IMPACT STUDIES

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IMPACT OF THE HEALTH SECURITY ACT

NEW YORK

IMPACT OF THE HEALTH SECURITY ACT

NEW YORK

I. SUMMARY: Impact of the Health Security Act On New York

The Health Security Act will reduce the cost of insurance in New York through universal coverage, cost containment, and the elimination of cost shifting.

- New York employers who currently offer insurance will save an average of $549 per worker (1.2% of payroll, $3.7 billion in total) on premiums in the year 2000.

- New York workers who are in firms that currently offer health insurance will save an average of $177 per worker ($1.2 billion in total) on premiums in the year 2000.

- As a purchaser of health care coverage for its employees, New York will save approximately $162 million in premium payments for active employees in the year 2000 due to slower growth in overall health care costs. Additionally, New York will save an estimated $48 million through federal support of health care for early retirees in the year 2000.

State expenditures for Medicaid and community-based long-term care are projected to decrease in New York under the Health Security Act, while Federal spending on public health initiatives will increase.

- Between 1997 and the year 2000, New York will save an estimated $11.7 billion in state Medicaid expenditures under the Health Security Act. In the year 1997, New York state Medicaid expenditures will be reduced by an estimated $84 million, while in the year 2000, New York will save approximately $4.9 billion.

- New York will realize savings of nearly $2 billion on community-based long-term care expenditures between 1996 and 2000 due to the Health Security Act's new program and the slowing of growth in Medicaid expenditures-- $555 million in the year 2000 alone.

- New York will receive an estimated $129 million in new Public Health Service funding in the year 2000.

IMPACT OF THE HEALTH SECURITY ACT ON NEW YORK: YEAR 2000

EXPENDITURE CATEGORIES	W/O REFORM	REFORM	SAVINGS
PURCHASING HEALTH COVERAGE UNDER THE HEALTH SECURITY ACT			
Employers' Share of the Premiums			
Total Employer Premium Payments: All Firms	$23.6 billion	$22.5 billion	$1.1 billion
Total Employer Premium Payments: Employers Currently Offering Insurance	$23.6 billion	$19.9 billion	$3.7 billion
Premium Payments as a Percent of Payroll: Employers Currently Offering Insurance	7.9%	6.7%	1.2%
Premium Payments Per Worker: Employers Currently Offering Insurance	$3,497 per worker ($291 /month)	$2,948 per worker ($246 /month)	$549 per worker ($46 /month)
Families' and Individuals' Share of the Premiums			
Total Worker Premium Payments: All Firms	$4.8 billion	$4.3 billion	$454 billion
Total Worker Premium Payments: Workers in Firms Currently Offering Insurance	$4.8 billion	$3.6 billion	$1.2 million
Worker Premiums: Workers in Firms Currently Offering Insurance	$708 per worker ($59 /month)	$531 per worker ($44 /month)	$177 per worker ($15 /month)
New Federal Funds for Discounts	----	$5.4 billion	----
State Expenditures on Active State Employees	$1.1 billion	$980 million	$162 million
State Expenditures on Early State Retirees	$98 million	$49 million	$48 million
MEDICAID			
State Medicaid Expenditures	$22.6 billion	$17.7 billion	$4.9 billion
NEW LONG-TERM CARE PROGRAM			
State Community Long-Term Care Expenditures	$3.0 billion	$2.4 billion	$555 million
PUBLIC HEALTH INITIATIVES			
Funds from the Public Health Initiatives	----	$129 million	----

NOTE: Numbers may not sum to totals due to rounding.

II. HEALTH SECURITY ACT: Major Policy Changes Affecting States

The following is a brief description of some of the major policy changes under the Health Security Act that affect state expenditures. *

UNIVERSAL COVERAGE & COST CONTAINMENT UNDER THE HEALTH SECURITY ACT

The Health Security Act guarantees all American citizens and legal residents coverage under a comprehensive package of benefits. Coverage continues with no lifetime limits regardless of a change of employer, employment status, marital status or medical condition.

The Health Security Act relies on the requirement of shared responsibility for the purchase of health coverage. It strengthens the private, employment-based system and augments it with a commitment to make the purchase of coverage affordable through discounts to small business and families.

The Health Security Act carries out the commitment to control the rising costs of health care by:

(1) Consolidating the purchasing power of consumers so that private payers in a competitive market can slow the growth of health insurance premiums. This process is backed up by a cap on the growth of insurance premiums.

(2) Reducing the rate of growth of the Medicare and Medicaid programs without reducing benefits or care.

PREMIUMS UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, health coverage is purchased in two shares: the individual or family share and the employer share. Each individual or family purchases a health plan designed to cover one of four categories by family type:

(1) A single adult policy;
(2) A policy covering two adults;
(3) A policy covering a single parent with children; and
(4) A policy covering two parents with children.

*Note: This analysis includes the major ways that states will be affected by the Health Security Act; other sectors that will be affected, such as hospitals and local governments, are not described in this report.

Employers' Share of the Premiums

Generally, employers pay 80 percent of the weighted average premium calculated on a per worker basis within a regional alliance for the appropriate family type policy.[1] Additionally, an employer may choose to pay part or all of the family share of the premium.

Employers' premium payments within regional alliances are capped. At full implementation, employers purchasing coverage through regional alliances will pay no more than 7.9 percent of payroll for health coverage for their workers. Businesses with fewer than 75 workers receive discounts that peg their payments to a sliding scale (3.5% to 7.9% of payroll) based on size and average wage.

Families' and Individuals' Share of the Premiums:

The family or individual pays the difference between the employer share and the actual premium of the health plan in which they choose to enroll. Those who choose to enroll in a lower-cost plan will pay lower premiums than those who choose higher-cost plans.

For families and individuals, as well as employers, premium payments are capped. Individuals with an annual income of $40,000 or less pay no more than 3.9 percent of their income toward their share of the premium. Those with incomes below 150 percent of poverty pay less than 3.9 percent of their income.

MEDICAID UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, Medicaid recipients under the age of 65 enter the alliance system to obtain the guaranteed comprehensive benefit package.

People not on cash assistance who now receive Medicaid choose their health plan and may qualify for discounts based on income, like other eligible individuals and families. States contribute toward premium discounts for their state residents by maintaining current Medicaid spending efforts for this population.

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[1] The weighted average premium is the average of the accepted bids for all health plans in the alliance, weighted to reflect enrollment of eligible individuals among the plans. For each class of enrollment (i.e., single, couple, family), the employer payment is the product of the weighted average premium and the number of full-time equivalent employees employed by the employer and enrolled in each class of enrollment in the previous month.

Individuals who qualify for Aid to Families with Dependent Children and Supplemental Security Income also choose their own health plans through regional alliances. The federal and state governments make premium payments for these individuals based on current state and federal Medicaid expenditures.

For low-income children under the age of 19, a new program is created to provide services currently offered under Medicaid but not included in the comprehensive benefits package, such as hearing aids and non-emergency transportation. States maintain current spending for children receiving cash assistance.

State expenditures on Medicaid will decrease under the Health Security Act for several reasons:

- **Coverage of current cash-eligible Medicaid recipients through regional alliances:** Acute care spending for cash-eligible Medicaid recipients will decrease because of their inclusion in regional alliances, where costs may be controlled more effectively. States will pay a capitated premium for these services that is based on 95 percent of current expenditures for this population. In addition to this reduction in expenditures, states will no longer make disproportionate share payments for their cash-eligible populations.

- **Coverage of current non-cash eligible Medicaid recipients through regional alliances and the new program for children's supplemental services:** Expenditures for non-cash eligible Medicaid recipients, like those for cash eligibles, will be reduced due to their inclusion in regional alliances. Although the states will make maintenance of effort (MOE) payments based on current expenditures for acute care services and disproportionate share for this population, these payments will not grow as rapidly as under the current system. Additionally, the Federal government will assume the costs of supplemental services for Medicaid eligible children. Because the MOE payments for cash eligible children's supplemental services will grow at a slower rate than do current expenditures for these services, states will achieve savings.

NEW LONG TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT

The Health Security Act creates a new home and community-based long-term care program for individuals with severe disabilities regardless of income or age. The program is financed by:

- **Federal Government:** New federal funds are allotted to states based on a formula that includes the number of persons with severe disabilities among other factors. Additionally, current federal Medicaid expenditures for these services for the severely disabled will be used to fund the new program to the extent that current Medicaid eligibles are served in the program. The federal share of public costs ranges from 78 to 95 percent when fully phased in.

- **States:** State spending for the new program will be matched by the federal government, although at a rate substantially higher than that of the current Medicaid program. Part of the state funds will come from the transfer of Medicaid expenditures for community-based long-term care for the severely disabled. At the most, states will pay between 5 and 22 percent of the public program costs.

- **Individuals:** Participants will contribute based on their income.

States have the flexibility to organize services to meet their populations' diverse needs; at a minimum, states must provide personal assistance with activities of daily living. States have the option to continue to provide community-based long-term care services under the state Medicaid program.

PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

The Public Health Initiatives under the Health Security Act will provide states and communities with new funds to create partnerships between government, alliances, health care providers, and communities that will:

- Enhance the capability of communities to protect the health of their populations and to address high-priority local health problems;

- Increase the number of minorities in health professions, support graduate nurse training initiatives, and expand training projects for primary care physicians and physician assistants;

- Assure access to essential health services for all Americans, particularly low-income, isolated, hard-to-reach populations; and

- Provide the knowledge and information systems necessary to prevent diseases and provide medical care more appropriately and efficiently.

Due to universal coverage under the Health Security Act, most personal health services provided the Public Health Service will be paid for by insurance.

III. BACKGROUND: New York and Health Reform

Over the past decade, state governments, residents, and employers have faced rapid increases in the already high health care costs.

- Between 1980 and 1991, spending in New York for hospital care, physician services, and prescription drug purchases in retail outlets rose at an average annual rate of 10.1%. (1)

- In 1992, New York ranked first among all states in Medicaid payments per recipient, at $5,975 per recipient. These expenditures amounted to almost a quarter of New York's state budget in 1992. (2)

New York - Health Care Environment	STATISTICS	RANK
Total Nonelderly Population Uninsured (1991) (3)	2.5 million (12.3%)	28th
Percentage of Population Covered by Medicaid (1991) (4)	14.0%	4th
Medicaid Payments per Recipient (1992) (2)	$5,975	1st
Medicaid Expenditures as a Percent of Total State Expenditures (1992) (2)	22.6%	5th
Percentage of Population in Underserved Areas (5)	14.2%	27th
Infant Mortality Rate per 1000 Live Births (1991) (6)	9.4	15th

New York has taken several steps to control the rise in health care costs and to increase access to health care for its residents. (7,8)

- In 1992, New York enacted small group (3-50 employees) and individual insurance market reforms which require guaranteed issue and renewal, limits on pre-existing condition waiting periods, pure community rating with adjustments for family composition and geography, and mandatory reinsurance or other types of risk-sharing mechanisms.

- Since the 1970s, New York has operated a multi-payer hospital rate setting system.

- New York has been conducting a demonstration project for data collection and electronic claims processing in which participating hospitals submit uniform electronic claims to a data clearinghouse, which batches claims and forwards them to insurers for payment.

- New York subsidizes primary care coverage for children under 13 who are below 220 percent of the poverty level through its Child Health Plus program.

Acting alone, New York is hampered in its efforts to control the growth of health care costs. The Health Security Act will enable New York to control the growth of health care expenditures and assure access to care for its residents.

- Universal coverage, achieved through a federal/state partnership, will reduce the burden on state and municipal programs and providers that today finance and deliver services to the uninsured and under-insured.

- Federal grants will help states provide special assistance to underserved rural and urban areas. States will be able to strengthen and improve essential public health efforts.

- The Health Security Act will control the increase in health care costs by introducing greater competition into the health care delivery system.

NOTES AND SOURCES:

(1) Health Care Financing Administration, as published in Levit, et al., Health Affairs, Fall 1993.

(2) National Association of State Budget Officers. 1992 State Expenditure Report.

