Richard

Ken

Judy

PRIVATE HEALTH CARE PREMIUMS

THE CLAIM:

New studies by KPMG Peat Marwick and Foster Higgins & Co. find that private health insurance premiums are increasing less than inflation, largely because of the growth of managed care. Some claim that this means that the Republicans are right in counting on big savings from increased use of managed care in Medicare.

THE FACTS:

- The surveys show that there is a one time savings from the move from more expensive fee-for-service to less expensive managed care plans. Both KPMG and Foster Higgins report that there is no evidence that these savings can be maintained over time. Foster Higgins says: "Where is this reduction in health care costs that we read about in the papers? When you look at the managed care plans, you see that there was none. It was simply the movement from indemnity to managed care."

- The real question is *why* premiums increased at a lower rate than inflation. The answer is simple. People are getting less or paying more out of their own pockets.

- Both studies show that large employers are saving money by increasing the amount their employees are paying. Employees are being asked to pay a greater share of the premium payment as well as higher copayments and deductibles, and many of them are moving into lower cost plans.

- In addition, employers are saving money by carving out expensive "specialty benefits" like prescription drugs and mental health and providing them in separate plans. Foster Higgins estimates that these two carve-outs save $600 per employee.

- Finally, KPMG found that in the past year, greater numbers of preferred provider plans limited coverage to people with so-called preexisting conditions.

- We believe that plans can and should be more efficient. But we also believe that it is disingenous to call cut backs in benefits or increases in out or pocket costs efficiency.

THE WASHINGTON POST
THURSDAY, SEPTEMBER 28, 1995

Health Care Costs Hit Milestone

Premium Increases Are Below Inflation Rate for First Time in 10 Years

By David Segal
Washington Post Staff Writer

Increases in health care premiums have fallen below the rate of inflation for the first time in 10 years, largely because of the growth of managed-care programs, according to a national survey released today by KPMG Peat Marwick LLP, a benefits consulting firm.

The report, which surveyed 1,037 randomly chosen employers, provides both heartening and disheartening news for congressional Republicans who want to curtail Medicare costs by increasing reliance on managed care. Authors of the survey said the ability of managed-care plans to contain costs may be short-lived.

The survey found that health premiums for a variety of plans increased at an average of just 2.1 percent from 1994 to 1995, while consumer prices rose 3.2 percent. The figures continue a two-year trend of moderating prices: In 1994, premiums rose by 4.8 percent and in 1993, by 8 percent.

"Managed care has turned the corner in moderating the rate of health premium increases by pushing it below the consumer price index," said Jim Buckley, partner in charge of health benefits at KPMG Peat Marwick. "But whether or not these savings will continue in the future is the real question."

The slower rate of premium increases generally may reflect one-time savings from the move away from less cost-efficient fee-for-service plans and into streamlined managed-care operations. Additionally, some health care analysts are skeptical that managed care will, in the long run, contain costs at a better rate than other health care delivery approaches.

"If I ran [a health maintenance organization], I would be able to squeeze out a fair amount of fat," said Uwe Reinhardt, a health care economist at Princeton University. "But once the doctors' fees have been squeezed to the bare bones, once hospital stays have been reduced, will you then be able to continue the trend? That's an open question now."

As evidence, Reinhardt cites the single-payer Canadian system, which spends less per capita on health care but has seen increases in health care spending that are similar to those in the United States.

What's limiting the premium increases, the survey found, is the gradual migration of employers to managed care, a catch-all phrase for health plans in which primary-care doctors act as "gatekeepers" to curtail surgical procedures and hospital stays. The survey found that enrollment in all kinds of managed-care plans rose by 4 percent from 1994 to 1995 and now stands at 69 percent of employees in the companies surveyed. Health maintenance organizations (HMOs) showed the smallest rate of increase in health premiums with just 0.4 percent.

The challenge, Buckley said, will be keeping premiums low as advances in technology make health care both better and, paradoxically, more costly.

The challenge, Buckley said, will be keeping premiums low as advances in technology make health care both better and, paradoxically, more costly. Unlike other businesses where technological advances reduce costs—computers, for instance, help retailers keep prices down—health care generally gets more expensive as its related technologies improve. A simple X-ray, for example, costs $80, but will not tell you nearly as much about a broken bone as the results of a $500 magnetic resonance imaging procedure, which costs about $500, Buckley said.

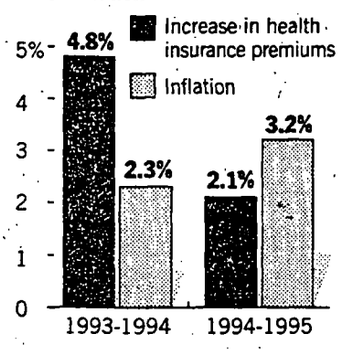
Equally vexing is the gradual aging of the population, a trend fueled by low birth rates and the passing into middle age of many baby boomers. For each year that a population ages, Buckley said, its health care spending rises by 2 percent to 3 percent.

These demographic and technological forces are a challenge to Republicans in Congress, who hope to save billions of dollars on health care in coming years by providing vouchers that seniors can use to enroll in managed-care facilities.

THE COSTS OF HEALTH CARE

Unlike in 1994, the cost of health insurance premiums this year has been growing more slowly than inflation overall . .*

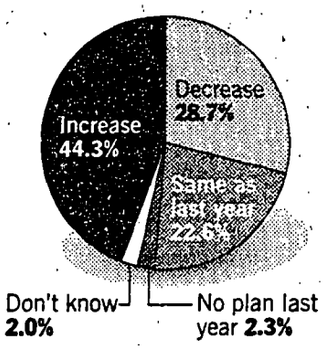
Health insurance premiums vs. inflation



**March 31, 1994-March 31, 1995*

. . . although premiums for many managed-care firms continued to rise in 1995.

Premiums for HMO firms, 1995



SOURCES: KPMG survey of 1,037 employers, Bureau of Labor Statistics

THE WASHINGTON POST

THE WASHINGTON POST
THURSDAY, SEPTEMBER 28, 1995

Supreme Court Accepts Dispute on Census

Decision Concerning Undercount Could Affect Political Districts, Federal Fund Allocations

By Joan Biskupic
Washington Post Staff Writer

The Supreme Court said yesterday it would decide the politically charged question of whether the government must adjust census figures to compensate for the undercounting of racial minorities in the nation's big cities.

A ruling in the case ultimately could change the apportionment of congressional seats and distribution of federal funds among states.

"It all boils down to power and money," observed Barbara Everitt Bryant, director of the Census Bureau from 1989 to 1993. Bryant, commenting yesterday on the court's announcement, noted that census data are used not only to reapportion Congress but to draw districts for legislative seats down to the city council level.

The case arises from a decision by Bush administration Commerce Secretary Robert A. Mosbacher not to adjust the 1990 population count after census officials determined that there had been an undercount of minorities and certain ethnic groups.

That decision, challenged by New York, Los Angeles, Chicago, the District and several other cities, became an issue in the 1992 elections. Democrats argued that the GOP administration deliberately refused to account for inner-city residents who were likely to vote Democratic. Ronald H. Brown, then chairman of the Democratic National Committee and now President Clinton's commerce secretary, attacked the Bush administration for the decision.

But after a federal appeals court in Manhattan ruled last year that Mosbacher did not do enough to ensure an accurate head count, the Clinton Justice Department appealed to the high court.

In accepting the appeal, *United States v. City of New York*, the court unofficially opened its new term. As is their tradition, the justices will not begin hearing cases until Oct. 2, the first Monday in October. But as the court has done in the last two years, it made an early start on new cases to supplement a relatively slim calendar carried over from last term.

