The Environment of Health Care

- Unemployment Concerns
- Reduced Corporate Profits
- Rapidly Rising Health Care Costs
- Concern Over Pharmaceutical Costs – Particularly for the Elderly
Rising Health Costs Threaten Generous Benefits...

“... the ... insurance fund, under ... orders to cut its huge deficit, is now threatening to take high drug costs out of the fees it pays to doctors if they write more prescriptions than it thinks they should. So Dr. Perez explains the problem to his patients, and some of them now pay for the medicine out of their own pockets instead of putting in claims.”

“... a retired post office employee ..., has found that ... doctors ... are becoming more reluctant to prescribe remedies like cough medicine that used to go on the insurance bill. Early evening television ..., he says, is now full of advertising pitches to get people to buy over-the-counter remedies that used to be reimbursable by insurance.”

“... more than half of the general practitioners ... now have budgets they cannot overspend for medicines and hospital care for their patients, forcing them to think twice or bargain hard with hospitals and surgeons about costs.”

Source: New York Times, Tuesday, August 6, 1996
# Health Care Worries in Context

With Other Worries

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having to pay more for your health care or insurance</td>
<td>45%</td>
</tr>
<tr>
<td>Your income not keeping up with rising prices</td>
<td>40%</td>
</tr>
<tr>
<td>Your health plan more concerned about saving money than what’s best</td>
<td>36%</td>
</tr>
<tr>
<td>Not being able to afford the prescr. drugs you need</td>
<td>35%</td>
</tr>
<tr>
<td>Being unable to afford hlth care svcs you think you need</td>
<td>34%</td>
</tr>
<tr>
<td>Losing your health insurance coverage*</td>
<td>30%</td>
</tr>
<tr>
<td>The quality of health care svcs you receive getting worse</td>
<td>28%</td>
</tr>
<tr>
<td>Not being able to pay your rent or mortgage</td>
<td>24%</td>
</tr>
<tr>
<td>Losing your savings in the stock market</td>
<td>19%</td>
</tr>
<tr>
<td>Being the victim of a terrorist attack</td>
<td>18%</td>
</tr>
<tr>
<td>Having to stay in your current job instead of taking a new job for</td>
<td>18%</td>
</tr>
<tr>
<td>fear of losing health benefits***</td>
<td></td>
</tr>
<tr>
<td>Being the victim of a violent crime</td>
<td>17%</td>
</tr>
<tr>
<td>Losing your job**</td>
<td>17%</td>
</tr>
</tbody>
</table>

* Based on those w/ health insurance coverage only
** Based on employed only
*** Based on those who are employed with health insurance cvg only.  
Source: Kaiser Family Foundation Health Poll Report Survey, June 2005
Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005

- **Health Insurance Premiums**
- **Overall Inflation**
- **Workers Earnings**

* Estimate is statistically different from the previous year shown at p<0.05. No statistical tests were conducted for years prior to 1999.
† Estimate is statistically different from the previous year shown at p<0.1. No statistical tests were conducted for years prior to 1999.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Percentage of All Firms That Report the Following Factors Contribute “A Lot” to Increases in Health Insurance Premiums, 2003

- Better Medical Technology: 29%
- Higher Insurance Company Profits: 32%
- Higher Spending for Physicians: 38%
- An Aging Population: 45%
- Higher Spending for Hospitals: 55%
- Higher Spending for Prescription Drugs: 61%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2003
Perceived Reasons For Rising Health Care Costs

- **Percent who say each is a “very important” factor in causing higher health care costs...**

  - High profits made by drug and insurance companies: 71%
  - Number of malpractice lawsuits: 58%
  - Amount of greed and waste that occurs in the health care system: 59%
  - Aging of the population: 50%
  - Use of expensive, high-tech medical equipment and drugs: 46%
  - Doctors making too much money: 31%
  - People having little incentive to look for lower cost doctors and services: 34%

- **When forced to choose, percent who say each is the MOST important factor**

  - High profits made by drug and insurance companies: 35%
  - Number of malpractice lawsuits: 19%
  - Amount of greed and waste that occurs in the health care system: 14%
  - Aging of the population: 8%
  - Use of expensive, high-tech medical equipment and drugs: 8%
  - Doctors making too much money: 5%
  - People having little incentive to look for lower cost doctors and services: 4%

*Note: also includes those who said only one factor was “very important”

Source: USA Today/Kaiser Family Foundation/ Harvard School of Public Health Health Care Costs Survey (conducted April 25 – June 9, 2005)
The Single, Primary Reason That Consumer Health Care Costs Are Rising, According to US Consumers:

- Cost of prescription medicines: 19%
- Doctors'/hospitals'/costs: 29%
- Health plan premiums: 15%
- Cost of new health technologies: 6%
- Consumers' overuse of care: 10%
- Lack of government regulation: 17%
- Employers' reducing employees' benefits: 5%

## Cost of an Appendectomy

<table>
<thead>
<tr>
<th>Company</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dayton-Hudson</td>
<td>39,000 Ninja Turtle action figures</td>
</tr>
<tr>
<td>Atlantic-Richfield</td>
<td>192,000 gallons of gasoline</td>
</tr>
<tr>
<td>Southern California Edison</td>
<td>1 year of electricity for 300 households</td>
</tr>
<tr>
<td>Anheuser-Busch</td>
<td>11,627 6-packs of Budweiser</td>
</tr>
<tr>
<td>Goodyear</td>
<td>461 radial tires</td>
</tr>
<tr>
<td>Johnson and Johnson</td>
<td>2,931,660 Band-Aids</td>
</tr>
</tbody>
</table>

Source: William Jessie, M.D., 1992
And now...

