EXPERIENCE IN CONTROLLING COSTS AND IMPROVING QUALITY IN EMPLOYER-BASED PLANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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EXPERIENCE IN CONTROLLING COSTS AND IMPROVING QUALITY IN EMPLOYER-BASED PLANS

TUESDAY, MAY 16, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 10:09 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

– Private-Sector Lessons to be Sought –

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, June 8, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

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** *NOTICE -- CHANGE IN LOCATION* **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 17, 1995
No. HL-11-Revised

CONTACT: (202) 225-3943

Thomas Announces Change in Location for Health Subcommittee Hearing on the Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the potential role for employers, associations, and medical savings accounts in the Medicare program, which was originally scheduled for Thursday, May 25, 1995, at 10:00 a.m., in Room B-318 of the Rayburn House Office Building, **will be held instead in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee Advisory No. HL-11, dated May 9, 1995.)

*****

Chairman THOMAS. The subcommittee will come to order, and I want to welcome you to our continuing series of hearings on Medicare and health reform in general. This is the 13th hearing the subcommittee has conducted this year, and this committee and this Congress have already moved aggressively to enact real health care reform for the American people.

As you know, the Congress has passed and the President has signed a law permanently increasing the health insurance tax deduction for the self-employed prospectively at 30 percent. And this House has passed long-term care insurance improvements and extension of the Medicare Select program, reforms in the malpractice area to prevent lawsuit abuse in the medical field. They are all over on the Senate side, and we were anxiously awaiting some action from the Senate.

Today's hearing will focus on experience in controlling costs and improving the quality of employer-provided health coverage as we begin to consider options for preserving Medicare. In the 21st century, it is to the private sector we should look for lessons that have been learned and changes that we might be able to make in our delivery system. Although Medicare remains predominantly a 1960s-style fee-for-service health insurance plan, private health coverage has evolved substantially since that same time period.

Employers, especially in the past 5 years, have moved more rapidly from traditional insurance into sponsoring more options for their employees, such as health maintenance organizations, preferred provider organizations [PPO's] and other coordinated care arrangements. Some 56 million Americans were enrolled in health maintenance organizations [HMO's] last year—that is up from 36 million in 1990—and 65 percent of people with employer-based coverage were enrolled in 1994 in some form of a coordinated care program.

Employers are also joining forces with each other in many market areas, using their buyer power and new-found knowledge to force dramatic changes in the health care delivery system to lower costs and improve quality. We will hear from witnesses today about these arrangements.

I believe employers in private health plans have turned a corner in terms of cost control in recent years. In the last Congress, Stuart Albert and I carried on a conversation about the fact that both of us believed that these changes are relatively fundamental and permanent, notwithstanding the relatively few years that these changes have been in effect.

In 1995, on average, HMO's are expected to reduce their per-person premiums by 1.2 percent. In 1994, private health spending grew at about 4.4 percent, compared to Medicare spending growth of over 11 percent.

As we consider solutions for Medicare, I believe we should take the time to focus on successful private-sector efforts so that we might learn from their experience as we seek changes in the Medicare program. I look forward to hearing from our witnesses.

I recognize the gentleman from California, Ranking Member Mr. Stark.

Mr. STARK. Mr. Chairman, thank you. I am pleased you have scheduled today's hearings to see what experiences with employer-

based health plans are relevant and possibly applicable to the Medicare program.

The hearings wouldn't be complete unless we heard from the prosecutors who are now trying to put the rest of the Prudential Life Insurance executives in jail for shoddy sales practices, and unless we examined all of the malpractice suits filed for denial of benefits to people which caused death or serious illness when zealous bean counters for insurance companies deny benefits in their interpretation of managed care.

I feel it is necessary to raise these words of caution before we hear from our witnesses today, particularly in light of the tone of the announcement for the hearing.

Your announcement described Medicare in the following manner:

> Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization. However, private health insurance has evolved substantially since that time.

There is some confusion, I think, over Medicare's commitment to health security for America's seniors, which does remain largely as it was originally in 1965, versus Medicare's means of paying for that security. Today over 99 percent of seniors have health insurance coverage. That is a commitment we made in 1965. And it is as necessary and valued a commitment today, as it was when we enacted it in 1965.

As to the operations of the Medicare Program over the past 20 years, Medicare has actually led the way in innovations in administration, cost containment, quality of care, and beneficiary choice. The fact is that no employer in the country, no witness today, provides the range of health insurance options to the range of Americans in the variety of locations as does the Medicare Program.

The diagnosis related group [DRG]-based hospital prospective payment system led the way in reforming the way hospitals get paid. Similarly, Medicare's resource-based relative value scale payment system has changed forever the way in which doctors are compensated. Both payment mechanisms are in widespread use across the country and across systems, both public and private. In our own State of California, Blue Cross and Blue Shield both use these methods of reimbursing hospitals and physicians.

Medicare has not only been concerned with costs but with the quality of patient care received. Medicare led the way in developing utilization review through its professional review organizations, review which is now the underpinning of most managed care in the private sector. Moreover, as I know the Chairman is aware, the Federal Government's involvement in outcomes research and the development of practice guidelines is serving to improve quality of care for Medicare and non-Medicare patients alike. As reported in lost month's issue of the Journal of Transplantation.

> Heart transplant patients at Medicare-approved hospitals have a 20 percent lower risk of death within 30 days of the procedure. Better outcomes persist for 5 years.

While I disagree with your characterization of Medicare today, I do agree that if the proposals put forth in the recent Republican budget are enacted, like abolishing the Agency for Health Care Policy and Research and slashing Medicare funding, the clock on Medicare could be turned right back to 1965.

The last issue I would like to touch on is the growth in Medicare and private-sector expenditures. There are available to us all charts and graphs prepared by a host of private consulting firms. Some show private health expenditure increasing at a slower rate than Medicare; others show private-sector spending above Medicare. None of the numbers are the same. Perhaps the most accurate numbers I have seen are from the Health Care Financing Administration's [HCFA] 1995 analysis of the National Health Expenditures Account. While total Medicare spending is projected to increase faster than private-sector expenditures, when they are adjusted for enrollment growth in Medicare, Medicare and private health insurance expenditures are anticipated to grow at almost exactly the same rate, 7.9 percent for Medicare and 7.6 for private health insurance.

I offer these thoughts to emphasize that there are lessons to be shared both ways between the private sector and Medicare. This hearing I think will be more fruitful if we keep that in mind.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman from California for his usual really constructive comments; and he is absolutely correct, no other program—certainly not those in the private sector—are going broke like Medicare, according to the trustees report.

I ask for the first panel, please—Mr. Hustead, Mr. Treat, and Mr. Fronstin.

Chairman THOMAS. I thank the panel. I would tell any of the panel that if they have a written statement, it will be made a part of the record, without objection, and you may proceed for 5 minutes to inform the subcommittee in any way you see fit.

We will start with Mr. Hustead and move across the panel.

STATEMENT OF EDWIN C. HUSTEAD, SENIOR VICE PRESIDENT, HAY/HUGGINS CO., INC.