(3) Employee Benefits Research Institute. Special Report: Sources of Health Insurance and Characteristics of the Uninsured; Analysis of the March 1992 Current Population Survey. Brief Number 133. January 1993.

(4) Health Care Financing Administration. HCFA Form 2082 - Statistical Report of Medical Care: Eligibles, Recipients, Payments, and Services, Federal Fiscal Year 1992.

(5) Health Resources and Services Administration. October 1993. Note: Percentage of total state population residing in counties that have been designated as Medically Underserved Areas and/or Health Professional Shortage Areas.

(6) Centers for Disease Control & Prevention. Monthly Vital Statistics Report, 42(2s). August 31, 1993.

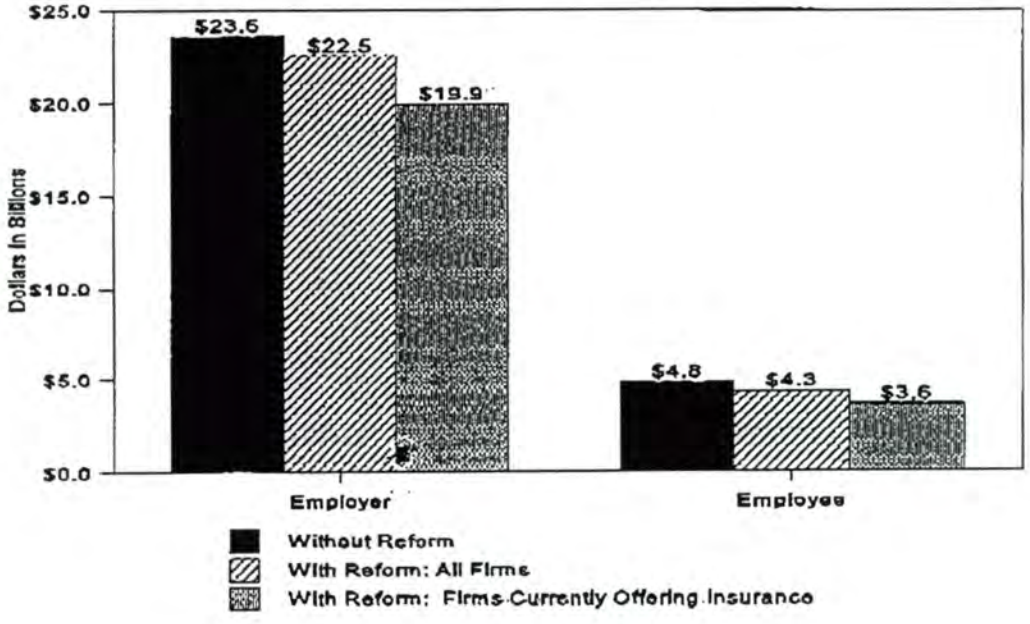
(7) BlueCross BlueShield Association. State Legislative Health Care and Insurance Issues, 1993 Survey of Plans.

(8) Office of Management and Budget Health Policy. Health Reform Briefing Book: States. October 1993.

IV. IMPACT ON THE PRIVATE SECTOR: NEW YORK

A. PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Total Annual Premium Payments: Year 2000
New York



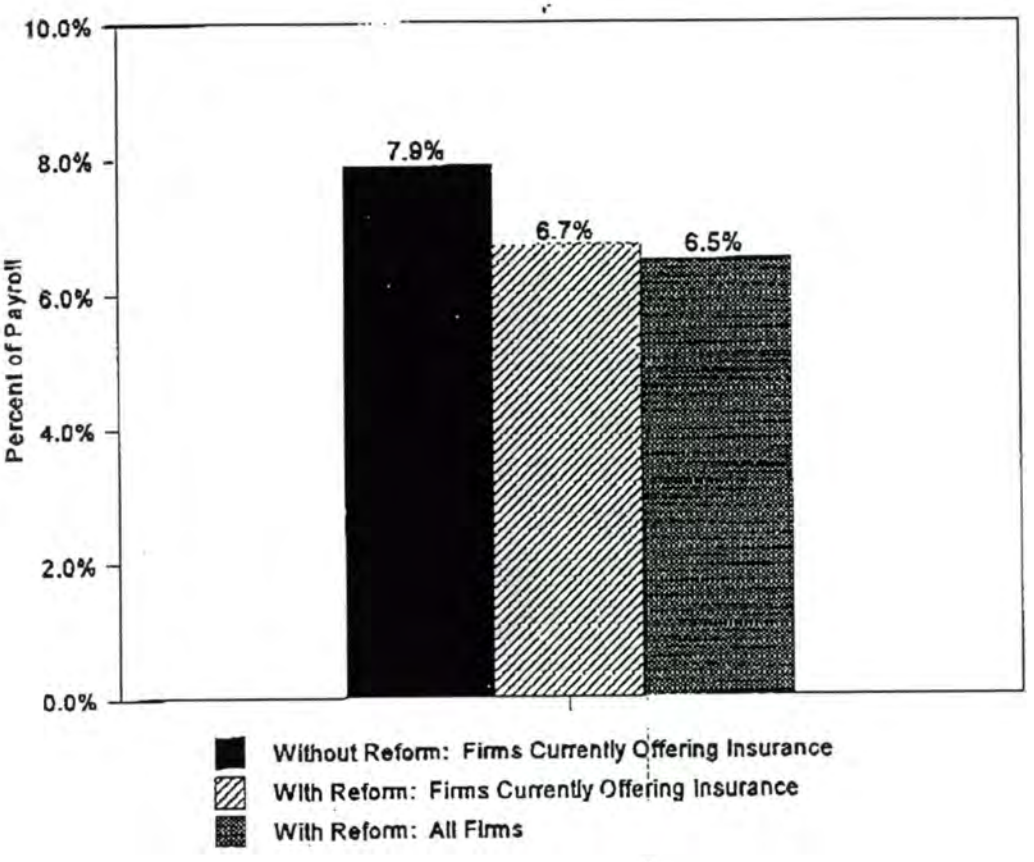
- Without reform, New York employers who currently offer insurance would pay an estimated total of $23.6 billion in premiums in the year 2000. Under the Health Security Act, all firms, including those that do not currently offer insurance, will pay $22.5 billion in premium payments for their employees. Firms that currently offer insurance to their employees will pay an estimated total of $19.9 billion in premium payments -- $3.7 billion less than they would pay without comprehensive reform.

- New York workers who currently work in firms that offer insurance would pay an estimated total of $4.8 billion in premium payments in the year 2000 without comprehensive reform. Under the Health Security Act, New York workers, including those who are not currently employed by firms offering insurance, will pay a total of $4.3 billion in premiums in the year 2000. Employees in firms that currently offer insurance will pay an estimated total of $3.6 billion in premiums in the year 2000, over $1 billion less than they would without comprehensive reform.

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Premium Payments as a Percent of Payroll: Year 2000
New York



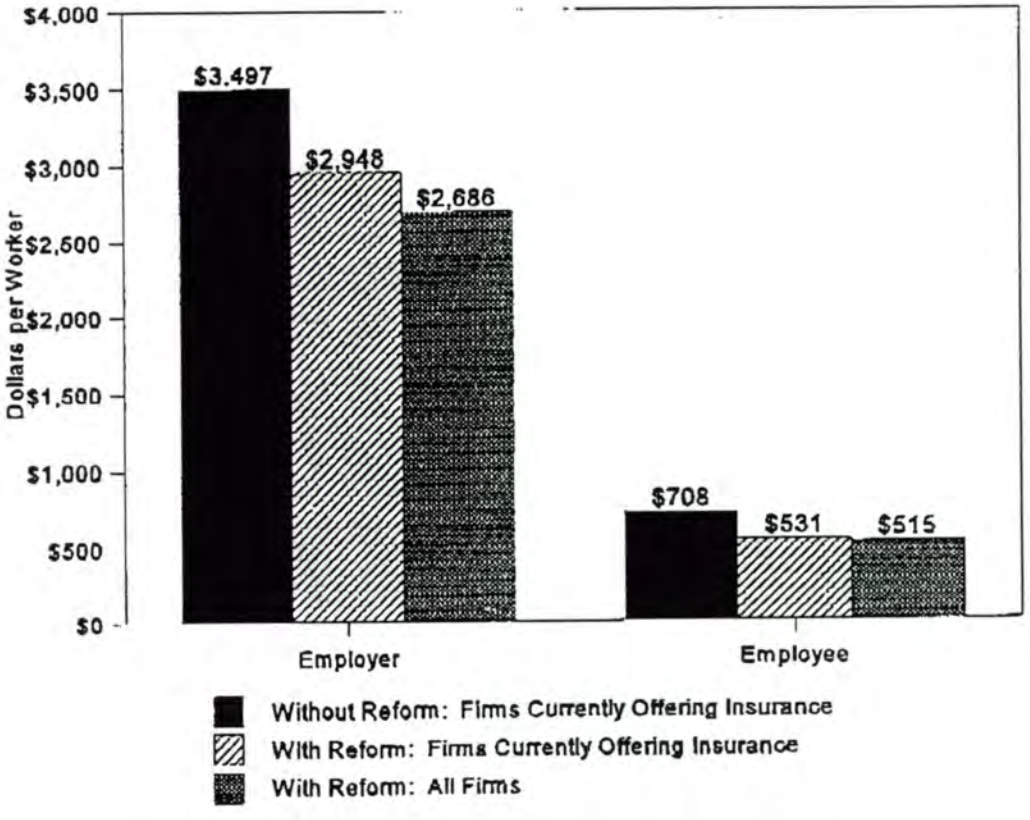
- The Health Security Act will reduce the amount that New York employers who currently offer health insurance will spend on premiums from 7.9 percent to 6.7 percent of payroll, a reduction of approximately 15 percent due to cost containment.

- In the year 2000, all New York employers will spend an average of 6.5 percent of their payroll on premiums under the Health Security Act.

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premium Payments per Worker: Year 2000
New York



- For all New York employers, the average premium payment per worker will be an estimated $2,686 in the year 2000 under the Health Security Act. Employers that currently offer health insurance will pay an estimated $2,948 in premium payments for workers -- $549 less than they would pay if there were no comprehensive reform.

- New York workers will pay an average premium share of approximately $515 in the year 2000. Employees in firms that currently offer insurance will pay on average $531 -- $177 less than they would pay on premiums if there were no comprehensive reform. Savings will be even greater for those workers who currently purchase health insurance directly from insurance companies.

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

B. DISCOUNTS UNDER THE HEALTH SECURITY ACT

New York: Year 2000

Qualified New York small and low-wage employers, low-income families, and early retirees will receive an estimated total of $9.0 billion in the year 2000 for premium and out-of-pocket payment discounts under the Health Security Act.

- New York will receive an estimated $5.4 billion in federal funds for discounts in the year 2000.
- The remaining $3.6 billion will come from state funds, a substitute for the $4.4 billion that New York would have paid for services for its non-cash Medicaid recipients without reform.

NOTES: The gross and net discount estimates come from HCFA OACT.
The distribution of gross discounts across states was determined through the Urban Institute's TRIM2 model.
The state-specific maintenance of effort estimates are described under the "Medicaid" section of this analysis.

SOURCE: HCFA OACT, ASPE, and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

V. IMPACT ON THE PUBLIC SECTOR: New York

A. STATES AS EMPLOYERS UNDER THE HEALTH SECURITY ACT

New York: Year 2000

As purchasers of health care coverage for their employees, states will benefit from slower growth in overall health care costs.

Federal support of health care for early retirees will produce large savings for state employee health benefits programs. Under the Health Security Act, the federal government will cover the 80 percent employer share of the early retirees' premiums, while the state will assume the 20 percent family share.

- New York will spend an estimated $980 million on its active employee health benefits in the year 2000 under the Health Security Act. This represents an estimated savings of $162 million when compared to the estimated spending without reform of $1.1 billion in the year 2000.

- New York, as an employer, will save an estimated $48.1 million on its premium spending for retirees between the ages of 55 and 64 years in the year 2000.