General Motors is “the nation’s largest private health-care purchaser...responsible for the health of some 1.1 million people, most of them retirees and their families, and paid $5.2 billion last year for the privilege. The cost of health care now adds more than $1,500 to every vehicle sold, and is rising at double-digit rates.” (1) “The company’s largest foreign competitor, Toyota Motor, Corp., spends less than $300 per vehicle on benefits...It’s about $4 an hour less to provide the same health care package for a Canadian worker versus a U.S. worker.” (2)

“The Medicare Modernization Act provided GM with some $500 million in prescription drug subsidies last year, accounting for roughly half the company’s North American auto profits.” (1)

Sources: (1) Murray, A Wall Street Journal, February 9, 2005
(2) Kennan,G The Globe and Mail, March 22, 2005
GM's soaring health bill

General Motors Corp., which is expected to pay $5.6-billion (U.S.) this year on bills from employees, families and retirees for doctors, drugs and hospital stays, is one of many U.S. businesses rethinking its corporate health plans.

GM health-care spending

<table>
<thead>
<tr>
<th>YEAR</th>
<th>BILLION U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>'96</td>
<td>3.0</td>
</tr>
<tr>
<td>'97</td>
<td>3.1</td>
</tr>
<tr>
<td>'98</td>
<td>3.3</td>
</tr>
<tr>
<td>'99</td>
<td>3.3</td>
</tr>
<tr>
<td>'00</td>
<td>4.2</td>
</tr>
<tr>
<td>'01</td>
<td>4.5</td>
</tr>
<tr>
<td>'02</td>
<td>4.8</td>
</tr>
<tr>
<td>'03</td>
<td>5.1</td>
</tr>
<tr>
<td>'04</td>
<td>4.0</td>
</tr>
</tbody>
</table>

GM health-care members

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MILLIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>'96</td>
<td>1.5</td>
</tr>
<tr>
<td>'97</td>
<td>1.4</td>
</tr>
<tr>
<td>'98</td>
<td>1.2</td>
</tr>
<tr>
<td>'99</td>
<td>1.2</td>
</tr>
<tr>
<td>'00</td>
<td>1.2</td>
</tr>
<tr>
<td>'01</td>
<td>1.2</td>
</tr>
<tr>
<td>'02</td>
<td>1.1</td>
</tr>
<tr>
<td>'03</td>
<td>1.1</td>
</tr>
<tr>
<td>'04</td>
<td>1.0</td>
</tr>
</tbody>
</table>

GM's estimated future health-care obligation: $67.5-billion U.S.

Increase in GM's drug spending over the past 30 years: 270%
REASONS FOR EMPLOYER COST SAVINGS

- SWITCH FROM TRADITIONAL INDEMNITY PLANS TO MANAGED CARE PLANS
- COST SHIFTING TO EMPLOYEES
- FEWER EMPLOYEES TAKING ADVANTAGE OF INSURANCE BENEFITS
- REDUCTION OF BENEFITS (RECENT)

Source: Joel Shalowitz, M.D.
Company Opinions on What Works

Distribution of Firms’ Opinions on the Effectiveness of the Following Cost Containment Strategies, 2005

- **Disease Management**
  - Very Effective: 14%
  - Somewhat Effective: 38%
  - Not Too Effective: 17%
  - Not At All Effective: 24%
  - Don't Know: 7%

- **Higher Employee Cost Sharing**
  - Very Effective: 12%
  - Somewhat Effective: 46%
  - Not Too Effective: 16%
  - Not At All Effective: 22%
  - Don't Know: 4%

- **Consumer-Driven Health Plans (E.g., high-deductible plan combined with a health savings account)**
  - Very Effective: 16%
  - Somewhat Effective: 45%
  - Not Too Effective: 15%
  - Not At All Effective: 17%
  - Don't Know: 7%

- **Tighter Managed Care Networks**
  - Very Effective: 7%
  - Somewhat Effective: 37%
  - Not Too Effective: 22%
  - Not At All Effective: 21%
  - Don't Know: 12%

Switch From Traditional Indemnity Plans to Managed Care Plans
Types of Group Health Plans
1984

Unmanaged FFS 96%

Other 4%

Source: HIAA (Now AHP)
Market Share for Various Types of Employer Coverage, 1992

- 38% Conventional with UR
- 22% Conventional w/o UR
- 25% HMO
- 8% POS
- 7% PPO

Source: Health Affairs, Winter 1992
Employer-Sponsored Health Insurance, 2005

Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2005

1988: 73% Conventional, 16% HMO, 11% PPO, 0% POS
1993: 46% Conventional, 21% HMO, 25% PPO, 7% POS
1996: 27% Conventional, 31% HMO, 28% PPO, 14% POS
1998: 14% Conventional, 27% HMO, 35% PPO, 24% POS
1999*: 10% Conventional, 28% HMO, 39% PPO, 24% POS
2000*: 8% Conventional, 29% HMO, 42% PPO, 21% POS
2001*: 7% Conventional, 24% HMO, 46% PPO, 23% POS
2002*: 4% Conventional, 27% HMO, 52% PPO, 18% POS
2003*: 5% Conventional, 24% HMO, 54% PPO, 17% POS
2004: 5% Conventional, 25% HMO, 55% PPO, 15% POS
2005*: 3% Conventional, 21% HMO, 61% PPO, 15% POS

* Distribution is statistically different from the previous year shown at p<.05. No statistical tests were conducted for years prior to 1999. Information was not obtained for POS plans in 1988.