Mr. HUSTEAD. Thank you, Mr. Chairman. My name is Edwin C. Hustead, senior vice president with the Hay/Huggins Co., Inc., former chief actuary of the Office of Personnel Management, currently chair of the American Academy of Actuaries Work Group on medical savings accounts [MSAs].

I would caution, as many of us will and as we have heard already, that solutions that work in the private sector may not necessarily be transferable both to Medicare and vice-versa. However, they all deal with the same basic problem and that is, when the patient, the buyer, is facing the physician, the seller, there is no economic buyer involved in that transaction. And each system in its own way is dealing with this basic problem which, in effect, creates a monopoly.

Since 1990, as you have noted, employers have moved rapidly to adopt a series of steps to involve a third party at the point of transaction. Our charts show that both the classic health maintenance organization and the more recent additions of preferred provider organizations and point-of-service plans have grown very rapidly until, together, they now all outweigh the number of traditional fee-for-service plans.

The result is hard to measure. There is much background noise in what is happening in the health sector, particularly in pre-

miums. As you have noted already, there are charts that show the private sector is worse than Medicare, and others show better trends.

One of the reasons for that is the underwriting cycle which I show in my written testimony and would be glad to discuss. When you cut through all of that, it does look, certainly in 1994, that health care cost increases in the private sector were around 4 to 5 percent. This year, however, as the HCFA study shows we think the increases are going to be around 8 to 10 percent.

We think that what happened last year, the 4-percent private sector versus the 11-percent Medicare, was an anomaly; just as many times in the past the private-sector growth has apparently been greater than Medicare, when in fact it has not.

When these provisions are adopted, when HMOs are put in place and PPOs and point-of-service plans, the immediate question is, what happens to the quality of care? The employers we work with, the employers that are thinking of their employees—and most of them do—look very carefully at this question and they look at a lot of ways to get feedback from their employees as to what is happening, and to get feedback from the health plans themselves.

One way that they can easily see what is happening is the way the employees vote with their feet. During the open seasons, if employees continue to stay in the HMO's and the PPO's and the point-of-service plans, then it is clear that quality is being provided; and when the individuals do choose a preferred provider organization or point-of-service plan, we look for 70 percent of the employees to use the networks that are set up by the employers. If they don't use those networks, we begin to question whether those networks are effective and advise employers to look at the quality of care that has been delivered.

In closing, let me mention that while it does look hopeful that cost increases are as low as 8 percent when they have been 15 percent, keep in mind that 8 percent is twice the rate of inflation and that 8 percent, even though it is below double digits, will cause us to continue to have health care that consumes a greater part of our economy.

Thank you very much.

Chairman THOMAS. Thank you.

[The prepared statement and attachment follows:]

TESTIMONY OF EDWIN C. HUSTEAD
HAY/HUGGINS CO., INC.

Thank you for the opportunity to address the Subcommittee on Health of the Committee on Ways and Means on the issues of controlling cost while preserving quality in employer-based plans. I am a Senior Vice President with the Hay/Huggins division of the Hay Group. We are an international benefits and compensation consulting firm. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

The central problem in the rising cost of health care has been the absence of an economic buyer. When confronted with a need for health care, a patient is usually not in a position to bargain for the best rates or search for the most efficient provider. This problem is exacerbated, in the United States, by the fact that a large share of most health care bills is paid for by a third party. The result is predictable - patients will "buy" much more health care than they need and at higher rates than could be negotiated. In effect, the health care system simulates a monopoly that sets the price and use of its product.

Cost Controls

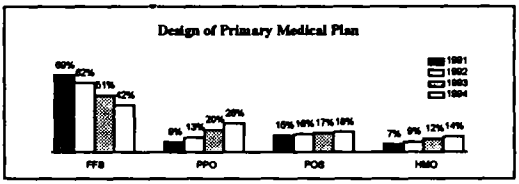
Insurers and employers have used two strategies to attack this problem. The first is to lessen unnecessary **utilization** of care through the management of the treatment. The second is to negotiate price **discounts** with the providers of care.

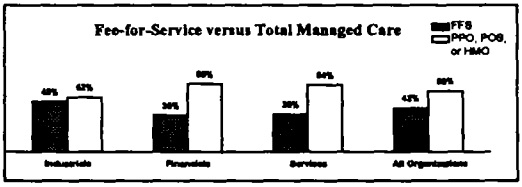
Health Maintenance Organizations (HMOs) apply both utilization and discounts. Other arrangements that deal with one or both of these aspects of health care have grown rapidly in recent years. These include Preferred Provider Organizations (PPOs) and Point of Service Plans (POS).

The PPOs deals only with the discount aspect of cost control. Patients are encouraged to select a physician or hospital from a network of providers who have agreed to provide services at a discount. The incentive to the patient is that the plan will pay a larger share of the bill for these providers.

The POS plan also asks the employee to select a provider at the time that services are needed. Unlike the PPO, however, if the employee selects the in-network POS plan then that plan manages the provision of care, as in an HMO, and provides discounts.

The following chart shows the percentage of employer health insurance plans by the type primary plan. The chart, and other data in my testimony, is from the Hay/Huggins Benefits Report (HHBR). This is a comprehensive report on the benefits practices of over 1,000 medium to large employers in the United States. Fee-for-service (FFS) plans are the traditional method of providing care. In the last four years, FFS plans have dropped from a majority of primary plans (69 percent) to a minority (42 percent). The fastest growing primary plan is the PPO but the POS and the traditional HMO plans have also increased substantially. We expect these trends to continue until very few primary plans are traditional FFS plans.

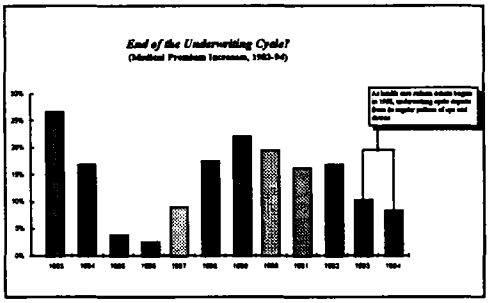




A recent innovation has been the application of **capitation** and **carve-out** arrangements by groups of health care providers. Capitation is the basis for HMO pricing but the new use is to capitate groups within the plan. Under these arrangements, a group of providers agrees to offer all of their services for a pre-determined fixed rate (the capitation). The insurer can then pass on the risk for that part of the care. Many plans carve out all of their psychiatric claims to a separate organization. And, capitation is now being applied to other parts of the delivery system such as nursing and drugs. Through sharing of risks, these arrangements should result in additional control of cost.

Results

An encouraging, but puzzling, trend in 1994 was the very low increase in health insurance rates. Some credit must go to the accumulative impact of the cost control measures. However, the true impact of these measures is masked by a phenomenon known as the **underwriting cycle.** The following chart of rate increases in the private sector since 1983 clearly shows that cycle in operation.



The underwriting cycle begins when actuaries set rates that are higher than needed to cover current costs. Rates must be set two to three years in the future and, given the volatility and growth in health care costs, actuaries tend to be very conservative about these trends. They may also need to cover past losses.

When experience shows that the rates are too high rate increases can be reduced to below the actual cost trend. Further, the excessive rates build large reserves that can be drawn on to keep rates at an artificially low level. These factors lead to unusually low trends for several years. The rates are kept down by market forces.

