospital services was by far the largest contributor to overall cost growth. Employers' health premium trends accelerated to their highest level since 1990, although the cost of insurance to employers and employees was even higher because of widespread "benefit buy-down," or reduced benefits and increased employee cost sharing.

### Data Sources

We use a variety of data sources to examine the health care cost trends that underlie private health insurance and the implications for employer coverage premiums and consumers' out-of-pocket spending. We chose data sources based on a given source's ability to provide reliable estimates with a short time lag, as we have done in prior analyses.

■ **Cost trend data.** To examine recent cost trends, we used the Milliman USA Health Cost Index (HCI), which measures the health care spending increases that underlie private health insurance premiums.<sup>5</sup> Milliman USA constructs this index from both publicly available and proprietary data on provider revenues (a proxy for spending on services) gathered through surveys of providers. Since the index is designed to reflect claims expenses experienced by private insurers for a typical policy, the HCI is limited to measuring health services that tend to be insured: inpatient and outpatient hospital services, physician services, and prescription drugs.<sup>6</sup> Because these provider revenue data reflect all patients, Medicare payments to providers are removed in an effort to arrive at a series more closely representing the population covered by private health insurance. Milliman USA is unable to remove revenues attributable to Medicaid and uninsured patients, which is a limitation in the

HCI's ability to track spending for privately insured patients.

Because the HCI contains proprietary data, Milliman USA does not release detailed information about how the index is constructed. However, we assessed its ability to measure cost trends by comparing it with the National Health Accounts (NHA) maintained by the Centers for Medicare and Medicaid Services (CMS), which is widely considered to be the "gold standard" for tracking health spending. More specifically, we compared the HCI with the private personal health care spending series, minus spending for services not usually covered by the HCI, such as dental and nursing home care. We found that the HCI tracks this NHA series closely. Over the ten-year period 1990–2000, both the HCI and the NHA series grew by an average annual rate of 4.8 percent. In any given year, growth in the two health care spending measures differs by an average of 1.2 percentage points. Therefore, the HCI is a good measure of health care costs, and we use it because it is available with a shorter time lag than is true for the NHA data.

To gain insight into the factors driving growth in spending on hospital services, we broke down the HCI's hospital spending trend into price and quantity components. We used the Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for hospitals to measure changes in hospital prices. More specifically, we used the "all other payers" series for "general medical and surgical hospitals" (hereafter referred to as the "hospital PPI"), to exclude the direct effect of changes in Medicare and Medicaid reimbursement rates. The hospital PPI series we used reflects negotiated payment rates rather than billed charges. When collecting baseline price quotes at each hospital in its sample, the BLS randomly selects hospital patient bills for a predetermined set of diagnosis-related groups (DRGs) and outpatient services. Using these patient bills, the BLS then records the nature of the hospital stay or outpatient service, the reimbursement method and payer type, and the full reimbursement of the stay or service (that is, the base period price quote). When the BLS re-

turns in future periods to obtain new price quotes, it attempts to reprice the original patient bills. Since the sample of patient bills (and therefore the characteristics of those bills in terms of what services are delivered, length-of-stay, method of reimbursement, and so on) remains constant over time, the hospital PPI is not usually affected by changes in length-of-stay.<sup>7</sup> However, depending on the method of reimbursement, the PPI is vulnerable to being influenced by changes in resource intensity.<sup>8</sup>

We calculated a hospital "quantity" index as the residual of the Milliman HCI for hospital services (inpatient and outpatient combined) and the hospital PPI. This component is driven by factors that influence the quantity and mix of services used by consumers and, therefore, measures the impact of changes in hospital use and length-of-stay on spending.

We analyzed the trend in spending on physician services in similar fashion. We used the BLS's "offices of physicians" PPI series (hereafter referred to as the "physician PPI") to measure changes in the price of physician services. This series includes the effect of changes in Medicare reimbursement rates; however, we used data on Medicare updates for physicians to remove this effect so that the series was more reflective of price changes that affect the privately insured population. The physician PPI methodology is similar to that of the hospital PPI. The quantity index is again calculated as the residual of the HCI for physician services and the physician PPI.

We used data on payroll costs for hospitals to understand changes in their largest input cost factor. These data, compiled monthly by the BLS and known as the Employment, Hours, and Earnings (EHE) series, are useful for their reliability and very short time lag. Both private and public employers are in the sample, which excludes nonsalaried health professionals, such as physicians or contracted workers from temporary agencies. Payroll costs are the product of total production (nonsupervisory) workers, average weekly hours per worker, and the average hourly wage. We report BLS payroll data per capita. This is the most relevant measure for policy-

makers; it is directly comparable to the HCI data and to data on premiums (what is charged to cover an individual or family).<sup>9</sup>

■ **Premiums and cost sharing.** Data on premiums and consumer cost-sharing requirements for employment-based health insurance come from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits and its predecessor surveys. The 2002 Kaiser/HRET survey is based on a stratified random sample of 2,014 employers with three or more workers selected from Dun and Bradstreet's listing of private and public businesses that have entered the credit market. Kaiser/HRET surveyors collected data through telephone interviews with employee benefit managers conducted during January–May 2002. Respondents were asked to report premium information that was in effect at the time of the interview. The survey continues the health benefit surveys conducted since 1987 by the Health Insurance Association of America (HIAA) and KPMG Peat Marwick. The core questions in these surveys are virtually identical. For the years 1991, 1992, 1994, and 1997, only firms with 200 or more workers were sampled.

### Health Care Spending Trends

Total health care spending per capita increased 10 percent in 2001—2.2 percentage points higher than in 2000 (Exhibit 1). This marked the fifth straight year that growth in spending exceeded the previous year's rate. This long period of accelerating annual spending growth is in stark contrast to the mid-1990s, when annual spending growth was low and decreased from one year to the next. With the economy in recession during the last three quarters of 2001, health care spending growth for the year exceeded that of gross domestic product (GDP) per capita by more than eight percentage points.

■ **Hospital spending.** Growth in hospital spending now stands out as the key driver of growth in total spending. Spending on hospital inpatient services increased 7.1 percent in 2001—nearly three times the 2000 rate of in-

**EXHIBIT 1**  
**Annual Percentage Change Per Capita In Health Care Spending And Gross Domestic Product, 1991–2002**

Year	Spending on type of health care service					Gross domestic product (GDP)
	All services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs	
1991	6.9%	3.5%	16.8%	5.4%	12.4%	1.8%
1992	6.6	2.8	13.9	5.9	11.7	4.2
1993	5.0	4.8	8.9	3.3	7.1	3.8
1994	2.1	-2.0	8.7	1.7	5.2	4.9
1995	2.2	-3.5	7.9	1.9	10.6	3.7
1996	2.0	-4.4	7.7	1.6	11.0	4.4
1997	3.3	-5.3	9.5	3.4	11.5	5.2
1998	5.3	-0.2	7.5	4.7	14.1	4.3
1999	7.1	1.6	10.2	5.0	18.4	4.4
2000	7.8	2.5	11.5	6.3	14.5	4.7
2001	10.0	7.1	16.3	6.7	13.8	1.4
2002 <sup>a</sup>	8.8	6.2	13.6	5.7	13.0	1.8

**SOURCE:** Health care spending data are from the Milliman USA Health Cost Index (HCI), zero deductible. GDP is from the U.S. Department of Commerce, Bureau of Economic Analysis.

**NOTES:** GDP is in nominal dollars. Milliman USA HCI data reflect the August 2002 revision. As a result of this revision by Milliman USA, some estimates for 1998–2000 changed from what we have reported in the past.

<sup>a</sup>Data through June 2002, compared with corresponding months in 2001.

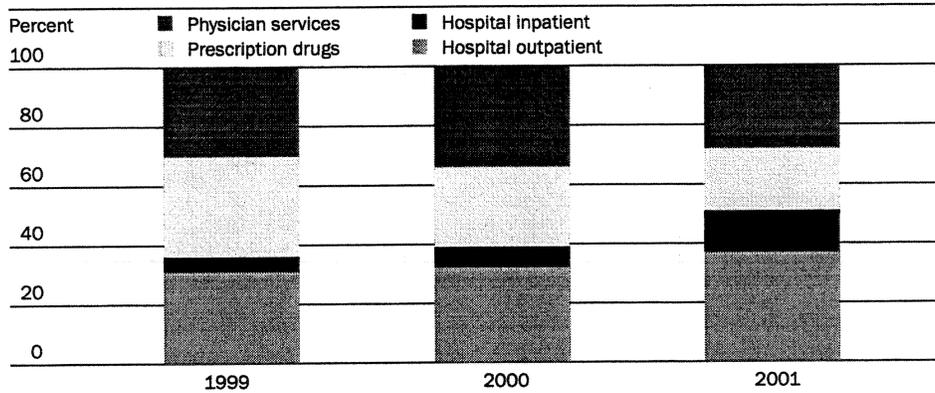
crease and by far the largest increase in more than a decade. Moreover, the 2001 growth rate represented a remarkable reversal compared with five years ago, when spending on inpatient services actually declined by 5.3 percent. Meanwhile, spending on outpatient services grew at such a high rate—16.3 percent in 2001—that it overtook prescription drug spending as the fastest-growing component of total spending. Taken together, growth in spending on hospital inpatient and outpatient services accounted for more than half of the growth in total spending (Exhibit 2).

The accelerating trend in hospital spending is attributable in part to higher prices being paid for hospital services. Growth in hospital prices (for both inpatient and outpatient services, as measured by the hospital PPI) has, like hospital spending, accelerated each year since 1997, reaching 3.6 percent in 2001 (Exhibit 3). This represents a reversal of the trend from 1994 to 1997, when annual hospital price increases slowed steadily from 4.0 percent to 1.7 percent.

Over the past few years hospitals have regained a sizable amount of negotiating leverage over health plans and have used it to demand large payment rate increases.<sup>10</sup> The shift in the balance of power between hospitals and health plans is the result of consumers' demand for broad networks, consolidation in the hospital industry, and recent hospital capacity shortages. Hospitals' subsequent "pushback" for higher payment rates reflects, in part, an effort to reverse the effect of agreeing to increasingly discounted payment rates during the mid-1990s. A recent surge in hospital wage rates is likely another factor driving hospitals to demand large payment rate increases (see below). Finally, hospitals may be attempting to gain higher rates for privately insured patients to make up for a recent decline in margins for Medicare patients.<sup>11</sup>

The other, and indeed more important, factor driving up hospital spending is rapid growth in the use of hospital services. During the mid-1990s hospital utilization (as measured by our residual hospital quantity index)

**EXHIBIT 2**  
**Shares Of Overall Health Care Spending Growth, 1999-2001**



**SOURCE:** Milliman USA Health Cost Index (HCI), zero deductible.

**NOTES:** Milliman USA HCI data reflect the August 2002 revision. As a result of this revision by Milliman USA, some estimates for 1999 and 2000 changed from what we have reported in the past.

declined from year to year by as much as 2.8 percent, probably reflecting efforts by managed care to reduce hospital admission rates, lengths-of-stay, and outpatient procedures. Since that time, however, the utilization trend has increased steadily, and in 2001 it surged by an annual rate of 8.0 percent. The 2001 increase in hospital use accounted for about two-thirds of the total increase in hospital spending.

Much of this growth in hospital use is likely associated with the recent retreat from tightly managed care. Recent evidence from the Center for Studying Health System Change's Community Tracking Study (CTS) site visits suggests that health plans have reduced their reliance on various tools, such as precertification requirements, to tightly manage utilization and are introducing new, less restrictive products, such as those that allow "direct ac-

**EXHIBIT 3**  
**Decomposition Of Hospital Spending Trends, Annual Percentage Change, 1994-2002**

	Spending on hospital services	Hospital prices	Quantity <sup>a</sup>
1994	1.8%	4.0%	-2.2%
1995	0.8	3.7	-2.8
1996	0.5	1.8	-1.2
1997	1.3	1.7	-0.4
1998	3.4	1.9	1.5
1999	5.8	2.5	3.2
2000	7.1	3.3	3.6
2001	12.0	3.6	8.0
2002 <sup>b</sup>	11.2	4.1	6.8

**SOURCES:** Data on hospital spending are from the Milliman USA Health Cost Index (HCI), zero deductible, and include both hospital inpatient and outpatient services. Hospital prices are from the Bureau of Labor Statistics' "other payers" Producer Price Index (PPI) series for general and surgical hospitals.

<sup>a</sup> Calculated as the residual of the hospital spending and hospital price trends.

<sup>b</sup> Data through June 2002, compared with corresponding months in 2001.

cess” to specialists.<sup>12</sup> There also has been a retreat from provider risk contracting, which may have reduced incentives for providers to control utilization.<sup>13</sup> Data from the Kaiser/HRET employer survey corroborate these findings.<sup>14</sup> For example, the percentage of employees in indemnity, PPO, and point-of-service (POS) plans who are subject to concurrent review of hospital stays has fallen from 79 percent in 1996 to 62 percent in 2002. Also, the percentage of workers who are enrolled in HMO and POS plans that require a referral from a primary care doctor to see a specialist and are subject to utilization review to obtain diagnostic tests (such as magnetic resonance imaging, or MRI) declined by eleven percentage points over the past three years. It is possible that the hospital utilization trend may also reflect a more difficult case-mix (sicker patients), but this is unlikely to have had such a large impact in such a short time.

■ **Prescription drug spending.** The Milliman HCI indicates that for the second year in a row, the rate of increase in prescription drug spending slowed compared with the previous year. Spending on prescription drugs in 2001 increased 13.8 percent—0.7 percentage points lower than the rate of increase in 2000 and 4.6 percentage points below the 1999 growth rate. Moreover, the 2001 increase in drug spending accounted for only about 21 percent of the growth in overall spending, compared with 34 percent two years earlier, although much of this change is attributable to the higher growth in hospital spending. The continuing increase in the use of three-tier drug copayment structures in health benefit offerings has likely been an important factor in slowing drug spending growth.<sup>15</sup> Other important factors in the slowdown likely include a continuing decline in the number of “blockbuster” drugs that have been brought to market in recent years and a number of recent and important drug patent expirations (most notably for the drug Prozac).<sup>16</sup>

“For the second year in a row, the rate of increase in drug spending slowed compared with the previous year.”