The justices also said yesterday they would hear a sentencing appeal from two police officers convicted in the highly publicized, videotaped beating of Rodney G. King in Los Angeles four years ago.

After former sergeant Stacey C. Koon and officer Laurence M. Powell were convicted by a federal jury of civil rights violations, they were sentenced to 30 months in prison. An appeals court, however, ruled last year that the sentencing judge improperly departed from federal sentencing guidelines and that the sentences should have been at least 70 months.

The trial judge had reduced their prison time largely because the defendant police officers initially had been provoked by King, because they would be susceptible to abuse in prison, and because they were tried both in state and federal courts.

The appeals court ruled that those factors were not proper grounds for departure from the rigid sentencing guidelines. The officers' acquittal in a 1992 state trial, which preceded the federal trial, sparked riots in Los Angeles that resulted in more than 50 deaths and more than $1 billion in property damage.

While the Supreme Court refused to take up Koon's complaint that the successive state and federal prosecutions violated his constitutional right against double jeopardy, the court's acceptance of the sentencing question eventually could clear up confusion nationwide on judges' discretion under the controversial federal sentencing guidelines.

The new cases would be heard in early 1996 with decisions handed down by the end of the 1995-96 term next summer.

The court, which will continue in upcoming weeks to accept new cases, has yet to reveal whether it will take up the Justice Department's challenge to the male-only Virginia Military Institute in Lexington. An appeals court last year endorsed VMI's exclusion of women after the state began offering a leadership program for women at nearby Mary Baldwin College. The Clinton administration is appealing a decision that allows for "separate, but substantially comparable" education for the sexes.

Another looming question is whether Chief Justice William H. Rehnquist, who had back surgery yesterday, will be on the bench next Monday when the term officially begins. A court spokesman said Rehnquist, who will be 71 Sunday, underwent a "laminectomy for spinal stenosis" at Washington Hospital Center and was "resting comfortably."

The operation involves a surgical chipping away of the bony arches of the vertebrae to relieve compression of the spinal cord. Rehnquist has had recurring back problems since 1977 and periodically stands and walks around during oral arguments to relieve the pain. A court spokesman said it was not known when the chief could return to the bench.

Yesterday's census case immediately became one of the most significant disputes on the court's new calendar. Billions of federal funds are at stake.

"In the last 20 years," said former census director Bryant, now a business professor at the University of Michigan, "we've gotten some 120 federal funding programs that move approximately $150 billion a year, which in their formulation for distribution use census counts."

The Census Bureau estimated that an adjustment would raise the official 1990 population by about 5 million—to 254 million. Hispanics, Indians and blacks reportedly were undercounted by about 5 percent and Asians by 3 percent.

Studies showed that if an adjustment were ordered, California and Arizona each could gain a congressional seat, at the expense of Pennsylvania and Wisconsin.

It is unlikely that a high court decision would affect districts in the 1996 elections, especially because any new standard articulated by the court probably would involve further lower court action.

The case, which arises from appeals by the states of Wisconsin and Oklahoma in addition to the Justice Department, is more likely to affect federal disbursements through 2000, and then the new census, said Paul Crotty, corporation counsel for New York City. "It is important . . . to answer why the Department of Commerce shouldn't be forced to use the most accurate method for best counting," he said.

The government acknowledges that undercounts happen: Blacks and Hispanics are undercounted more than whites; men are missed at a higher rate than women; the young are missed more than the elderly; and renters are missed more than homeowners.

Solicitor General Drew S. Days III said in a brief that courts should not try to determine what the best census policy should be, but rather whether a commerce secretary's decision not to make an adjustment is within a range of "constitutionally permissible options." In this case, the secretary rejected a recommendation from the Census Bureau to make an adjustment after finding, according to Days, that the adjusted figures were less accurate than the unadjusted count.

HMO Premiums to Stay Steady in 1996, Lagging Behind Inflation, Survey Says

By RHONDA L. RUNDLE
Staff Reporter of THE WALL STREET JOURNAL

Medical-care prices charged by health-maintenance organizations will be nearly the same in 1996 as this year, lagging behind the projected general inflation rate for the first time in years, a survey finds.

HMOs across the country expect an average 0.8% increase in premiums, with rates declining 0.5% in the mountain region, including Arizona, Colorado, Idaho and five other states, according to the survey conducted by Sherlock Co., a Gwynedd, Pa., investment-banking firm specializing in the managed-care industry. Economists generally expect overall inflation to be about 3% next year.

HMOs are responding, in part, to criticism in recent years that their price increases have been higher than the general inflation rate and have shadowed the increases of more expensive traditional medical plans, said John Erb, a principal at Foster Higgins & Co., a New York-based consulting firm. "Now with all the complaints about huge profits and executive salaries, some HMOs may be fearful of losing market share based on price."

Anonymous Responses

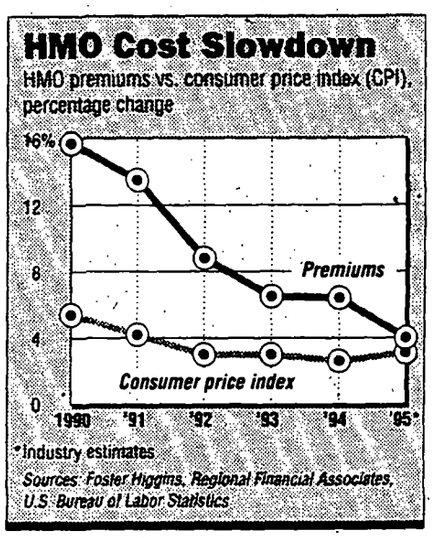
The survey findings were "relatively even" across different geographic regions and present "a fair picture of the kind of premium-rate increase consumers and their employers could expect to receive next year," said Douglas Sherlock, the firm's principal. He cautioned that most of the responses were anonymous, so the results could be skewed somewhat by a an overrepresentation of either too many large or small HMOs.

Responses were received from 92, or almost 17%, of the 547 HMOs to whom questionnaires were sent in August, Mr. Sherlock said. The results appear in the October edition of his firm's newsletter, Pulse, mailed Friday. Subscribers are mainly HMO financial officers, investment professionals, hospitals and doctors.

Medical-Loss Ratios

Consultants, analysts and HMOs contacted at random last week said they expected 1996 increases to be quite small, an expectation in line with the survey results. Negotiations are just heating up now between employers and HMOs, insurance companies and other health plans, so that final contracts can be nailed down in November and December before most arrangements go into effect Jan. 1.

"From our client work with large employers, the 1996 increases will be minimal, if any, across the board," said Mr. Erb. "Many HMOs are repricing even their current plans to give decreases, or no increase," he said.



Of the survey respondents, 52% anticipated increases in their premium rates, while almost 22% expected declines and 26% anticipated flat rates. Of the responding HMOs, 42% expected deteriorations in their medical-loss ratios, meaning that their payments to doctors and hospitals would be a larger portion of their total revenue; 26% expected the ratios to improve; and nearly 35% expected no change. Medical costs are generally about 80% of HMO revenue.

Overall, the medical-loss ratio is expected to rise 0.5%, meaning that HMOs will pay slightly more of their total revenue toward medical care, the survey showed. Mr. Sherlock calculated, based on the findings, that HMO payments to doctors, hospitals, and other providers, will increase 1.5% next year.

Mr. Sherlock said he was surprised to find rates firming in the Pacific region, which is dominated by California, one of the most competitive HMO markets. At the same time, HMOs in that region expect a small improvement in their medical-loss ratio, indicating their profit margins will rise, he said. That reflects the "overwhelming pressure on doctors and hospitals" that California HMOs are exerting, he said.