The cycle begins again when the excess reserves are expended and costs appear to be increasing again. Actuaries again set trends higher than needed and the reserves that might have been available to offset these increases have been spent.

Prior patterns suggest that 1994 should have begun the movement upward and that we should be faced with unusually large increases in 1995 and 1996. In fact, preliminary indications are that rate increases in 1995, while higher than in 1994, may not reach the double digit level that occurred in most years from 1980 through 1994.

There has been speculation that one of the reasons for the low rate of increase in 1994 was a restraint on cost increases by insurers and providers to show that health care reform was not needed. However, in the cases that we have examined, we find that the low cost increases resulted from a build-up in reserves because of overstated premiums before 1994.

Our hypothesis is that the extensive cost control measures introduced by most large plans in the last few years have resulted in a slowing down of the underlying trend of health care cost increases. The result is that insurers still hold much of the large reserves that they built in the early 1990s and increases continue to be moderate.

If the hypothesis is correct then we may finally have broken the back of the underwriting cycle. One very troublesome feature of that cycle is that it has resulted in artificial effects on the national health care debate. The alarming peak of the cycle leads to widespread calls for health care reform. The reform proposals take several years to develop and, by the time they are ready for consideration, the low part of the cycle causes us to relax and wait for the next cycle to consider large-scale reform.

Quality

Most of the employers we work with are very sensitive to the quality of health care provided to their employees. They work with the HMOs, PPOs and other organizations to assure themselves that the controls being used do not result in a deterioration in the quality of health care provided to their employees. This assessment is done through a number of feed back mechanisms such as employee surveys.

Outcomes measurement, a relatively new tool, shows promise of quantifying the quality of health care. These systems measure the quality of treatment from a number of perspectives including the most critical one of the success in curing the patient. Employers and insurers are working with providers to develop effective outcomes measures.

A critical part of many employer packages is the choice offered to the employee. We find that, when offered as a choice, well managed HMOs and similar organizations, will attract a significant and growing portion of the employee group. By maintaining a traditional FFS choice, or an out-of-network benefit, employees can always use unmanaged care if they become unsatisfied with managed care.

As risk is shared to smaller units through carve-outs there is a danger that quality will be lost. For example, if a separate organization is in charge of all mental care then there is a danger that the critical co-ordination of mental and physical treatment will not be effective. This could easily result in a deterioration of care.

Future

Health care cost increases have been very difficult to predict. Even when the underwriting cycle was predictable, it was difficult to be optimistic when rate increases were very high. Conversely, it is difficult to be pessimistic when, as is the case today, rate increases are low.

Our best guess at this point is that rates for 1995 will average about 5 to 10 percent higher than in 1994. This is lower than during the underwriting peaks but is still significantly higher than general inflation. Even at these relatively low trends, health care will continue to grow as a percent of our economy.

The trend toward tightly controlled health care plans, that is now becoming the norm in the market, appears to have significantly lowered health care costs. The critical question now is whether the cost controls put into place will reduce future health care cost increases to near the rate of general inflation. If so, then major health care reform may not be needed. If not, then health care will continue to consume a greater share of the economy and major reform will be needed.

Again, thank you for the opportunity to address the Subcommittee on Health. I will be happy to address any questions on these important topics.

Chairman THOMAS. Mr. Treat.

STATEMENT OF DENNIS J. TREAT, MANAGING CONSULTANT, FOSTER HIGGINS & CO., INC.

Mr. TREAT. Good morning, Mr. Chairman, members of the subcommittee, I am honored to be part of the proceedings this morning. Thank you for inviting me.

I am Dennis Treat with Foster Higgins, a benefits consulting firm that has been doing a survey on employer-sponsored health care for 9 years. I would like to give you an overview of the 1994 results.

In concert with an unprecedented increase in managed care enrollment, U.S. employers successfully drove down overall health benefits costs last year. This marks the end of two decades of health benefit cost increases that have consistently outpaced inflation.

Total health benefit costs in 1994 averaged $3,741 per employee, down 1.1 percent from 1993's average of $3,781. While aided by relatively low medical cost inflation, the reduction in benefit costs was a direct result of employer cost management activity, namely: First, shifting employees from traditional indemnity plans to managed care plans; second, carving out medical plan benefits with more volatile costs such as prescription drug and mental health/substance abuse care and offering them through freestanding managed plans; and third, enrolling a growing number of retirees in managed care plans, particularly HMOs.

Large employers were the most active in 1994; 29 percent of employers with 500 or more employees reported making significant changes to their health benefits program in 1993, compared to only 20 percent of smaller employers, and large employers had the most success in holding down costs. While the average total health care cost dropped 1.9 percent among large employers, among small employers it rose 6.5 percent.

The slowdown in costs was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of our survey. In 1994, 63 percent of all covered employees were in a PPO, point-of-service, or HMO plan, up from 52 percent in 1993. This represents a 21 percent increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans, which include open-ended HMOs as well as insurance carrier plans. As the number of employers offering point-of-service plans more than tripled, enrollment jumped from 7 to 15 percent of all covered employees. Enrollment in traditional closed-panel HMO's grew moderately in 1994 from 19 to 23 percent. Among the managed care alternatives, only PPO's failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27 to 25 percent in 1994 despite a slight increase in the number of employers offering a PPO.

If more evidence was needed to prove that health care markets around the country vary widely, the survey supplied it. In the Northeast, where the biggest shift in enrollment into managed care occurred, rising from 34 percent of covered employees in 1993 to 63

percent in 1994, employers experienced a dramatic 9.7 percent decline in total health care benefit costs from $4,267 to $3,851.

In the Midwest, managed care enrollment grew from 51 to 60 percent in 1994 with costs essentially flat, rising from $4,020 to $4,048. In the West, where managed care enrollment was already high, the growth in 1994 was more moderate, from 72 to 80 percent, and costs rose 2 percent to $3,693. In the South, there was little growth in managed care enrollment, from 57 percent to 58 percent, and total costs rose 3.9 percent to $3,389.

Because cost is measured per active employee, the employers who provide retiree coverage have significantly higher average costs than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221; among those who don't, average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to join HMO's, particularly in the West. Among large employers, defined as 500 or more employees, 17 percent offer an HMO under a Medicare risk contract, up from 7 percent in 1993. In the West, 36 percent of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMO's. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

While total health benefit plan costs per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans—and even among the three types of managed care plans—and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health costs has become more complex. In addition, changing plan selection by retirees also affects medical plan costs. Significant retiree enrollment in HMO's will raise HMO costs but may lower the actual cost of providing retiree medical benefits.

For instance, in HMO's, costs rose 6.4 percent from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans which raises the per-employee HMO cost but lowers the total cost of providing health benefits to retirees.

The survey results also show that many employers are beginning the process of measuring the performance of their health care vendors: cost-effectiveness and quality of care, including medical outcomes, access to providers, and patient satisfaction. With this information, employers can determine which plans offer the best value, and make their buying decisions accordingly. Fifty percent of large employers offering HMO's tried to evaluate the quality of their plans in 1994, up sharply from 38 percent in 1993. In the West, where managed care first took hold, 68 percent of large employers measured HMO quality last year.