■ **Spending on physician services.**

Spending on physician services increased 6.7 percent in 2001, which was 0.4 percentage points higher than the 2000 increase. Like spending on hospital services, spending on physician services has been trending upward since the mid-1990s, but at a much slower pace. The 2001 increase in spending on physician services accounted for about 28 percent of the growth in overall spending.

Breaking the trend in spending on physician

services into price and quantity components reveals that both components have contributed to physician spending growth. Over the three-year period 1998–2001, spending on physician services grew by an average annual rate of 6 percent.

During this period the

price of physician services (that is, payment rates) grew by an average annual rate of 1.7 percent, and quantity factors, by 4.2 percent. In contrast to the hospital sector, however, neither physician prices nor use of physician services has exhibited a clear change in trend.

■ **Early evidence for 2002.** Although total spending per capita grew at a double-digit rate in 2001, this may prove to be a peak in the cost trend. Through the first six months of 2002 (compared with the same months in 2001), the increase in total spending per capita, while still high, slowed to 8.8 percent. This reflects a slowdown in the trends for all four spending components.

Two potential mechanisms may explain this slowing of cost trends. One, which is examined later in this paper, is a sharp increase in cost sharing for employer coverage plans in 2002 over 2001. Increased cost sharing slows the rate of growth in use of services. A second potential mechanism is the completion of the adjustment to more loosely managed care. If the retreat from tightly managed care has in fact been responsible for an important portion of higher usage trends, then completion of this transition will lead to a return to more moderate trends in the longer term.

■ **Role of aging.** Many people assert that the aging of the U.S. population, largely a result of the baby-boom generation, is a major driver of health care cost growth for people under age sixty-five. However, two of the authors (Strunk and Ginsburg) have analyzed this and found that population aging has less impact than is popularly believed.<sup>17</sup> This analysis estimated that aging of the population under age sixty-five contributed about 0.7 percentage points to the cost trend in 2001. Viewed in relation to the 2001 overall cost trend of 10 percent, the impact of population aging is small.

### Payroll Trends For Hospitals

Data on payroll costs from the BLS (which, unlike the Milliman HCI, reflect services for patients covered by all payers, including Medicare) illustrate that hospitals are facing large increases in their most important input cost factor (Exhibit 4). Hospitals' payroll costs grew by 8.6 percent in 2001—more than double the increase in the previous year.

Hospital workers' average hourly wages rose substantially and were a major factor behind the steep acceleration in the hospital payroll cost trend. In 2001 these wages grew by 6.1 percent—nearly double the annual rate of increase in 2000 and much higher than growth in wages for all industries combined. In contrast, the wage trend changed little from 1997 to 2000.

The surge in hospital wage rates is likely attributable to the severe labor shortage—particularly of nurses—that has plagued the hospital industry for a number of years.<sup>18</sup> Hospitals have been forced to offer much higher wages to attract nurses and other skilled personnel. The magnitude of the increase likely exceeded what hospitals expected when they signed contracts with health plans for payment rates in 2001. As a result, hospitals will likely seek even larger rate increases in 2002 to cover sharply higher wage rates.

The trend in hospital workers' total number of hours worked also accelerated in 2001. In particular, total hours worked increased 2.4

**EXHIBIT 4**  
**Annual Percentage Change in Hospital Payroll Costs, Hours Worked, And Underlying Wage Rates, 1991-2002**

Year	Payroll <sup>a</sup>	Total hours worked <sup>b</sup>	Average hourly wage	
			Hospitals	All industries
1991	8.2%	2.1%	6.0%	3.1%
1992	6.4	2.2	4.2	2.4
1993	3.4	0.1	3.3	2.5
1994	1.2	-1.5	2.7	2.7
1995	2.4	-1.0	3.4	2.8
1996	2.5	-0.3	2.8	3.4
1997	4.2	1.9	2.3	3.9
1998	4.1	1.2	2.9	4.1
1999	2.6	-0.6	3.2	3.6
2000	3.7	0.4	3.3	3.9
2001	8.6	2.4	6.1	4.1
2002 <sup>c</sup>	7.9	2.4	5.3	3.4

**SOURCE:** U.S. Department of Labor, Bureau of Labor Statistics, Employment, Hours, and Earnings series (data accessed 9 August 2002).

**NOTE:** Data are calculated on a per capita basis.

<sup>a</sup> Product of total hours worked and average hourly hospital wage.

<sup>b</sup> Product of total production workers (excludes executives and managers) and average hours per week of production workers.

<sup>c</sup> Data through June 2002 compared with corresponding months in 2001.

percent compared with 0.4 percent in 2000. This surge in hours worked was likely connected to growth in hospital use associated with the retreat from tightly managed care, as discussed in the previous section.

Although the increase in payroll costs in 2001 was very large, it may actually understate the true increase. The BLS data do not reflect the impact of hospitals' increased contracting for temporary nurses or other personnel. From 1996 to 2000 the number of temporary agency nurses working in hospitals rose from about 15,000 (1.2 percent of all registered nurses) to about 26,000 (2 percent).<sup>19</sup> More recent anecdotal evidence suggests that the use of nurses from temporary agencies has increased further.<sup>20</sup>

Early evidence for 2002 suggests that the nursing shortage and other factors may still be exerting pressure on hospital payroll costs. Through the first half of 2002 the trends of both average hourly earnings and hours worked continued as payroll costs grew by another 7.9 percent compared with the same months in 2001.

### Health Insurance Premium Trends

Premiums for employment-based insurance increased 12.7 percent from 2001 to 2002 (Exhibit 5). This was the largest increase in premiums since 1990 and the sixth consecutive year of accelerating premium increases. Small firms (those with fewer than 200 workers) had increases similar to those of large firms (13.2 percent versus 12.5 percent). Since 1998, premiums for different types of plans have increased by remarkably similar amounts, ranging from 39.4 percent for POS plans to 44 percent for HMOs. The retreat from tightly managed care has probably affected HMOs' ability to control costs more than it did other plans.

During the past few years the health insurance underwriting cycle, along with underlying cost trends, has played an important role in premium increases.<sup>21</sup> For a few years insurers have been raising premiums more rapidly than underlying costs have been rising; this is known as "catch-up pricing." Catch-up pricing is one characteristic of the "hard" phase of the underwriting cycle, when insurers focus

**EXHIBIT 5**  
**Annual Percentage Change In Employment-Based Insurance Premiums And Underlying Health Care Spending, 1991-2002**

Year	Premiums		Underlying health care spending
	Large firms <sup>a</sup>	All firms	
1991	11.5%	- <sup>b</sup>	6.9%
1992	10.9	- <sup>b</sup>	6.6
1993	8.0	8.5%	5.0
1994	4.8	- <sup>b</sup>	2.1
1995	2.1	2.3	2.2
1996	0.5	0.8	2.0
1997	2.1	- <sup>b</sup>	3.3
1998	3.3	3.7	5.3
1999	4.1	4.8	7.1
2000	7.5	8.3	7.8
2001	10.2	11.0	10.0
2002	12.5	12.7	8.8 <sup>c</sup>

**SOURCE:** Health care spending data are from the Milliman USA Health Cost Index (HCI), zero deductible. Premiums are from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits for 1999-2002 and from the KPMG Survey of Employer-Sponsored Health Benefits for 1991-1998.

<sup>a</sup> Firms with 200 or more workers.

<sup>b</sup> Survey covered only firms with 200 or more workers in this year.

<sup>c</sup> Data through June 2002, compared with corresponding months in 2001.

on restoring and solidifying their profitability rather than gaining market share.

It appears that the health insurance industry continues to be in the hard phase of the underwriting cycle. Second-quarter 2002 earnings reports from managed care organizations indicate that profits continue to rise at rates exceeding analysts' estimates.<sup>22</sup> Such strong profitability reflects insurers' continuing ability to raise prices more rapidly than their costs are rising. In addition, there is little evidence that insurers are entering new markets. The absence of entry into new markets is another characteristic of the hard phase of the underwriting cycle, whereas active entry would signal a turn toward the "soft" phase of the cycle, when insurers engage in fierce price competition to increase membership.

**"While employers increased cost-sharing amounts, they did not change the proportion of the total premium that employees are required to pay."**

### Implications For Consumers

To control rising health insurance premium expenses, many employers "bought down" the price of health insurance in 2002 by reducing benefits and increasing patient cost-sharing requirements.<sup>23</sup> According to calculations performed at our request by John Bertko, vice-president and chief actuary of Humana, Inc., using data on employee cost-sharing requirements from the Kaiser/HRET employer survey, benefit buy-down in 2002 was 2-3 percent.<sup>24</sup> Therefore, the increase in the cost of health insurance for employers and employees was actually in the area of 15 percent. Bertko reported that his informal discussions with other industry actuaries indicate that this buy-down was notably larger than it was in 2001.

Changing economic conditions made buy-downs possible. Between 1996 and 2001 a tight labor market had insulated employees from rising health insurance premiums. The economy fell into recession during the spring of 2001, however, and the unemployment rate rose from 4.1 percent to 6.0 percent in April 2002. With looser labor markets and lower

profits, employers became more aggressive in reducing the richness of their health benefit plans.

The large benefit buy-down in 2002 was driven by two cost-sharing changes in particular: (1) a large increase in in-network PPO deductibles, and (2) increases in drug copayment amounts. From 2001 to 2002 the average in-network deductible among PPO plans increased from \$201 to \$276, or about 37 percent. More employers used tiered drug copayments,

and the average copayment requirement for a brand-name drug with a generic substitute rose from \$20 to \$26. Many other forms of employee cost sharing, such as provider copayments and co-insurance, rose as well, but the effect of each was much less important than

the two discussed above.<sup>25</sup>

While employers increased cost-sharing amounts to control rising premiums, they did not change the proportion of the total premium that employees are required to pay. In both 2001 and 2002 employees paid about 15.5 percent of the cost of single coverage and 27.3 percent of the cost of family coverage. More importantly, these figures remained well below the peak of employee contributions in 1993, when employees contributed 20 percent and 32 percent of single and family coverage, respectively.

### Outlook For The Future

The most recent trends in private health care costs provide new and more concrete evidence that costs are back to where they were before managed care began to dominate the health insurance landscape. In retrospect, one of the most important effects that the managed care revolution had on health care costs was its success in slowing the growth in hospital spending. Managed care did this by getting providers to accept discounted payment rates, reducing admission rates and lengths-of-stay, and controlling growth in the rate at which

certain outpatient procedures were performed. It is clear, however, that managed care's ability to constrain payment rates for and use of hospital services has diminished. Meanwhile, hospital wages are rising, presumably to address shortages of nurses and other skilled workers, and hospitals' prices will likely reflect these increases.

There appear to be few innovative approaches to cost containment being discussed to take the place of the managed care techniques that are being abandoned. Some now single out disease management programs as an innovative new way to control costs, but little evidence of the impact of these programs exists. Moreover, there is little information about what proportion of people who could benefit from these programs are actually enrolled in them, nor is it clear the extent to which disease management principles can be applied to other diseases beyond the few now targeted by these programs, such as asthma, diabetes, and heart disease.

Nevertheless, developments are afoot that make it unlikely that cost trends will accelerate further, if at all. Lacking a new silver bullet to control costs, health plans and employers across the country are returning to familiar territory. They are now moving to shift a greater portion of the health care bill to patients and to create more powerful and transparent incentives that will influence where, with whom, and how often patients obtain health care. This movement is characterized by both basic increases in deductibles and copayments and more sophisticated innovations such as tiered provider networks and "consumer-driven" health plans.<sup>26</sup> Indeed, the increased cost sharing introduced for 2002 could explain almost half of the reduction in the trend in health spending in the first half of that year.<sup>27</sup>

There are other reasons to believe that the early 2002 slowdown in cost trends could continue. One reason—the completion of the transition to more loosely managed care—was discussed earlier. Also, the recent slowdown of the U.S. economy will surely slow the rate of growth in health care costs, albeit with a sub-

stantial lag. Reflecting these and other factors, the CMS recently forecast a slowdown in private personal health care spending growth starting in 2003.<sup>28</sup>

If health care cost trends continue to slow, premium trends will eventually reverse course as well. The increase in health insurers' profitability can go only so far before the underwriting cycle turns to its soft phase and insurers become more aggressive in attempting to expand their market share. We have not yet, however, seen many signs of insurers' shifting their strategic focus toward growing market share, entering new markets, and engaging in fierce price competition to attract new membership, so we would not expect to see much moderation in premium growth until the 2004 plan year.

Rapid growth in costs and premiums will make it difficult for the nation to continue the modest gains in insurance coverage achieved during 1999 and 2000. Research has shown that when health care spending exceeds growth in income, more people lack health insurance coverage.<sup>29</sup> Indeed, recent trends in spending are likely to be a powerful force against efforts to expand coverage.