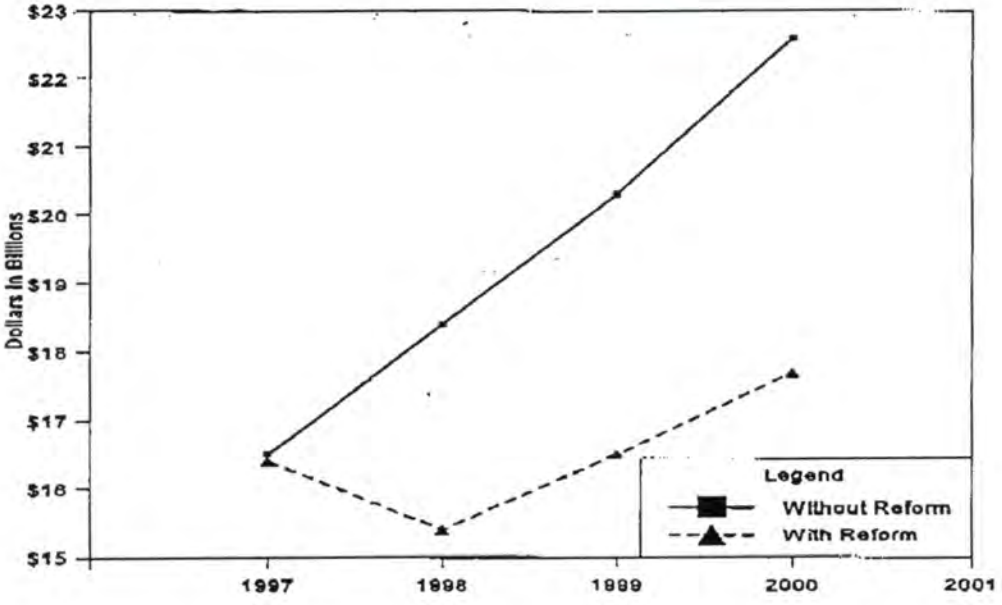
NOTES: Estimates are based on a survey of states as employers by the Segal Company (1993), employee workforce growth rates from WEFA, and reform premium estimates from The Urban Institute's TRIM2 model.
Coverage for retirees age 65 or older will not change under the Health Security Act.

New York currently offers its employees a benefits package that is comparable to that of the comprehensive benefit package under the Health Security Act, with three exceptions. First, New York offers a mental health benefit in which the employee can choose a managed care benefit using in-network providers that does not have specified limitations or, if going out of network, be subject to separate deductibles and limitations. These deductibles are substantially higher than those included in the Health Security Act. Second, New York offers adult dental coverage; however, this service represents less than 2% of its current health benefits' expenditures. Third, the comprehensive benefits package offers richer coverage for preventive services. New York covers approximately the same percent of the employees and families' premium (81%) as it would under the Health Security Plan (80%).

SOURCE: ASPE

B. STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT

New York Medicaid Growth: 1997 - 2000 *
(Assuming State Alliances Formed in 1997)



- Under the Health Security Act, New York will save approximately $11.7 billion between the years 1997 and 2000. These savings will result primarily from the inclusion of Medicaid recipients in regional alliances, where growth in health care costs will be controlled.

- Significant savings will not be realized until the year following implementation due to outstanding payments from the year prior to reform.

ASSUMPTIONS AND NOTES:
Assumes that:
States will continue their spending on non-cash adult wrap-around services;
Sources of revenue for Medicaid disproportionate share remain and funds were used for uncompensated care;
All states implement reform in 1997 (community-based long-term care estimates assume 1996 implementation).
1997 estimates include payment lags for expenditures from the prior fiscal year.
Long-term care includes both institutional and community-based long-term care. These estimates include offsets due to the new community-based long-term care program (see next section).
Maintenance of effort payments include expenditures for non-cash alliance covered services, non-cash disproportionate share, and cash children's wrap-around services.
Numbers may not sum to totals due to rounding.

*Estimated savings will change slightly due to normal baseline revisions which accompany new economic data.

SOURCE: HCFA OACT and ASPE

STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT
New York Medicaid Expenditures: 1997 - 2000
(Assuming State Alliances Formed in 1997)

	Dollars in Millions				
	1997	1998	1999	2000	Total
CURRENT MEDICAID	16,464	18,091	20,338	22,832	77,765
HEALTH SECURITY ACT	16,380	15,198	16,535	17,938	66,090
Acute Care Medicaid (Cash)	6,911	5,369	5,837	6,358	24,475
Long-Term Care Medicaid	6,285	6,732	7,218	7,751	27,985
Maintenance of Effort	3,184	3,337	3,480	3,629	13,630
NET STATE MEDICAID SPENDING	-84	-2,893	-3,804	-4,894	-11,673

- New York will save an estimated $4.9 billion in the year 2000 in Medicaid expenditures due to coverage of Medicaid recipients through the regional alliances and other policy changes under the Health Security Act.

- New York Medicaid spending on acute care, which includes premium payments for cash assistance recipients and wrap-around services for adults, will be an estimated $6.4 billion in the year 2000. This will be lower than the acute care spending under the current system because of slower growth of health care costs under the Health Security Act.

- New York Medicaid spending on long-term care under the Health Security Act will be approximately $7.8 billion in the year 2000. This includes institutional long-term care and community-based long-term care for the non-severely disabled population.

- New York will contribute an estimated $3.6 billion in the year 2000 in maintenance of effort payments that will be used for premium discounts for low-income New York residents and small businesses.

ASSUMPTIONS AND NOTES:

Assumes that:
- States will continue their spending on non-cash adult wrap-around services;
- Sources of revenue for Medicaid disproportionate share remain and funds were used for uncompensated care;
- All states will implement reform in 1997 (community-based long-term care estimates assume 1996 implementation).

1997 estimates reflect payment lags for expenditures from the prior fiscal year.

Long-term care includes both institutional and community-based long-term care. These estimates include offsets due to the new community-based long-term care program (see next section).

Maintenance of effort payments include expenditures for non-cash alliance covered services, non-cash disproportionate share, and cash children's wrap-around services.

Numbers may not sum to totals due to rounding.

* Estimated savings will change slightly due to normal baseline revisions which accompany new economic data.

SOURCE: HCFA OACT and ASPE

C. NEW LONG-TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT

New York Expenditures for Community-Based Long-Term Care: 1996-2000

	Dollars in Millions					
	1996	1997	1998	1999	2000	Total
CURRENT SYSTEM	1,669	2,429	2,587	2,798	3,001	12,563
State Medicaid Spending (1)	1,565	2,283	2,452	2,635	2,832	11,766
State Only Spending on the Severely Disabled (2)	104	146	155	163	169	737
HEALTH SECURITY ACT	1,453	2,100	2,206	2,373	2,416	10,530
New Program Spending (3)	33	183	260	346	440	1,335
State Spending to Match New Federal Funds	106	53	64	75	84	309
State Spending to Match Medicaid Transfer	1,314	1,864	1,884	1,902	1,922	8,886
State Spending on Continuing Medicaid						
NET STATE SPENDING ON COMMUNITY-BASED LONG-TERM CARE	-216	-329	-399	-475	-555	-1,973

- New York would spend an estimated $3 billion in Medicaid and non-Medicaid (state-only) funds on home health, personal health care services, and home and community based waivers in the year 2000 in the absence of comprehensive reform.

- Under the Health Security Act, expenditures for community-based long-term care will be divided between the new program and the Medicaid program. New York will spend an estimated $440 million in the year 2000 to match the federal funds for the new program. Additionally, New York will spend approximately $84 million to match their share of the Medicaid expenditures 2000.

- New York will spend an estimated $1.9 billion in the year 2000 in Medicaid expenditures for community-based services that continue to be offered through Medicaid.

- New York will save an estimated $555 million on its spending for community-based long-term care under the Health Security Act, with a total savings of approximately $2 billion between 1996 and 2000.

NOTES:
(1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail elderly, and CSLA.
(2) Includes only estimated spending for persons who are likely to meet the eligibility criteria for the new program.
(3) Assumes full state participation in the new program.
Program is not fully implemented until FY 2003.
These net savings include some of the Medicaid program savings counted on the previous page.

* Estimated savings will change slighly due to normal baseline revisions which accompany new economic data.

SOURCE: ASPE

Federal Expenditures for Community-Based Long-Term Care for New York: 1996-2000

	Dollars in Millions					
	1996	1997	1998	1999	2000	Total
CURRENT SYSTEM (1)	1,564	2,082	2,452	2,634	2,832	11,764
HEALTH SECURITY ACT	1,796	2,474	2,993	3,341	3,719	14,323
New Program Spending						
New Federal Funds for Program	367	628	890	1185	1510	4,580
Estimated Medicaid Transfer (2)	115	182	220	255	287	1,059
Federal Spending on Continuing Medicaid (3)	1,314	1,864	1,883	1,901	1,922	8,884
NET FEDERAL SPENDING ON COMMUNITY-BASED LONG-TERM CARE	232	392	541	707	887	2,759

- The federal government would spend an estimated $2.8 billion in Medicaid funds on home health, personal health care services, and home and community based waivers in New York between in 2000 in the absence of comprehensive reform.

- Under the Health Security Act, New York will receive an estimated $1.5 billion in new funds in the year 2000 for the new program for the severely disabled. Additionally, New York will receive an estimated $287 million in Medicaid funds to match the transfer of state Medicaid funds to the new program.

- New York will receive an estimated $1.9 billion in the year 2000 in federal Medicaid expenditures for community-based services that continue to be offered through Medicaid.

- Between 1996 and 2000, federal spending for New York's home and community-based health care services will increase by an estimated $2.8 billion under the Health Security Act.

NOTES:
(1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail elderly, and CSLA.
(2) Federal Medicaid spending on persons with severe disabilities who are expected to be transferred to the new program. Assumes that no more than 75% of the new program's expenditures will be used for the Medicaid severely disabled during the phase-in.
(3) Medicaid with federal matching funds continues for the non-severely disabled receiving home and community-based long-term care.
Program is not fully implemented until FY 2003

Estimated savings will change slightly due to normal baseline revisions which accompany new economic data.

SOURCE: ASPE

D. PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

Public Health Service Funding for New York: 1995 - 2000
(Dollars in Millions)

	1997	1998	1999	2000	TOTAL
NEW PHS FUNDS	305	336	332	304	1,277
Health Services & Workforce Funding (1)	189	209	205	177	780
Health Research Funding (2)	116	127	127	127	497
OFFSETS	101	161	175	176	612
TOTAL FUNDS	204	175	157	129	665

- Between 1997 and 2000, Public Health Initiatives of the Health Security Act will provide the state of New York and its localities with an estimated $665 million in new funds for its community health centers, training of primary care physicians, core public health functions such as immunizations and disease prevention, and health research, among other programs.

- With universal coverage, payments from health plans will replace (offset) the current Public Health funds for the personal health services, totalling approximately $612 million between 1996 and 2000.

NOTES:

It is assumed that all states will implement reform in 1997.

(1) Federal funds for Health-Related Services and Workforce are allocated to states based on the state's percentage of its population beneath the poverty level in 1992.

(2) Federal funds for Health Research are allocated to states using proportional distribution based on total FY 1993 AHCPR and NIH funds to each state.

(3) Offsets are allocated to states based on FY 1993 distribution of funds from HRSA, SAMHSA, CDC, IHS, and NIH.

Numbers may not sum to totals due to rounding.

SOURCE: OASH, PHS

file

To: Distribution
From: Walter Zelman
Re: Summaries of recent studies that offer some support for the Health Security Act.

February 16, 1994

Attached are summaries of 5 fairly recent studies (or sets of studies) that offer some positive findings regarding the potential of the Health Security Act to achieve various goals.

Among other things, parts of these studies might be used to support the following propositions.

1. Notions of managed care are changing --entailing more choice, and more emphasis on value and quality.

2. The price gap between managed care plans and traditional fee-for-service systems is increasing, suggesting that, in an alliance-type system, consumers will see real differences in premium prices. This could increase cost-consciousness and make achievement on premium cap targets more manageable.