While employee satisfaction surveys are the most common type of quality evaluation, employers are also seeking data on provider outcomes. Thirty-seven percent of large employers sought outcomes data from their point-of-service plans, 29 percent from their PPO's, and one-fourth from their HMO's.

Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher-cost plan to a lower-cost plan. The underlying factors driving health care costs—the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured—have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care and better outcomes. To help achieve that potential, employers will have to face new challenges with new measures of success. Quality, access and effectiveness of care—issues employers haven't had to deal with in the past—will now be of greater concern.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF DENNIS J. TREAT
FOSTER HIGGINS & CO.

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While aided by relatively low medical cost inflation, the reduction in benefit cost was a direct result of employer cost management activity:

- Shifting employees from traditional indemnity plans to managed care plans
- Carving out medical plan benefits with more volatile cost, such as prescription drug and mental health/substance abuse care, and offering them through freestanding "managed" plans
- Enrolling a growing number of retirees in managed care plans, particularly HMOs

Large employers were the most active in 1994 — 29% of employers with 500 or more employees reported making "significant" changes to their health benefit program in 1993, compared to only 20% of smaller employers. And large employers had the most success in holding down cost. While the average total health care cost dropped 1.9% among large employers, among small employers it rose 6.5%.

The slowdown in cost was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of the survey. In 1994, 63% of all covered employees were in a PPO, point-of-service plan, or HMO, up from 52% in 1993. This represents a 21% increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans (which include "open-ended" HMOs as well as insurance carrier plans). As the number of employers offering POS plans more than tripled, enrollment jumped from 7% to 15% of all covered employees. Enrollment in "traditional" closed-panel HMOs grew moderately in 1994, from 19% to 23%. Among the managed care alternatives, only PPOs failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27% to 25% in 1994, despite a slight increase in the number of employers offering a PPO.

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Because cost is measured per active employee, employers who provide retiree coverage have significantly higher average cost than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221.

Among those who don't average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to joint HMOs, particularly in the West. Among large employers (500 or more employees), 17% offer an HMO under a Medicare risk contract, up from 7% in 1993. In the West, 36% of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMOs. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

While total health benefit plan cost per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans (and even among the three types of managed care plans), and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health cost has become more complex. In addition, changing plan selection by retirees also affects medical plan cost. Significant retiree enrollment in HMOs will raise HMO cost but may lower the actual cost of providing retiree medical benefits.

HMO costs rose 6.4%, from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans, which raises the per employee HMO cost but lowers the total cost of providing health benefits to retirees.

Survey results also show that many employers are beginning the process of measuring the performance of their health care vendors: cost-effectiveness and quality of care, including medical outcomes, access to providers, and patient satisfaction. With this information, employers can determine which plans offer the best value and make their buying decisions accordingly. Fifty percent of large employers offering HMOs tried to evaluate the quality of their plans in 1994, up sharply from 38 percent in 1993. In the West, where managed care first took hold, 68 percent of large employers measured HMO quality last year.

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Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher cost plan to a lower cost plan. The underlying factors driving health care cost — the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured — have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care, and better outcomes. To help achieve that potential, employers will have to face new challenges, with new measures of success. Quality, access, and effectiveness of care — issues employers haven't had to deal with in the past — will now be of greater concern.

KEY DATA FROM THE 1994 SURVEY RESULTS

	ALL* EMPLOYERS	LARGE** EMPLOYERS	SMALL*** EMPLOYERS
AVERAGE PER EMPLOYEE COST			
Total Health Benefit Costs	$3,741	$4,040	$3,452
MEDICAL PLAN COST			
Traditional Indemnity Plans	$3,850	$4,229	$3,528
Preferred Provider Organizations	3,386	3,529	3,140
Point-of-Service Plans	3,609	3,975	2,884
Health Maintenance Organizations	3,485	3,663	3,230
PERCENT OF EMPLOYERS OFFERING			
Traditional Indemnity Plans	46%	60%	46%
Preferred Provider Organizations	30	40	30
Point-of-Service Plans	15	25	15
Health Maintenance Organizations	22	53	22
PERCENT OF EMPLOYEES ENROLLED			
Traditional Indemnity Plans	37%	34%	42%
Preferred Provider Organizations	25	23	27
Point-of-Service Plans	15	17	13
Health Maintenance Organizations	23	27	17

* All employers in the US with 10 or more employees
** Large employers: 500 or more employees
*** Small employers: 10–499 employees

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Foster Higgins

National Survey of Employer-sponsored Health Plans 1994

EXECUTIVE SUMMARY

With 2,097 respondents in 1994, the *Foster Higgins National Survey of Employer-sponsored Health Plans* is the largest, most comprehensive annual survey on the topic. This summary, released in advance of the full report, focuses on the movement of employees into managed care plans and on health benefit costs. In addition to a more detailed discussion of cost and enrollment trends, the full report provides a wealth of plan design information for each of the four major medical plan types (traditional indemnity plans, preferred provider plans, point-of-service plans, and health maintenance organizations). It also reports on:

- Dental benefits
- Prescription drug benefits
- Mental health and substance abuse benefits
- Retiree health benefits
- Flexible benefit programs
- Wellness programs

The report will be available in April 1995.

Overview

In concert with an unprecedented increase in managed care enrollment, U.S. employers successfully drove down their overall health benefit cost last year. This marks the end of two decades of health benefit cost increases that have consistently outpaced inflation. Total health benefit cost in 1994 averaged $3,741 per employee, down 1.1% from 1993's average of $3,781.

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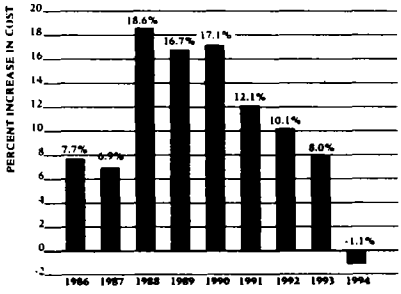
- Enrolling a growing number of retirees in managed care plans, particularly HMOs

Large employers were the most active in 1994—29% of employers with 500 or more employees reported making "significant" changes to their health benefit program in 1993, compared to only 20% of smaller employers. And large employers had the most success in holding down cost. While the average total health care cost dropped 1.9% among large employers, among small employers it rose 6.5%.

Increase in total health benefit cost per employee, 1986–1994



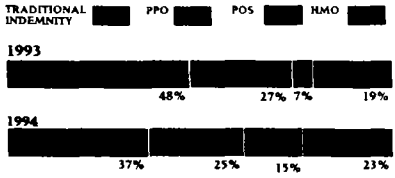
Enrollment in managed care surges

The slowdown in cost was driven by the biggest increase in employee enrollment in managed care plans in the nine-year history of the survey. In 1994, 63% of all covered employees were in a PPO, point-of-service plan, or HMO, up from 52% in 1993. This represents a 21% increase in managed care enrollment nationwide.