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## NOTES

1. B.C. Strunk, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs," 26 September 2001, [www.healthaffairs.org/WebExclusives/Strunk\\_Web\\_Excl\\_92601.htm](http://www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_92601.htm) (19 August 2002).
2. See, for example, R. Abelson, "Hard Decisions for Employers as Costs Soar in Health Care," *New York Times*, 18 April 2002.
3. Deloitte and Touche and International Society of Certified Employee Benefit Specialists (ISCEBS), "Deloitte and Touche and ISCEBS Announce Results of Annual Employee Benefit Survey," Press Release, 20 January 2002, [www.deloitte.com/vc/0,1029,sid=2283&cid=3633,00.html](http://www.deloitte.com/vc/0,1029,sid=2283&cid=3633,00.html) (20 May 2002).
4. According to a national survey conducted by Public Opinion Strategies and Greenberg Quinlan Rosner Research, Inc. for National Public Radio. See National Public Radio, "Poll Could Be a Warning to Republicans," 20 May 2002, [www.npr.org/news/specials/polls/may20/index.html](http://www.npr.org/news/specials/polls/may20/index.html) (20 May 2002).
5. Often the terms *cost* and *spending* are used interchangeably. Conceptually, the primary interest is in costs, which reflect the resources devoted to health care that are not available to produce other goods and services. Practically, most available data, including the Milliman HCI, reflect spending, or what is paid for health services by those who purchase them (or received by providers of health services). Costs and spending differ when the payment is greater or less than the resources that go into providing the services.
6. The index that Milliman USA provides to its clients is intended to assist insurers in forecasting their claims payments and comparing them with those of others. It simulates trends in claims for a "standard" private health insurance policy with a \$250 deductible. The trend in such an index would slightly overstate the actual trend in spending because the standard policy would pay for a slightly higher proportion of expenditures each year. To avoid this problem, Milliman USA has provided us with a version of the index that reflects a hypothetical policy with no deductible.
7. The PPI would be vulnerable to picking up changes in length-of-stay if the original patient bill was paid with a case rate or capitation payment, because these methods of reimbursement are not dependent on length-of-stay. However, payments using these methods of reimbursement make up a small proportion of total payments to hospitals, so the impact of changes in length-of-stay on the PPI is probably minimal. For a more detailed discussion of the PPI's methodology, see B. Catron and B. Murphy, "Hospital Price Inflation: What Does the New PPI Tell Us?" *Monthly Labor Review* (July 1996): 24-31.
8. This would be the case for methods of payment that are not based on fee-for-service (FFS), such as per diems, case rates, and capitation. The BLS holds the method of reimbursement constant over time, and these reimbursement types are not dependent on the resources used to care for a patient with a particular diagnosis.
9. For additional discussion of this point, see P.B. Ginsburg and J.D. Pickreign, "Tracking Health Care Costs," *Health Affairs* (Fall 1996): 140-149.
10. B.C. Strunk, K. Devers, and R.H. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief no. 40 (Washington: Center for Studying Health System Change, June 2001).
11. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2002).
12. D.A. Draper et al., "The Changing Face of Managed Care," *Health Affairs* (Jan/Feb 2002): 11-23.
13. R. Hurley et al., "A Longitudinal Perspective on Health Plan-Provider Risk Contracting," *Health Affairs* (July/Aug 2002): 144-153.
14. J. Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs* (Sep/Oct 2002): 143-151.
15. Because the Milliman HCI focuses on aggregate spending per person rather than on costs borne by insurers or employers only, three-tier copayment structures would be expected to affect the growth rate of prescription drug spending only if they induce less use of drugs, switches to cheaper drugs, or lower prices based on purchasers' greater ability to shift demand to preferred drugs. Cost shifting to consumers alone would not be expected to affect the HCI.
16. The number of new pharmaceutical products approved in 2001 was the lowest since 1994. For a more detailed discussion of the effect of this trend and the trend in patent expirations, see F. Teitelbaum et al., *Express Scripts 2001 Drug Trend Report* (St. Louis: Express Scripts, June 2002).
17. B.C. Strunk and P.B. Ginsburg, *Aging Plays Limited Role in Health Care Cost Trends*, Data Bulletin no. 23 (Washington: HSC, September 2002).
18. See U.S. General Accounting Office, *Emerging Nurse Shortages Due to Multiple Factors*, Pub. no. GAO-01-944 (Washington: GAO, 10 July 2001); and GAO, *Adequacy of Pharmacy, Laboratory, and Radiology Workforce Supply Difficult to Determine*, Pub. no. GAO-02-137R (Washington: GAO, 10 October 2001).
19. See E.B. Moses, *The Registered Nurse Population, March 1996: Findings from the National Sample Survey of Registered Nurses* (Washington: Department of Health and Human Services, Health Resources

- and Services Administration, Bureau of Health Professions, Division of Nursing, September 1997), Table 20; and E. Spratley et al., *The Registered Nurse Population, March 2000: Findings from the National Sample Survey of Registered Nurses* (Washington: BHP, Division of Nursing, February 2002), Table 20.
20. See, for example, K. Olsen, "Contract Nurses Boost Expenses," *Vancouver Columbian*, 1 July 2002.
  21. The underwriting cycle is the interdependent pattern of profitability and pricing that has occurred historically in the health insurance industry. When insurers earn underwriting profits (profits before investment income), new insurers enter local markets and set off fierce price competition. This eventually leads to financial losses and the exit of insurers from these local markets. Remaining insurers aim to restore profitability, not by seeking larger market share but by raising premiums.
  22. R.W. Goodman and A.R. Urban, *Managed Care: The Hair of the Bear* (New York: Merrill Lynch, 14 August 2002).
  23. Benefit buy-down is usually accomplished by increasing copayments or coinsurance for physician visits, hospital stays, or prescription drugs; raising deductibles for both in-network and out-of-network care; or paring down or excluding benefits, such as hearing and vision or substance abuse services, from coverage. For more detailed discussions of the nature of benefit buy-down and the magnitude of its effects, see J.C. Robinson, "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design," 20 March 2002, [www.healthaffairs.org/WebExclusives/Robinson\\_Web\\_Excl\\_032002.htm](http://www.healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm) (19 August 2002); and J.S. Lee and L. Tollen, "How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing," 19 June 2002, [www.healthaffairs.org/WebExclusives/Lee\\_Web\\_Excl\\_061902.htm](http://www.healthaffairs.org/WebExclusives/Lee_Web_Excl_061902.htm) (20 August 2002).
  24. John Bertko, vice-president and chief actuary, Humana, Inc., personal communication, 21 June 2002.
  25. *Ibid.*
  26. See, for example, D. Lee, "Hospital Choice Grows Costlier," *Los Angeles Times*, 5 May 2002.
  27. To make this calculation, we used demand elasticities that are also used by the Congressional Budget Office (-0.1 for hospital/physician services and -0.3 for prescription drugs). Mark Miller, assistant director, Congressional Budget Office, personal communication, 20 August 2002. Since increases in both in-network PPO deductibles and prescription drug copayments were the dominant factors in the 2002 cost-sharing increase, we assumed an overall elasticity of -0.2. Coupled with a total buy-down of 2-3 percent, this would imply about a 0.5 percent reduction in utilization.
  28. S. Heffler et al., "Health Spending Projections for 2001-2011: The Latest Outlook," *Health Affairs* (Mar/Apr 2002): 207-218.
  29. R. Kronick and T. Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," *Health Affairs* (Mar/Apr 1999): 30-47.





# Can Defined Contribution Health Insurance Reduce Cost Growth?

by Len M. Nichols, Center for Studying Health System Change,  
and EBRI Fellow

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Issue Brief

- This *Issue Brief* focuses on one key question: Can a widespread shift to defined contribution health plan arrangements (DC health) lower the growth rate of health care costs? The answer to this question is in two parts: (1) What are the root causes of health care cost inflation? (2) What will be the price responsiveness of workers with structured incentives to choose among health plans?
- There is widespread agreement (in the research community) that by far the most important source of cost growth (greater than 50 percent) has been technological advance, such as new surgical techniques, drug therapies, and diagnostic and treatment devices.
- National health expenditure experts are forecasting 7 percent–9 percent annual cost growth in health insurance premiums for the next 10 years. This is especially troubling to employers, who had hoped that tightly managed care had “solved” the cost growth problems of the late 1980s and early 1990s.
- There is evidence that health care cost growth never really declined, but instead was temporarily masked during the transition to managed care. Thus, while utilization management and price discounts represent real efficiencies, they may prove to be more of a “one-time shot” than a fundamental reduction in the rate of cost growth that is driven by the development and adoption of new medical technologies.
- Employment-based insurance pays for only approximately 27 percent of national health care expenditures. While employment-based health insurance can be a leader in developing techniques that may improve efficiencies in the public sector, Medicare and Medicaid purchasing strategies are likely to be more important than employment-based insurance in affecting market-wide rates of technical advance in medical care.
- DC health benefits can be part of a solution that enables workers to choose between health care cost and quality, and thereby enforce a discipline on health plans and providers that has not been present before. But DC health benefits cannot force this choice upon an unwilling work force/patient base; it is likely that Americans would do this, collectively, only if the foregone quality and outcomes are acceptably close, on average, to what could be obtained at higher cost. Whether such a tradeoff is either truly attainable or can be measured with enough precision to be persuasive is the crucial empirical question.

Len M. Nichols, vice president of the Center for Studying Health System Change, and EBRI Fellow, wrote this *Issue Brief* when he was at the Urban Institute, with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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## Introduction

Despite the fact that more individuals than ever are covered today through employment-based health plans, serious policy debate about the future structure and viability of employment-based health insurance has intensified in recent years (U.S. Census, 2000; Holahan and Kim, 2000; Fronstin, 2001b; Salisbury, 1999). Defined contribution (DC) health plan arrangements—characterized broadly as those which shift choice of and responsibility for the details of health insurance arrangements from employers to employees—have recently been the focus of much attention (PriceWaterhouseCoopers, 2000; Fronstin, 2001a, Center for Studying Health System Change, 2001).

Following the growth in popularity of defined contribution *retirement* benefits, some see defined contribution *health* benefits as a promising tool for controlling employers' benefit costs. Defined contribution retirement plans allow employers to exercise more control over most or all of the costs associated with providing retirement benefits to employees. Employers assume all of the investment risks and administrative costs for providing a defined benefit pension, whereas all of the investment risks and all or most of the administrative costs are transferred to workers in a defined contribution retirement plan. In the same way, through defined contribution health plans employers could accelerate the drive toward a more individual-based and "efficient" health care system and gain more control over their contributions to the costs of health care by transferring to employees the authority to control the terms of their own health insurance.

It is clear that the term "DC health" means quite

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different things to different people (Fronstin 2001a). Some have in mind the employer playing the role of sponsoring “managed competition” among the health plans it chooses (such as the federal government does in the Federal Employees Health Benefits Plan), based on a set of defined criteria, including quality. In these cases, the employer contribution is predetermined and uniform across multiple plans so that employees pay more out of their own pocket for more expensive plans. In this version of “DC health,” all plans would still have benefit levels *that are determined by the employer*, but may cost more in total than the employer’s contribution.

For others, “DC health” evokes images of individuals selecting their preferred plan among the range of products available in the non-group market, with a fixed-dollar contribution from their employer, to help defray the costs of health insurance. Still others use the term quite specifically to mean something else.

This report focuses on one key question: Can a widespread shift to defined contribution health plan arrangements lower the growth rate of health care costs? In order to answer this question, two other questions must be answered first: (1) What are the root causes of health care cost inflation? (2) What will be the price responsiveness of workers with structured incentives to choose among health plans?

The first section of this *Issue Brief* describes recent trends that have intensified employer interest in DC health plans, followed by an explanation of how employers came to embrace managed care and how interest in DC health flows from the subsequent disappointment over managed care. The following section outlines how certain kinds of DC plans could—theoretically—help contain health care cost growth; this section also identifies the necessary conditions, including institutional development, for DC health plan effectiveness. The final section explains the limits on DC plans’ ability to constrain cost growth over time, and the additional research that is needed.

## Recent Trends

Employers continue to be the main source of health insurance for most Americans (Fronstin, 2001b), and currently provide coverage to over 67 percent of those under age 65. This is true for four important reasons: (1) The administrative loads for employment-based group health insurance arrangements are about 25–35 percent lower than the individual insurance market. (2) The employment-based group offers a “natural selection” of people covered for health insurance. Workers and their families are drawn together for a purpose other than health insurance. This minimizes adverse selection for larger employment-based groups. (3) The tax preference for employer premium payments in lieu of cash wages is a substantial subsidy for the employee. (4) Offering employees health insurance allows employers to compete for skilled labor that can obtain health insurance offers from other employers. Indeed, in tight labor markets like the United States has had since about 1995, employers compete for workers so intensely that the majority of the work force would find it difficult to obtain a job offer that did not include health insurance coverage. Thus, it is not surprising that most working Americans (and their families) under age 65 receive health insurance coverage through employment arrangements. In addition to all these efficiencies flowing to workers, employers may gain as well, from fewer lost workdays and higher productivity (Fronstin and Holtmann, 2000). In recent years the percentage of Americans covered by employment-based health insurance coverage has risen (Fronstin, 2001b; Holahan and Kim, 2000) (figure 1). Most recently, “offer rates” (the percentage of workers who are offered insurance by their employer), even among small firms, have been higher than they were in the 1980s and early 1990s (Cooper and Schone, 1997; Gabel et al., 2000, Fronstin, 2002). This

Figure 1  
**NONELDERLY AMERICANS WITH SELECTED SOURCES OF HEALTH INSURANCE COVERAGE, 1987-2000**

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Population	214.4	216.6	218.5	220.6	222.9	225.5	228.0	229.9	231.9	234.0	236.2	238.6	240.7	242.8
Employment-Based Coverage	150.3	151.2	151.7	149.6	149.5	147.8	146.7	148.1	149.7	151.7	153.6	156.7	160.3	163.4
Own name	73.5	74.5	75.1	74.1	74.1	72.7	76.0	76.3	76.9	78.0	78.5	80.2	81.4	83.7
Dependent coverage	76.8	76.7	76.6	75.5	75.4	75.0	70.7	71.9	72.8	73.7	75.1	76.5	78.9	79.7
Individually Purchased	15.0	14.3	15.2	15.1	14.3	15.3	17.5	17.3	16.8	16.8	16.6	16.3	16.6	16.1
Public	28.8	29.1	29.1	32.2	34.8	36.4	38.5	39.4	38.8	37.8	35.3	34.6	34.5	34.3
Medicare	3.1	3.2	3.2	3.5	3.5	4.0	3.7	3.7	4.1	4.6	4.7	4.8	4.9	5.3
Medicaid	18.6	19.1	19.5	22.7	25.2	26.9	29.4	29.1	29.4	28.6	26.4	25.2	25.3	25.3
Tricare/CHAMPVA <sup>a</sup>	8.6	8.2	7.9	7.9	7.9	7.5	7.5	8.7	7.5	6.9	6.6	6.9	6.6	6.2
No Health Insurance	29.5	31.1	31.7	32.9	33.6	35.4	36.4	36.5	37.3	38.3	39.9	40.7	39.0	38.4
							(millions)							
Total Population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Coverage	70.1	69.8	69.4	67.8	67.1	65.5	64.3	64.4	64.6	64.8	65.0	65.7	66.6	67.3
Own name	34.3	34.4	34.4	33.6	33.2	32.2	33.3	33.2	33.2	33.3	33.2	33.6	33.8	34.5
Dependent coverage	35.8	35.4	35.1	34.2	33.8	33.3	31.0	31.3	31.4	31.5	31.8	32.1	32.8	32.8
Individually Purchased	7.0	6.6	7.0	6.8	6.4	6.8	7.7	7.5	7.2	7.2	7.0	6.8	6.9	6.6
Public	13.4	13.4	13.3	14.6	15.6	16.1	16.9	17.1	16.7	16.2	15.0	14.5	14.3	14.1
Medicare	1.5	1.5	1.5	1.6	1.6	1.8	1.6	1.6	1.8	2.0	2.0	2.0	2.0	2.2
Medicaid	8.7	8.8	8.9	10.3	11.3	11.9	12.9	12.7	12.7	12.2	11.2	10.6	10.5	10.4
Tricare/CHAMPVA <sup>a</sup>	4.0	3.8	3.6	3.6	3.5	3.3	3.3	3.8	3.2	2.9	2.8	2.9	2.7	2.5
No Health Insurance	13.7	14.4	14.5	14.9	15.1	15.7	16.0	15.9	16.1	16.4	16.9	17.0	16.2	15.8
							(percentage)							

Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 1988-2001 Supplements.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

<sup>a</sup>TRICARE (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

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expansion has been driven by competition over increasingly scarce labor. It appears that low unemployment has more influence over the extent of employment-based health insurance than the recently countervailing pressure of increasing health care costs. But clearly, frustration with the costs of employment-based insurance combined with the prospects for softening labor markets in conjunction with an economic downturn has piqued interest in more aggressive cost containment measures (Salisbury, 1998; PriceWaterhouseCoopers, 2000; Fronstin, 2001b).