Note: A portion of the change in enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section in the report for additional information: www.kff.org/insurance/7315/.

Percentage of Employers Providing a Choice of Health Plans, by Firm Size, 2003

* Distribution is statistically different from All Firms.

Employer Choice of Health Plans
Percentage of All Firms That Say the Following Features are ‘Very Important’ When Choosing a Health Plan, 2003

- HEDIS Performance Scores: 1%
- NCQA or URAC Accreditation Status: 3%
- Tiered Physician or Hospital Benefit: 19%
- Measurable Employee Satisfaction: 45%
- Internet Tools to Help With Enrollment and Claims Processing: 46%
- Accuracy and Speed of Claims Payment: 46%
- Range of Benefit Options: 54%
- Number of Physicians Enrollee Can Choose From: 66%
- Cost of the Plan: 80%

Among Firms Offering Health Benefits, Percentage That Shopped For a New Plan or Health Insurance Carrier, by Firm Size, 2005

- All Small Firms (3-199 Workers): 60%
- Mid-Size Firms (200-999 Workers): 56%
- Large Firms (1,000-4,999 Workers): 40%*
- Jumbo Firms (5,000 or More Workers): 35%*
- All Firms: 60%

Among Firms That Shopped, Percentage Reporting That They Changed Insurance Carrier And/Or Health Plan Type, 2005‡

- All Small Firms (3-199 Workers): 24% Changed Insurance Carriers, 31% Changed Health Plan Type
- Mid-Size Firms (200-999 Workers): 25% Changed Insurance Carriers, 23% Changed Health Plan Type
- Large Firms (1,000-4,999 Workers): 39% Changed Insurance Carriers, 22% Changed Health Plan Type
- Jumbo Firms (5,000 or More Workers): 45% Changed Insurance Carriers, 30% Changed Health Plan Type
- All Firms: 24% Changed Insurance Carriers, 30% Changed Health Plan Type

* Estimate is statistically different from All Firms at p<.05.
‡ These answers are not exclusive; 10% of firms that shopped switched both carrier and type of health plan offered.

When asked to name the top factors in purchasing a health plan for employees, 76% of respondents said cost, 72% said quality, according to a survey of 303 senior corporate executives and benefits managers. When asked if they are implementing standards to evaluate the quality of medical care delivered by their managed care network, 12% said yes, 61% said no. A majority said they would pay very little extra or nothing at all for a higher-quality managed care plan.

Small Employer Price Sensitivity to Purchasing Health Insurance

10%

3%

33%

5%

14%

46%

0%

10%

20%

30%

40%

50%

Change coverage

Drop Coverage

If healthcare insurance costs rose one percent

If healthcare insurance costs rose five percent

If healthcare insurance costs rose ten percent

1997 RWJF Employer Health Insurance Survey
Cost Shifting to Employees
Average Annual Premiums for Covered Workers, by Plan Type, 2005

- **All Plans**
  - Single: $610, $3,413, $4,024
  - Family: $2,713, $8,167, $10,880

- **Conventional**
  - Single: $498, $3,284, $3,782
  - Family: $2,321, $7,658, $9,979

- **HMO**
  - Single: $556, $3,203, $3,767*
  - Family: $2,604, $7,852, $10,456*

- **PPO**
  - Single: $603, $3,548, $4,150*
  - Family: $2,641, $8,449, $11,090

- **POS**
  - Single: $731, $3,183, $3,914
  - Family: $3,250, $7,551, $10,801

* Estimate of total premium is statistically different from All Plans by coverage type at p<.05.

Note: Family coverage is defined as health coverage for a family of four.

Average Monthly Worker Contribution, 1988-2005

* Estimate is statistically different from the previous year shown at p<.05. No statistical tests were conducted for years prior to 1999.


Percentage of Premium Paid by Covered Workers, 1988-2005

* Estimate is statistically different from the previous year show at p<.05. No statistical tests were conducted for years prior to 1999.

Average Annual Deductibles for Single Coverage, by Plan Type, 1999-2005

* Estimate is statistically different from the previous year shown at p<.05.
^ Information was not obtained for HMO single coverage prior to 2003.

Note: Average deductibles for PPO and POS plans are for in-network services. Averages include covered workers who do not have a deductible. If covered workers with no deductible are excluded from the calculation, the average deductibles for single coverage for 2005 are as follows: conventional - $671; HMO - $568; PPO - $455; POS - $495.

Percentage of Firms That Offer Employees a High-Deductible Health Plan, by Firm Size, 2003-2005

* Estimate is statistically different from previous year shown at p<.05.

High-deductible health plan (HDHP): A plan with an annual deductible of at least $1,000 for single coverage and $2,000 for family coverage. In 2003 and 2004, the survey used a different definition and asked if firms offered a health plan with a deductible of more than $1,000 for single coverage. The survey did not specify a minimum deductible for family coverage. The prevalence shown is for all HDHPs, regardless of whether they are offered with an HRA, are HSA qualified, or neither.