3. The HSA is likely to provide much more choice than employees and families are now seeing. Many employees now have a limited choice of plans, and the numbers of employers offering traditional fee-for-service plans is declining.

4. Many often-quoted reviews of potential savings in managed care (including those undertaken by CBO) may be out of date and may understate the potential for savings in these systems. Specifically, the notion that HMO's offer only one-time savings may be erroneous.

    - The data and trends reviewed in some of these reports also suggest that premiums in a new system may be lower than is generally anticipated.

5. The Health Security Act is building on trends -- consolidation of purchasing power, competition on price and value, more informed consumers-- that are already very present in the marketplace and that appear to be generating positive results.

6. At least one major state, California, stands to save substantial amounts and to see its long-term economic prospects enhanced.

THE FIVE STUDIES REVIEWED ARE

1. "Trends in Health Insurance," (KPMG Peat Marwick): a review of trends in managed care and fee-for-service plans.

2. "Managed Care Cost Containment," Robert Giffen: a review of 14 recent research studies on cost savings achieved in managed care.

3. "Implications of the HSA for California," California State Legislative Analyst: a study of the impact of the HSA on California.

4. Five Surveys of Employer-based Insurance: a review of five recent surveys on premium costs, choice of plans, enrollment trends.

5. "Market-based Health Care Reform, Well Beyond the Drafting Table," Ingrid A. Tillman: a review of advanced models of managed care and managed competition.

The summaries were prepared, at my request, by Paul W. Youket, PhD., a volunteer on the project.

Both short and long forms of the summaries are attached.

DIFFERENCES BETWEEN HMO PLANS AND FFS AND PPO PLANS

Paul W. Youket, Ph.D.

Summary of
Trends in Health Insurance:
HMOs Experience Lower Rates of Increase Than Other Plans,
authored by Jon Gabel and Derek Liston

INTRODUCTION

This study was conducted by KPMG Peat Marwick for the Group Health Association of America and was released January 31, 1994. It combines and analyzes data from the 1988, 1989, and 1990 Health Insurance Association of America Surveys of Health Benefits and the 1991, 1992, and 1993 KPMG Peat Marwick Surveys of Employer Sponsored Health Benefits. The study sought to compare health maintenance organization (HMO) plans with fee-for-service (FFS) and preferred provider organization (PPO) plans over the five-year period 1988-1993.

KEY FINDINGS

Premium Costs

- Premiums for HMO plans are significantly lower than premiums for FFS and PPO plans.
- The rates of increase in premium costs are significantly lower in HMO plans than in FFS or PPO plans. From 1988 to 1993, HMO premiums increased 40 percent less than FFS premiums and 32 percent less than PPO premiums.
- HMO savings in health care costs are not one-time savings; they persist over time.
- The gap in costs between HMO plans and FFS and PPO plans is widening.
- Promotion of HMOs can slow the rate of increase in national health care expenditures over the long term.

Benefits

- HMO plans provide more comprehensive benefits than FFS or PPO plans do. In particular, they offer more preventive services, such as office visits, adult physicals, and well-baby care, than do FFS or PPO plans.

Out-of-Pocket Costs

- Out-of-pocket costs are significantly lower in HMO plans than in FFS or PPO plans.

- While HMO plans do require modest (flat-rate) copayments for member visits, they rarely impose deductibles or require coinsurance as do FFS and PPO plans. From 1988 to 1993, deductibles under FFS plans rose 59 percent for individual coverage and 52 percent for family coverage. The annual rates of increase in these FFS deductibles are far greater than the average increase in wages and have outpaced overall inflation by almost three to one.

Pre-existing Conditions

- HMO plans generally do not postpone coverage of new enrollees' pre-existing conditions as FFS and PPO plans commonly do. Sixty-three percent of employees in FFS plans in 1993 were in plans with pre-existing condition limitations; a new enrollee in one of these plans had to wait an average of nine months for a pre-existing condition to be covered. Seventy-two percent of employees enrolled in PPO plans in 1993 were in plans with pre-existing condition limitations; a new enrollee in one of these plans had to wait an average of ten months for a pre-existing condition to be covered.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

- Recent trends suggest that the premium-cap targets in the Health Security Act (HSA) may be more achievable than some critics suggest.

- Trends suggest that estimates of premium charges under the HSA may be conservative, i.e., premiums may turn out to be lower than anticipated.

- If a widening gap between FFS and HMO plans causes cost-conscious consumers to shift to lower-cost plans, the weighted average premium in alliances may go up more slowly than some fear.

- The study may suggest that, unless the HSA is passed, FFS plans may be less and less available. As their prices increase relative to HMOs, more employers may be expected to drop FFS plans. The HSA requires that alliances offer a FFS plan and may aid FFS plans by risk-adjusting plan payments. (If, in fact, older and sicker individuals are more likely to enroll in FFS plans, the alliance will assist those plans through risk adjustment. In the current market, without risk adjustment, those plans will just get more costly.)

COST SAVINGS OF MANAGED CARE PLANS

Paul W. Youket, Ph.D.

Summary of
Managed Care Cost Containment: A Review and Reassessment (Revised),
authored by Robert B. Giffen, Ph.D.

NEW FINDINGS

This report summarizes the findings of 14 recently published research studies on the cost savings achieved by managed care plans to determine if the findings of reviews based on earlier studies remain valid. The study then estimates what the aggregate savings would be if these new savings rates were applied nationally. This new review found that:

- Commonly-held beliefs about the ineffectiveness of managed care plans in containing health care costs are based on reviews of earlier studies which are now out-of-date and which no longer reflect the current impact of managed care plans.

- The author includes reviews by the Congressional Budget Office in this category. The Congressional Budget Office's estimates may reflect this failure and not give adequate credit to managed care.

- All types or models of HMOs can be effective in reducing health care costs, including those, such as IPAs, that give individuals more choice of physicians. Total costs are reduced an average of 27 percent below indemnity plans, in part because hospital admissions and lengths of stay are substantially reduced.

- Point-of-service plans reduce health care costs 13 percent below indemnity plans, but PPOs do not consistently do so.

- Savings achieved by managed care plans persist over time; they produce more than one-time savings and continue to reduce costs over time relative to indemnity plans. The gap in costs between HMO and indemnity plans will, therefore, continue to widen.

- These new, higher managed care savings rates need to be utilized in estimating the impact of health care reform. Health care reforms which result in more individuals being enrolled in managed care plans will quickly realize significant savings in health care costs. If additional cost-containment measures are incorporated in health care reform, even greater savings rates will be achieved.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

High Potential for Price Competition

- In a managed-competition environment, savings in health care costs by managed care plans should result in significant differences in prices between managed care plans and indemnity plans. Therefore, consumers should have a substantial choice in prices between managed care plans and indemnity plans. Competition among plans should drive prices downward.

Support for Conservative Nature of Administration's Premium Estimates

- The report's findings support the Administration's contention that its estimates of the costs of the Health Security Act are conservative because the estimates of the average premium rates used are based on the prices of indemnity plans, not managed care plans.

Manageability of Administration Budget Targets

- Reaching the Administration's budget targets for health care alliances may be much more manageable than people think for three reasons:

  - visible price competition, i.e., consumers will have significant price choices among plans;

  - slower rates of growth in the prices of managed care plans; and

  - switching of individuals to lower-cost, managed care plans.

IMPACT OF THE HEALTH SECURITY ACT ON CALIFORNIA

Paul W. Youket, Ph.D.

Summary of
The President's Health Care Reform Proposal:
A Review of Its Implications for California, Policy Brief,
Legislative Analyst's Office, State of California

ASSESSMENT

This report analyzed for the California State Legislature the impact that the Health Security Act would have in California if passed and implemented.

Overall Fiscal Impact

- State and local governments would save "several hundred million dollars" in the initial years and even more later. Savings would be less, however, if the state fully implemented the Health Security Act's long-term care program.

Costs as Employers

- Caps on premium increases and federal assumption of the costs of health benefits for early retirees would lower costs for state and local governments, but coverage of part-time employees would raise them.

Indigent Program Costs

- State and county governments would save $1.4 billion in costs for indigent health care programs because many individuals now in these programs would be enrolled in private health care plans.

- AFDC costs would be lower because many individuals would no longer need to enroll in AFDC to receive health coverage through Medi-Cal. The Health Security Act will thus facilitate getting individuals off the welfare rolls.

Fiscal and Economic Effects

- California's long-term economic prospects would be enhanced. Only low-wage employment would be reduced. Cigarette surtax revenues would fall $200 million.

Managed Competition

- Managed competition will produce a more efficient health care market in the long run than would a single-payer system. Although the Health Security Act contains many of the key elements needed for managed competition, a number of additional

changes would be needed to maximize its effectiveness in containing health care costs.

Implementation

- California should implement the Health Security Act as quickly as possible because it will save California more than $100 million annually.

- Premium caps would prove valuable because they would force efficiencies to occur in the health care system sooner than would otherwise be the case.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

- The official state agency responsible for providing independent analysis on public policy issues to the legislature of the largest state in the Union not only endorses the reform approach taken by the Health Security Act, but recommends that the Act be implemented as soon as possible because the benefits to the state are so great.

EMPLOYER SURVEYS

Paul W. Youket, Ph.D.

Summaries of Five Surveys of Employer-Based Health Insurance

TRENDS

Recent surveys of primarily larger employers by a number of organizations (Foster Higgins, the Health Insurance Association of America, Hewitt Associates, KPMG Peat Marwick, and the U.S. Chamber of Commerce) document changes that are presently occurring in the market for employee health insurance benefits.

Coverage

- While most larger firms provide health insurance benefits to full-time employees, most do not provide health insurance benefits to part-time employees.

Choice

- Most employers, especially smaller employers, offer their employees little or no choice of health plans; few employers offer more than two plans.

Types of Plans Offered

- Fewer employers are offering indemnity plans and more employers are offering managed care plans.

Enrollment

- Enrollment in indemnity plans is declining and enrollment in managed care plans is rising. In some surveys, enrollment in managed care plans has surpassed enrollment in indemnity plans. Enrollment in indemnity plans is significantly higher in smaller firms than in larger firms.

Costs

- Costs per employee are rising more slowly for managed care plans, especially HMO plans, than for indemnity plans, particularly for smaller employers. The gap in costs between indemnity plans and managed care plans, especially HMO plans, is widening.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

- The Health Security Act will provide most employees with much more choice of health plans than they presently have.

- The Health Security Act offers special advantages for small and midsize employers and their employees. These individuals currently suffer from several factors:

  - they have little choice of plans;

  - most plans available to them are higher-cost plans; they have less access to lower-cost plans; and

  - they have to pay more for these plans than do larger employers.

  Therefore, the Health Security Act will give them more choice and will put them on an equal footing as to price.

- The Health Security Act will extend coverage of health insurance benefits to part-time employees as well as to full-time employees. Most employers presently do not provide coverage of health insurance benefits to part-time employees.

- While the Health Security Act will give more families the opportunity to save money in managed care plans, the Act will ensure that all Americans will have the option to enroll in a fee-for-service plan, an option that is becoming less available. The Act will also give more choice to those enrolling in managed care plans by guaranteeing everyone a point-of-service option.

- More employers and employees may be choosing managed care plans over indemnity plans for two reasons:

  - Managed care plans are providing quality health care at less cost than indemnity plans.

  - The rate of increase in costs is less in managed care plans than in indemnity plans.

  The Health Security Act promotes the choice of health plans on the basis of value.

NEW MODELS OF MANAGED CARE AND MANAGED COMPETITION

Paul W. Youket, Ph.D.

Summary of
Market-Based Health Care Reform: Well Beyond the Drafting Table,
authored by Ingrid A. Tillman, Nancy S. Bagby, and J. Brian Garrett

ADVANCEMENTS

This report describes the most advanced models of managed care and managed competition that are being developed around the country and the implications of these changes for national health care reform.