Widely accepted economic theory contends that, at least in the long-term, all health insurance costs are borne by workers. In other words, as “employer-paid” health insurance costs per worker rise, cash wages for workers are reduced relative to what they otherwise would have been. The employer does not, in the long-term, absorb increases in health care costs, but passes them through to the employee.

Received theory notwithstanding, many employers act as if they do bear some costs of health insurance. This may be because, in the absence of perfect information in such a complex market, some employers fear that other employers are more efficient at managing health care costs, and can therefore offer higher wages and comparable benefits. Thus, employers who are unable to manage health care costs fear that they might lose a competitive advantage in their labor and product markets for reasons unrelated to their core business competence. Four trends described below help explain why employers have become interested in different benefit models that may allow them to stabilize *their* costs and to put some distance between them and care decisions made by their employees.

## Return to Rapid Growth in Health Benefit Costs

Health premium cost growth slowed in the mid-1990s, but is rising again at double-digit annual rates for many employers (Hogan, et al., 2000; Strunk et al., 2001).

National health expenditure experts at the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) are forecasting 7–9 percent cost growth in health insurance premiums for the next 10 years (Heffler, et al., 2001). This is especially troubling to employers who had hoped that more tightly managed care, along with forceful bargaining with insurers and service providers, had “solved” the cost growth problems of the late 1980s and early 1990s.

## Rising Complexity of Health Care Purchasing

In the “good old days” of unmanaged fee-for-service health insurance, the employer-employee bargain regarding health insurance was simply about money: how much to reduce wages to finance employer payments, what premium share employers would pay, and what level of co-payments would be required with the chosen insurance plan. Under this financial arrangement, the employee had choice of providers, and by exercising that choice, the worker explicitly selected the desired level of health service quality.

Today, managed care complicates this simple bargain. Under managed care, the employer, or more likely, its insurer (i.e., the managed care organization) selects and negotiates with health care providers directly. Instead of the employee controlling the selection of providers and the expected level of service quality as in the fee-for-service arrangement, now the employer or its insurer selects providers and monitors services rendered through utilization management and selective contracting techniques. The open-ended choice available to workers in the fee-for-service plan no longer exists in the managed care plan, with the result that many workers feel a loss of control over the ultimate point chosen on the inevitable cost-quality tradeoff.

Frustration from this loss of control has made workers willing co-conspirators with health care providers in the backlash against managed care, which has shown itself most dramatically in the various “patient’s

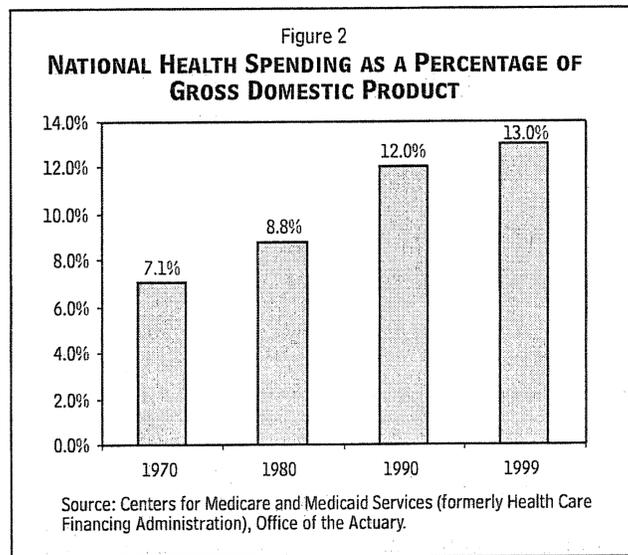
bill of rights” (PBOR) legislation at the state and federal levels. Some employers are tired of arguing with employees about the constraints on choice with

respect to providers and services that are perceived as negative attributes of managed care. This fatigue is due largely to the current difficulty in making persuasive arguments about quality in the present context of restricted provider choices. In the absence of compelling quality measurement and information dissemination techniques, some workers have come to fear that employers and managed care plans choose affordability over quality. This choice implies a new role for employers that some did not seek and do not want to fulfill, for it reaches far beyond the mere financial sponsorship role it had in the old fee-for-service environment. Employer discomfort with the quality-tradeoff role is exacerbated by health plan liability provisions enacted in some states and proposed in PBOR legislation in Congress.

## Declining Employer Share and “Rising Decliners”

Despite the perception that employers are reducing the share of premiums they pay in the face of premium inflation, hard data do not support this conclusion. In fact, recent data suggest that the employer share has been constant or increasing (Fronstin, 2001c). However, even if the employer share of health insurance costs on average have been constant, if premiums rise faster than wages then there has been a *relative* price increase of health insurance compared with other consumer goods—and this relative price change, though small in any one year, can still induce a larger fraction of workers to decline health insurance. This does appear to have occurred over the last 15 years (Cooper and Schone, 1997; Farber and Levy, 2000, Fronstin, 2002).

More workers declining employment-based health insurance even in the face of rising health care



costs implies that something fundamental may be misunderstood about employer premium-wage tradeoffs. A puzzle for traditional economic theory

on this issue is, why would any worker willingly take a job that offers health insurance and forego wages equal to 75–80 percent of the premium, and then decline that employer’s offer for insurance when the marginal cost of insurance to the worker at that point is so low? Basic research about the employer-employee tradeoff is necessary.<sup>1</sup> The increase in the proportion of workers who decline employment-based health insurance offers is also consistent with the possibility that workers have increased confidence in access to free care (Herring, 2000), as well as confidence in their ability to purchase health insurance in the future when their health care needs might be greater.<sup>2</sup> But the immediate point is that with all the difficulties entailed by employer sponsorship of health insurance, if increasing fractions of workers are declining health insurance when it is offered, why should employers do more than contribute some tax-free, fixed-dollar amount and then get out of workers’ way?

## Patient Protection Backlash and Fears

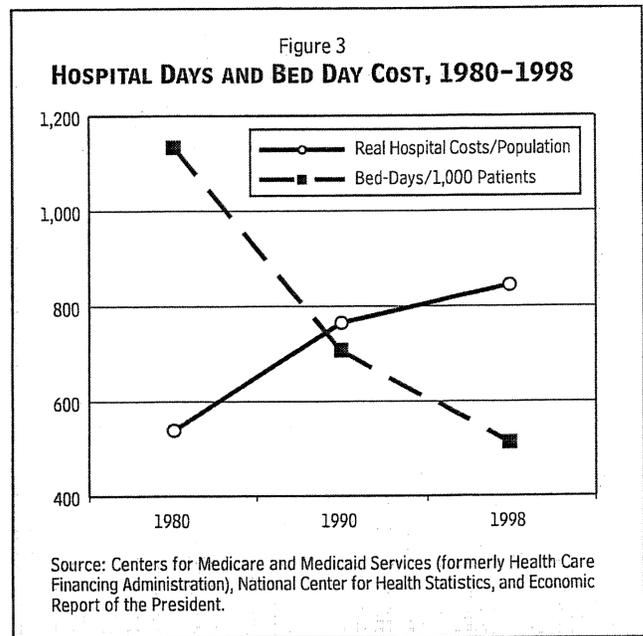
Inevitably, the explosion of managed care restrictions and patient protection acts in state legislatures (Bovbjerg and Marsteller, 1998) and the continued debate at the federal level over health plan and self-insured employer liability for denial of necessary care has frightened a growing number of employers. To control costs driven by the availability of, and demand for, innovative and expensive diagnostics, treatments and devices, and liability for care decisions with adverse outcomes, health-plan sponsors are considering the risks of continuing to determine or select plan benefit provisions for their employees. It may be more affordable and safer to simply define the *amount contributed* toward health insurance—and leave it at that.

## Cost Growth and Interest in DC Health

Health care costs in the United States have grown faster than gross domestic product (GDP), on a per capita basis, since 1929 (Newhouse, 1992; Centers for Medicare and Medicaid Services, 2001) (Figure 2). After years of confusion and fairly sterile debates, the key causes of health care cost growth in the United States are becoming increasingly clear.

### Sources of Cost Growth

Technically, health care cost growth can be broken down into medical price inflation, growth in the volume of services, and growth in the intensity of services. The vast majority of cost growth is accounted for by increasing intensity (Figure 3). Bed days per thousand persons have fallen by more than half since 1980, but aggregate real hospital costs per person have risen in the same time period by almost 60 percent. Thus, more intensive services per bed day are clearly being delivered to hospital patients over time. While this basic point about the importance of health service intensity is true, the breakdown of cost growth in this way is overly simplistic, since the measurement of medical price inflation is flawed by its failure to account for productivity increases (Newhouse, 1992; Cutler and Berndt, 2001). Interest in the causes of health care cost growth has intensified as the share of U.S. gross domestic product (GDP) claimed by health care has grown from 5 percent to more than 13 percent in the last 40 years (Newhouse, 1992; Cutler, 1995; Chernew et al., 1998; Smith et al., 2000; Mohr et al., 2001; Technical Review Panel for the Medicare Trustees Reports, 2000). Each of these recent reports has



examined hypotheses and data about alternative sources of cost growth over the long term—the aging of the population, the spread of ever more comprehensive insurance, the growth in disposable income, medical price inflation (properly measured), the rise of defensive medicine, and the adoption and diffusion of new medical technologies of diagnosis and treatment. There is widespread agreement that by far the most important source of cost growth (greater than 50 percent) has been technological advance (Figure 4). This advance spans new surgical techniques, new drug therapies, and new diagnostic and treatment devices. Other countries have had similar cost growth experience despite having very different health delivery and financing systems (Figure 5). This is consistent with technological improvement as the underlying cause of medical cost inflation—the one feature all health systems have in common.

Technology drives cost growth so much because

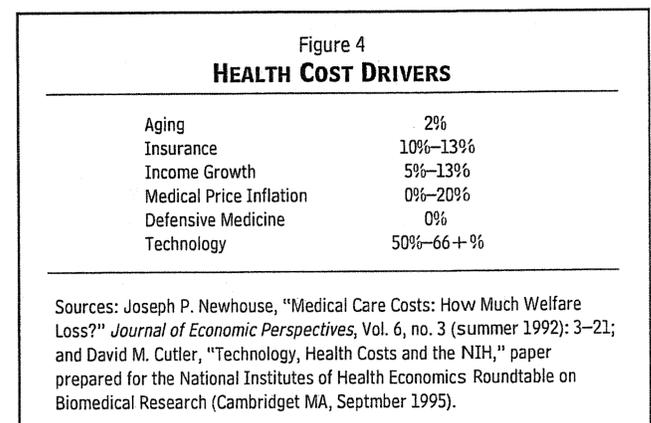
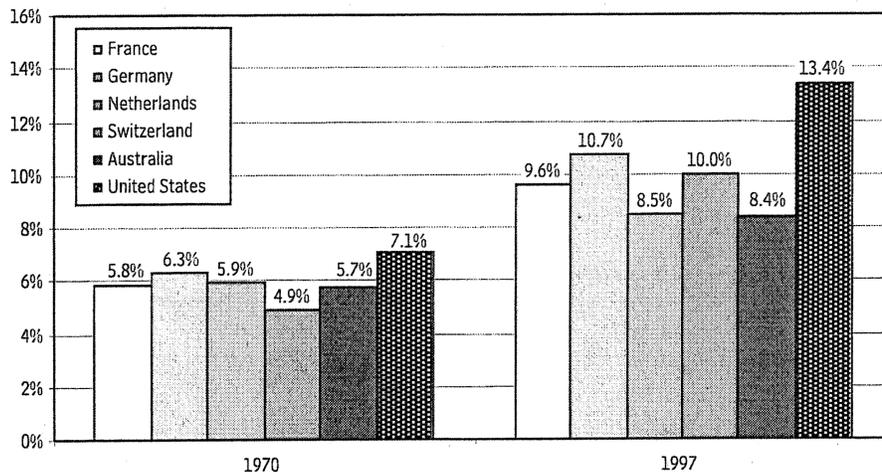


Figure 5  
**WORLDWIDE HEALTH CARE COST GROWTH**  
**(NATIONAL HEALTH EXPENSE AS A PERCENTAGE OF GDP)**



Source: National Center for Health Statistics.

it affects both volume and intensity. Providers must charge higher prices for more complex and resource-intensive technologies (e.g., bypass surgery). At the same time, less invasive technological advances that lower price may nonetheless be shared with many more patients and thus increase costs overall (e.g., laparoscopic cholecystectomy). Perhaps one example sums up the role of technological diffusion: in 1984, 11 percent of Medicare patients with a heart attack received some kind of surgical treatment; by 1994, 47 percent of Medicare patients with a heart attack received a surgical intervention (Cutler, McClellan, et al., 1998, 2000). Many of these patients were clearly helped by the spread of effective surgical techniques, but almost 60 percent more is now being spent per case, in real terms. In addition to higher costs per service for a given health problem, the application of new technology often necessitates more both “upstream” and “downstream” complementary service use. For example, before either angioplasty or bypass surgery can be performed, heart patients must receive cardiac catheterization. And naturally post-acute rehabilitation services for surgical patients are greater than for those who are being managed medically. Finally, and perhaps most importantly, much of new technology improves outcomes and prolongs and/or improves the quality of life. At the same time, prolonged life increases the likelihood that other diseases will manifest themselves, and thus total health care costs per capita rise still more.