The fastest growth by far was in point-of-service plans (which include "open-ended" HMOs as well as insurance carrier plans). As the number of employers offering POS plans more than tripled, enrollment jumped from 7% to 15% of all covered employees. Enrollment in "traditional" closed-panel HMOs grew moderately in 1994, from 19% to 23%. Among the managed care alternatives, only PPOs failed to capitalize on declining indemnity plan enrollment. In fact, nationwide PPO enrollment fell from 27% to 25% in 1994, despite a slight increase in the number of employers offering a PPO.

National employee enrollment in plan type

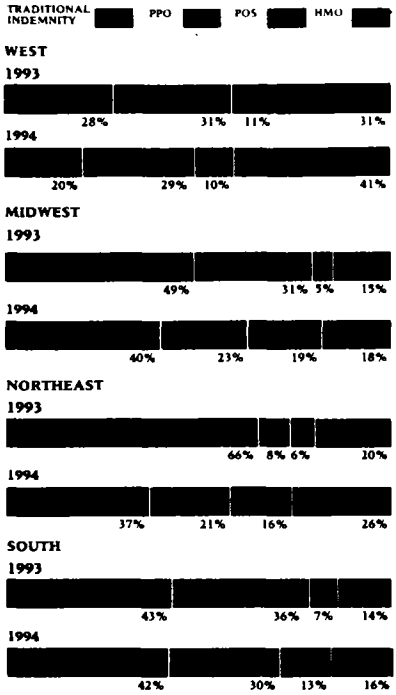
PERCENTAGE OF ACTIVE COVERED FULL-TIME AND PART-TIME EMPLOYEES IN EACH TYPE OF PLAN



Regional differences in cost

If more evidence was needed to prove that health care markets around the country vary widely, the survey supplied it. In the Northeast, where the biggest shift in enrollment into managed care occurred—rising from 34% of covered employees in 1993 to 63% in 1994—employers experienced a dramatic 9.7% decline in total health care benefit cost, from $4,267 to $3,851.

Regional employee enrollment in plan type

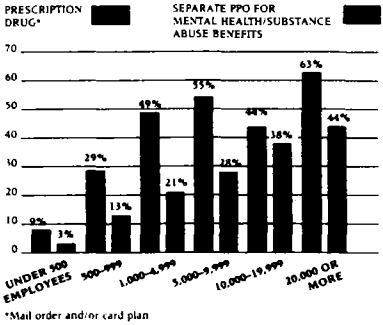


In the Midwest, managed care enrollment grew from 51% to 60% in 1994, with costs essentially flat, rising from $4,020 to $4,048. In the West, where managed care enrollment was already high, the growth in 1994 was more moderate (from 72% to 80%), and cost rose 2.0% to $3,693. In the South, there was little growth in managed care enrollment (from 57% to 58%), and total costs rose 3.9% to $3,389.

Use of medical plan carve-outs

Many employers—particularly among the trend-setting Fortune 500 companies—"carved out" their high-cost prescription drug and mental health care benefits from their medical plans and provided them through special managed care programs. More than a third of large employers (500 or more employees) offer a freestanding prescription drug plan (mail order and/or card plan). Among very large employers (20,000 or more employees), the percentage offering prescription drug card plans leapt from 36% to 66% in 1994. The proportion of these large employers offering a separate PPO for mental health care rose from 23% to 44%.

Use of medical plan carve-outs, by employer size



*Mail order and/or card plan

Effect of retiree coverage on total health benefit cost

Because cost is measured per active employee, employers who provide retiree coverage have significantly higher average cost than those who don't. Among employers of all sizes who provide retiree coverage, average total cost is $4,221. Among those who don't, average cost is $3,238.

In 1994, for the first time, employers induced a significant number of retirees to join HMOs, particularly in the West. Among large employers (500 or more

employees), 17% offer an HMO under a Medicare risk contract, up from 7% in 1993. In the West, 36% of large employers offer a Medicare risk contract HMO to their employees. Retirees traditionally have been very reluctant to leave their own doctors and join HMOs. Employers who move this high-cost population into low-cost plans will improve their health care liability over the long term.

Medical plan cost increases

While total health benefit plan cost per employee decreased, the average cost of the four types of medical plans rose at various rates. With significant shifts in enrollment from indemnity plans into managed care plans (and even among the three types of managed care plans), and growing use of prescription drug and mental health carve-outs, the relationship between the medical plan costs and the all-inclusive total health cost has become more complex. In addition, changing plan selection by retirees also affects medical plan cost. Significant retiree enrollment in HMOs will raise HMO cost but may lower the actual cost of providing retiree medical benefits.

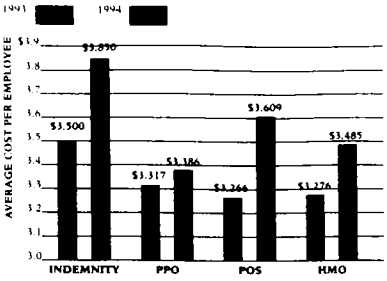
Indemnity plan cost averaged $3,850 per employee in 1994, up 10 percent from 1993's average of $3,500. This was a higher increase than was experienced in 1993. Enrollment in indemnity plans dropped from 48% to 37% in 1994. Lower enrollment raises the potential for adverse risk selection in indemnity plans, which likely contributed to higher cost.

Point-of-service plans, which saw a surge in enrollment in 1994, cost on average $3,609 per employee in 1994. While this is a 10.5% increase over the average cost reported in 1993, the increase largely reflects a change in the regional distribution of POS enrollment. In 1993, 46% of the employers offering POS plans were in the West region, where the average POS cost was low. Because of the rapid growth of POS plans in the higher-cost Northeast and Midwest regions, in 1994 employers in the West represented only 17% of those offering POS plans.

PPO plan cost rose 2.1% in 1994, from $3,317 to $3,386. PPO sponsors benefited not only from a lower rate of growth in medical care costs, but also from a significant increase in the use of financial rate guarantees from PPO administrators.

Medical plan cost, 1993–1994

IN THOUSANDS OF DOLLARS



HMO costs rose 6.4%, from $3,276 per employee in 1993 to $3,485 in 1994. Some of this cost increase is the result of growing retiree enrollment in HMO plans, which raises the per employee HMO cost but lowers the total cost of providing health benefits to retirees.

Implications for employers

Despite these encouraging results, the health care cost crisis is by no means over. A large part of employers' favorable experience in 1994 is a one-time savings due to moving employees from a higher cost plan to a lower cost plan. The underlying factors driving health care cost—the aging population, expensive new technology, and cost-shifting from government programs and the working uninsured—have not gone away.

At the same time, managed care has the potential to deliver long-term savings by emphasizing prevention, more efficient care, and better outcomes. To help achieve that potential, employers will have to face new challenges, with new measures of success. Quality, access, and effectiveness of care—issues employers haven't had to deal with in the past—will now be of greater concern.

About the survey

The Foster Higgins National Survey of Employer-sponsored Health Plans had 2,097 respondents in 1994. Both printed questionnaires and telephone interviews were used to collect data.

The survey was conducted using a national probability sample of public and private employers. Results are weighted to reflect the demographics of all employers in the U.S. with 10 or more employees who offer health insurance. Therefore, the survey results are valid for more than 550,000 employers and 68 million full-time and part-time employees.