"Flat rates are what we see for 1996," said a spokesman for **Health Systems International** Inc., a big HMO based in Woodland Hills, Calif. Another California-based HMO, **FHP International** Corp., expects rates to decline by between 1.5% and 2% in the year ending June 30, 1996, a an FHP spokeswoman said. FHP's rate declines are driven by the June 1994 acquisition of TakeCare, she said, whose rates "were on the high end of the market."

Pitofsky Will Test Marketplace of Ideas Theory In FTC's Review of Time Warner-Turner Deal

By BRYAN GRULEY
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON – As a scholar and teacher, Robert Pitofsky has preached the controversial notion that antitrust laws should not only protect competition in the economic marketplace, but also in "the marketplace of ideas."

Now the new chairman of the Federal Trade Commission is preparing to investigate a deal that could allow him to put his theories to the test – the proposed $7.5 billion merger of Time Warner Inc. and Turner Broadcasting System Inc.

Robert Pitofsky

In a private showdown last Thursday night, Mr. Pitofsky and Anne Bingaman, the assistant attorney general for antitrust, finally agreed that the FTC, rather than the Justice Department, would handle the review of the mega-media merger. The decision followed two weeks of spirited jockeying between the two agencies, which share the responsibility for overseeing the nation's antitrust laws.

Fought to Get Case

The fervor with which the FTC fought for the case is a sign that Mr. Pitofsky intends to conduct a lengthy and rigorous review, and could in the end raise some serious antitrust concerns. "This is one Bob Pitofsky really, really wanted," said an associate of Mr. Pitofsky's. In particular, the FTC is expected to look closely at whether Time Warner-Turner would wield undue control over the programming distributed by its vast cable network, covering an estimated 40% of U.S. households.

Even if the deal is approved, Mr. Pitofsky is making it clear that he believes media mergers – which are expected to proliferate – deserve special scrutiny under the antitrust laws.

In a recent interview, Mr. Pitofsky declined to comment on the Time Warner-Turner merger. But he provided a window onto his views regarding media mergers. "We always take an especially close look at mergers in an industry where there's a very pronounced trend toward concentration [and] media mergers looks to be quite a pronounced trend," he said.

Media Deals Are Different

He also said media mergers deserve tougher scrutiny than, say, mergers in the shoe industry. "You might take a tougher stance . . . in the media field because you are concerned that too much power in too few hands will impair freedom of expression."

That's a notion that the former Georgetown University law professor has been pushing since the 1970s, when he wrote "The Political Content of Antitrust," a law review article he recommends to those who ask about his thinking on media mergers.

"It is bad history, bad policy and bad law to exclude certain political values in interpreting the antitrust laws," Mr. Pitofsky wrote. Rather, antitrust enforcers should consider the potential that "excessive concentration of economic power will breed antidemocratic political pressures."

His ideas conflict with the more conventional view – embraced, for example, by President Reagan's antitrust enforcers – that mergers' effects on competition should be judged solely on analysis of such economic factors as market shares and prices. Even some who think Mr. Pitofsky raises good questions wonder how to quantify competition in his "marketplace of ideas."

"How do you measure someone's control in that marketplace?" asks Judith Whalley, who teaches antitrust law at Georgetown. "Is it the number of stories? The number of reporters? And when do you start being concerned? Should you have more diversity in media than you would have in making widgets?"

Ideas Could 'Tip a Decision'

Government officials and antitrust experts who know Mr. Pitofsky say he isn't about to embark on a First Amendment crusade in the application of antitrust law. Rather, as he told a Senate panel in December of 1993, his ideas are likely to apply "in a close case" where "the fact that we are talking about something that has an effect on the First Amendment could tip a decision in favor of enforcement."

But given the trend toward media mergers, its seems likely such a case will eventually surface. "Before this merger surge is over," Mr. Pitofsky said in the recent interview, "one of these cases is going to go to court, and these questions will be raised."

Time Warner is preparing for a tough review. The main potential problem stems from the involvement of Tele-Communications Inc., the nation's largest cable operator, closely trailed by Time Warner. TCI has agreed to swap its 21% stake in Turner Broadcasting for 9% of the new company. To address a federal rule barring a single firm from controlling cable systems that reach more than 30% of the U.S. market, TCI would put its Time Warner shares in a voting trust controlled by Time Warner chairman Gerald Levin.

Time Warner officials say they are confident the stock swap will be approved, but some insiders fear the voting trust will face pointed scrutiny in Washington. Those people worry that federal bureaucrats will be uncomfortable approving an arrangement so specifically tied to an individual.

The Time Warner-Turner deal also could test Mr. Pitofsky's advocacy of closer scrutiny of vertical mergers. The new company would control a huge amount of the programming distributed by its vast cable network. Noncable businesses trying to enter the cable industry could find it more difficult or costly to buy programming from their new, bigger rivals, some antitrust experts say. Conversely, smaller programmers might have a tougher time selling their wares to an operator that generates much of its programming internally. The FTC is expected to explore those issues, partly because Mr. Pitofsky has argued that lax enforcement of vertical arrangements in the 1980s wasn't necessarily wise.

Again, this is an area where Mr. Pitofsky's ideas have met with some skepticism from his more conservative colleagues, who argue there's little factual evidence that vertical mergers adversely affect consumers. "Given the choice of two uncertain alternatives, we should allow competition and not government officials to watchdog consumer welfare," antitrust lawyer Mary B. Cranston argued in a presentation last spring to the American Bar Association.

The traditional rivalry between the antitrust agencies has intensified since Mr. Pitofsky's arrival at the FTC. He chaired the Clinton administration transition team that focused on antitrust, and was expected by many to get the Justice antitrust job, which went to Ms. Bingaman instead. In her two years on the job, Ms. Bingaman has heightened her division's profile with a sharp increase in investigations, including well-publicized probes of Microsoft Corp. and Archer-Daniels-Midland Co.

Both Mr. Pitofsky and Ms. Bingaman play down any such competition. But associates say Mr. Pitofsky particularly wanted the Time Warner-Turner merger because the Justice Department previously won the right to review the proposed combination of Walt Disney Co. and Capital Cities/ABC Inc. If the Justice Department also had snagged the Time Warner-Turner deal, it could have argued that its cumulative expertise entitled it to any future media mergers.

–Eben Shapiro contributed to this article.

Question: A new study by KPMG Peat Marwick finds that health care premiums increased less than inflation for the first time in ten years between 1994 and 1995, largely because of the growth of managed care. Doesn't that prove that the Republicans are right in counting on big savings from increasing the use of managed care in the Medicare program?

Answer: No. The survey shows that there is a one time savings from the move from more expensive fee-for-service to less expensive managed care plans. However, CBO says that under the Republican plan new enrollment in managed care will increase to 21 percent in the year 2002, instead of 14 percent under current law. Only $7 billion would be saved because of new enrollment. Both KPMG and Foster Higgins report that there is no evidence that these savings can be maintained over time. Foster Higgins says: "Where is this reduction in health care costs that we read about in the papers? When you look at the managed care plans, you see that there was none. It was simply the movement from indemnity to managed care."

Question: A new study by KPMG Peat Marwick finds that health care premiums increased less than inflation for the first time in ten years between 1994 and 1995, largely because of the growth of managed care. Doesn't that prove that the Republicans are right in counting on big savings from increasing the use of managed care in the Medicare program?

Answer: The real question is *why* premiums increased at a lower rate than inflation. The answer is simple. People are getting less or paying more out of their own pockets. The same study also found that the amount employees are paying in cost sharing has increased. It also found that in the past year greater numbers of preferred provider plans limited coverage to people with so-called preexisting conditions. We believe that plans can and should be more efficient. But we also believe that is disingenous to call cut backs in benefits or increases in out of pocket costs efficiency.