New technology increases diagnostic and treatment options and may improve outcomes in many cases.

Thus, some technological advance is clearly worth the extra cost. Indeed, one recent analysis concluded that in the aggregate, medical technology research is very likely to generate benefits that far exceed the costs of that research (Murphy and Topel, 2000). Given the generally enhanced chance of a better clinical outcome, the individualistic impulse to try heroically against the odds (and sometimes the better judgment of disinterested experts) intensifies the demand for use of the latest diagnostic, surgical, and pharmaceutical applications. Inculcating a social ethic of balance—so that private and public third-party payers finance cost-effective efforts, but no more than that—may be particularly difficult in the American context. Denying services with low probabilities of success may require a higher burden of proof in the U.S. than in northern Europe or Japan, and sufficient proof has proven to be largely elusive in the American context. Tempering the demand for technological advancement is key to long-run cost containment, a point elaborated on later in this report.

## *Cost Growth and DC Health*

The uninterrupted historical fact of U.S. health care cost growth—from 5.1 percent of GDP in 1960 to 13.2 percent in 2000 without a commensurate rise in population health status measures—demonstrated to most policy

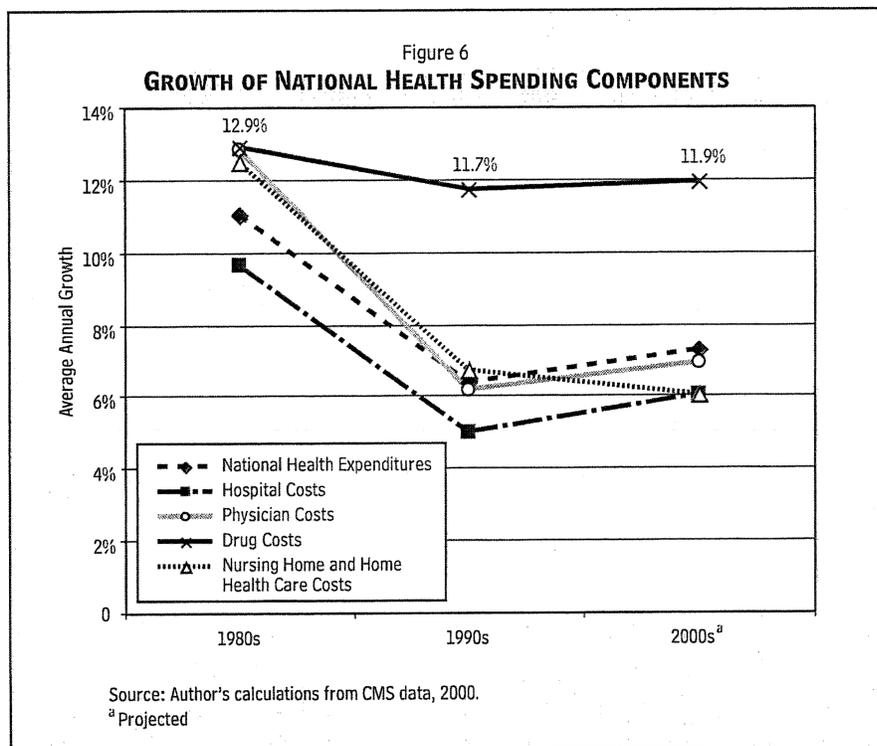
makers that fee-for-service delivery and indemnity insurance systems were incapable of balancing costs and the clinical value of medical advances.

Extensive

research has shown that the primary failures of unfettered fee-for-service coverage were poor incentives for providers to control costs and inadequate information systems and bargaining power on the part of most insurers and patients. In the face of these failures, managed care came to be seen as a way to prevent providers from “over-supplying” health care while preserving and even enhancing health care quality as well. The responsiveness of patients to out-of-pocket health care costs, while present, was never great enough (elasticities are in the  $-0.2$  to  $-0.6$  range) (Newhouse, 1993) to be able to curtail demand for services as effectively as managed care could by changing the incentives on the supply side.

But managed care fell from grace despite reducing costs when its utilization management and selective contracting techniques managed to infuriate enough patients and health care providers to form a powerful coalition against a common enemy. The fact that high rates of cost growth are now coming back, despite managed care’s spread in recent years, makes many people seriously question whether managed care is such a bargain after all. If it infuriates providers and annoys patients and still cannot contain costs, what is its value?

There are many answers to this question, most of which are beyond the scope of this paper, but two salient points are worth noting. First, Figure 6 shows that national health care cost growth slowed consider-



ably in the 1990s (precisely when managed care was spreading rapidly among U.S. employers), so there was some recent success against cost growth. Perhaps managed care

did what was asked of it, but patients and providers did not like the methods employed—and now that cost growth has returned, managed care has few steadfast friends and many highly motivated (and some self-interested) enemies.

The second and more subtle point is that, perhaps, health care cost growth never really declined, but instead “hid” for a while. After all, managed care mostly reduced hospital admissions and provider prices; once admissions per enrollee were down to the minimum, and provider prices were as low as local conditions would allow, managed care plans were subject to the same cost pressures from technology adoption as any other type of health plan. Consider the following illustrative example: Suppose an employer offers two health plans and pays 90 percent of the premium regardless of which one the employee selects. One plan has a premium 10 percent higher than the other. The high-cost plan might not restrict providers, but both plans have the same underlying growth rate of health costs—say 10 percent per year—since they have identical technology adoption strategies. Suppose that each of the last 10 years, half the employees chose each plan, but that this year 25 percent of the employees switch from the high-cost plan to the low-cost plan due to changes in the employer’s premium contribution policy. The average premium reduction from the employee shift to the lower-cost plan partially offsets the cost inflation in the low-cost plan. Thus, the measured “per worker” premium

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inflation would be only about 7.5 percent—not the 10 percent that is the fundamental underlying growth rate in both plans by construction in the example.

Now relax the conditions of the example, and imagine similar plan-switching occurring not immediately but over a few years. During this time, the inpatient utilization reductions and price discounts of the “first generation” of managed care also take some time to reach their zenith. There can then be a series of years wherein the measured growth in per enrollee cost is less than 10 percent, even though all plans have the same underlying growth rate. But ultimately, when all employees are in the managed care plan, managed care cost containment over time will not be able to conceal the real growth of health care costs. Thus, while utilization management and price discounts represent real efficiencies, they may prove to be more of a “one-time shot” than a fundamental reduction in the rate of cost growth that is driven by the development and adoption of new medical technologies.

The major point here is that employers who had come to rely on managed care are having second thoughts, and so the search is underway for another device that will allow employers to contain *their* costs, whether or not it controls *total* health care costs. Thus, DC health plan arrangements, at least in some forms, appear to hold considerable promise, and they are now getting a serious look (Fronstin, 2001a; Center for Studying Health System Change, 2001).

## How DC Health Plans Could Reduce Cost Growth

As has been pointed out, DC health benefits take many different forms and indeed the term means different things to different people (Fronstin 2001a). But a unifying theme behind the concept is to shift responsibility and choice for specific health care and health insurance arrangements from the employer to the employee. The theory of “managed competition” (Enthoven, 1978, 1988, 1993; Enthoven and Kronick, 1989) articulates a work-

able vision of health plan competition that would promote efficiency and that could be implemented by employers and/or governments as purchasers. At its core, managed competition has a DC element, in that employers and other plan sponsors are expected to set their contribution limits in such a way that employees would be fully responsible for any higher premiums above the benchmark plan determined by the purchaser. Surveys report that while examples of the managed competition model are alive and well (e.g., Meyer et al., 1997; Maxwell et al., 1998), it has not been widely adopted despite its considerable promise (Marquis and Long, 1999). As a result, the empirical economic literature of health plan choice has been limited to somewhat special cases. Furthermore, it has not been able to test alternative models of DC health benefits against each other, but the literature has focused on the conditions under which price sensitivity of employees is enhanced, and has tried to estimate just how price-sensitive workers can be (Feldman et al., 1989; Short and Taylor, 1989; Feldstein and Buchmeuller, 1996; Royalty and Solomon, 1998; Cutler and Reber, 1998; Nichols et al., 1998).

The consensus answer is that workers choosing health plans can become quite price sensitive, indeed. Whereas in general the demand for health insurance is considered to be fairly price-*inelastic*—most estimates are in the  $-0.4$  to  $-0.6$  range (Gleid, 2001)—plan switching elasticities are much higher, with a consensus range between  $-2.0$  and  $-5.0$ . Thus, whereas a 10 percent premium increase might induce only a 5 percent reduction in the probability of purchasing health insurance at all, a 10 percent premium differential—or differential growth rate over time—might engender as much as a 50 percent reduction in the market share of the high-cost plan. This price sensitivity is the key to any potential success DC health benefits may have in lowering cost growth over time.

The natural experiments studied in the literature largely relate to specific settings—typically, university faculty behavior after a new employer contribution policy is implemented—although Feldman et al.,

(1989), and Nichols et al. (1998), looked at private-sector enrollees, and Short and Taylor (1989), used a nationally representative sample of workers. Given the specialized nature of the populations and settings, it is persuasive to find such consistency among the elasticity estimates, with all studies finding a degree of price responsiveness considerably larger than the take-up or non-group purchase elasticities generally associated with the decision to purchase health insurance at all. Nichols et al. (1998) also included a specific test for whether price sensitivity was enhanced by the presence of a “fixed-dollar” or defined contribution rule—controlling for the level of the employer contribution—and generally found this to be the case.

The following example illustrates the types of effects on cost growth that DC health benefit arrangements could have under the best conditions. Parameters are drawn from the economic literature.

Suppose the plan-switching elasticity with DC health benefits is  $-3.0$ , but  $-0.5$  without a DC health structure. Let there be two plans, one unfettered fee-for-service and inefficient, with a 10 percent higher premium than the more efficient managed care plan; however, the fee-for-service plan has been around a long time and has every local provider in its “network” and therefore has an 80 percent market share due to inertia. Furthermore, assume the inefficient plan has a cost growth rate of 6 percent, while the efficient plan grows at only 3 percent per year because it only pays for new technology that is proven to be cost-effective. Given these premium and growth rate differentials, and the assumed plan switching elasticities, Figure 7 shows how the inefficient plan’s market share and employer-wide premium cost growth will change if a defined contribution plan is in effect versus if it is not.

The example merely shows that even under the

Figure 7  
**EXAMPLE OF DC HEALTH EFFECT ON MARKET SHARE AND PREMIUM GROWTH RATE**

Year	Market Share of Inefficient Plan		Per Enrollee Premium Growth Rate	
	If no defined contribution plan	With defined contribution	If no defined contribution plan	With defined contribution
0	80.0%	80.0%	5.4%	5.4%
1	74.8	48.8	5.2	4.5
2	69.9	29.8	5.1	3.9
3	65.4	18.2	5.0	3.5
4	61.1	11.1	4.8	3.3
5	57.2	6.8	4.7	3.2
6	53.5	4.1	4.6	3.1
7	50.0	2.5	4.5	3.1
8	46.7	1.5	4.4	3.0
9	43.7	0.9	4.3	3.0
10	40.9	0.6	4.2	3.0

Source: Author’s example.

best of conditions, DC health benefits will merely get to the growth rate of the most efficient plan faster, and then only if workers accept the technology/quality package embedded within that more-

conservative approach to medical practice. American workers’ acceptance may or may not be forthcoming in the long run—but in any event, DC health plan price incentives are best considered as necessary but not sufficient conditions for systemwide reductions in health cost growth.

So, despite the slowness with which the principles of managed competition are being implemented nationwide, the research question is not whether workers can be induced to select low-cost health plans, but whether the lowest-cost plan can reduce the diffusion and development of new medical devices and techniques, and thereby lower the rate of cost growth for all plans. The answer is “potentially yes,” but only if lower-tech health care is perceived to be a viable quality health care strategy by patients and a critical mass of providers alike. This will require either: (a) that all plans and delivery systems adopt identical technology strategies; or (b) that patients are willing to trade some technological sophistication for lower costs. This will make it possible for plans that follow a conservative (frugal) technology implementation strategy to compete successfully on price. Of these two preconditions, option (b) seems more likely than (a), at least in the short run, but (b) will work only if plans with lower-tech delivery patterns can prove their outcomes are as good or better than those achieved by other approaches to health care delivery.

The difficulty of proving equal-quality outcomes will be addressed later, but note that the evidence is mixed on whether markets with the highest managed care penetration rates have slower technology adoption rates (Chernew et al., 1998). There is considerable

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evidence that health maintenance organizations (HMOs) and fee-for-service plans tend to adopt specific technologies at similar rates, but studies looking at the health services market as a whole do find lower adoption rates where managed care penetration is higher. There is recent evidence that HMO penetration does indeed lower the rate of cost growth, but not by enough to reduce the share of GDP devoted to health care; i.e., premium growth in the best cases still exceeds the rate of growth in GDP per capita. Plus, the studies reviewed by Chernew et al. have all been conducted in a period of fairly rapid transition to managed care and new technology, and the resulting cost growth estimates may be lower-bound estimates for long-run purposes if the gains turn out to be due to “one shot” factors that were described above.