New Paradigm

- More employers, especially larger ones, are providing more incentives to employees to utilize providers that offer "high value" in terms of the quality and cost of the services that they provide.

Managed Care

- Managed care has changed significantly. Today, there is less emphasis on utilization controls, price discounts, and access constraints.

- The new forms of managed care are putting more emphasis on delivering "value", defined in terms of better health outcomes, preventive care, continuous quality improvement, integrated service delivery, and cost savings achieved through improved efficiency. They utilize tools lacking in earlier forms of managed care: "information systems, financial incentives, purchasing power, and integrated structures".

- Many criticisms of managed care are based on outmoded conceptions of managed care and are no longer valid.

Providers

- "A new generation of providers" is forming. These new providers adopt broad missions, assume financial risk, integrate horizontally and vertically, and enhance quality and efficiency to provide value to purchasers of health care services.

Purchasers

- Employers are joining together in purchasing coalitions to proactively increase the value of the health care that they purchase. They are doing so in a variety of ways, but they all seek to define the outcomes that they wish to purchase, instill

competition among providers on measures of quality and efficiency, provide incentives to reward providers offering the highest value, and work with "providers to improve the overall health of the community".

National Policy

- National policymakers need to be aware of these developments, so that further progress can be facilitated and not deterred.

- National reforms can encourage this progress by fostering the "further development, dissemination, and use of reliable data on provider performance", building upon the rapid advances being made in outcomes management and quality improvement, to expand the purchase of health care based on value.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

- The Health Security Act encourages positive trends already visible in the health care marketplace. Many areas of the country are already developing the types of managed care and managed competition systems that would be implemented under the Health Security Act. These prototypes have effectively contained health care costs while maintaining quality of care. The initiatives studied demonstrate that these kinds of systems can be successfully developed locally and that they do work as intended.

- The Health Security Act will build on these trends and extend the concept of competition based on value to all, not just larger employers. Many elements of the Act are geared to facilitate the expansion of this competition.

- While the Health Security Act compels no one into managed care, there is increasing evidence that new forms of managed care may be great improvements over old forms and public perceptions of those forms. We need not be defensive about acknowledging that the Health Security Act encourages the development of a quality managed care system. Managed competition has the capacity to spur improvements in quality and value.

MANAGED CARE COST CONTAINMENT: A REVIEW AND REASSESSMENT (REVISED)

Summary by Paul W. Youket, Ph.D.

"Some common assumptions about managed care savings are based on anachronistic notions of managed care held over from the 1960's and 1970's and which are simply not supported by evidence."

"When more recent evidence is considered, it is clear that the CBO's picture of managed care savings is outdated and inaccurate."

Introduction

This is a summary of the report *Managed Care Cost Containment: A Review and Reassessment (Revised)*, authored by Robert B. Giffin, Ph.D., of Health Care Strategy Associates, Inc., commissioned by the AMCRA Foundation of the American Managed Care and Review Association, and dated November 1, 1993.

Main Theme/Focus of Study

The purpose of this study is to re-examine the issue of the extent to which managed care saves health care costs. Earlier studies, in particular widely-publicized ones by the Congressional Budget Office, cast doubt on the ability of managed care to significant lower health care costs over time. This study looks at more recent data from newer models of managed care to determine if the negative conclusions are still valid.

The report reviews and synthesizes "evidence on the cost savings that can be achieved through managed care". It reviews "the literature on managed care savings and uses this review to calculate average managed care savings rates". These rates are then used to estimate "total savings in national health expenditures" if managed care was fully utilized.

Main Points/Conclusions

- The beliefs that many people in the policy community have about managed care savings "are based on anachronistic notions of managed care held over from the 1960's and 1970's and ... are simply not supported by evidence." In particular, "CBO's picture of managed care savings is outdated and inaccurate."

- HMOs do reduce overall health care costs. Although utilization of ambulatory care generally increases, hospital admissions and lengths of stay are substantially reduced.

- HMO savings do not differ substantially by model type. IPA-model HMOs reduce utilization and costs as effectively as staff-model and group-model HMOs.

- Total health care costs in HMOs are, on average, 27.1 percent below total health care costs in traditional fee-for-service plans. HMOs reduce hospital costs by 39.4 percent, admissions by 34 percent, and lengths of stay by 16 percent.

- The costs of point-of-service plans are estimated to be 13.2 percent less than the costs of traditional fee-for-service plans.

- There is no consistent evidence that PPOs reduce utilization of health care services.

- Managed care savings have not diminished over time nor are they one-time-only savings.

- Managed care savings cannot be assessed by comparing HMO penetration in a market and hospital cost trends in that market; too many other factors interfere.

- If the estimated rates of savings by HMOs are applied to the portion of the insured population in the United States not in HMOs in 1990, national expenditures for health care would have dropped $81.4 billion, a net savings of 12.2 percent. Health care expenditures as a percentage of Gross Domestic Product would have fallen from 12.1 percent to 10.6 percent. The author believes that the actual savings resulting from health care reform would "far exceed" these estimates.

- Projecting into the future, the study estimates that, if managed care was fully applied nationally, national health expenditures would be 12.6 percent lower in 1995, 16.5 percent lower in 2000, and 22.6 percent lower in 2010. National health expenditures as a percentage of Gross Domestic Product would be 13.9 percent instead of 15.6 percent in 1995, 15.5 percent instead of 18.1 percent in 2000, and 17.9 percent instead of 22.0 percent in 2010.

- Managed care produces substantially greater savings in health care costs than reported in earlier studies, especially those by the CBO. It is important that these new findings be taken into account in the effort to reform the health care system.

- Health care reforms which fully utilize managed care will quickly realize significant cost savings. IPA-model HMOs and point-of-service plans will generate major savings, not just group-model and staff-model HMOs. Even greater savings will be achieved if additional cost-containment measures are incorporated in health care reform.

Data/Evidence

This study reviews 14 research studies published in peer-reviewed journals from January 1985 to June 1993. The findings of these studies are summarized on the attached pages.

Implications for the Health Security Act *(views of P. Youket, not R. Griffin)*

The findings of this study strongly support the Administration's argument that the reforms contained in the Health Security Act, especially managed competition among managed care and fee-for-service plans, will result in substantial savings in health care costs in a short period of time.

Table II-1

Summary of Recent Controlled Studies of Managed Care Savings

Study	Data Years	Unit of Analysis	Controls	MCOs*	Major Findings
HMO Studies					
Private Payor Studies					
Rapoport 1992	1989-90	One Hospital ICU*	Case mix Severity	Staff IPA PPO	ICU LOS -38%* Hosp LOS -27% Charges -28%
Greenfield 1992	1986	Phys. Offices	Severity Health Status Socio-demographic Others	All HMOs	Admissions -34% (avg.) Phys. visits +6.5% (avg.) Drugs -7.5% (avg.) Tests - mixed
Bradbury 1991	1988-89	10 IPAs 10 Hospitals	Severity Demographics	IPA	LOS -14%
Bradbury (unpub.)	1988-89	10 Hospitals 9 IPAs Surgical admiss.	Severity Case mix Demographics	IPA	LOS -10% Charges -6% Ancillary Charges -4.3%
Stern 1989	1983-85	One Hospital One HMO	Severity Demographics	Staff	LOS -14% Total Costs -4%

Table II-1

Summary of Recent Controlled Studies of Managed Care Savings

Study	Data Years	Unit of Analysis	Controls	MCOs*	Major Findings
Medicare Studies					
Brown 1993	1990	Medicare enrollees	Health status Demographic	All HMOs	IPA: LOS -18% IPA, Group, Staff: No stat. sig. diff. in LOS IPA: more SNF days* Staff phys. visits and home health higher
Bradbury 1992	1989-90	5 Hospitals 5 IPAs Medicare admiss.	Severity Demographics	IPAs	LOS -23% Charges -16%
Hill 1992	1990	Medicare enrollees	Health Status Demographic	All HMOs	Admissions -0% LOS -17% Days/1000 -19% Visits - inconclusive SNF Admissions +74% Home health (various measures) -31% to -57%
Retchin 1992	1989	Medicare admissions	Ex post analysis of severity and outcomes	All HMOs	LOS -18% to -25% ICU LOS -34% to -37%

Table II-1

Summary of Recent Controlled Studies of Managed Care Savings

Study	Data Years	Unit of Analysis	Controls	MCOs*	Major Findings
PPO Studies					
Wells 1992	1985-96	3 Employers 3 HMOs	Prior use Demographic	PPO	Decline in prob. of use Decline in actual use
Zwanziger 1991	1986-87	One Employer One PPO	Prior expend. Demographics	PPO	Expenditures increase Slight inpatient decrease
Wouters 1990	1982-85	One Employer One PPO	Health status	PPO	Episode costs -0% Phys. charges +10% Physician visits -6% Drug charges +23% Diagnostic charges -18%
Hosek 1990	1985-86	5 Employers 5 PPOs	Prior Use Demographic	PPO	Inpatient/outpatient utilization declines Increase in prob. of visit Total charges -18.2 (avg.)
POS Study					
Goetzel 1992	1985-89	One Employer One POS Plan	Demographic Total Empl. Cost	PPO	Admissions -25% Total Costs -13%

*Definitions: "MCO" refers to "managed care organization;" "LOS" refers to "length of stay;" "SNF" refers to "skilled nursing facility;" "ICU" refers to "intensive care unit."

THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL: A REVIEW OF ITS IMPLICATIONS FOR CALIFORNIA

Summary by Paul W. Youket, Ph.D.

Introduction

This is a summary of the report *The President's Health Care Reform Proposal: A Review of Its Implications for California, Policy Brief*, authored by Bill Wehrle of the Legislative Analyst's Office of the State of California, and dated December 9, 1993.

Main Theme/Focus of Study

The report is a brief summary and analysis of the President's health care reform proposal, prepared for the California State Legislature. It specifically focuses on the estimated impact that the President's plan would have on California if implemented as is and the major decisions the State Legislature must make. The report is supportive of the plan's general approach, but recommends certain changes that the author believes would strengthen the ability of the plan to contain health care costs.

Main Points/Conclusions

Overall Fiscal Impact

- The net savings to state and local governments in California under the President's plan would amount to several hundred million dollars from 1995 to 1997. Savings would be even greater in later years for two reasons:

  - State expenditures would increase more slowly over time than they would otherwise because of the plan's Medicaid and maintenance-of-effort provisions.

  - Caps on premiums paid by alliances will reduce expenditures for employee health insurance by state and local governments as employers.

- If the state fully implemented a long-term care program, savings would be less. Higher than present costs might occur in later years depending on how the state would structure this program. Costs for long-term care could be $1 billion higher by the year 2003, if the state fully implemented a long-term care program.

Costs as Employers

- Costs for state and local governments as employers would:

  - be less under the President's plan because the plan limits the annual growth of premium costs for employee coverage to a medical inflation factor based on the Consumer Price Index;

- decrease because the federal government would assume 80 percent of employer costs for health care benefits provided to early retirees between the ages of 55 and 65;

- increase because state and local governments would have to cover part-time employees, which they do not do now.

Indigent Program Costs

- Costs to state and county governments for indigent health care programs would drop approximately $1.4 billion.

  - $100 million in Medi-Cal costs would be saved annually because those who receive cash grants under AFDC or SSI/SSP would be enrolled in health alliances.

  - Annual General Fund costs would increase $100 million if the state continued covering optional benefits for all individuals who are currently eligible to receive them.

  - Elimination of federal Medicaid payments to hospitals with large volumes of uncompensated care to indigents would result in a net loss of $700 million annually.

  - Because of the plan's maintenance-of-effort provisions, states would make annual lump-sum payments to alliances for the medically indigent. These would be adjusted annually to reflect national population growth for persons under age 65 and a medical inflation factor. Savings would amount to $150 million within a few years and would be greater in later years.

- State AFDC costs would be less because fewer people would enroll in order to obtain health care coverage through Medi-Cal.