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MEMO FOR: JENNIFER KLEIN

FROM: RICHARD HINZ

SUBJECT: Thoughts on why employer costs are declining in KPMG survey

Below are some ideas as we discussed yesterday about how to interpret the finding in the KPMG survey released yesterday that employer's total premium costs have declined to below the CPI. They are not particularly well organized but I hope they are of some use to you. Give me a call if you have questions or need more help.

What KPMG 1995 survey shows

KPMG's annual survey of 1,000 large firms shows steadily declining health plan premium increases across all types of plans -- i.e., both conventional (indemnity) and managed care.

Overall plan premium increases have fallen sharply in 1990s -- 11.5% in 1991, 10.9% in 1992, 8.0% in 1993, 4.8% in 1994, and 2.1% in 1995 -- and specific plan types show same pattern as overall health plans. (Figure 1)

Premium increases for both indemnity and managed care plans have dropped more or less in concert from peak in 1989. (Figure 3)

HMO health plan premium increase dropped most from 1994 level, and lowest of all plan types in 1995. (Figures 1, 3)

KPMG survey shows rapidly shifting enrollment towards managed care plans, particularly HMO and POS (point-of-service) plans.

Employee enrollment in managed care plans has expanded rapidly in recent years -- 56% in 1992, 58% in 1993, 65% in 1994, and 69% in 1995. (Figure 4)

KMPG reports that employee premium contributions are rising across all types of plans, and that health plan enrollment is rising -- 81% in 1995.

They appear to have done a good job of controlling for some of the more obvious factors that might provide a misleading measurement of premiums. They have (1) included the full employer and employee share in their premiums, (2) controlled for shifts in the broad categories of plan types and (3) only used employers who appear in all of the years of their sample.

What they have not been able to control for are (1) changes in the generosity of the benefit package (2) increases in copays and deductibles or (3) changes in coverage or eligibility.

The analyst tells me that the reason they do not do this is that the sample size is not large enough but that in looking at the data on each of these factors they do not appear to be a significant influence. Taken together these factors probably have some effect but cannot explain the a change of the magnitude they have measured however.

Unfortunately we do not have any good data that covers such a recent time period to make such comparisons. The Employee Benefits Survey that would tells us this only give us data up to 1993 so is not much use. The latest CPS data on coverage seems to show that after many years of eroding coverage there does not appear to be a loss of direct employer coverage in the last several years and they may be right about the small increase.

Therefore, the most likely explanation is that in fact the larger firms have been achieving some cost containment over the last several years. It appears that they have been achieving this by cutting back on their contributions and increasing the employee share, moving toward level contribution type formulas. All of the survey data shows increases in the proportion of employers who pay only part of the premium. Fostor Higgins shows a 2% increase in employers with premium sharing since 1993 and Hay Huggins shows a 7% change since 1991.

This appears to be moving employees into lower cost plans, many of which are managed care, probably as much by employee choice as they respond to full marginal costs for richer benefits as any other factor. Although we can't readily find data to support it is likely that these are less generous benefit packages which is as much responsible for the lower cost as is the managed care character.

This has been accompanied by very aggressive cost management practices by the larger employers many of whom have significant leverage in their markets and have been carving up their health plans to manage costs in areas like prescription drugs. Keep in mind that the KPMG survey is of firms with more than 200 workers who have the ability to do these sorts of things.

On balance I think that a reasonable interpretation of the survey's finding is:

> Private employers have been aggressively managing health benefit costs for nearly a decade now and are now achieving some results.
>
> The largest private employers are in a position to do this most effectively and that is what the survey shows. What remains to be seen are whether the small groups or

individual markets will suffer for this success.

Large employers are shifting health benefit costs towards the employee -- increasing the employee share of the premium contribution, and increasing plan copayments and deductibles. This is moving people into lower cost plans.

Large employers are creating strong incentives for shifting enrollment towards managed care plans -- setting level premiums for conventional and managed care plans.

Large employers are carving out volatile "specialty" benefits -- e.g., prescription drugs, mental health/substance abuse services -- and providing them through "free-standing" managed plans.

Large employers are aggressively negotiating prices with health plans. They are big enough and have developed new strategies to do this

It is premature to attribute the cost containment that is observed solely to managed care although it may be a factor. We will not know until these one time effects of the fundamental shifts wash out when we reach some stability in the types of plans and benefit packages what the long term cost patterns will be.

I think there is some validation of these interpretations in the 1994 Foster Higgins survey as outlined below:

<u>What Foster Higgins 1994 survey shows</u>

Foster Higgins' annual survey of all firms (with 10 or more workers) shows sharply declining health benefit cost increases.

Total health benefit cost per worker increases for all firms have declined steadily from peak in 1988, and plummeted in most recent survey year -- 8% in 1993 and -1.1% in 1994. (Figure 2)

Large employers (500 or more workers) had cost decrease of 1.9% -- or increase of -1.9% -- in 1994.

Foster Higgins survey shows enrollment shifting rapidly towards managed care plans.

Large employers are shifting enrollment towards managed c are plans -- 57% in 1993 and 67% in 1994 -- and POS plans, specifically -- 9% in 1993 and 17% in 1994. (text on p. 9, Figure 3)

Large employers are creating freestanding (or carve-

out) plans for prescription drug and mental health/substance abuse services to manage use -- 44% drug and 19% mental health/substance abuse plans in 1994. On average, both carve-outs together save $600 per employee. (text on p. 11, Figure 6)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

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REMARKS: Comments on Growth rates in the private sector. Also, I'll call you later re. Rural Hospitals

August 21, 1995

Medicine & Health
PERSPECTIVES

Managed Care Agnostics Question Savings Claims

With shouting and sometimes shoving matches breaking out in the provinces over Medicare and Medicaid during the congressional recess, a welcome calm fell inside the Beltway. In fact, at one gathering of prominent analysts and scholars, the utterly refreshing topic was how much we don't know about health care cost trends.

Lighting up the event with the quip of the month was John Erb, a principal with Foster Higgins, the consultants whose estimate of a 1.1 percent drop in per-employee health benefit costs from 1993 to 1994 became a mantra for champions of market-based reform, widely touted as proof that the private sector can slay the dragon of costs with managed care.

Erb himself is much more cautious.

"Because we collect so many numbers, we're in a situation where we can tell you that we don't know where this is going," he says. "Most people intuitively try to tell you that. We've got the numbers to *prove* that we don't know where health care costs are going."

Congress being out of town, it was a slow news week in the capital, and Erb's remarks earned a spate of replays on C-SPAN as a result. But it remains to be seen whether his point will work its way into the increasingly feverish and rhetorical debate about remaking Medicare and Medicaid in the private sector's image.

The nub of the Foster Higgins interpretation is that the '93-'94 slowdown was "a one-time savings due to moving employees from a higher cost plan to a lower cost plan." In the sampling of 2,000 large firms surveyed by the consultants, the number of employees with indemnity coverage dropped from 43 percent in '93 to 33 percent in '94.

According to Erb, the major lesson from the data is in the breakdown of the types of managed care plans that these employees moved to. The percentage in preferred provider organizations (PPOs) remained stable at 23 percent, while HMOs grew marginally from 23 percent to 25 percent.

The managed care hybrid that gained most dramatically, and absorbed most of the shift out of indemnity coverage, was point-of-service (POS) plans. POS plans allow enrollees to go out of their managed care network to physicians or other providers of their choice for a higher out-of-pocket cost. Coverage by these plans jumped from 9 percent to 17 percent of employees in the Foster Higgins survey.