Among Covered Workers Facing Copayments for Physician Office Visits, Distribution of Copayments, 2004-2005

*Distribution is statistically different from previous year shown at p<.05.

Note: Copayments for in-network services in PPO and POS plans were used to calculate the distribution shown. The distribution does not include covered workers who do not face a copayment for office visits (e.g., workers who face coinsurance).

Among Covered Workers Facing Prescription Drug Copayment Amounts, Average Copayments, 2000-2005

* Estimate is statistically different from the previous year shown at p<.05.

^ Fourth-tier copayment information was not obtained prior to 2004.

Note: Average copayments for generic, preferred and nonpreferred drugs are calculated by combining the weighted average copayments for those types of drugs among firms with a single copayment amount or a multi-tier cost sharing structure. The average copayment for fourth-tier drugs is calculated using information from only those plans that have a fourth-tier copayment amount.

# Distribution of All Large Firms (200 or More Workers) Reporting the Likelihood of Making the Following Changes in the Next Year, 2005

<table>
<thead>
<tr>
<th>Change in Health Benefits</th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Not Too Likely</th>
<th>Not At All Likely</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the Amount Employees Pay for Health Insurance</td>
<td>43%</td>
<td>31%</td>
<td>13%</td>
<td>12%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Increase the Amount Employees Pay for Prescription Drugs</td>
<td>12%</td>
<td>33%</td>
<td>36%</td>
<td>18%</td>
<td>1%</td>
</tr>
<tr>
<td>Increase the Amount Employees Pay for Deductibles</td>
<td>16%</td>
<td>32%</td>
<td>33%</td>
<td>18%</td>
<td>1%</td>
</tr>
<tr>
<td>Increase the Amount Employees Pay for Office Visit Copays or Coinsurance</td>
<td>12%</td>
<td>31%</td>
<td>37%</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>Introduce Tiered Cost Sharing for Doctor Visits and Hospital Stays</td>
<td>2%</td>
<td>16%</td>
<td>39%</td>
<td>40%</td>
<td>3%</td>
</tr>
<tr>
<td>Restrict Employees Eligibility for Coverage</td>
<td>2%</td>
<td>6%</td>
<td>34%</td>
<td>56%</td>
<td>1%</td>
</tr>
<tr>
<td>Drop Coverage Entirely</td>
<td>0%</td>
<td>2%</td>
<td>5%</td>
<td>93%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

Fewer Employees Taking Advantage of Insurance Benefits (Employer offering or employee accepting)
Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2005

* Estimate is statistically different from the previous year shown at p<.05.

^ Estimate is statistically different from the previous year shown at p<.1.

# The 2005 offer rate for All Small Firms is not statistically different than the 2004 offer rate for All Small Firms at p<.05. The difference between the offer rate for All Small Firms in 2000 (68%) and the offer rate for All Small Firms in 2005 (59%) is statistically significant at p<.05.

Note: The percentage of All Large Firms (200 or more workers) offering health benefits in 1999 was 99%, not 100% as reported last year. Data for years prior to 1999 do not reflect several methodological changes that were made to the survey, including standardizing survey weights to U.S. Census data.

Percentage of Firms Offering Health Benefits, by Firm Size, 2005

- 3-9 Workers: 47%
- 10-24 Workers: 72%
- 25-49 Workers: 87%
- 50-199 Workers: 93%
- All Large Firms (200 or More Workers): 98%

Among Firms Not Offering Health Benefits, Percentage of Firms Who Say the Following Are “Very Important” Reasons for Not Offering, 2005

- High Premiums: 73%
- Employees Covered Elsewhere: 33%
- High Turnover: 16%
- Obtain Good Employees Without Offering A Health Plan: 22%
- Administrative Hassle: 14%
- Firm Is Too Newly Established: 2%
- Firm Is Too Small: 52%
- Firm Has Seriously Ill Employee: 4%

Eligibility, Take-Up Rates, and Coverage in Firms Offering Health Benefits, 2003

Overall % of Workers Covered
- 68%

% of Eligible Workers Who Accept Coverage (Take-Up)
- 83%

In Firms That Offer Coverage, % of Employees Who Are Eligible
- 81%

Take-up rate: The percentage of eligible workers who choose to participate in health benefits offered by their employer.

Percentage of Workers Covered by Their Employer’s Health Benefits, in Firms Both Offering and Not Offering Health Benefits, by Firm Size, 1999-2005

[Graph showing the percentage of workers covered by health benefits for different firm sizes over the years 1999 to 2005.]

# Year-to-year estimates are not significantly different at p<.05. However, there is a significant change between 2000 and 2005 for All Firms and All Small Firms at p<.05.

Percentage of Workers Employed in Firms That Offer Part-Time and Temporary Workers Health Coverage, 1999-2003

Most Common Reasons Cited by Firms as to Why Workers Decline Coverage for Which They Are Eligible, 2001

- Don't Want or Need Health Insurance: 34%
- Can't Afford Employee Share of Premium: 9%
- Don't Know: 1%
- Have Coverage Elsewhere: 3%
- Other: 54%
Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage Offering Retiree Health Benefits, 1988-2005*

* Tests found no statistically different estimates from the previous year shown at p<.05. No statistical tests were conducted for years prior to 1999.

Reduced Benefits
Percentage of Covered Workers in Partially or Completely Self-Funded Plans, By Firm Size, 1999-2005

* Estimate is statistically different from the previous year shown at p<.05.