Fiscal and Economic Effects

- Cigarette surtax revenues would fall approximately $200 million. The author was unable to estimate the effect of the President's plan on revenues from the state tax on insurance premiums.

- Low-wage employment would be reduced, but there is unlikely to be a significant long-term effect on mid-wage and high-wage employment.

- To the extent that the President's plan lowers federal health care expenditures and budget deficits, California's long-term economic prospects will be enhanced. The net effect of these economic changes on state and local revenues "is extremely difficult to determine".

Managed Competition

- The author favors a managed competition approach to health care reform over a single-payer system because he believes that a competitive market system will be more efficient in the long run than a regulatory approach.

- The author acknowledges that the "President's plan includes many of the key elements that advocates of managed competition argue are necessary to achieve maximum cost containment", including the following: regional health alliances, a standard package of benefits, guaranteed issuance and renewal of coverage, prohibition of exclusion based on preexisting conditions, risk-adjusted payments to providers, uniform measures of plan performance to monitor quality, and "nearly universal coverage through subsidies to lower-income individuals. Taken together, these are significant steps that should expand the access to health care coverage and probably slow the rate of increase in health care expenditures."

- However, the author believes that the President's plan contains a number of weaknesses that lessen its effectiveness in containing health care costs. Specifically, the plan allows:

  - too many individuals to obtain coverage outside of the health alliances, e.g., veterans, the military, employees of large companies, reducing the effectiveness of the alliances and maintaining cost-shifting;

  - employers to pay too much of the costs of coverage for employees and to offer more generous benefits and allows individuals to deduct the cost of more generous benefits, insulating them from the costs of more expensive plans;

  - choices among three types of health plans, instead of only two;

  - individuals to utilize providers outside of a plan's network of providers;

  - individuals to purchase supplemental insurance policies; and

  - physicians to join more than one plan network of providers, reducing their incentives to practice more cost-effectively.

Implementation

- The author recommends that, if the President's plan is enacted, the state should implement it in the first year after passage because it would realize fiscal benefits of more than $100 million annually.

- The author believes that the caps on premium increases in the President's plan will be reached. He argues that the caps will simply force efficiencies to occur in the health care system sooner than they would otherwise. "However, in later years --

when possible efficiencies have already been achieved -- the caps could affect the quality and overall supply of medical care in the United States."

Recommendations

The author makes the following recommendations to the State Legislature to strengthen containment of health care costs under the President's plan:

- Integrate the health coverage currently provided through workers' compensation, automobile insurance, and perhaps Medicare.
- Prohibit certain supplemental insurance policies.
- Discourage employer contributions that exceed the lowest-cost plan in any given region.
- Discourage "out-of-network" services when consumers have selected HMO or PPO coverage.
- Increase taxes on products, such as alcohol and tobacco, that are linked to behavior that increases costs to the health care system.
- Limit state and local contributions to the cost of public employee health coverage to 80 percent of the average cost of available health plans.
- "Take steps to increase the supply of health care providers, particularly of nonspecialized physicians, physician assistants, nurse practitioners, and other primary care and prevention-oriented providers."

Other Issues

The author highlights other issues that the State Legislature must decide:

- The types of optional benefits to provide to the medically needy under Medi-Cal.
- How to reduce barriers that prevent "providers from serving the widest number of individuals whom they are qualified to serve".
- "Whether or not to participate in the new home- and community-based long-term care program" and to control program costs by limiting enrollment on a first-come, first-served basis or by limiting the level of services.
- How to integrate services provided through the health alliances and the home- and community-based long-term care program with similar services provided through other state programs.

Data/Evidence

The fiscal effects in California estimated by the author are summarized in the attached table.

Implications for the Health Security Act *(Views of P. Youket, not B. Wehrle)*

The report supports a managed competition approach to health care reform and essentially endorses the President's plan. The author believes that the state of California, the largest in the country, will significantly benefit from the plan and should implement it as quickly as possible. His basic criticism of the plan is only that it does not go far enough to contain health care costs as he believes it should.

Figure 4

Major Fiscal Effects of the President's Plan in California

Summary: Net savings to state and local governments, potentially several hundred million dollars annually in 1995-96 and 1996-97 and increasing thereafter. If the state fully implements a new long-term care program, these savings could be reduced, particularly in later years, possibly resulting in net costs.

Governments as employers

■ Requires state and local governments to purchase a standard package of health benefits through regional health alliances.	**Costs or Savings.** Depends on whether costs resulting from alliance premiums will be higher or lower than those currently negotiated by PERS and other governmental entities.
■ Requires coverage for part-time employees.	**Costs.** $50 million to $75 million annually to the state; probably in excess of $100 million annually for local governments.
■ Increases premiums annually by a medical inflation factor.	**Savings.** Unknown, depending on the extent that the medical inflation factor results in lower premium increases than would otherwise occur.
■ Transfers 80 percent of health benefit costs for early retirees to the federal government.	**Savings.** $200 million annually to the state; probably in the hundreds of millions annually for local governments.

Indigent health programs

■ Provides universal coverage to legal California residents.	**Savings.** About $1.4 billion net annually to indigent health programs: • $350 million state funds. • $1.1 billion realignment and county funds.
■ Eliminates federal payments to hospitals with a disproportionate share of the uncompensated care burden.	**Revenue Loss.** About $700 million annually in reduced federal funds that currently offset indigent health care costs (see above). • $150 million state funds. • $550 million county funds.
■ Requires the state to (1) make payments to alliances on behalf of AFDC and SSI/SSP recipients, based on 95 percent of 1993 Medi-Cal costs for these recipients, and (2) make annual lump-sum payments in lieu of other Medi-Cal costs.	**Savings.** About $100 million annually for the first few years, probably increasing over time. Savings depend on how the required annual increases in state expenditures compare with what would otherwise occur in the Medi-Cal Program.
■ Eliminates federal funding for Medi-Cal optional benefits to persons not receiving AFDC or SSI/SSP payments.	**Potential Costs.** At least $100 million annually if the state continues these services.

Revenue effects

■ Reduces state cigarette and tobacco products surtax (C&T) receipts because increased federal surtax will reduce consumption.	**Revenue Loss.** At least $200 million annually from the C&T Fund.
■ Increases insurance premium tax receipts by requiring health care coverage for virtually all state residents, but reduces receipts by encouraging greater use of tax-exempt HMOs.	**Revenue Gain or Loss.** Unknown, depending on the extent that the universal coverage requirement results in a net increase in expenditures for health insurance through for-profit providers who are subject to this tax.

New long-term care program

■ Enacts a new federal program for home- and community-based long-term care, and requires the state to share in the program's costs if it chooses to participate.	**Potential Costs.** Up to $200 million in 1996 and significantly higher amounts annually thereafter if fully implemented. Initially, these costs probably could be met by current General Fund expenditures from programs that provide similar services.

SUMMARIES OF EMPLOYER SURVEYS

Paul W. Youket, Ph.D.

INTRODUCTION

This is a summary of selective data on health insurance benefits from five surveys of employers conducted by the following organizations: Foster Higgins (FH), the Health Insurance Association of America (HIAA), Hewitt Associates (HA), KPMG Peat Marwick (KPMG), and the U.S. Chamber of Commerce (CC). Except where noted, primarily larger employers were surveyed; the experience of smaller employers is substantially different in most cases.

SUMMARY OF FINDINGS

- Most larger firms provide health insurance benefits to full-time employees, but not to part-time employees. (CC)

- Most employers, especially smaller employers, offer their employees little or no choice of health plans; few employers offer more than two plans. (HA, KPMG)

- Fewer employers are offering indemnity plans and more employers are offering managed care plans. (FH, HA, KPMG, CC) Fewer employers are offering only an indemnity plan to their employees. (FH, HA)

- Enrollment in indemnity plans is declining and enrollment in managed care plans is rising. (FH, HIAA, KPMG) In some surveys, enrollment in managed care plans has surpassed enrollment in indemnity plans. (FH, KPMG) Enrollment in indemnity plans is significantly higher in smaller firms than in larger firms. (KPMG)

- Costs per employee are rising more slowly for managed care plans, especially HMO plans, than for indemnity plans, especially for smaller employers. (FH, HIAA, KPMG) The gap in the rate of increase in costs between indemnity plans and managed care plans, especially HMO plans, is widening. (FH, HIAA)

DATA

COVERAGE

U.S. Chamber of Commerce

In 1992, 97 percent of the firms surveyed provided health benefits to full-time employees, but only 23 percent provided health benefits to part-time employees.

In the supplemental survey, 99 percent of the respondents said that they offered a health plan in 1991; in 1992, 98 percent said that they did. Twenty percent said that they provided health benefits to part-time employees in 1992.

NUMBER OF TYPES OF PLANS OFFERED

Hewitt Associates

Most employers offer their employees only one type of health plan, but fewer are doing so.

1991: 90%

1993: 79

Half of all employers who provide health insurance coverage offer their employees only one or two health plans to choose from. In 1993, 12 percent offered their employees only one plan; 38 percent offered their employees only two plans.

KPMG Peat Marwick

When small employers do provide health care coverage, most offer their employees little or no choice of types of health plans.

	Number of Employees	
Number of Types of Health Plans Offered	1-24	25-49
One	94%	84
Two	6	15
Three		1

TYPES OF PLANS OFFERED

Fewer employers are offering indemnity plans and more employers are offering managed care plans. Fewer employers are offering only an indemnity plan.

Type of Plan Offered/Survey	1988	1991	1992	1993
Indemnity				
Foster Higgins		76	72	
Hewitt Associates		73		66
KPMG Peat Marwick	89%	71		65
U.S. Chamber of Commerce		80	77	
Indemnity only				
Foster Higgins		27	23	
Hewitt Associates		64		47
HMO				
Foster Higgins		60	61	
KPMG Peat Marwick	72	72		74
U.S. Chamber of Commerce		57	52	
PPO				
Foster Higgins		31	39	
Hewitt Associates		29		39
KPMG Peat Marwick	12	24		42
U.S. Chamber of Commerce		46	46	
POS				
Foster Higgins		11	11	
Hewitt Associates (POS HMOs)		6		12
KPMG Peat Marwick				23

Foster–Higgins

In 1992:

- 77 percent of the respondents offered at least one managed care option to their employees;
- 30 percent offered only managed care plans and no indemnity plan; and
- 47 percent offered both traditional indemnity and managed care plans.

ENROLLMENT

Enrollment in indemnity plans is declining and enrollment in managed care plans is rising. In the Foster Higgins and KPMG Peat Marwick surveys, enrollment in managed care plans has surpassed enrollment in indemnity plans.

Type of Plan	1988	1991	1992	1993
Indemnity				
Foster Higgins		55	49	
HIAA	71%		58	
KPMG Peat Marwick		53	45	42
HMO				
Foster Higgins		23	26	
HIAA	18		19	
KPMG Peat Marwick		23	22	26
PPO				
Foster Higgins		17	20	
HIAA	11		20	
KPMG Peat Marwick		21	26	22
POS				
Foster Higgins		5	5	
HIAA			3	
KPMG Peat Marwick		3	8	10

KPMG Peat Marwick

Enrollment in indemnity plans in 1993 was significantly higher in smaller firms than in larger firms.

	Number of Employees	
Type of Plan	<50	50–199
Indemnity	73%	63
HMO	9	17
PPO	11	16
POS	7	4

COSTS

Foster Higgins

Health plan costs per employee have risen from $1645 in 1984 to $3968 in 1992. In 1992, health plan costs per employee amounted to 10.8 percent of payroll costs and 50 percent of earnings.

The gap between the cost of traditional indemnity plans and the cost of managed care

plans, particularly HMO plans, is widening.

Cost per Employee by Type of Plan	1988	1990	1992	88–92	90–92
Indemnity	$2,160	3,161	4,080	88.9%	29.1
HMO	1,991	2,683	3,313	66.4	23.5
Difference	8.5%	17.8	23.2		
PPO		2,952	3,708		25.6
Difference		7.1	10.0		

Health Insurance Association of America

The gap between the cost of indemnity plans and the cost of managed care plans is widening.