Erb spells out the implications: "Nearly all of the migration into managed care plans in 1994 was into managed care plans that retain an out-of-network benefit. This is not migration into HMOs."

While two-thirds of the employees in the survey are in some type of managed care plan, he points out, "three-quarters of all employees are enrolled in a plan that offers an out-of-network benefit, that offers choice, that retains the indemnity plan characteristics."

"This shift did create a one time savings for employers," Erb concludes. "The question is, will it continue?"

What Agnostics Believe

The relevance of the "one-time savings" analysis to the hot summer debate over entitlement budgets is argued by two scholars from the Urban Institute in a recently released paper comparing public and private health cost trends. If managed care savings are over-estimated, after all, the premise on which the proposed restructuring of Medicare and Medicaid is based may well be faulty.

Contrary to the commonplace perception that Medicare spending is out of control, co-authors Marilyn Moon and Stephen Zuckerman conclude that when measured on a per-capita basis, "growth rates between private insurance and Medicare have actually been quite similar."

"Preliminary numbers for 1994 growth rates do indicate a stronger showing for private insurance relative to Medicare," Moon and Zuckerman acknowledge. "But we do not yet know whether such results can be sustained over time since

such results can be sustained over time since some of the savings being achieved in the private sector represent one time gains as employees shift from expensive to less expensive plans. While Medicare could also achieve such savings, they are likely to be short term in nature and, thus, would not necessarily result in low rates of growth needed year after year to achieve the federal budget targets."

Medicare aside, additional evidence brought to bear by Foster Higgins in its 1994 survey seems to increase the burden on managed care to prove its claim to be winning the war on costs. A breakdown of average annual cost growth per employee finds that POS costs are going up faster, at 13.1 percent, than indemnity plans, which increased by 10.2 percent from 1993 to 1994. HMO cost growth was just slightly less, at 9.7 percent, while only PPOs got cheaper, by 2.6 percent.

The somewhat mind-boggling implication is that average per employee costs increased significantly in all types of plans except PPOs, although overall spending went down — because of shifting enrollment. That is the kind of hell that the rapidly changing private health care market plays with the numbers.

Putting the business of cost estimation in an even worse light is Henry Aaron, of the Brookings Institution, who says that health economists are trapped in a state of uncertainty because the quantity of services (Q) in the equation E (expenditure) = P (price) x Q is a factor that no one knows how to measure.

"The character of health care services is changing at blinding speed," Aaron wrote last winter in *Health Affairs*. "No market evaluations of these services exist to permit comparisons among services and over time. If outpatient lens replacement goes up and inpatient exploratory surgery goes down, has the quantity of medical care risen or fallen? If magnetic resonance imaging (MRI) exams replace myelograms, has the quantity of health care risen or fallen? . . .

"For that reason, we cannot know what is happening to real health care services. To put the matter even more bluntly, despite the attention lavished on various health care price indices, we do not know whether health care prices are rising more rapidly than general prices, are rising more slowly than general prices, are rising at about the same rate, or are falling."

Blooming Hybrids

The data are unambiguous about the rapid enrollment growth in POS plans. Where these plans fit in the managed care revolution is less clear. Some regard them as a transitional form, designed to lure recalcitrant employees and benefit managers into the scary new world of managed care.

"It's there to make everyone feel good," says Richard Sharpe, former program director of the John A. Hartford Foundation, which has supported innovative care and financing systems.

Knowing they have a choice makes employees — and the executives who make health benefit decisions — more comfortable with HMOs, even if they rarely exercise their choice, Sharpe and others say.

But Erb suggests that the out-of-network benefit is more than just a symbolic, feel-good option. "Twenty-two years after the HMO Act of 1973, only a quarter, a little more than a quarter [of employees in the annual Foster Higgins survey] have enrolled in an HMO. The rest have opted for a more lenient, if you will, form of managed care. . .

Hybrid plans are "not a transition to HMO's but an essential choice that consumers want," a San Francisco consultant told the *New York Times* last month.

Observers say that POS cost increases have occurred because the hybrid plans have offered rich benefits to attract new enrollees, and because recent enrollees, accustomed to fee-for-service coverage, use out-of-network providers more than those accustomed to HMO restrictions on choice, the *Times* reports.

That implies that those costs will eventually come down. But Erb counters that persistent cost increases in HMOs indicate that managed care has yet to live up to its promise.

"Where is this reduction in health care costs that we read about in the papers?" he asks rhetorically. "When you look at the managed care plans, you see that there was none. It was simply the movement from indemnity to managed care."

A return to first-dollar (no deductible) coverage by many HMOs is one factor pushing up costs, according to Erb. Another is the demand for stockholder earnings in investor-owned plans. Increased administrative costs implicit in managed care utilization and quality controls also are driving increases, he says.

"We do not know how much money HMOs

will burn in administering managed care. . . ." says Princeton University economist Uwe Reinhardt, who appeared with Erb at an August 7 briefing for congressional staff members and journalists sponsored by the Washington-based Alliance for Health Reform, ". . . especially since none of the HMOs have any data system worthy of the name. So wait until they have to put those in place."

Reinhardt describes himself as an "agnostic" on the issue of managed care's potential for controlling health costs. The numbers can be argued either way, he says. "Unless somebody paid me to say something different, I would say that I do not know what's going on."

"Unless somebody paid me to say something different, I would say that I do not know what's going on."

Managed Care vs. Discount Care

In the absence of definitive data, decision-makers have to be guided by instinct and common sense, says Erb. "Some managed care plans work and some managed care plans don't work, and it's up to the employer and the employee to figure out which are the good ones and which are the bad ones."

Providers, he might have added, also have an interest in figuring out "which are the good ones and which are the bad ones." In a growing number of markets, they are deciding that the bad ones are loose managed care networks slapped together to command market share and anchored only by discounts and third-party utilization review.

Minneapolis consultant David W. Allen, of McGladrey & Allen, calls this the "inspection model of managed care, where management is by a third party looking over the shoulder" of providers.

After preliminary experience with capitation in an early generation of physician-hospital organizations (PHOs), frustrated primary care physician groups are now breaking away to form their own managed care organizations in an increasing number of markets, Allen says.

In mature managed care markets like Minneapolis and Los Angeles, these physician groups and PHOs are looking more and more to contract directly with employers, as *Perspectives* has reported previously. Lately, primary care doctors are beginning to take similar steps in other major markets including Denver and New Orleans, as well as second-tier markets such as Knoxville, Omaha, Austin (TX), Worcester (MA) and parts of exurban Pennsylvania.

"They are tired of being beholden either to hospitals or insurance companies. Doctors are breaking out and saying, 'We know how to manage care,'" Sharpe says of the new breed of physician groups in the managed care arena.

The "inspection" model amplifies administrative inefficiency, filling hospitals and doctors' offices with staff who contribute nothing to giving care, Allen says. That creates opportunities for well-run PHOs and physician groups to save money by taking over the management of care themselves.

"There's a whole industry springing up now of those sorts of practice management companies" that provide physician groups with the business skills they need, he says. Ultimately, such groups may become customers of insurance companies and buy actuarial services or other capabilities that insurers have, Sharpe and Allen say. But the groups envision going to market on their own.

According to Sharpe, purchasing cooperatives and business coalitions will create new opportunities for provider organizations to sell direct to employers. "Co-ops are a kind of supermarket that would permit these groups to display their wares," he says.

"The insurance industry is going to throw fits about this," Allen predicts.

Hardball, Anyone?