Finally, this entire discussion has presumed a set of preconditions is in place—a kind of DC health plan infrastructure—in order to reach maximum effectiveness. First, an effective risk-adjustment mechanism will have to be implemented to negate the major consequences of risk selection among plans. Some organizations have had reasonable (though not perfect) success with this, but a standard benefit package is clearly a prerequisite for doing this well. As a result, employers—or other health plan sponsors, be they employer groups or agents of employer groups—will need to define such a package for bidding purposes (this does not mean that insurers cannot offer supplements to the standard package and charge separately for them, just that they cannot offer less generous benefits than the standard package). Next, the purpose of employee choice is to provide valid plan comparison information to workers and their families; therefore, some entity—again, the employer or a sub-contractor—will need to negotiate with and select plans, and then collect and disseminate plan performance information on a variety of agreed-upon measures. This is an “active sponsors” role, and these functions must be performed in any DC health plan context—whether employment-based or not (see Fronstin, 2001a, for the range of options)—if fully

empowered individual choice is to be channeled to produce more efficient health plan outcomes. For this to ultimately be effective in reducing cost growth, technology developers are going to have to see that they can profit from cost-saving as well as from cost-enhancing technologies, and redirect their investments accordingly.

## *Limits to Affecting Cost Growth*

Even under the best of circumstances, there are serious limits on the ability of employment-based DC health benefit arrangements to actually affect overall health care cost growth. First, employment-based insurance pays only for about 27 percent of national health care expenditures (NHE).<sup>3</sup> The share of health care services paid for by the largest public programs combined, Medicare (20 percent) and Medicaid (17 percent), is larger than that purchased by employment-based insurance. These public programs may be even more important for technology development, adoption, and diffusion than their overall share might imply, since Medicare plus Medicaid account for 48 percent of all hospital spending. So while employment-based health insurance can be a leader in developing techniques that may improve efficiencies in the public sector, Medicare and Medicaid purchasing strategies are likely to be more important than employment-based insurance in affecting marketwide rates of technical advance in medical care. Another limit on the ultimate scope of DC health plans is the lack of health plan choice for many workers. Slightly more than half of all workers (57 percent) are offered a choice of health plans by their employer (Medical Expenditure Panel Survey, 1998). Without a choice of plans, there is no context for a DC health structure incentive. Thus, only about 15 percent of national health expenditures could be affected by DC health plan structures at the present time.

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And of those employers that do offer a choice of health plans, only about 27 percent currently use some type of fixed contribution scheme that is consistent with DC health benefits theory (Fronstin, 2001a). Thus today, on net, only about 4 percent of national health expenditures are potentially under the sway of DC health benefit techniques. This is obviously not enough to make a big difference in overall health care system costs or technology adoption rates.

More organized and consumer-choice-oriented purchasing by Medicare and Medicaid—i.e., fundamental public-sector health insurance purchasing reform—is possible, and could certainly expand the range of national health expenditures that DC health benefits could influence, thereby improving the likelihood of changing the cost-benefit calculus of technology developers within the health sector. But the fundamental limitation on the ability of DC health benefits arrangements to reduce technology adoption and health care cost growth is and will remain the acceptance by workers, families, and patients. Will cost-effective styles of health care delivery ever be viewed as “good enough” or of equal or greater quality than more expensive and interventionist systems—especially in the American context of individual rights and extensive third party payments?

Enthoven and Vorhaus (1997) lay out a vision of how this type of health care system could come into being. In its final form, this vision is self-sustaining, since individuals would be choosing the level of technology and health plan options they are willing to pay for. But as McGlynn (1997), Lohr (1997), Gosfield (1997), and the IOM (2000) make clear, implementing anything like this vision will take time and resources, both private and public. Not only must quality measures be developed and improved while data collection and dissemination are institutionalized, but workers, patients, and citizens must all be educated about the nature of the real cost-quality tradeoffs they are facing. And a critical mass of participating workers must come to choose lower-cost plan options. DC health benefits can be part of a solution that enables workers to make these choices—and

thereby enforces a discipline on health plans and providers that has not been present before.

But DC health benefits cannot force this choice upon an unwilling work force/patient base. The most challenging education is to learn the art of self-restraint, but that is the ultimate prerequisite for health care cost-containment in the U.S. context. Given our cultural emphasis on individual freedom, Americans must *choose* a lower health-cost growth trajectory if they are to *experience* one. It is likely that Americans would do this, collectively, only if the foregone quality and outcomes are acceptably close, on average, to what could be obtained at higher cost. Whether such a tradeoff is either truly attainable or can be measured with enough precision to be persuasive is the crucial empirical question. Note there are two steps: First the basic research into quality measurement, followed by the development of an information infrastructure that will usher in an era in which evidence-based medicine is the norm in all settings. The cost of not taking these two steps, which would depend heavily on federal funding to be credible, may be to consign the nation to spending 25 percent of its annual gross domestic product on health care by 2050. Perhaps that will seem like a bargain then, given the potential for medical and pharmaceutical technology seemingly just around the corner. But perhaps 25 percent of GDP will not seem like such a bargain—and if not, then stronger price incentives and steeper quality tradeoffs are both likely to be part of the future, whether or not Americans are happy about it and fully informed about their implications.

## Endnotes

<sup>1</sup> See papers presented at the Department of Labor, Pension and Welfare Benefits Administration conference, “Why Do Employers Do What They Do?” April 27, 2001,

published in a recent issue of *The International Journal of Health Finance and Economics*, for an example of an emerging basic research paradigm. The Robert Wood Johnson Foundation has also begun a major initiative by creating an Economic Research Initiative on the Uninsured at the University of Michigan.

<sup>2</sup> For competing views about the likelihood of doing this in the non-group market, see Pollitz et al. (2001), and Pauly and Herring (1999).

<sup>3</sup> Private health insurance paid for 33.6 percent of national health care expenditures in 1999 (Centers for Medicare and Medicaid Services, 2001). This includes payments by Medicare supplemental policies as well as by non-group insurers for the non-elderly population. Approximately 14 percent of private health insurance was for Medicare supplemental policies (Cohen, et al., 2000), and approximately 94 percent of nonelderly private insurance enrollment is in group vs. non-group plans (Pauly and Percy, 2000; Chollet, 2000; U.S. Census, 2000). Assuming expenditures are proportional to enrollment, employment-based health insurance then accounts for  $.336 \times .86 \times .94 = 27$  percent of NHE.

## Bibliography

- Buchmeuller, Thoms C., and Paul J. Feldstein. "The Effect of Price on Switching Among Health Plans." *Journal of Health Economics*. Vol. 16, no. 2 (1996): 231-247.
- Centers for Medicare and Medicaid Services (formerly HCFA). *National Health Care Expenditure Projections*. August 14, 2001. [www.hcfa.gov/stats/NHE-Proj/](http://www.hcfa.gov/stats/NHE-Proj/)
- \_\_\_\_\_. *National Health Care Expenditures*. August 14, 2001. [www.hcfa.gov/stats/nhe-oact/](http://www.hcfa.gov/stats/nhe-oact/)
- Center for Studying Health System Change. "Defined Contributions: The Search for a New Vision." *Issue Brief #37* (April 2001). [www.hschange.com/CONTENT/310/](http://www.hschange.com/CONTENT/310/)
- Chernew, Michael E., R.A. Hirth, S.S. Sonnad, R. Ermann, and A.M. Fendrick. "Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence." *Medical Care Research and Review*. Vol. 55, no. 3 (September 1988): 259-288.
- Chollet, Deborah. "Consumers, Insurers, and Market Behavior." *Journal of Health Politics, Policy, and Law*. Vol. 25, no. 1 (February 2000): 27-44.
- Cohen, JW, SR Machlin, SH Zuvekas, MN Stagnitti, JM Thorpe. *Health Care Expenses in the United States, 1996*. Medical Expenditure Panel Survey Research Findings No. 12. Washington, DC: Agency for Healthcare Research and Quality, 2000.
- Congressional Budget Office Cost Estimate. H.R. 3605/S.1890: Patient's Bill of Rights Act of 1998 (July 16, 1998). [www.cbo.gov/showdoc.cfm?index=667&sequence=0&from=8](http://www.cbo.gov/showdoc.cfm?index=667&sequence=0&from=8)
- Cooper, Philip F., and Barbara Steinberg Schone. "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs*. Vol. 16 (November/December 1997): 142-149.
- Cutler, David M. "Technology, Health Costs, and the NIH." Harvard University and the National Bureau of Economic Research. Paper prepared for the National Institutes of Health Economics Roundtable on Biomedical Research. Cambridge, MA, September 1995.
- Cutler, David M., and Ernst R. Berndt, eds. *Medical Care Output and Productivity*. Chicago: University of Chicago Press, 2001.
- Cutler, D., and S. Reber. "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection." *Quarterly Journal of Economics* (May 1998) 433-466.
- Cutler, David M., Mark McClellan, Joseph P. Newhouse, and Dalia Remler. "Are Medical Prices Declining? Evidence from Heart Attack Treatments." *Quarterly Journal of Economics* (November 1998): 991-1024.
- \_\_\_\_\_. "Pricing Heart Attack Treatments." In David M. Cutler and Ernst R. Berndt, eds., *Medical Care Output and Productivity*. Chicago: University of Chicago Press, 2001.
- Enthoven, A. C. "Consumer Choice Health Plan: A National Health Insurance Proposal Based on Regulated Competition in the Private Sector." *New England Journal of Medicine* (23 and 30 March, 1978): 650-658 and 709-720.
- \_\_\_\_\_. *Theory and Practice of Managed Competition in Health Care Finance*. DeVries Lectures. North Holland, 1988.
- \_\_\_\_\_. "The History and Principles of Managed Competition." *Health Affairs*. Vol. 12 (Supplement 1993).
- Enthoven, Alain C., and Carol B. Vorhaus. "A Vision of Quality in Health Care Delivery." *Health Affairs*. Vol. 16, no. 3 (May-June 1997): 44-57.
- Enthoven, A.C., and R. Kronick. "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System to Promote Quality and Economy (5 and 12 January, 1989): 29-37 and 94-101.
- Farber H.S., and H. Levy. "Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?" *Journal of Health Economics*. Vol. 19 (January 2000): 93-119.
- Feldman, Roger, Michael Finch, Bryan Down, and Steven Cassou. "The Demand for Employment-Based Health Insurance Plans." *Journal of Human Resources*. Vol. 24, no. 1 (1989): 115-142.
- Fronstin, Paul. "Defined Contribution Health Benefits." *EBRI Issue Brief* no. 231 (Employee Benefit Research Institute, March 2001a).
- \_\_\_\_\_. "Employment-Based Health Benefits: Trends and Outlook." *EBRI Issue Brief* no. 233 (Employee Benefit Research Institute, May 2001b).
- \_\_\_\_\_. "Is There a Trend Towards More Affordable, Less Comprehensive Health Benefits?" Paper prepared for Connecting Public Policy to Health Benefit Design, a roundtable sponsored by Health