Levels of Benefits for Covered Workers Compared to Last Year, All Plans, 2004

- Same as Last Year: 79%
- More than Last Year: 6%
- Less than Last Year: 15%

Note: The survey asks about changes to benefits "other than cost sharing." In this year and prior years, the question asks about changes in the level of benefits for family coverage.

Managed Care –
With a Focus on HMOs
Health Spending 2004
$1,877.6 Billion or 16% of GDP or $6,280.3 Per Capita

(a) Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.
(b) Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research” expenditures and instead are included in the category in which the product falls.

Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, U.S. Dept. of Commerce, Bureau of Economic Analysis and Bureau of the Census
## Physician’s Control of Health Care Expenditures

<table>
<thead>
<tr>
<th>Sectors under physician control</th>
<th>Amount spent in 1993 in billions</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>$363</td>
<td>38.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>$176</td>
<td>18.7%</td>
</tr>
<tr>
<td>Drugs and devices</td>
<td>$87</td>
<td>9.2%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>$76</td>
<td>8.1%</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$702</strong></td>
<td><strong>74.6%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sections not controlled</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (such as alternate site care)</td>
<td>$93</td>
<td>9.9%</td>
</tr>
<tr>
<td>Dental</td>
<td>$92</td>
<td>9.8%</td>
</tr>
<tr>
<td>Administration</td>
<td>$54</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$239</strong></td>
<td><strong>25.4%</strong></td>
</tr>
</tbody>
</table>

**TOTAL**                         | **$941**                         | **100.0%**          |

"In the general course of human nature, a power over a man's subsistence amounts to a power over his will."
Alexander Hamilton, Federalist No. 79 (referring to legislative tampering with judicial salaries.)

“It is difficult to get a man to understand something when his salary depends upon his not understanding it.”
Upton Sinclair
“... systems or techniques generally used by third-party payers expressly to provide what they consider an appropriate mix of medical and social services at the lowest cost to payers and patients.”

American Medical Association

“... systems that integrate the financing and delivery of appropriate health care services to covered individuals...”

Health Insurance Assn. of America (Now AHIP)
“... a variety of interventions of health care delivery and financing intended to eliminate unnecessary and inappropriate care and to reduce cost.”

Congressional Budget Office

“... an organized system of medical care that integrates financing and delivery of appropriate health care and organizes care around the consumer, that provides seamless continuity of health care services.”

American Managed Care and Review Association
“A set of techniques used by or on behalf of purchasers of health care to manage health care costs by influencing patient care decision making through case-by-case assessment of the appropriateness of care prior to its provision.”

*The Institute of Medicine (1989)*

“A process to maximize the health gain of a community within limited resources, by ensuring that an appropriate range and level of services are provided, and by monitoring on a case-by-case basis to ensure that they are continuously improved to meet national targets for health and individual health needs.”

*Coopers & Lybrand, European healthcare trends: towards managed care in Europe, May, 1995*
WHAT DIFFERENTIATES MANAGED CARE FROM FEE FOR SERVICE CARE IS FINANCIAL AND CLINICAL ACCOUNTABILITY AIDED BY ENHANCED COORDINATION OF SERVICES.

Source: Joel Shalowitz, M.D.
HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

A. DEFINITION

An HMO is a health care plan that delivers comprehensive, coordinated medical service to voluntarily enrolled members on a prepaid basis.

B. TYPES OF HMOs

An important point to remember is that the type of HMO is defined by the organizational structure of the contracted physicians and their relationship to the plan.

1. Group/Staff Model - Delivers services at one or more locations through a group of physicians. If the group is independent of the HMO it is a group model. If physicians are employees of the HMO it is a staff model. Also called “closed panel” plans.

2. Individual Practice Association (IPA) - Individual community physicians contract with the HMO to see prepaid patients in their traditionally fee for service practices. Also called “open panel.”

Other models are blends of these two basic types, e.g., a network model is an “IPA of groups.”

Source: J. Shalowitz, M.D., 1994
PRIMARY CARE IS THE PROVISION OF INTEGRATED, ACCESSIBLE HEALTH CARE SERVICES BY CLINICIANS WHO ARE ACCOUNTABLE FOR ADDRESSING A LARGE MAJORITY OF PERSONAL HEALTH CARE NEEDS, DEVELOPING A SUSTAINED PARTNERSHIP WITH PATIENTS, AND PRACTICING IN THE CONTEXT OF FAMILY AND COMMUNITY.

THE TERM INTEGRATED IS USED TO DENOTE THE PROVISION OF COMPREHENSIVE, COORDINATED, AND CONTINUOUS SERVICES THAT PROVIDE A SEAMLESS PROCESS OF CARE.

Source: Committee on the Future of Primary Care, Institute of Medicine.