"True care management," as Sharpe calls the regime of provider-centered plans, is already threatened by the providers' perennial adversaries in the insurance community.

Earlier this month, the National Association of Insurance Commissioners (NAIC) issued a draft bulletin advising state insurance regulators that, "If a health care provider enters into an arrangement with an individual, employer or

other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the business of insurance. Providers wishing to engage in the business of insurance must obtain the appropriate license."

"Providers have become increasingly frustrated with their standing in traditional managed care," the NAIC's work group on health plan accountability explains in a memo that went out to state insurance commissioners with the bulletin, which is advisory and does not have the force of law or regulation.

"It appears that provider groups have recently begun joining together in ever-increasing business combinations to sell and provide their services directly to employers," the memo notes. "Under the capitated payment mechanisms, the providers are counting on the vast majority of people they are under contract to serve not getting sick, yet these agreements expose them to the risk that everyone will."

The Group Health Association of America, the Blue Cross and Blue Shield Association, the American Association of Preferred Provider Organizations, and the American Managed Care and Review Association have all endorsed the NAIC's call for tight state regulation of PHOs and other provider organizations that assume financial risk.

The American Hospital Association (AHA) and the American Medical Association argue against the NAIC's recommendation.

"These types of integrated delivery systems are competitive with the insurance industry and somewhat of a threat," says Allen, and insurers have lobbied the NAIC to come to their aid.

The AHA argues that regulation of physician-sponsored networks would crimp the financing of fledgling groups and discourage providers from accepting capitation at a time when most theorists say that risk-sharing is the surest way to reap real, long term savings from managed care.

Southern California's robust physician networks have been able to escape the purview of insurance regulation because state law says that if they own a hospital in their service area, they are not considered to be in the insurance business. So these plans acquire small hospitals, which they are proud to keep as empty as possible.

In Minnesota, a consensus-oriented business community is presumed to be strong enough to get what it needs in the way of state policy, Allen says, and in Minnesota, business wants to contract directly with providers.

A greater threat, he says, is the possibility that the Federal Trade Commission will hold up provider groups on antitrust grounds, with price-fixing complaints.

In any case, the more successful provider-centered networks become, the more negative pressures they will inevitably attract from rival stakeholders.

"The big picture that needs to be kept in mind," says Allen, is that this type of activity should be encouraged. It's in the best interest of health care, and particularly the economics of health care. . . .These folks are trying to do something the marketplace needs."

Standards should be developed for the new plans, and consumers protected, according to Allen and the AHA. The American Society of Internal Medicine (ASIM) last week came out with an extensive set of reccommendations for safeguarding the quality of care and financial soundness of capitated plans. They include use of stop-loss coverage and the creation of "carve-outs" for high cost patients.

John DeMoulin, the organizaation's director of managed care and regulatory affairs, points out that physicians also have the ability to care for patients, which constitutes a significant asset not recognized in insurance regulations. "Is it really necessary that they have to have the same kind of financial reserves that insurance companies do?" DeMoulin asks. "Someone has to figure out how to evaluate that."

"Health care is primarily a function of hospitals and physicians," says Allen. "It is not primarily the function of insurance companies."

"Insurance companies should be in the background, providing administrative expertise, systems expertise, underwriting expertise, and capital, and some of those things. But at the forefront should be the relationship between the patient and the physician who is providing care."—*R.C.*

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OCTOBER 1995

Health Benefits in 1995 — KPMG's Fifth Annual Survey Shows Lowest Rates of Increase In Health Plan Premiums Since 1986

In this issue

KPMG's *Health Benefits in 1995*, the fifth annual national telephone survey of health benefits offered by firms with 200 or more workers, reveals a continued decline in the rates of premium increases and a continued increase in managed care enrollments. KPMG conducts this survey of over 1,000 employers to collect the most current information available on the status of health benefits for U.S. workers. This survey report and the database on which it is based provide critical data to help KPMG serve the group benefits needs of its clients nationwide.

Objectives of the Survey

- To determine which types of health benefits plans employers offer their work force.
- To document the design of these plans.
- To learn how these plans have changed over time.

Major Findings of the 1995 Survey

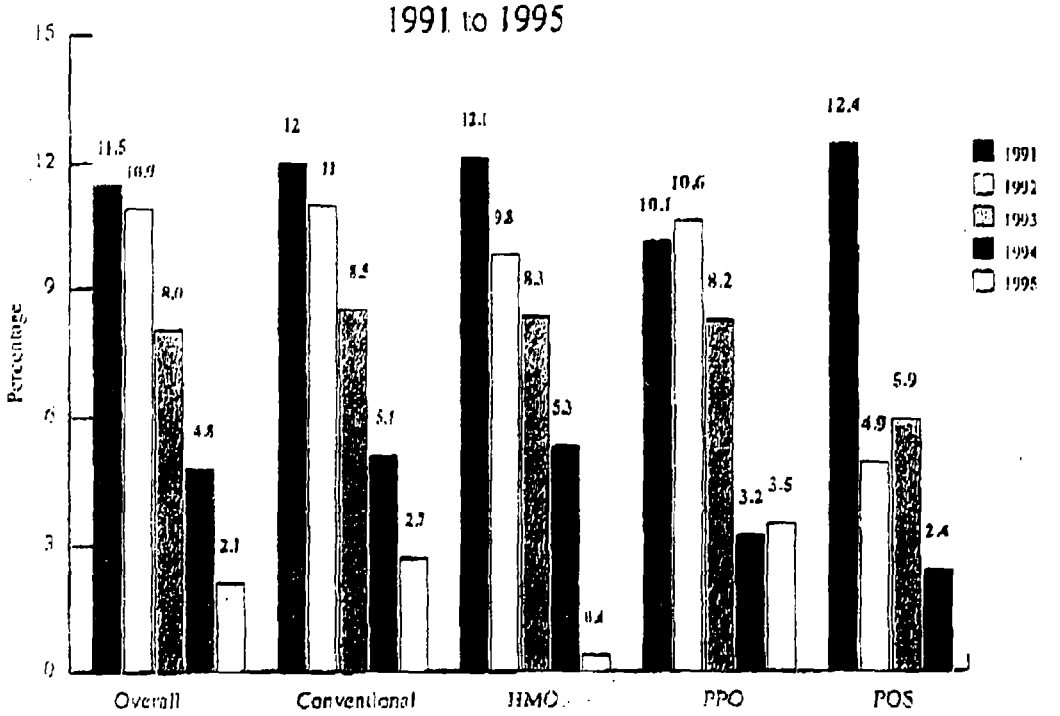
Premium Increases

From 1994 to 1995, health plan premiums increased at an average rate of just 2.1 percent. (Fig. 1, page 2.) This is the lowest rate of increase since 1986. This rate of growth of health plan premiums is slightly lower than the 3.2 percent overall rate of inflation during the same period. It is also substantially lower than another key indicator, medical inflation, which grew at 4.6 percent. (Fig. 2, page 2.) HMO plans experienced the lowest average rate of premium increase at just 0.4 percent. (Fig. 3, page 3.)