ORDER FORM

If you would like to order a survey report, please provide the information requested below. The report will be available in April 1995.

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Comprehensive analysis of data by Foster Higgins consultants, covering traditional indemnity plans, managed care plans, flexible benefit plans and retiree benefits.

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Chairman THOMAS. Dr. Fronstin.

STATEMENT OF PAUL FRONSTIN, Ph.D., RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Mr. FRONSTIN. Mr. Chairman and members of the committee, I am pleased to appear before you this morning to discuss employer responses to rising health care costs. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute [EBRI], a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has committed, since its founding in 1968, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third-party reimbursement, and technological advances. Firms have been increasingly requiring workers to contribute to health insurance premiums and subjecting them to direct out-of-pocket provisions.

There has also been a simultaneous increase in the cost-sharing provisions of traditional fee-for-service health insurance. There have been increases in the use of deductibles, coinsurance and out-of-pocket maximums. In 1992, 83 percent of employers required coinsurance of 20 percent for physician visits, up from 77 percent in 1989.

Evidence from the RAND health insurance experiment suggests that increased cost-sharing does reduce health care costs and utilization. Employers have increased their use of utilization review programs [UR]. These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis.

For example, in 1992, 83 percent of surveyed employers required prior authorization for certain procedures nonemergency hospital admissions and elective surgery, up from 73 percent in 1989.

Studies have found that UR is an effective mechanism for controlling health care costs and utilization. One study found that UR lowered hospital expenditures by 11.9 percent, total medical expenditures from 8.3 percent, hospital admissions by 12.3 percent, and inpatient stays by 8.3 percent.

The use of HMO's has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMO's with 9.1 million enrollees. By 1994, there were 547 HMO's with 43.4 million enrollees. These plans range from staff models where the HMO owns its health care facilities and employs health care providers on a salaried basis, to independent practice arrangements where groups of physicians practicing independently contract with an HMO to provide health care services to the HMO enrollees. The recent movement of individuals into HMO's has not been into the more controlled staff or group model HMO's but into the Independent Practice Association [IPA's], where patients have a greater choice of physician. New evidence suggests that HMO's reduce use of health care services by an aver-

age of 8 percent, compared with services that similar patients would be expected do use in a traditional fee-for-service indemnity plan. However, staff and group model HMO's were shown to reduce services by nearly 20 percent, and IPA's reduce use by an average of 0.8 percent.

Preferred provider organizations and point-of-service plans have also emerged as strong alternatives to fee-for-service plans and HMO's. The number of individuals enrolled in these arrangements increased significantly between the mid-1980's and today. Evidence on the savings from these plans is largely lacking, but does suggest there is a potential for savings. For example, AT&T was able to reduce its annual growth rates for medical expenses from 12.9 percent in 1991 to under 5-percent in 1992, partly because they moved their workers into a point-of-service plan. Other factors contributing to reduction include managed care, hospital discounts, and an increase in employee coinsurance when out-of-pocket network providers are utilized.

In 1991, Cincinnati Bell, General Electric Aircraft Engines, Proctor & Gamble, and the Kroger Co. formed a health care coalition to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. Annual savings in the Cincinnati area have been estimated at $75 million for all private and public payers of health care because of a 5-percent decrease in the average charge per patient and a 10-percent decrease in the average hospital length of stay.

Coalitions have also been formed in many other cities. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

Thank you for the opportunity to testify this morning.

[The prepared statement and attachment follow:]

TESTIMONY OF PAUL FRONSTIN
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Introduction

Mr. Chairman and members of the committee, I am pleased to appear before you this morning to discuss employer responses to rising health care costs. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions. I would ask that my full statement be placed in the record.

Currently a majority of workers receive health insurance through their employers.[1] In addition, over 60 percent of nonelderly Americans participate in an employment-based health plan. The employment-based health system has been evolving since World War II, with employers being very active in the development and implementation of cost management strategies.

Cost Management Strategies

Employers' use of cost management strategies in health care has become more prevalent as a result of the growth in employment-based health insurance, third party reimbursement, and technological advances. Responding to rising health care costs, employers have moved to managed care, which can be defined as any type of intervention in the provision of health care services or reimbursement of health care providers that is intended to provide health care services in the most efficient settings. These interventions not only include the movement of individuals into health maintenance organizations (HMOs) but also include increased employee contributions for health insurance premiums and increased cost sharing in traditional fee-for-service health insurance.

Premium and Cost Sharing

Firms have been increasingly requiring workers to contribute to health insurance premiums and subjecting them to direct out-of-pocket provisions. In 1979, employers fully paid for single coverage health insurance for 73 percent of full-time workers employed in medium and large private establishments. By 1993, only 37 percent of workers had their individual coverage fully paid for. In 1979, employers fully paid for family coverage health insurance for 54 percent of full-time workers employed in medium and large private establishments. By 1993, only 21 percent of workers had their family coverage fully paid for.[2]

There has also been a simultaneous increase in the cost-sharing provisions of traditional fee-for-service health insurance (table 1). In 1992, 26 percent of surveyed employers required a deductible of over $200, up from 11 percent in 1989. In 1992, 65 percent of employers required coinsurance of 20 percent for inpatient care, up from 62 percent in 1989. In 1992, 83 percent of employers required coinsurance of 20 percent for physician visits, up from 77 percent in 1989. In 1992, 26 percent of employers limited out-of-pocket expenses to between $1,500 and $2,499, an increase from 21 percent in 1989.

Evidence suggests that increased cost sharing does reduce health care costs and utilization. The RAND Health Insurance Experiment found that individuals enrolled in health plans with a 25 percent coinsurance rate had 15 percent lower per capita costs than individuals in plans with no coinsurance. The RAND study also found that low-income individuals with lower coinsurance rates experienced health specific gains for high blood pressure, myopia, and dental problems—three prevalent chronic conditions that are relatively inexpensive to diagnose and treat. If individuals choose to forego preventive care and intervention services because of high cost sharing, they run the risk of necessitating more costly services in the future. This may have the effect of increasing total health care expenditures and utilization because individuals may be sicker once they seek treatment for a health problem.

Utilization Review

Employers have increased their use of utilization review (UR) programs (table 2). These programs are designed to monitor the progress and appropriateness of health care services on a case-by-case basis. In 1992, 83 percent of surveyed employers required prior authorization for certain procedures, nonemergency hospital admissions, and elective surgery, up from 73 percent in 1989. In 1992, 66

percent of employers required health care to be monitored as it was provided and/or determined the length of a hospital stay and the scope of the treatment prior to treatment, up from 52 percent in 1989. Second surgical opinions were the only type of UR whose use decreased between 1989 and 1992. Studies have found that UR is an effective mechanism for controlling health care costs and utilization. One study found that UR lowered hospital expenditures by 11.9 percent, total medical expenditures by 8.3 percent, hospital admissions by 12.3 percent, and inpatient days by 8 percent.[3]

HMOs

The use of HMOs has been one of the most prevalent methods utilized by employers to control rising health care costs. In 1980, there were 236 HMOs, with 9.1 million enrollees.[4] By 1994, there were 547 HMOs, with 43.4 million enrollees.[5] These plans range from staff models where the HMO owns its health care facility and employs health care providers on a salaried basis, to independent practice arrangements (IPAs), where groups of physicians practicing independently contract with an HMO to provide health care services to the HMO enrollees. The recent movement of individuals into HMOs has not been into the more controlled staff or group model HMOs but into the IPAs, where patients have a greater choice of physician. Between 1993 and 1994 there was a 42.6 percent increase in enrollment in mixed models, followed by a 7.6 percent increase in enrollment in IPAs. Group-based plans, i.e., staff, group, and network models, experienced a decline in enrollment between 1993 and 1994. New evidence suggests that HMOs reduce use of health care services by an average of 8 percent, compared with services that similar patients would be expected to use in a traditional fee-for-service indemnity plan.[6] However, staff and group model HMOs were shown to reduce services by nearly 20 percent, and IPAs reduced use by an average of 0.8 percent.