# Distributing Prepaid Premiums

**40%**  
**PHYSICIAN CAPITATION**  
PHYSICIAN FEES:  
INPATIENT OPERATING COSTS  
OUTPATIENT PHARMACEUTICALS  
REFERRALS SURGICAL CENTER CHARGES  
OUTPATIENT (FACILITY ONLY) REINSURANCE FOR  
SERVICES: LABORATORY SPECIAL SERVICES:  
INPATIENT SKILLED NURSING FACILITY TRANSPRANTS  
CHARGES  
HOME CARE CARDIAC SURGERY  
DURABLE EQUIPMENT CHRONIC HEMODIALYSIS  
STOP LOSS INSURANCE PSYCHIATRY/  
CHEMICAL DEPENDENCY  
STOP LOSS INSURANCE**

**40%**  
**HOSPITAL FUND**  
INPATIENT HOSPITAL OPERATING COSTS  
CHARGES PHARMACEUTICALS  
SURGICAL CENTER CHARGES  
(FACILITY ONLY) REINSURANCE FOR  
SERVICES: LABORATORY SPECIAL SERVICES:  
INPATIENT SKILLED NURSING FACILITY TRANSPRANTS  
CHARGES  
HOME CARE CARDIAC SURGERY  
DURABLE EQUIPMENT CHRONIC HEMODIALYSIS  
STOP LOSS INSURANCE PSYCHIATRY/  
CHEMICAL DEPENDENCY  
STOP LOSS INSURANCE

**20%**  
**ADMINISTRATION**  
OPERATING COSTS PHARMACEUTICALS  
REINSURANCE FOR SPECIAL SERVICES:  
SERVICES: LABORATORY SPECIAL SERVICES:  
INPATIENT SKILLED NURSING FACILITY TRANSPRANTS  
CHARGES  
HOME CARE CARDIAC SURGERY  
DURABLE EQUIPMENT CHRONIC HEMODIALYSIS  
STOP LOSS INSURANCE PSYCHIATRY/  
CHEMICAL DEPENDENCY  
STOP LOSS INSURANCE
First Cut Estimate of Savings from Capitation
Composition of Savings

- Specialty Services: 60%
- Drugs: 5%
- Phys. Ancillary Servs.: 5%
- Hospital Services: 30%

Source: Foster Higgins Survey 1992; Business & Health Magazine, January 1993; Milliman & Robertson Actuaries, 1992; Analysis from BDC Advisors, San Francisco, California; Governance Committee Analysis.
Do HMOs make hospitals more efficient?

A study of 1992-1994 Medicare hospital admissions in major metropolitan areas found the lowest costs and mortality rates in markets with high HMO penetration. All percentages are compared with U.S. average.

<table>
<thead>
<tr>
<th>HMO Penetration</th>
<th>Markets</th>
<th>Costs</th>
<th>Lengths of Stay</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (above 30%)</td>
<td>14</td>
<td>-11.18%</td>
<td>-6.32%</td>
<td>-5.25%</td>
</tr>
<tr>
<td>Medium (15%-30%)</td>
<td>21</td>
<td>-2.34%</td>
<td>+5.36%</td>
<td>-2.91%</td>
</tr>
<tr>
<td>Low (under 15%)</td>
<td>15</td>
<td>+7.85%</td>
<td>+3.36%</td>
<td>-2.06%</td>
</tr>
</tbody>
</table>

* Risk adjusted. Rates are lower than U.S. average because study excluded rural areas.

Source: KPMG Peat Marwick LLP. Based on Medicare data. American Medical News/2-26-96
WHAT CONSUMERS WANT FROM THEIR INSURANCE PLANS

- ACCESS
- QUALITY CARE
- COMPREHENSIVE BENEFITS
- NO “ADMINISTRATIVE HASSLES”
- LOW PREMIUMS
- FIRST DOLLAR COVERAGE
- FREEDOM TO CHOOSE PROVIDERS
Where consumers seek health information, by percentage

- Any source: 38.2%
- Books and magazines: 23.0%
- Friends or relatives: 19.7%
- Internet: 16.1%
- TV or radio: 11.3%
- Other: 2.2%

Note: Categories are not mutually exclusive. Some respondents selected multiple categories.

Influence of ratings on consumers
(June 2002 survey of 1013 adults)

<table>
<thead>
<tr>
<th></th>
<th>Percentage of consumers who have seen information ratings</th>
<th>Percentage of those who considered a change based on the ratings</th>
<th>Percentage of those who actually made a change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>26%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Health Plans</td>
<td>22%</td>
<td>3%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Physicians</td>
<td>10%</td>
<td>1%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

•SOURCE: STRATEGIC HEALTH PERSPECTIVES; HARRIS INTERACTIVE
How satisfied are you with your current health insurance coverage?

- Very dissatisfied: 4%
- Somewhat dissatisfied: 7%
- Somewhat satisfied: 27%
- Very satisfied: 56%

Another view
Rate your feelings about HMOs:
- Very negative: 31%
- Somewhat negative: 25%
- Neutral: 17%
- Somewhat positive: 15%
- Very positive: 6%
- Don't know: 6%

Source: Watson Wyatt 2004 WorkUSA Study of 13,000 workers
Among 82% who are insured: How satisfied are you with what you pay for the health insurance you have?

- Very satisfied: 39%
- Somewhat satisfied: 39%
- Not too satisfied: 12%
- Not at all satisfied: 9%
- Don’t know: 1%

Source: USA Today/Kaiser Family Foundation/ Harvard School of Public Health Health Care Costs Survey (conducted April 25 – June 9, 2005)

Survey of 1531 adults over age 18.
Percentage of Americans giving their health plan a low rating (average, poor or failing), by extent of choice, 1997.