(Continued on page 2)

Figure 1

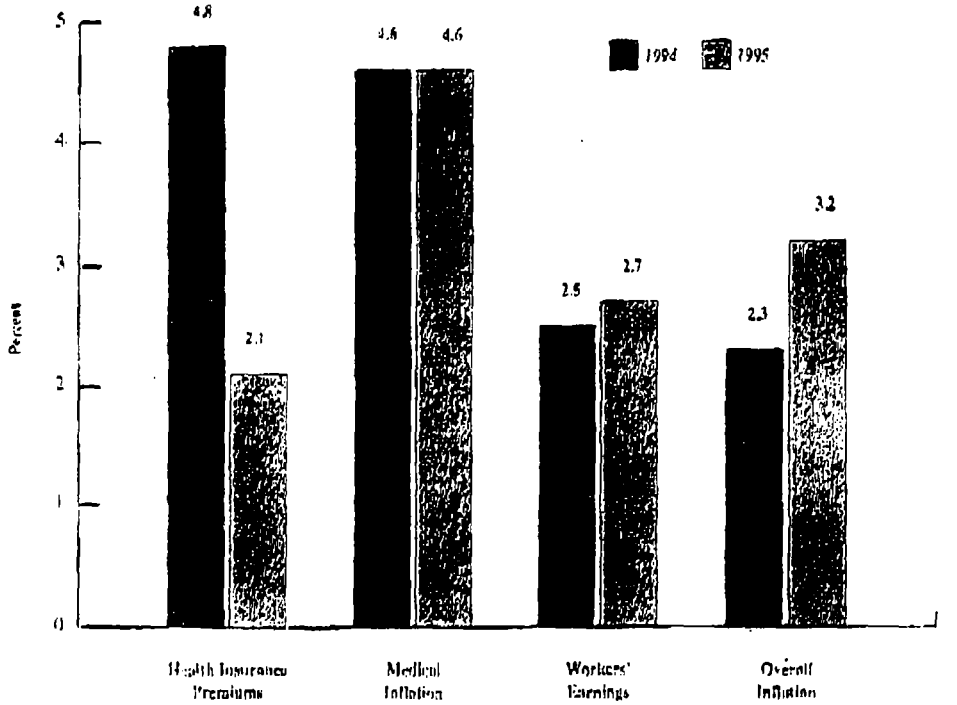
Rates of Increase in Health Plan Premiums 1991 to 1995



Sources: KPMG Surveys of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1992; 1991

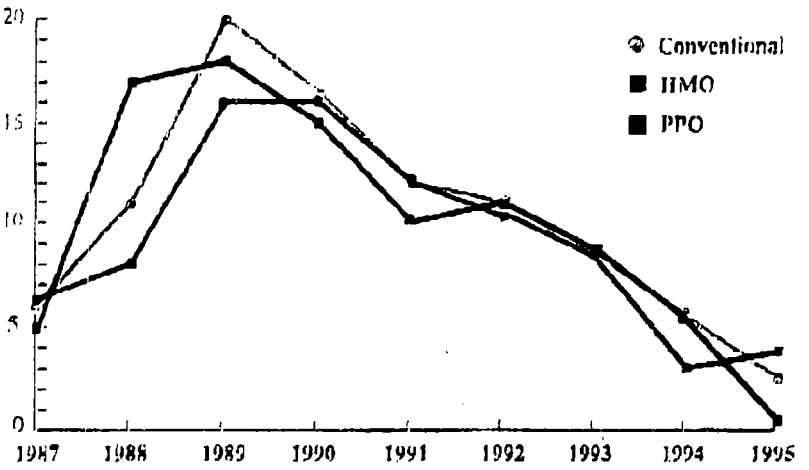
Figure 2

Increases in Health Insurance Premiums Compared to Other Indicators — 1994 to 1995



Sources: KPMG Surveys of Employer Sponsored Health Benefits, 1995; 1994

Figure 3 Premium Increases for Conventional, HMO, and PPO Plans — 1987 to 1995



Sources: KPMG Surveys of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1992; 1991

Health Benefits in 1995

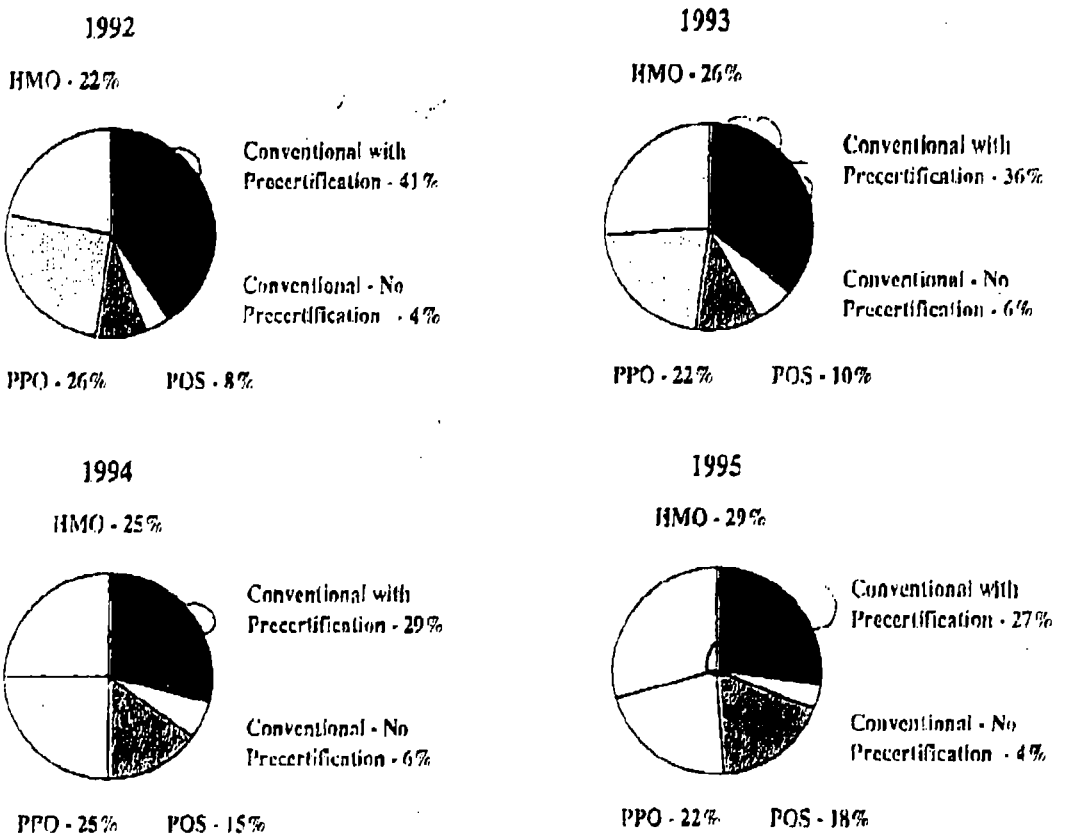
(Continued from page 1)

Managed Care Continues to Expand Its Market Share

Enrollments in managed care plans grew 4 percentage points from the 1994 averages, with 69 percent of employees participating in health maintenance organizations (HMOs), preferred provider organizations (PPOs), or point-of-service plans (POS) in 1995. Only 27 percent of employees are enrolled in conventional fee-for-service plans with precertification for inpatient services. The enroll-

(Continued on page 4)