Preferred Provider Organizations and Point-of-Service Plans

Preferred provider organizations (PPOs) and point-of-service (POS) plans have also emerged as strong alternatives to fee-for-service plans and HMOs. The number of individuals enrolled in these arrangements increased significantly between the mid-1980s and today. Recently, the growth rate of enrollees in these plans has exceeded the growth rate of enrollees in HMOs because they allow greater choice of physician. Evidence on the savings from these plans is largely lacking but does suggest there is a potential for savings. For example, AT&T was able to reduce

its annual growth rates for medical expenses from 12.9 percent in 1991 to under 5 percent in 1992 because they moved their workers into POS plan. In 1991, the Pacific Telesis Group moved their fee-for-service enrollees in POS plans and reduced its annual growth rate from 12 percent to 5 percent. Surveys of their employees found that they were generally satisfied with the system once they understood it.

Coalitions and Cooperatives

In 1991, Cincinnati Bell, General Electric Aircraft Engines, Proctor and Gamble, and the Kroger Company formed a health care coalition to increase bargaining power for discounts with area hospitals, monitor quality improvements, and search for other ways to control costs. Annual savings in the Cincinnati area have been estimated at $75 million for all private and public payers of health care because of a 5 percent decrease in the average charge per patient and a 10 percent decrease in the average hospital length of stay.[7]

Coalitions have also been formed in Denver, CO; Memphis, TN; Cedar Rapids, IA; Houston, TX; Minneapolis, MN; Kingsport, TN; and many other cities. The activities of these coalitions have varied greatly, including the selection of preferred providers on the basis of efficiency, assistance in the purchase of cardiovascular care, the provision of mental health and substance abuse programs at reduced rates, the enactment of healthy lifestyle programs for adults and children, and the provision of small business insurance options. These coalitions are successful in reducing expenditures on health care because they create a competitive market with sound economic principles such as volume purchasing and competitive bidding.

States have responded to growing health care costs not only as government entities but also as employers. The California Public Employees' Retirement System (CalPERS) has had success with its own purchasing cooperative for health care services. CalPERS experienced premium decreases in both 1994 and 1995 by negotiating more aggressively with health care providers, asking HMOs to forego rate increases, and the state introduced a standard benefits package in 1993, requiring copayments of its employees.

Conclusion

The health care delivery and financing system is evolving rapidly. There have been changes in the way health care is financed, the types of treatments available, the sites of care, and the physician-patient relationship. These changes have resulted primarily from reactions to health care cost inflation, and employers' experiences in managing health care costs have varied with the methods chosen. We can expect to observe a continued increase in cost-sharing responsibilities of workers, the monitoring of care, the movement of workers and their dependents into managed care arrangements, especially those that offer greater choice of physician, such as IPAs, PPOs, and POS plans, and the formation of employer coalitions to negotiate for volume discounts for health care services.

Thank you for the opportunity to testify this morning. I'll be glad to answer any questions you may have.

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[1] In 1993, 54.2 percent of workers aged 18-64 received health insurance coverage from their employer. See Sarah Snider and Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no. 158 (Employee Benefit Research Institute, February 1995).

[2] U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms*, 1979–1989 (Washington, DC: U.S. Government Printing Office, selected years); *Employee Benefits in Medium and Large Private Establishments*, 1991 and 1993 (Washington, DC: U.S. Government Printing Office, 1993 and 1995).

[3] Paul J. Feldstein, Thomas M. Wickizer, and John R.C. Wheeler, "Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures," *New England Journal of Medicine* (May 1988): 1310-1314.

[4] Nancy Kraus, Michelle Porter, and Patricia Ball, *Managed Care: A Decade in Review 1980-1990*, (Excelsior, MN: The InterStudy Edge, 1991).

[5] The InterStudy *Competitive Edge*, 5.1 (Minneapolis, MN: Interstudy, 1995).

[6] U.S. Congressional Budget Office, "The Effects of Managed Care and Managed Competition," CBO Memorandum, February 1995.

[7] Danae A. Manus, Robert J. Strub, and Thomas R. Werner, "The Cincinnati Initiative," *Managed Care Quarterly* (Winter 1994): 20-26.

Related EBRI Publications

"The Future of Employment-Based Health Benefits." *EBRI Issue Brief* no. 161 (Employee Benefit Research Institute, May 1995).

Sarah Snider, and Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the 1994 Current Population Survey," *EBRI Special Report* SR-28/*Issue Brief* no.158 (Employee Benefit Research Institute, February 1995).

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Paul Yakoboski, et al. "Employment-Based Health Benefits: Analysis of the April 1993 Current Population Survey." *EBRI Issue Brief* no. 152 (Employee Benefit Research Institute, August 1994).

"The Changing Health Care Delivery System: An EBRI/ERF Policy Forum." *EBRI Issue Brief* no. 148 (Employee Benefit Research Institute, April 1994).

William Custer. "Health Care Reform: Examining the Alternatives." *EBRI Issue Brief* no. 147 (Employee Benefit Research Institute, March 1994).

Table 1

Percentage of Employers With Cost-Sharing Provisions, by Level of Cost Sharing and Year for Traditional Indemnity Plans, 1989–1992

Individual Deductible Amount	1989	1990	1991	1992
$100 or less	40%	38%	34%	29%
$150	15	15	15	13
$200	29	27	28	28
Over $200	11	18	23	26
Coinsurance Rate for Inpatient Care	**1989**	**1990**	**1991**	**1992**
0%	23%	25%	27%	25%
10	7	5	4	4
15	2	2	2	2
20	62	65	63	65
25	a	2	1	1
Coinsurance Rate for Physician Visits	**1989**	**1990**	**1991**	**1992**
0%	8%	6%	6%	5%
10	6	5	4	4
15	2	2	2	2
20	77	84	82	83
25	a	2	1	1
Employee Out-of-Pocket Maximums	**1989**	**1990**	**1991**	**1992**
<$1,000	35%	37%	30%	28%
$1,000-$1,499	38	37	39	38
$1,500-$2,499	21	20	24	26
$2,500-$4,999	4	5	6	6
$5,000+	2	2	2	2

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey, Report 1: Indemnity Plans: Cost, Design and Funding* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990-1993).