With a choice of three or more plans
- 22%

With a choice of two plans
- 22%

Not forced to change plan
- 25%

Forced to change plan by their employer in past 5 years
- 36%

Had choices and enrolled in traditional health insurance
- 11%

Had choices and enrolled in light managed care
- 22%

Had choices and enrolled in heavy managed care
- 29%

Had no choice and was enrolled in traditional insurance
- 29%

Had no choice and was enrolled in light managed care*
- 37%

Had no choice and was enrolled in heavy managed care*
- 50%

With choice of plans
- 23%

With no choice of plans
- 39%

*Heavy managed care is defined as plans requiring that participants choose doctors from a list and pay more for care from doctors not on the list, select a primary care doctor or medical group, or obtain a referral before seeing a specialist or doctor outside the plan. Light managed care is defined as plans having some, but not all, of these characteristics.

Source: Gawande et al., Health Affairs, September/October 1998
HOW PEOPLE CHOOSE A HEALTH PLAN

- Having a plan that offers a wide choice of doctors
  - 1996: 17%
  - 2000: 15%

- Keeping costs of coverage low
  - 1996: 17%
  - 2000: 18%

- Having a wide range of benefits or a particular benefit you need
  - 1996: 14%
  - 2000: 17%

- Having a health plan that provides a high quality of health care
  - 1996: 42%
  - 2000: 44%

- Keeping costs of coverage low
  - 1996: 74%
  - 2000: 70%

- Having a wide range of benefits or a particular benefit you need
  - 1996: 78%
  - 2000: 74%

- Having a health plan that provides a high quality of health care
  - 1996: 91%
  - 2000: 87%

PRIMARY CARE PHYSICIANS/ GROUPS WANT PLANS TO:

- Give Them Enough Patients to Diffuse Risk or Develop Creative Payment Schedules Until Those Targets Are Met
- Provide Timely and Accurate Eligibility Data, Preferably Via On-Line Computer Linkages
- Set Capitation Based on Realistic Risk, Compensating for Adverse Selection
- Provide Appropriate Stop-Loss Insurance and First Dollar Reinsurance (The Latter for High Risk Cases, e.g., Open Heart Cases, Psych and Chemical Dependency, etc.)
- Help Them Obtain Favorable Supplier Contracts Using the Plan’s Market Share Power, e.g., To Purchase Packages and Obtain Aggressive Specialist Contracts
PRIMARY CARE PHYSICIANS/GROUPS WANT PLANS TO (CONT’D):

- Do Their Own Benefit Interpretations
- Leave Them Alone to Manage Their Business, i.e., Not Micromanage the Care
- Share Profits as Befits a Partnership
MANAGED CARE PLANS WANT
PRIMARY CARE PHYSICIANS WHO:

- Practice High Quality Medicine
- Practice Efficiently
- Provide a Patient-Friendly Atmosphere
- Provide Medically Necessary Services
PHYSICIANS WANT HOSPITALS TO:

- Contract with Plans Physicians Want to Join
- Be Competitive in Price and Quality
- Profit on Managed Care Contracts by Being Able To Control Costs and Provide Services Efficiently
- Provide a Range of High Quality Services (Centers of Excellence)
- Be Responsible for Hospital-Based Physician Services - Especially for “PEAR” Physicians
- Package Services
HOSPITALS WANT PHYSICIANS WHO:

- ARE LOYAL TO THEM
- PRACTICE MEDICINE ECONOMICALLY
  USE SERVICES APPROPRIATELY
  USE SERVICES EFFICIENTLY
- DELIVER QUALITY CARE
- COOPERATE WITH THEM IN CONTRACTING
- ARE AVAILABLE TO SERVE ALL SEGMENTS OF THE POPULATION
## Some Necessary Changes for Physician-System Integration

<table>
<thead>
<tr>
<th>Current State</th>
<th>Desired State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Focus</td>
<td>Primary Care Focus</td>
</tr>
<tr>
<td>Inpatient Focus</td>
<td>Outpatient Focus</td>
</tr>
<tr>
<td>Acute Care Model</td>
<td>Continuum of Care Model</td>
</tr>
<tr>
<td>Individual Patient Focus</td>
<td>Meeting Needs of Populations</td>
</tr>
<tr>
<td>Functional Orientation</td>
<td>Process Orientation</td>
</tr>
<tr>
<td>Short Term Quality Goals</td>
<td>Long Term Assessments</td>
</tr>
</tbody>
</table>

**Summary:** A Cooperative Relationship

An Integrated Clinical System

Source: Joel Shalowitz, M.D.
Some Benchmarking Questions and Measures of Successful Physician-System Integration

1. Shift to Primary Care Focus
   Conceptual Questions:
   To what extent is the system being run by primary care physicians?
   Are these physicians practicing broad-based primary care?
   Sample Measures:
   Appropriate PMPM specialty referral expenses
   Review of in-area emergency room use

2. Shift to Outpatient Focus
   Conceptual Questions:
   Are the hospitalizations appropriate?
   Were other appropriate sites available to treat these patients?
   Were hospital services used appropriately?
   Were the services provided efficiently?
   Sample Measures:
   Bed days/1000 members
   Admission rates for select conditions, e.g., asthma
   Length of stay for select conditions, e.g., NSVD and hip repair
   Compliance with critical paths