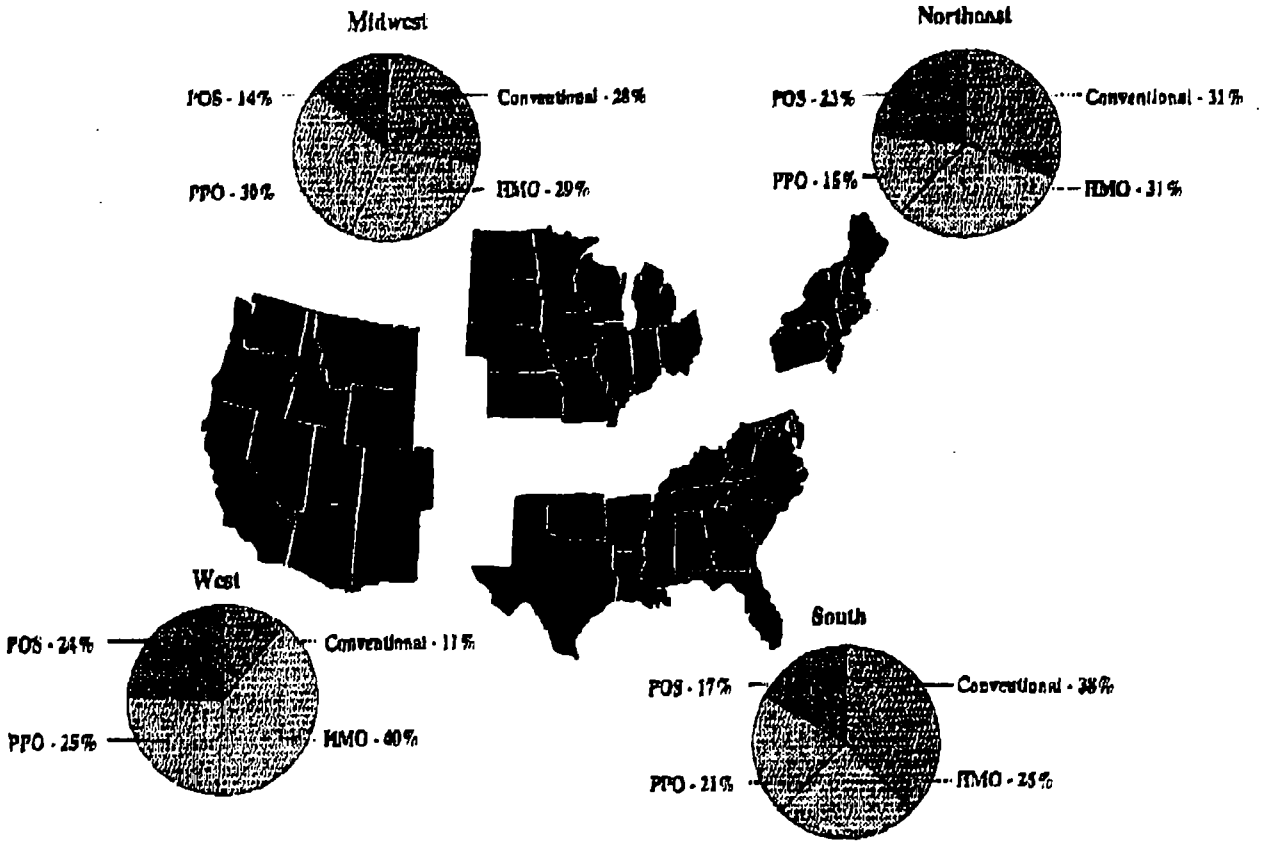
Figure 4 Health Plan Enrollments — 1992 to 1995



Sources: KPMG Surveys of Employer Sponsored Health Benefits, 1995; 1994; 1993; 1992

Figure 5

Health Plan Enrollments by Region 1992 - 1995



Source: *KPMG Survey of Employer Sponsored Health Benefits, 1995*

Health Benefits in 1995

(Continued from page 8)

nient rate for conventional plans without precertification restrictions was drastically lower at 4 percent. As recently as 1992, managed care represented just 56 percent of health care enrollments. *(Fig.4.)*

Managed care programs continue to dominate in the West, where 89 percent of employees are enrolled in either an HMO, PPO, or POS plan. By contrast, in the South, conventional plans enroll 38 percent of eligible employees. *(Fig. 5.)*

Plan Choices

While past trends indicated employers were streamlining their health plan offerings, the recent expansion of managed care systems and greater competition among health plans of all types have allowed firms to cut health care costs while increasing the number of plans they offer their workers. Consequently, the number of health care plans being offered to workers is on the rise.

Flexible Benefits

Since 1992, there has been a steady and gradual increase in the use of flexible benefits plans. In 1995, the health care market exhibited an increase of 3 percentage points in the use of flexible benefits plans. Among firms using flexible benefits, the most popular option (82 percent) is paying for health insurance premiums with pre-tax dollars.

Employee Cost-Sharing

With the exception of PPO family premiums, the average monthly employee contributions for all four types of health plans for both single and family coverage have increased.

(Continued on page 5)

Health Benefits in 1995

(Continued from page 4)

At the same time, plan deductibles have not increased significantly.

Eligibility for Health Care Coverage

The number of workers covered by employer-sponsored health plans continues to grow, with 81 percent of employees enrolled in such plans in 1995. This increase represents a growing awareness of the importance of health care coverage as a tool in recruiting and retaining high quality employees. The average wait for health coverage for new employees dropped by a small margin in 1995 to an average of 36 days (1.2 months), representing an average decrease of 2 days from 1994.

Pre-existing Conditions

While the number of conventional plans with pre-existing condition clauses fell by 3 percentage points to 56 percent in 1995, the number of PPO plans with pre-existing condition clauses increased to 76 percent, up 6 percentage points from 1994. The number of POS plans with pre-existing condition clauses stayed the same.

Satisfaction with Health Plans

A majority of employers are satisfied with the cost of their health plans, and human resource professionals are generally comfortable in recommending their health plans to other benefits managers. HMO and PPO plans inspire the highest recommendations, with almost nine out of ten benefits managers recommending these types of plans to others. Conventional and POS plans are not far behind in popularity, with 84 percent of health benefits managers recommending POS and conventional plans to others.

Optimistic Outlook for the Next Few Years

The seventh straight year of health insurance underwriting profitability underscores an optimistic outlook for the next few years. The underwriting results for health insurers often predict what will happen in terms of health insurance premium increases. Since 1965, health insurance has been part of a well-defined six-year cycle of profitability — three years of profits followed by three years of losses. According to the underwriting cycle, losses should have begun in 1992. But KPMG's *Health Benefits* survey data indicate this cycle has been broken as health insurance premium rates are continuing to grow, but in smaller increments.

For more details on *Health Benefits in 1995* contact your KPMG adviser. An order form for the survey is located on the last page of this *BenefitsSpectrum*. ■

— Derek Liston, San Francisco

The Disruption Study — An Aid to Changing Managed Care Networks

The dramatic shift in employer-provided health benefits from fee-for-service benefits to managed care networks in the last four years means that employers seeking to change health care vendors no longer simply change third-party administrators, but actually change the health care providers their employees use. Employee goodwill and morale dictate that such changes be kept at a minimum wherever possible. To minimize the disruption in employee/health care provider relationships when changing vendors, KPMG's group benefits consultants have adopted a "disruption study" variation designed to go beyond simply comparing the managed care network's coverage to the zip codes of employees.

Pitfalls of Geographic Matching — Potential, Not Actual Coverage

As managed care systems have expanded and seek to market themselves aggressively in major cities, these systems generally rely on the geographic access process of showing potential clients how comprehensively their health care provider network covers the zip codes of the client's employees. Such "geo-access" analysis generally demonstrates a very high employee coverage "potential." In large cities a managed care network commonly can show 95 to 99 percent area coverage for high-density work forces. These high rates of geographic access for employees are so common among competing managed care vendors, the numbers may become a relatively meaningless comparison factor during a vendor search. Unfortunately, once a vendor is chosen and enrollment completed, it is equally common to

(Continued on page 6)

Health Benefits in 1995 Available

KPMG Peat Marwick's annual health benefits survey has been published. This year's survey includes more than 100 graphics and tables with industry, region, and size of firm statistics.

Health Benefits in 1995 contains data on premiums, premium increases, employee contributions, deductibles, coinsurance, utilization management, self-insurance, covered benefits, cafeteria plans, claims review, and other statistics.

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