- Affairs and the Kaiser Permanente Institute for Health Policy. San Francisco, CA, September 10–11, 2001c.
- \_\_\_\_\_. "Trends in Health Insurance Coverage: A Look At Early 2001 Data." *Health Affairs*. Vol. 21, no. 1 (January–February 2002): 188–193.
- Fronstin, Paul, and Alphonse G. Holtmann, "Productivity Gains From Employment-Based Health Insurance." In Paul Fronstin, ed., *The Economic Costs of the Uninsured: Implications for Business and Government*. Washington, DC: Employee Benefit Research Institute, 2000.
- Gabel, Jon, Larry Levitt, Jeremy Pickreign, Heidi Whitmore, Erin Holve, Samantha Hawkins, and Nick Miller. "Trends: Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows." *Health Affairs*. Vol. 19, no. 5 (September/October 2000): 144–151.
- Glied, Sherry. "Inside the Sausage Factory: Understanding and Improving Estimates of the Effects of Health Insurance Expansion Proposals Using a Reference Case Approach." Prepared for Robert Wood Johnson Foundation, January 2001.
- Gosfield, Alice. "Who Is Holding Whom Accountable for Quality?" *Health Affairs*. Vol. 16, no. 3 (May–June 1997): 26–40.
- Heffler, Stephen, et al. "Health Spending Growth Up In 1999; Faster Growth Expected In The Future." *Health Affairs*. Vol. 20, no. 2 (March/April 2001): 193–203.
- Herring, Bradley. *Access to Free Care for the Uninsured and Its Effect on Private Health Insurance Coverage*. Ph.D. Dissertation. University of Pennsylvania, 2000.
- Hogan Christopher, Paul B. Ginsburg, Jon R. Gabel. "Tracking Health Care Costs: Inflation is Back." *Health Affairs*. Vol. 19, no. 6 (November/December 2000).
- Holahan, John, and Johnny Kim. "Why Does the Number of Uninsured Continue to Grow?" *Health Affairs*. Vol. 19, no. 4 (July/August 2000): 188–196.
- Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy of Sciences, 2000.
- Lohr, Kathleen N. "How Do We Measure Quality?" *Health Affairs*. Vol. 16, no. 3 (May–June 1997): 22–25.
- Marquis, M. Susan, and Steven H. Long. "Prevalence of Selected Employer Health Insurance Purchasing Strategies in 1997." *Health Affairs*. Vol. 20, no. 4 (July–August 2001): 219–230.
- McGlynn, Elizabeth A. "Six Challenges in Measuring the Quality of Health Care Delivery." *Health Affairs*. Vol. 16, no. 3 (May–June 1997): 7–21.
- Medical Expenditure Panel Survey—Insurance Component Tables, 1998. [www.meps.ahrq.gov/Data\\_Pub/IC\\_TOC.htm](http://www.meps.ahrq.gov/Data_Pub/IC_TOC.htm)
- Meyer, Jack A., Sharon Silow-Carroll, Ingrid A. Tillman, and Lise S. Rybowski. *Employer Coalition Initiatives in Health Care Purchasing, Parts I and II*. Washington, DC: Economic and Social Research Institute, 1997.
- Marsteller, Jill A., and Randall R. Bovbjerg. "Federalism and Patient Protection: Changing Roles for State and Federal Government." Urban Institute. New Federalism Occasional Paper No. 8. August 1999.
- Maxwell, James, Forrest Briscoe, Stephen Davidson, Lisa Eisen, Mark Robbins, Peter Temin, and Cheryl Young. "Managerial Competition in Practice: 'Value Purchasing' by Fourteen Employers." *Health Affairs*. Vol. 17 (May/June 1998): 216–26.
- Mohr, Penny, Curt Mueller, Peter Neumann, Sheila Franco, Meredith Milet, Laurie Silver, and Gail Wilensky. *The Impact of Medical Technology on Future Health Care Costs*. Project Hope, Center for Health Affairs. Prepared for the Health Insurance Association of America and the Blue Cross and Blue Shield Association, February 2001. [www.projecthope.org/CHA/pdf/newtech\\_final.pdf](http://www.projecthope.org/CHA/pdf/newtech_final.pdf)
- Murphy, Kevin, and Robert Topel. "Medical Research: What's It Worth?" *Milken Institute Review* (First Quarter 2000): 23–30.
- Newhouse, Joseph P. "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*. Vol. 6, no. 3 (Summer 1992): 3–21.
- \_\_\_\_\_. *Free for All*. Cambridge, MA: Harvard University Press, 1993.
- Nichols, Len, Richard E. Curtis, Mark Merlis, and Jeanne McGee. *Consumer Choice of Plans, Employer Contribution Policy, and Health Plan Prices*. Final Report for the Robert Wood Johnson Foundation. November 11, 1998.
- Pauly, Mark, and Allison Percy. "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets." *Journal of Health Politics, Policy, and Law*. Vol. 25, no. 1 (February 2000): 9–26.
- Pauly, Mark, and Bradley Herring. *Pooling Health Insurance Risks*. Washington, DC: American Enterprise Institute, 1999.
- Pollitz, Karen, Richard Sorian, and Kathy Thomas. *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* Kaiser Family Foundation Report. June 2001.
- PriceWaterhouseCoopers. *Defined Contribution Healthcare: Is It in Your Future?* Prepared for the Health Insurance Association of America. November 2000.
- Royalty, A.B., and N. Solomon. "Health Plan Choice: Price Elasticities in a Managed Competition Setting." *Journal of Human Resources*. Vol. 34, no. 1 (1998): 1–41.
- Salisbury, Dallas L., ed. *The Future of Medical Benefits*. Washington, DC: Employee Benefit Research Institute, 1998.
- \_\_\_\_\_. *Severing the Link Between Health Insurance and Employment*. Washington, DC: Employee Benefit Research Institute, 1999.
- Short, Pamela Farley, and Amy Taylor. "Premiums, Benefits, and Employee Choice of Health Insurance Options." *Journal of Health Economics*. Vol. 8 (1989): 293–311.
- Smith, Sheila D., Stephen K. Heffler, and Mark S. Freeland. "The Impact of Technological Change on Health Care Cost Increases: An Evaluation of the Literature." Health Care Financing Administration. Mimeo. August 2000.
- Strunk, Bradley C., Paul B. Ginsburg, and Jon R. Gabel. "Tracking Health Care Costs." *Health Affairs*. Web publication exclusive, September 26, 2001 ([www.healthaffairs.org/](http://www.healthaffairs.org/))
- Technical Review Panel for the Medicare Trustees Reports. *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections*. December 2000. [www.hcfa.gov/pubforms/actuary/TechnicalPanel/report.pdf](http://www.hcfa.gov/pubforms/actuary/TechnicalPanel/report.pdf)
- U.S. Census Bureau. "Health Insurance Coverage, 1999." *Current Population Reports*. P60-211 (September 2000). [www.census.gov/prod/2000pubs/p60-211.pdf](http://www.census.gov/prod/2000pubs/p60-211.pdf)



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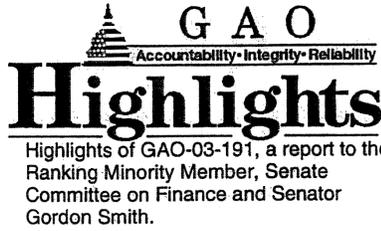


October 2002

# HEALTH INSURANCE

## States' Protections and Programs Benefit Some Unemployed Individuals





# HEALTH INSURANCE

## States' Protections and Programs Benefit Some Unemployed Individuals

### Why GAO Did This Study

In March 2001, the longest economic expansion in United States history ended, and the country entered a recession, signified in part by a significant increase in unemployment. Because rising unemployment can adversely affect individuals' health insurance status, GAO was asked to review the policies of six states with significant recent increases in unemployment to

- (1) identify protections in place that assist unemployed individuals in maintaining or obtaining health insurance coverage and
- (2) assess the extent to which unemployed individuals and their families can rely on Medicaid and the State Children's Health Insurance Program (SCHIP) as a source of health insurance.

### What GAO Found

The six states reviewed had in place a variety of protections, established prior to the economic downturn, to assist unemployed individuals in maintaining health insurance coverage:

- State-mandated continuation coverage, which required small businesses to extend their group health coverage to former employees and their families who choose to pay for it.
- Guaranteed conversion, which required insurers to allow eligible individuals to convert their group coverage to individual health insurance policies.
- Guaranteed issue, which required insurers to offer coverage to those who did not have access to group coverage or public insurance.
- High-risk pools, state-created associations that offered comprehensive health insurance benefits to individuals with acute or chronic health conditions.

However, individuals generally bore the full cost of the premiums, which was usually higher than their premium cost under employer-sponsored plans. For individuals who relied on unemployment benefits as their principal income, premiums absorbed a significant share of the benefit.

**State Protections that Facilitate Access to Health Insurance Coverage for the Unemployed in Six Selected States**

State	State-mandated continuation coverage	State-mandated guaranteed conversion	State-mandated guaranteed issue	High-risk pool
Colorado	✓	✓		✓
New Jersey	✓		✓	
North Carolina	✓	✓		
Ohio	✓	✓	✓	
Oregon	✓			✓
Utah	✓	✓		✓

Source: State information, October 2002.

Unemployed workers were less likely than their children to be eligible for coverage under state Medicaid or SCHIP programs because adult eligibility thresholds were less generous than those for children. Coverage of adults was limited in four of the six states, as average unemployment benefits were at least twice the amount of income allowed for Medicaid eligibility. Colorado, Oregon, and Utah have received recent federal approval to expand Medicaid and SCHIP coverage for certain low-income adults. While New Jersey had a similar expansion of coverage in 2001, it suspended new enrollment for adults in June 2002 due to budgetary constraints.

We incorporated technical comments provided by representatives from states' insurance departments, high-risk pools, and Medicaid programs, as appropriate. We did not obtain comments from the Department of Health and Human Services because we did not assess its role in these programs.

[www.gao.gov/cgi-bin/getrpt?GAO-03-191](http://www.gao.gov/cgi-bin/getrpt?GAO-03-191).

To view the full report, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen (202) 512-7114.

OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

**OVERHEADS**

*Rhonda Medows, M.D.*



## Health Care Cost Increases in Florida

Agency for Health Care  
Administration (AHCA)

## The Agency's Role

- **AHCA is both regulator/policy maker and payer of health care services**
  - Medicaid payments and policies, all provider types
  - Health facility regulation—licensure and survey/certification for 32 facility/provider types, including hospitals, nursing homes, assisted living facilities, home medical equipment companies, home health agencies
  - HMO quality of care regulation, licensure and accreditation
  - **AHCA has no authority to regulate any aspect of Medicare**

## Why Are Health Care Costs Increasing in Florida?

- Population Issues
- Health System Issues

3

## Population Issues

- Florida's Population is:
  - Growing
  - Aging
  - Diversifying
- These three factors will lead to increases in health care costs even if nothing else changes.

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## Why?

- More people automatically means more health services will be needed, used and funded in some way.
- Older people use health care services much more than younger people.
- Immigrant and minority residents are more likely to be uninsured, which means they delay seeking services.
- Delay means deterioration: disease is more expensive than prevention.

5

## U.S. Census Projections for Florida

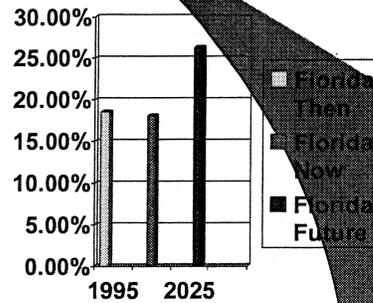
- Between 1995 and 2025, Florida will add **6.5 million** people—a 48.5% increase.
- Florida will move from being the 4<sup>th</sup> most heavily populated state to the 3<sup>rd</sup> most populated—behind California and Texas—but ahead of New York.

6

## Florida Had the Highest Percentage of Older People in 1995.....

...And we will have the highest percentage in 2025

- In 2011, the first baby boomers will turn 65—and chronic illness is more prevalent in older population groups.



7

## Florida's Diversity

- The U.S. Census projects that Florida will gain 1.9 million residents through international migration between 1995 and 2005.
- By 2025, Florida's Non-Hispanic white population will comprise 58.9% of the population --down from 70.7% in 1995.
  - Hispanic increase = 3 million
  - Non-Hispanic white increase = 2.2 million
  - Non-Hispanic African American increase = 1.1 million

8

## Health Systems Issues

- Hospital Revenues and Beds
- Managed Health Care
- HMO Mergers
- Financial Pressures
- Consumer Complaints
- Managing the Uninsured
- Emergency Preparedness

9

## Florida's Hospitals

- Gross revenues for hospitals increased nearly 56% from 1997 to 2001.
- Gross inpatient revenues increased by more than 39% and outpatient revenues increased by more than 52%.
- Florida has approved nearly 1,150 new hospital beds since early 2000.
- Statewide acute care utilization has jumped approximately 5% in just two years.

10

## Managed Care in Florida

- Medicaid enrollment increased from 415,000 in 1998 to 654,000 in 2002
- Commercial enrollment decreased from 3.7 million in 1998 to 3.1 million in 2002
- Medicaid enrollment decreased from 777,000 in 1998 to 654,000 in 2002, with a significant negative impact on the elderly

11

## Financial Pressures on HMOs

- While some HMOs are showing signs of recovery, several still show significant losses for the period January through September 2002. Out of 29 HMOs with certificates of authority, 11 showed losses.
- Net income for all 30 HMOs totaled \$88,262,938 for the period January 1, 2002 through September 30, 2002.

12

## Recent HMO Mergers

- Increasingly, HMOs are merging. Following the known consolidations, there will be 25 commercial HMOs (down from 30) and 11 Medicaid HMOs (down from 14).

13

## Changes in Product Lines

- Several HMOs have left or are leaving the commercial and Medicare markets.
- Neither AHCA nor DOI can require HMOs to remain in the market; that is strictly a private business decision.
- When HMOs leave the Medicare market, the elderly generally lose their drug benefit package and incur higher out of pocket prescription expenses.

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## Relationship Between HMOs and Their Providers

- HMOs must rely on the willingness of health care providers to contract with them to ensure adequate networks.
- Refusal of hospitals and physician groups to contract with some HMOs has caused access problems.
- Reduced federal payment to hospitals affects the ability of hospitals to offer discounted rates to HMOs.

15

## Addressing Consumer Complaints

- The Statewide Provider and Subscriber Assistance Panel (SPSAP) provides a forum for resolving consumer dissatisfaction with HMO decisions.
- Medicaid and commercial HMO members unhappy with the outcomes of their HMO grievances can bring their concerns to SPSAP.
- Medicare consumers must address their grievances through the federal Medicare program.

16

## Addressing Rising Premium and Co-payment Costs

- Cost containment measures in the HMO industry include reducing mandated benefits, raising deductibles and co-payments and controlling utilization of services.

17

## Florida's Uninsured

- Uninsurance rates, after an initial decline from 18% of Floridians in 1999 to 17.3 % percent in 2000, rose again in 2001, to 17.5 percent of Floridians (2,856,000 people, per U.S. Census Data)
- Uninsured health care is a burden borne by all Floridians--regardless of original payer source--through taxes and rising health care costs.

18

## Addressing Florida's Problem of the Uninsured

- The 2002 Legislature passed the Health Flex Plan, a pilot program covering 22 Florida counties to provide access to health insurance for the working poor.
- Legislative intent is to expand health options for low income uninsured by encouraging health insurers, HMOs, and provider sponsored organizations to develop alternatives to traditional insurance that emphasize coverage for basic and preventive care.

19

## Emergency Preparedness

- Post 9/11, emergency preparedness has become a major concern and will create increasingly large cost issues as systems are implemented to handle potential crises.
- We have only just begun to anticipate/investigate the fiscal impact of emergency preparedness on our health care systems.