Source: J. Shalowitz, M.D.
## C-SECTION

<table>
<thead>
<tr>
<th></th>
<th>Loosely Managed</th>
<th>Moderately Managed</th>
<th>Well Managed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Admits/1000</strong></td>
<td>4.42</td>
<td>3.84</td>
<td>3.26</td>
</tr>
<tr>
<td><strong>ALOS</strong></td>
<td>4.38</td>
<td>3.52</td>
<td>2.65</td>
</tr>
<tr>
<td><strong>Number of Days/1000</strong></td>
<td>19.36</td>
<td>13.52</td>
<td>8.64</td>
</tr>
</tbody>
</table>

Source: Milliman and Robertson, 1994
## TOTAL UTILIZATION

<table>
<thead>
<tr>
<th></th>
<th>Loosely Managed</th>
<th>Moderately Managed</th>
<th>Well Managed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Admits/1000</strong></td>
<td>83.70</td>
<td>70.80</td>
<td>57.42</td>
</tr>
<tr>
<td><strong>ALOS</strong></td>
<td>5.38</td>
<td>4.19</td>
<td>3.11</td>
</tr>
<tr>
<td><strong>Number of Days/1000</strong></td>
<td>450.68</td>
<td>296.60</td>
<td>178.45</td>
</tr>
</tbody>
</table>

Source: Milliman and Robertson, 1994
Questions and Measures - Continued

3. Shift to Continuum of Care Model
   Conceptual Questions:
   Same as above
   Were hospital services preventable?
   Sample Measures:
   Total cost per case, e.g., hip repair
   Immunization and appropriate screening rates

4. Shift to Population Focus
   Conceptual Questions:
   To what extent are resource decisions being made for community’s benefit as opposed to individual or physician benefit?
   Are we conducting any community-wide clinical epidemiology studies?
   Sample measures:
   How are we identifying, preventing and treating high risk pregnancies?
   Patient satisfaction surveys regarding met/unmet medical needs

Source: J. Shalowitz, M.D.
5. **Shift to Process Orientation**

**Conceptual Questions:**

To what extent are we combining services from functional areas to create programs which meet the needs of our patients?

To what extent have we identified our customers and their needs?

Do we realize that primary care physicians are our customers and specialists are our business partners?

**Sample measure:**

What programs do we offer which “package services,” e.g., cataract surgery, open heart surgery and multi-step testing (thallium stress tests)?

6. **Shift to Long Term Quality Assessments**

**Conceptual Question:**

Have we made our patient’s lives any better by our interventions?

**Sample Measures:**

SF36

NY Heart Association Functional Classification

Functional Scale Assessment after TURP

Source: J. Shalowitz, M.D.
TWENTY ONE WAYS MANAGED CARE HAS CHANGED DURING THE PAST DECADE

1. The rapid growth of for-profit HMOs
2. The rapid growth of network and IPA models
3. The growth of mixed models
4. Product diversification
5. HMO consolidation
6. The decline of community rating
7. Arrangements for paying physicians
8. Increased patient cost sharing
9. Declining hospital use
10. Clinical practice guidelines
11. Increase in market share maximization as prevalent strategy
12. Increased risk - shifting to providers
13. Increased contracting with single specialty networks and disease management programs
14. Responses to disease - specific legislative mandates
15. Treatment of primary care physicians as suppliers rather than business partners
16. Emergence of Pharmacy Benefits
17. Rise and Fall and Rise (?) of Medicare HMOs
18. Increased liability exposures, e.g., RICO, ERISA, new technology
19. Response to “open access” legislative mandates
20. Shift from defined benefits to fixed contribution plans
21. Emergence of Consumer-Directed Health Plans (HSAs)

Sources: 1-10: Gabel, Jon, Health Affairs 16:134-145, 1997
11-21: Shalowitz, J.
REASONS FOR HMOs
CONTRACTING WITH SINGLE SPECIALTY NETWORKS

1. EASE OF CONTRACTING
2. STATE-SPECIFIC MANDATES
3. ARBITRAGE OPPORTUNITIES
4. ENHANCED QUALITY (???)

Source: Shalowitz, J.
Recommendations

1) Increase member cost sharing for discretionary behavior and emergency room use

2) Review benefit design
   - Cover catastrophic events for all
   - Omit non-value added benefits that increase costs
   - Offer choice of health plan types but members must pay for freedom of choice and extra benefits
   - Exclude third party liability coverage, when it is applicable

3) Don’t micromanage utilization review
   - Choose your partners wisely and trust them

4) Elderly (Medicare in U.S.) HMO market is still a good one

5) Improve information systems
   - Eligibility
   - Capitation Payment
   - Quality Data
6) Physician Payments
   - Capitate primary care physicians
   - Provide them sufficient number of patients
   - Share profits appropriately

7) Terminate providers who do not meet cost/quality expectations

8) ASO Contracting

9) Attention to national accounts understanding healthcare is all local

10) Contract with providers who can package services and give them volume. Help physicians access these contracts.

11) Develop rational technology application policies, including a pharmaceutical formulary and guidelines for coverage and use of new and existing drugs, devices and procedures. Explain policies in subscriber information.

12) Differentiate yourself from competitors on the basis of quality - be able to define it in the customer’s terms and defend your claims.
Preferred Provider Organizations (PPO’s)

Definition and Operational Features - No single definition exists for organizations calling themselves PPO’s. The following are some common operational features they share:

- Insurer or third parties contract with a panel of providers
- They negotiate a fee schedule with these providers
- The providers agree to abide by a utilization review process
- Patients are not “locked in,” i.e., if they obtain care outside the panel of contracted providers they will retain some coverage, though not as comprehensive as had they stayed within the network.