	1988		1992		Increase	
Plan Type	Individual	Family	Individual	Family	Individual	Family
Indemnity	$96*	206*	167	420	74%	104
HMO						
IPA	88	220				
Group/ staff	93	203	153	391	65	93
PPO	103	233	168	406	63	74

*Weighted average of unmanaged and managed indemnity plans.

KPMG Peat Marwick

For firms with 200 or more employees, the rate of premium increases for HMO plans has been only slightly lower than the rate of premium increases for indemnity plans.

Type of Plan	1991	1992	1993
Indemnity	12.0%	11.0	8.5
HMO	12.1	9.8	8.3
PPO	10.1	10.6	8.2
POS		12.4	4.9

However, for firms with less 200 employees, the rate of premium increases from 1992 to 1993 for managed care plans has been significantly lower than the rate of premium increases for indemnity plans.

	Number of Employees		
Type of Plan	1–24	25–49	50–199
Indemnity	12.0%	12.5	10.0
HMO	6.2	7.3	5.5
PPO	1.2	6.9	7.0

The monthly premium cost in 1993 for indemnity plans was higher than for HMO plans.

Type of Plan	Single	Family
Indemnity	$170	441
HMO	158	422
PPO	181	454
POS	186	530

For employers offering both types of plans in 1993, the cost of HMO plans was approximately 19 percent less than the cost of indemnity plans for single coverage and 16 percent less for family coverage.

For small employers, too, the monthly premium cost in 1993 for indemnity plans was higher than for managed care plans.

Type of Coverage:	Single		Family	
Number of employees:	1–24	25–49	1–24	25–49
Type of Plan				
Indemnity	$188	178	430	422
HMO	165	143	408	361
PPO	176	161	347	417

U.S. Chamber of Commerce

In their report, the category of benefits, "medical and medically related" is an aggregate of the following types of benefits: "hospital, surgical, medical, and major medical

insurance", "retiree hospital, surgical, medical, and major medical insurance", "short-term disability, sickness or accident insurance (company plan or insured plan)", "long-term disability or wage continuation (insured, self-administered, or trusts)", "dental insurance", and "other (vision care, physical and mental fitness benefits for former employees)".

Employers' cost of medically related benefits per employee per year rose from $2,853 in 1989 to $3,504 in 1992, an increase of 22.8 percent. Medical and medically related benefits as a percentage of payroll increased from 9.9 percent in 1990 to 10.3 percent in 1992.

Health and dental insurance costs per employee per year rose from $860 in 1980 to $2,754 in 1992, an increase of 220.2 percent. Costs as a percent of payroll rose from 5.5 percent in 1980 to 8.1 percent in 1992.

The net employers' cost of hospital, surgical, medical, and major medical insurance premiums per employee per year was $2,579 in 1992 and constituted 7.6 percent of payroll costs (7.7 percent of payroll costs for companies paying employee benefits).

Most employers fund their health insurance benefits through a variety of sources. In 1992, 63 percent of employers had self-funded health insurance plans, 51 percent had commercially insured plans, 35 percent had Blue Cross/Blue Shield plans, and 60 percent had plans funded through other sources.

No data was reported on costs by type of plan.

IMPLICATIONS FOR THE HEALTH SECURITY ACT

- The Health Security Act will provide most employees with more choice of health plans than they presently have.

- The Health Security Act will extend coverage of health insurance benefits to part-time employees as well as to full-time employees. Most employers presently do not provide coverage of health insurance benefits to part-time employees.

- The Health Security Act supports the shift toward managed care plans, but ensures that an indemnity plan will be available for everyone. An increasing number of employees presently no longer have the choice of an indemnity plan. The Health Security Act also provides the point-of-service option to everyone; few employees have such a choice today.

- More employers and employees may be choosing managed care plans over indemnity plans for two reasons:

    - Managed care plans are providing quality health care at less cost than indemnity plans.

- The rate of increase in costs is less in managed care plans than in indemnity plans.

The Health Security Act promotes the choice of health plans on the basis of value.

SOURCES

Foster Higgins

1992 Health Care Benefits Survey, Report 1, Medical Plans. (The 1993 report is due shortly.)

Health Insurance Association of America

Private communications. (The *1993 Source Book of Health Insurance Data*, containing 1992 data, is due shortly.)

Hewitt Associates

Private communications. The report, *Health Care Benefits Provided by Major U.S. Employers in 1992, SpecSummary*, splits all data between manufacturing and nonmanufacturing employers and does not report aggregate data. The data that the report does present are not relevant for our purposes. No 1993 report is planned.

The data presented above from private communications and the data contained in the printed report do not contain data on standard HMO plans; only data on POS HMOs is included.

KPMG Peat Marwick

Except as noted, the data presented above is from the report, *Health Benefits in 1993*. This report provides data from a survey of employers with 200 or more employees. The data presented above for smaller employers is from a survey of employers with less than 200 employees and was provided through private communications.

U.S. Chamber of Commerce

U.S. Chamber Research Center, *Employee Benefits, Survey Data from Benefit Year 1992, A Reference Guide for Employers and Benefits Specialists, 1993 Edition*, 1993. This survey was in two parts, the main survey and a supplemental section. When a similar question was asked in both parts, the responses were slightly different in some cases. These instances are noted above.

MARKET-BASED HEALTH CARE REFORM: WELL BEYOND THE DRAFTING TABLE

Summary by Paul W. Youket, Ph.D.

"Advancements have revolutionized 'managed care'. Many who criticize managed care see it as it was in the 1980s, an attempt to contain costs through utilization controls. Today, managed care pursues better health outcomes as well as cost savings, through continuous quality improvement, greater efficiency, and integrated service delivery. Armed with concepts and tools not available a decade ago, managed care now has more potential than ever before."

Introduction

This is a summary of the report *Market-Based Health Care Reform: Well Beyond the Drafting Table*, authored by Ingrid A. Tillmann, Nancy S. Bagby, and J. Brian Garrett of the Economic and Social Research Institute, commissioned by the Kaiser Family Foundation, and dated October 1993.

Main Theme/Focus of Study

This is a study of the recent transformations that are occurring in health care markets around the country. In particular, it focuses on the ways in which the new, expanded models of managed care that are being developed today are significantly different from the more limited forms of managed care that existed up until recently.

Main Points/Conclusions

New Paradigm

The authors argue that significant changes are occurring independently in the health care market in many parts of the country and that the patterns and trends of these "market-based reforms" point to a new "paradigm" for the provision of health care in this country. Under this new paradigm, purchasers of health care, primarily employers, seek to compare the "value" of various providers of health care by measuring the quality and cost of the services they provide. The purchasers then provide incentives for patients to utilize "high-value" providers, who are rewarded with high patient volumes.

In this new system of health care, purchasers are able to hold providers accountable, providers have an incentive to maintain patient health and to compete with each other on the basis of quality and cost, "and consumers have the responsibility to adopt healthful behaviors and use efficient providers".

Managed Care

The authors also argue that managed care has changed significantly. Formerly, managed care referred to utilization controls, HMOs, and PPOs. Its focus was limited to containing costs.

"Today, managed care pursues better health outcomes as well as cost savings, through continuous quality improvement, greater efficiency, and integrated service delivery." Its focus is now on "delivering value. It has outgrown its former limitations to (1) encompass a much broader set of organizational possibilities, (2) develop a commitment to quality and health outcomes, and (3) pursue cost savings through efficiency rather than through price discounts and access constraints."

The authors contend that the new tools that managed care is now using to do this "-- information systems, financial incentives, purchasing power, and integrated structures --" were lacking in earlier forms of managed care. Consequently, according to the authors, criticisms of managed care, which are based on outmoded models of managed care, are no longer valid.

> Organizational, structural, and philosophical transformations among growing numbers of providers groups have given risen to a totally new meaning for 'managed care'. Integrated health care systems dedicated to continuous quality improvement, preventive care, and the health of communities are rewriting the book on what it means to manage care. Their potential for producing favorable health outcomes cost-effectively appears vastly greater than those of 'old-school' HMOs and PPOs.

Providers

Based on their study of new forms of competition in health care markets around the country, the authors observe that "a new generation of providers" is being formed. These new types of providers will:

- adopt broad missions, such as assuming responsibility for providing comprehensive care to local populations;
- assume financial risk;
- be vertically and horizontally integrated; and
- use internal standards and techniques and advanced information systems to enhance quality and efficiency and respond to purchasers' demands for value.

Purchasers

The authors argue that employers are significantly changing the ways in which they purchase health care, which they term "community health reform". In this new "grass roots movement", employers are:

- working with each other in coalitions and pooling their purchasing power;
- becoming proactive, rather than reactive, about health care and assuming "roles that were once the exclusive province of insurers, managed care vendors, and even

providers";

- learning about health care "value" and defining the health care "products" that they wish to purchase;

- utilizing financial incentives and measuring the quality and efficiency of providers to determine value, to instill competition among providers based on value, and to reward providers of superior value; and

- working in partnership with "providers to improve the overall health of the community".

By providing providers with the "*right*" incentives to allow the health care market to function as it should, the authors contend that health costs are lower, health care delivery is improved, and health outcomes are enhanced.

The authors also emphasize that while all of the employer health care coalitions that they studied around the country share the goal of increasing the value of the health care that they purchase, they all take very different approaches to achieving that goal. What they choose to do "is highly subject to local interpretation of the mission by purchasers and receptivity to the effort by providers".

Similarly, they report that many health care purchaser groups around the country do not believe that standardized provider practice guidelines should be developed and enforced. Rather, purchasers should define the outcomes they wish to buy and allow providers to meet those performance standards in whatever way that they wish to.

National Policy

The authors wish to alert national policymakers that the health care market in this country is rapidly changing "in ways that are fostering competition, efficiency, and quality among providers". They warn that "policymakers at the national level need to be attuned to current local dynamics, so that their recommendations can promote and not deter the progress being made".

Because "the fields of outcomes management and quality improvement are exploding", the authors recommend that "national reforms should foster further development, dissemination, and use of reliable data on provider performance, since it is this information that makes value-based purchasing possible".

Data/Evidence

To support their contentions, the authors describe a number of case examples in the private sector and in the public sector.

PRIVATE SECTOR

Purchasers

The authors describe the efforts of a sample of employer health care coalitions around the country.

Metropolitan Areas

Chicago

The Midwest Business Group on Health, representing 140 companies in 11 Midwestern states, was a pioneer in the shift from cost-containment to value-enhancement and in studying the barriers among employers in focusing on quality and in becoming proactive in local health care delivery. Three demonstrations have been established to get providers and purchasers to systematically work together on quality improvement.

In Chicago, six hospitals are sharing information and pooling efforts to learn from each other to develop an optimal "clinical pathway" for clinical management of patients having coronary artery bypass graft surgery. Lengths of stay have declined and costs appear to have (now being verified).

The experience of the MBGH demonstrates the importance of providers and purchasers working together, a long-term focus for getting involved in health care issues, training in quality improvement for employers, and using meaningful data.

Cleveland

The Cleveland Health Quality Choice (CHQC) program represents both small and large businesses, covers approximately 20 percent of the population of Greater Cleveland, and works with almost all of the hospitals and physicians in the Cleveland area. The CHQC has spent several millions of dollars over a number of years to carefully develop a sound system for measuring and comparing the quality of services among hospitals using clinical outcomes and patient satisfaction.

They chose to make this major long-term investment, so that they would have data that was credible and acceptable to all. They are now meeting with managed care plans to develop incentives to use high-value "providers who demonstrate high quality and efficiency". Other employers are working with hospitals to improve their performance in certain areas. For the first time, hospitals are able to compare their performance in different areas with each other.

Denver

In response to ever rising health care costs, the Colorado Business Coalition for Health convened meetings between business leaders and hospital executives to discuss the problems and seek solutions. As a result, in 1988, the Colorado Health Care Purchasing Alliance was formed to represent all businesses and to become an agent for change in Denver. Problems were identified and a provider network was established.