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OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

**OVERHEADS**

*Rich Robleto, M.B.A., C.L.U., F.L.M.I.*



Florida Health Care Summit

## Health Care Cost Pressures and Financing Fundamentals

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Office of Insurance Regulation  
January 9-10, 2003

Presented by Rich Robleto, Chief  
Bureau of Life and Health Forms and Rates

### Market Overview

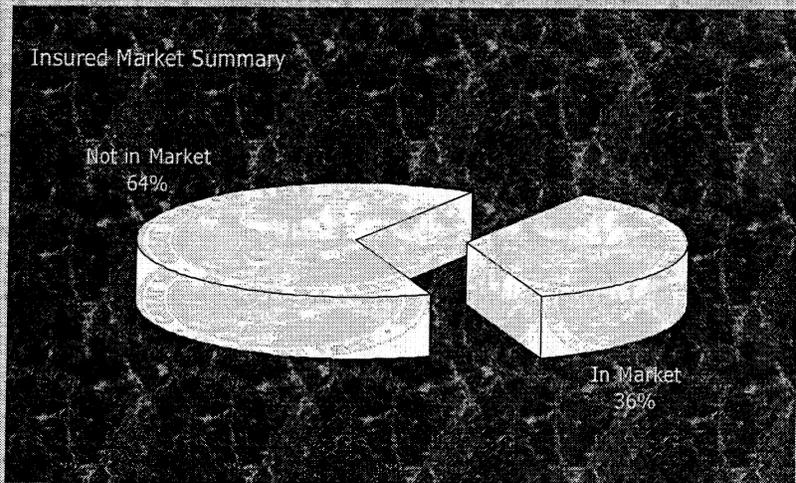
Defining the Insured Market

Instate vs. Out-of-State Regulation

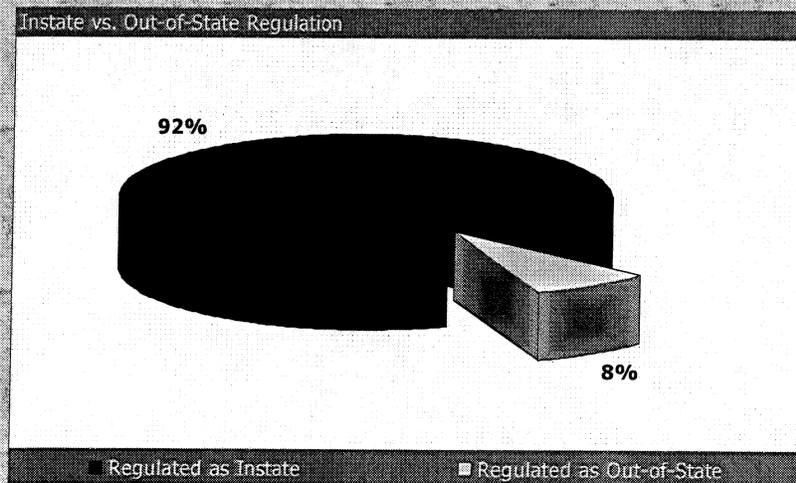
Market Segmentation

HMO vs. Insurance Carrier

# Market Overview

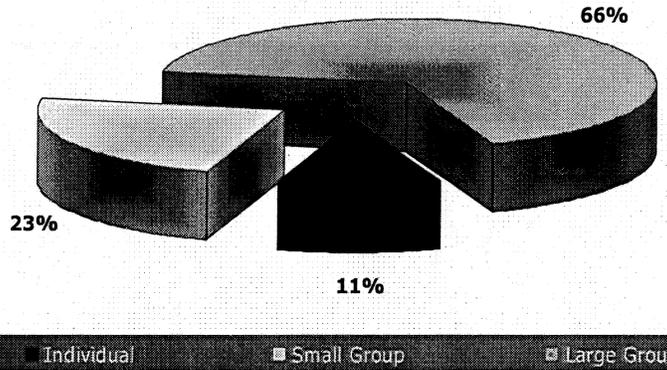


# Market Overview



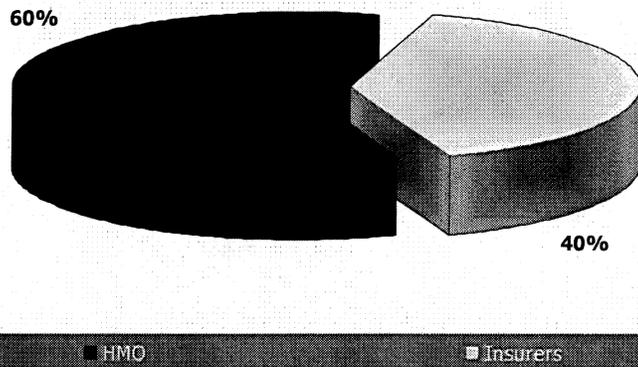
# Market Overview

Market Segmentation



# Market Overview

HMO vs. Insurance Carriers

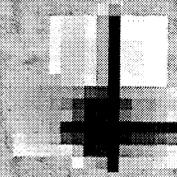


# Individual Market Overview

Health Underwritten vs. Guarantee Issue

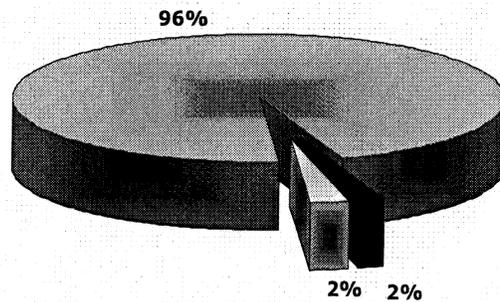
Instate vs. Out-of-State Regulation

HMO vs. Insurance Carrier



# Individual Market Overview

Guarantee Issue vs. Individually Underwritten



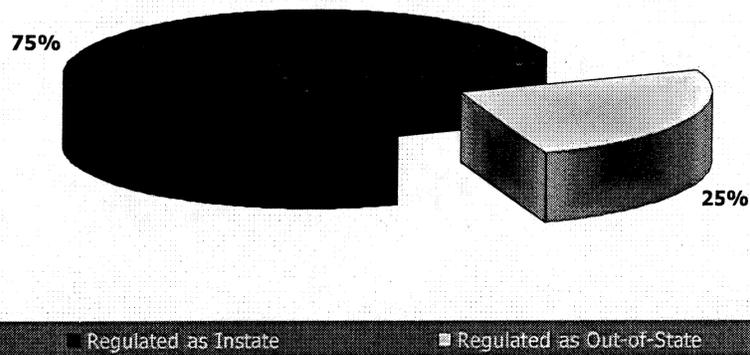
HIPAA

Conversion

Underwritten

# Individual Market Overview

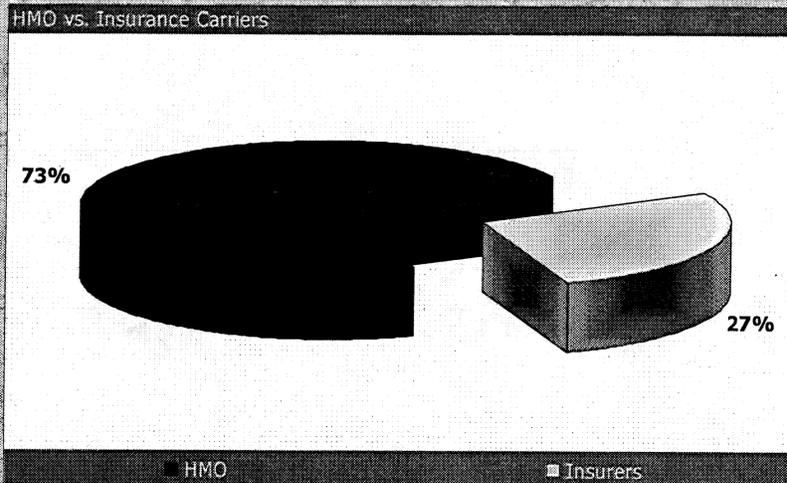
Instate vs. Out-of-State Regulation



# Individual Market Overview

Consumer Protections	Regulated Individual Market	Un-Regulated Individual Market
Prior approval of new policy forms required (Assures policy meets statutory requirement)	Yes 627.410 (1)	No 627.6515
Prior approval of initial rates and all rate changes required (Avoids predatory pricing)	Yes 627.410 (6)	No * 627.6515
Annual rate certification required (Assures that companies monitor rates)	Yes 627.410 (7) (a)	No
Durational rating prohibited (Raising rates solely based on the number of years the policy has been in force)	Yes 627.410 (6) (d)	No
Prohibition against canceling a policy form and offering replacement coverage to only health individuals	Yes 627.410 (1) (e) (2)	No
Pooling experience of all forms with similar benefits required (Prohibits creation of death spirals)	Yes 627.410 (6) (e) (3)	No
Free look provision required	Yes Rule 4.154.003	No
Pre-existing condition exclusion limits required	Yes 627.6045	No
Timely payment of claims required	Yes 627.613	No
Number of mandates required	48	14
12-Month extension of benefits (Protects persons on claim when coverage is terminated)	Yes 627.667	No
Dependents covered up to age 25 (Students or fully dependent children)	Yes 627.6562	No

## Individual Market Overview



## Individual Market Trends

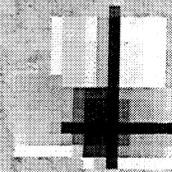
Rate Increases from Major Carriers

Medical Care Cost Trends

Changes in Carrier Participation Levels

Changes in Policy Forms

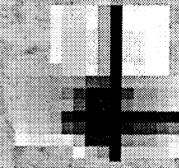
Changes in Market Size



# Small Group Market Overview

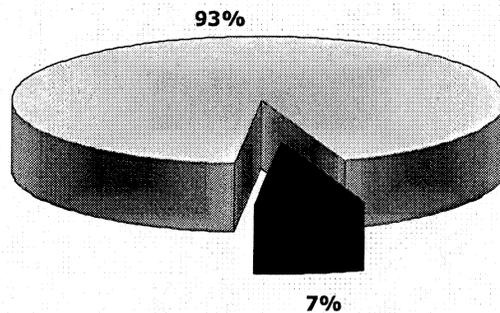
One-Life Groups vs. Groups of 2-50

HMO vs. Insurance Carrier



# Small Group Market Overview

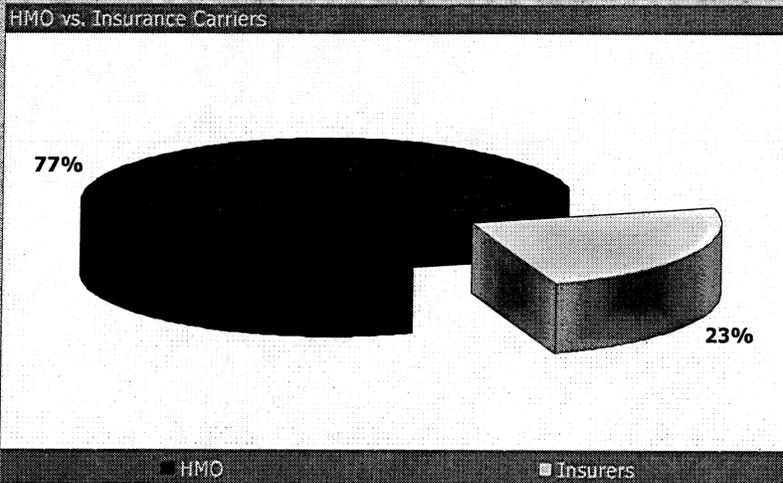
Groups of One vs. 2-50 Member Groups



■ Groups of One

■ 2-50 Member Groups

## Small Group Market Overview



## Small Group Market Trends

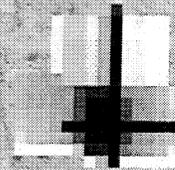
Rate Increases from Major Carriers

Medical Care Cost Trends

Changes in Carrier Participation Levels

Changes in Policy Forms

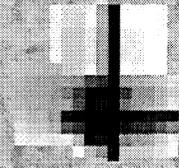
Changes in Market Size



# Large Group Market Overview

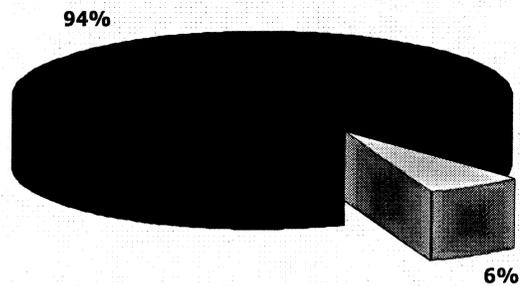
In-state vs. Out of State

HMO vs. Insurance Carrier



# Large Group Market Overview

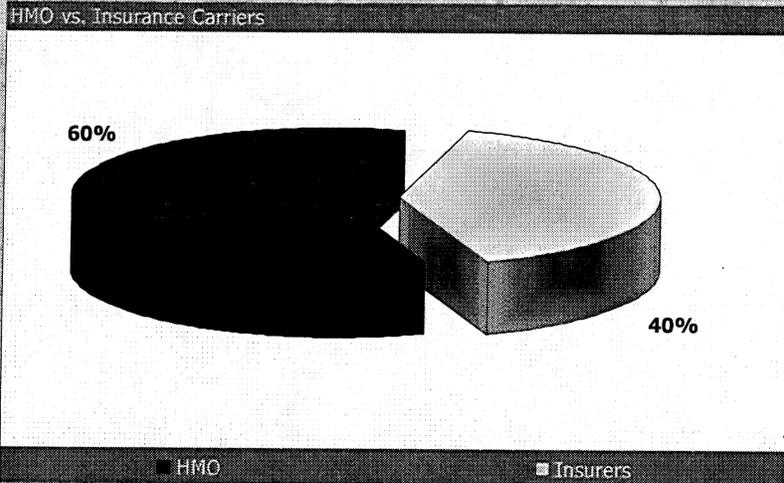
Instate vs. Out-of-State Regulation



■ Regulated as Instate

■ Regulated as Out-of-State

## Large Group Market Overview

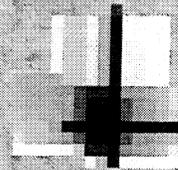


## Large Group Market Trends

Rate Increases from Major Carriers

Medical Care Cost Trends

Changes in Market Size



## Medicare Complementary Market Overview

State vs. Federal Regulation

Medicare Enrollees vs. Medigap

## Medigap Trends

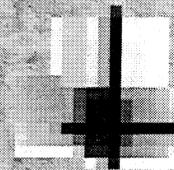
Rate Increases / Medical Cost Trends

Medical Care Cost Trends

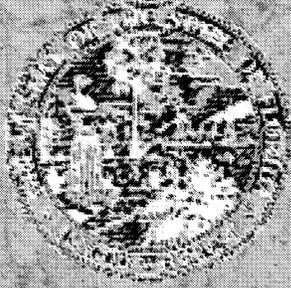
Changes in Carrier Participation Levels

Changes in Policy Forms

Changes in Market Size



# Office of Insurance Regulation



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