Employers can "choose a variety of risk-sharing relationships" with the 25 hospitals in the network. As a result, "the average cost of a member's hospital stay is roughly one-third of the overall average for the metro-Denver area".

The 4,000 individual medical providers in the network "agree to a schedule of maximum fees and to outcomes monitoring". The Alliance worked with the providers to design the system of outcomes measurement and output analysis used.

A third component of the Alliance is the Utilization Management Services (UMS) program which educates consumers about the medical benefits of procedures to enable them "to make better-informed decisions about health care utilization". UMS also "uses Value Health Sciences to review the appropriateness of care of select medical and surgical procedures".

Des Moines

The Health Policy Corporation of Iowa is a coalition of over 50 businesses and organizations that seeks to work cooperatively with providers to manage health care and health care costs. In contrast to other coalitions, in response to local priorities, they have chosen to focus their efforts initially on only one major disease category, cardiovascular disease. Through a demonstration project in the Des Moines area, they want "to work through the full spectrum of details attendant to quality-based, performance-driven health care purchasing". They seek to better manage cardiovascular care and to measure provider performance and outcomes.

Memphis

After finding that hospital charges varied by as much as 80 percent for the same procedure, the Memphis Business Group on Health (MBGH), representing 50 employers, first sought bids for price discounts on hospital care in 1987. Only one hospital bid, offering a 20 percent discount, and was awarded the contract.

The other hospitals subsequently saw their revenues decline and quickly launched productivity drives and quality improvement programs to improve their competitive positions. "By the time the next round of bidding took place, ... all hospitals took it very seriously." Members of the employers coalition are now saving tens of millions of dollars in hospital charges.

Now, the MBGH seeks bids on quality measures first and on price second. Hospitals which do not raise their performance levels will lose business and may go out of business.

In addition, with a foundation grant, a community-wide information system is being established which will "link every provider in the city to a database that will track every health care encounter". Initially, the system will be used to reduce the administrative burden of billing and claims processing.

With clinical data, physicians will be able to compare their own performance with that

of other physicians and "self-correct (e.g., on the frequency of conducting certain procedures)". Data reports will be made available to the community and a full-scale clinical outcomes management program will be supported.

States

Florida

Six independent regional coalitions are working together in a statewide umbrella organization called the Employers Purchasing Alliance. It is "perhaps the most comprehensive private-sector effort to control the cost of health care" in the country.

The Alliance seeks to:

- "combine and broaden the purchasing power of the individual coalitions";
- "lower costs by concentrating on value-based purchasing, and by promoting the practice of continuous quality improvement among providers";
- "establish uniform standards for medical care";
- create "community-wide databases that measure the quality and costs of physician" and hospital services;
- "obtain comparative data on the outcomes and costs of hospitals within" each area; and
- contract with networks of the highest-quality providers.

Three of the coalitions, Orlando, Tampa, and Miami, are each taking the lead in developing one component of a comprehensive program, which will be shared with other coalitions. The Orlando coalition is focusing on "implementing data systems that measure provider quality and efficiency", the Tampa coalition is focusing on "creating collective purchasing arrangements", and the Miami coalition is concentrating "on wellness and prevention programs".

The Orlando and Tampa coalitions have already achieved significant savings in health care costs. The Miami coalition is just setting up its purchasing and data systems, but "will be offering its members a broader set of purchasing options".

The bargaining power of the Employers Purchasing Alliance is being further strengthened because out-of-state groups with in-state employees are interested in accessing the Alliance's provider network.

Minnesota

In Minnesota, a number of different private-sector organizations have been active in

reforming health care in the state.

A coalition of the Twin Cities' largest employers have signed a three-year contract with a provider network:

- to provide primary care physician "gatekeepers" to manage patient care and authorize referrals to specialists;
- to provide comprehensive health services to enrollees;
- to develop practice guidelines to "ensure quality and eliminate unnecessary care";
- to jointly develop a system for capturing "meaningful data on quality and utilization"; and
- to reduce the growth in the cost of their total health benefits to the overall rate of inflation.

A coalition of small and midsize employers have contracted with the Prudential Insurance Company to reduce health care costs through quality improvement and "to increase value through financial incentives, practice guidelines, outcome measurements, consumer education, and cooperative provider relationships".

Another coalition of small and midsize businesses focuses on advocacy and education. They helped secure legislation establishing "a statewide data utility to collect, analyze, and disseminate information on health care quality, utilization, and costs".

Blue Cross and Blue Shield of Minnesota is establishing incentives for "providers to deliver care more effectively, appropriately, and efficiently" through such vehicles as "an outcomes-based reimbursement system, a select network for cardiac care, and a clinic-based quality improvement program. With the largest and oldest data base in the state, BCBSM is well positioned to perform the outcomes analyses needed in evaluating provider quality".

Providers

The authors profile four providers as examples of the new generation of providers being developed.

Lovelace, recently acquired by CIGNA Corporation, is the largest integrated managed care provider in New Mexico. It consists of a physician group, a medical center, a health plan, and satellite service centers. It has focused strongly on quality improvement, functional and geographic expansion, customer service, and community wellness promotion.

Presbyterian Healthcare Services in New Mexico and southern Colorado is developing an integrated managed care system with an IPA-type HMO to compete with Lovelace. They are building a network of physicians which links primary care practitioners with new specialty group practices, a system to align hospital and physician incentives for capitated contracts

with insurers and employers, "a systemwide continuous quality improvement program", and "an integrated management information system that will link all inpatient and outpatient treatment settings".

In Los Angeles, UniHealth America is similarly building an integrated delivery system to compete with Kaiser Permanente. A "medical group foundation" is being set up for each hospital to administer a physician group practice, "track ... patient care, cost, and outcome data ... for competitive managed care contracting", and "link reimbursement to treatment costs and outcomes, rewarding physicians who practice high-quality, cost-efficient medicine".

Sentara Health System in Norfolk, Virginia, expanded from the hospital business to a well-developed, integrated, regional health care delivery system. The cradle-to-grave system "includes four hospitals, an IPA-model HMO, a staff-model HMO, a mental health HMO, primary/urgent care centers, home health services, outpatient diagnostic centers, a child day care center, eight nursing homes, and an assisted living center for the elderly". Its "systemwide quality improvement program" has generated significant cost savings as well as enhanced customer satisfaction.

PUBLIC SECTOR

State Level

Florida

New legislation this year established a statewide system of managed competition in which 11 Community Health Purchasing Alliances (CHPAs) throughout the state offer a choice of health plans to participating employers and employees. The plans are networks of insurance companies, HMOs, physicians, and hospitals that must meet specified requirements. The CHPAs will negotiate with these plans to obtain the best care at the lowest rates and will "gather and disseminate information on the quality of the care they provide", allowing comparisons of value. Premiums will be paid to the plans directly.

Poor and uninsured residents are to be covered by an expanded Medicaid program, if approved by the federal government. Otherwise, a low-cost, basic benefit package will be made available.

Minnesota

Minnesota passed the HealthRight Act last year as the first in "a series of steps to control costs; reform the small employer health insurance market; extend coverage to the uninsured; establish funding to cover premium subsidies; and assist rural areas". The Act created a 25-member Minnesota Health Care Commission to develop:

- "a cost containment plan that would limit the growth of health care expenditures by at least 10 percent each year for five years" and

- "strategies for improving the quality, access, and affordability of coverage".

The cost containment plan that was developed recommended institution of a system of managed competition among new HMO-type integrated service networks, "global limits on the growth in public and private health care spending; payment system reform; health insurance pooling mechanisms; a comprehensive data system; and technology assessment". If the plan is fully implemented, savings are estimated to approach $7 billion over five years.

Federal Level

Federal Employees Health Benefits Program

The authors believe that more attention should be paid to the experience of the Federal Employees Health Benefits Program because it "is based on consumer choice and health plan competition" and is "perhaps the largest and oldest approximation of managed competition extant". It has achieved "an impressive record of cost control and benefit enhancement", comparing favorably to Medicare and private employer health benefit plans and enabling federal employees "to get more value for their money". The government's fixed rate of contributions may have provided an incentive for many enrollees to shift from higher-cost fee-for-service plans to lower-cost HMO plans.

Implications for the Health Security Act *(views of P. Youket, not I. Tillman, N. Bagby, or J. Garrett)*

On the positive side, the report shows that the health care market is already being transformed throughout the country in many of the ways envisioned by the Health Security Act. Innovative efforts are occurring in a number of localities and states around the country.

The current health care system is being changed and new models of care are being developed. Successful examples of "managed care", employer purchasing alliances, and "managed competition" are rapidly being created.

Efforts to redesign the system are working and are paying off. Costs are being held down, significant savings are being realized, and quality and performance are being improved through more advanced and expanded models of managed care, purchasing coalitions, and managed competition. Thus, the types of reforms embodied in the Health Security Act are already being implemented in a number of places around the country and the desired results are being achieved.

The study also documents that the capability exists in many parts of the country to take control of the health care system and reconfigure it to better meet the needs of purchasers and patients. It demonstrates the importance of local involvement, local initiative, and tailoring the process of change and the system redesign to local needs, desires, and priorities.

Based on the diverse state and local initiatives underway, a new model of an optimal health care system is emerging. The Health Security Act is based on this new model of care. The momentum of change in many areas of the country to realize this new model of care will continue whether the Health Security Act is enacted or not.

On the negative side, however, the authors are fearful that too heavy a federal hand in health care reform (e.g., too stringent federal regulations) will stifle and smother innovations in the private-sector health care market. Some opponents of the Health Security Act may use this report and the cautions raised to argue against not only the Health Security Act, but any meaningful federal initiatives in health care reform. It is important to stress, therefore, that the Health Security Act provides strong incentives for states, localities, employers, and health plans to develop innovative reforms within a broad framework of requirements.

It is also important to realize that the benefits of these "market-based", "community health reform" movements are limited to certain areas of health care, certain states and localities, and certain parties within those localities, primarily large employers, their employees, and their families. Many other smaller businesses, individuals, and families in those and other areas are not helped.

Without the Health Security Act, there would continue to be a hodgepodge of diverse local initiatives, primarily benefiting large employers. Statewide reforms will occur here and there, but the types of efforts and outcomes would vary widely across states and localities. Some states and metropolitan areas would be very active and effective, while little or no action would occur in many others. Even in those areas where efforts are made, results would be mixed; strong in some areas and weak in others.

The impacts would be haphazard. Some individuals, families, and businesses would benefit from these dispersed, nonuniform activities, but many others would not. Not all areas of health care would be equally improved or at the same rate. Mental health care and long-term care would likely be neglected for many years. Left on their own, in the absence of the Health Security Act, ad hoc, "market-based", "community health reform" efforts would not achieve either universal coverage or comprehensiveness of benefits and would not benefit most small employers.

In addition, the underlying dynamics propelling the dysfunctional dynamics of the current health care system are so strong that localized efforts may be too limited or too slow to reverse the accelerating systemwide dysfunctions and establish an effective new order for everyone.

Even effective innovations would take a long time to spread around the country if left to do so on their own. We cannot afford to wait; the mental, physical, and financial suffering are too great. Everyone needs to benefit quickly from adoption of an optimal health care system.

Larger scale action, as provided by the Health Security Act, is needed to provide the spur, the means, the standards, and a framework for all states and localities nationwide to deal with the out-of-control health care system, to harness its destructiveness, to bring in those individuals, families, and businesses who have been pushed out of the system, to move quickly and on a larger scale, to learn from the efforts of others, and to foster even more state and local initiatives and innovations.

In a pending op-ed article, the senior author of this study questions whether the

5,000-employee threshold in the Health Security Act for employers to be allowed to form a corporate health alliance is too high. She believes that smaller employers may also be able to design innovative corporate health alliances. That well may be true. However, the Health Security Act, as presently written, reflects the fact that most of the advances in private-sector health care reforms have come from large employers.

In contrast to other legislative proposals, the Health Security Act is consistent with and would promote, build upon, and accelerate the changes in the competitive health care market in the direction in which they are already occurring.