[a]Data not available.

Table 2

Percentage of Surveyed Employers with Utilization Review Programs for Traditional Indemnity Plans, 1989–1992

Type of Program	1989	1990	1991	1992
Precertification of Elective Admissions	73%	81%	81%	83%
Concurrent Review	52	65	65	66
Catastrophic Case Management	55	65	67	69
Outpatient Utilization Review	19	20	19	22
Second Surgical Opinion	89	88	82	71
Mandatory[a]	59	55	49	45
Voluntary[b]	30	33	33	26
None of These	9	7	8	7

Source: A. Foster Higgins & Co., Inc., *Health Care Benefits Survey* (Princeton, NJ: A. Foster Higgins & Co., Inc., 1990–1993).

[a]For specific procedures.

[b]For all procedures.

Mr. ENSIGN [presiding]. I want to thank the panel.

Mrs. Johnson.

Mrs. JOHNSON of Connecticut. Thank you.

I won't ask the panel what their opinion is of the claim that has been made that managed care reduces costs primarily and simply by negotiating hospital discounts.

What is your opinion of that analysis?

Mr. HUSTEAD. I think HMO's, in particular, use discounts as well as the management of the care through the primary care provider.

Mrs. JOHNSON of Connecticut. Is there any difference in the mix now and 5 years ago? In other words, what proportion of the cost savings was the result of negotiated agreements with hospitals, 5 years ago versus now?

Mr. HUSTEAD. I am not sure. I do know that hospitals are a much lower percentage of the total cost now, through all the control measures, but the hospital discounts you mentioned actually now go throughout the economy. It is no longer just HMO's; it is all insurance plans, all employers are negotiating hospital discounts.

Mr. TREAT. If I might add, discounts are just one factor in reducing costs. The philosophy of managed care is providing the right care, and as I mentioned earlier, there is a push to measure the quality being provided by vendors in terms of patient satisfaction surveys, outcomes measurements and so forth; and that knowledge and experience will just increase over time. But, again, discounts are just a small part of the overall.

Mrs. JOHNSON of Connecticut. Would you enlarge on how those other things actually affect the cost structure?

Mr. TREAT. If we can determine through outcomes measurement processes that care is better provided a certain way, the logical outcome of that is that you will not be providing unnecessary care and, that way, costs are reduced.

Mr. FRONSTIN. I would have to agree, it is a combination of discounts and decreased utilization. Not only have HMO's been negotiating for discounts, but other types of health plans have also been negotiating for discounts as well as just employers provide their own care to their own population of workers.

Mrs. JOHNSON of Connecticut. I am interested in your comments because it appears to me, from having watched the system evolve at fairly close range, that hospital discounts were more important to soft savings initially and now it is more the system's ability to determine what is appropriate care, get prevention in there early, and things like that that have to do with quality and appropriateness and elimination of excess care.

Mr. TREAT. You are absolutely correct.

Mrs. JOHNSON of Connecticut. The more information you can give us about that in the future, the better off.

I did want to ask you, Mr. Treat, about this chart that you gave us. I don't understand why point-of-service plans are doing as poorly as you report they are doing, when for small employers they clearly are dramatically lower cost.

Mr. TREAT. One of the things I didn't mention earlier is that in 1993, 46 percent of the employers offering point-of-service plans were in the West region where costs were actually already very low

and kept under control. Because of the increase in point-of-service plans' in 1994, particularly in the Northeast and the Midwest, where costs are naturally higher, you see a dramatic rise in point-of-service plans, but it is due to the mix or the shift from the West Coast to the East and the greater popularity of point-of-service plans.

Mrs. JOHNSON of Connecticut. Thank you.

Thank you, Mr. Chairman. I thank the panel.

Mr. ENSIGN. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me first comment about the discounting as a way of saving costs. I find that somewhat suspect. I appreciate managing the utilization of services as being a real way of bringing down health care costs.

I am concerned that by discounting, in many cases, what we are doing is shifting costs, rather than bringing down health care costs generally; and that because of the large presence of certain health care providers in our community, they can negotiate lower costs when, in reality, it is not lower health care costs for our community because the cost is just picked up by another segment.

Just to underscore that, in Maryland where we have an all-payer rate system for hospital care, where we have no discounting, you still have a very high penetration of HMO, the third highest in the country on a per capita basis, which indicates that managed care can work very efficiently by managing utilization and not relying upon the deep discounts, which is happening in many other parts of the country.

But my question I would ask any of the panelists, if they would like to respond, is why have we not seen much improvement in HMO's or managed care as it relates to special needs categories? Is there a way in which a capitated plan can deal with people who have special needs? Has the private sector come up with any way of dealing with targeted groups?

I know that the private insurance market has found it hard to come up with ways of doing risk adjustments. Is there some way that we can utilize a capitated system for dealing with target groups, whose health care needs may be more expensive than others? I find in most cases HMO's try to steer away from these groups of people. Any suggestions?

Mr. HUSTEAD. Well, actually, quite a bit is going on in that area. The sellers and buyers of health care at all levels are working with innovations like disease management approaches where, say, the drug companies will work with the HMO's to try to take charge and control of all asthma cases and make sure that the most effective delivery is made of treatment to these asthma cases.

It may not necessarily involve the drugs of that particular company. We are trying to take an overview of all care.

Another thing that happens with psychiatric care is that a good deal of carving-out is going on. One problem with all of that is that if these are segmented, there is a danger of loss of total treatment of the individual. If one group is dealing with the psychiatric care for this individual and another person with their nonpsychiatric, there may be a loss of quality and control on them.

Mr. CARDIN. But my concern is that—within a capitated plan is that managing the risks within that plan, or is that identifying prior to entering into an agreement, that there are certain risks that we need to handle? You understand my point? Is it just trying to manage the risk within a plan, or is there identification prior to the selection of the person or the entering into the contract on a capitated rate?

Mr. HUSTEAD. I think it is largely cost driven, and I think it probably doesn't address what you are searching for as helping the individual by saying "let's identify people with these particular conditions and let's deal most cost effectively with them."

Mr. CARDIN. What I am raising is that with asthma treatment the plans, or that an HMO has less asthma cases than the typical population that is out there. Fine. They are managing their asthma cases in the most cost-efficient way. We appreciate that.

But is there an effort made to have a representative group within an HMO? Or do we find that they are taking more of the easier cases and not handling the more difficult cases because there—as a capitated system, you make money by taking in easier patients.

Mr. TREAT. I think that is an argument of probably 10 years ago, and I think it is less of an argument today.

Another way that managed care vendors will manage risks within the confines of capitation is through centers of excellence programs where they perhaps could develop global case rates for certain types of problems and carve out niches that way, have all of their cardiac problems done at a particular facility or by a particular organization.

Mr. CARDIN. Could I just proceed—just for one more moment, if I might?

I appreciate that and that, in fact, is occurring, but we also have difficulty in financing the academic health centers, and I haven't seen many suggestions coming forward with the HMO's willing to help pay the extra costs associated with hospital care on training costs. It is something that we may want to take a look at.

I appreciate the fact that you use centers of excellence for particular needs, but we don't find any real initiatives coming forward from the managed care community to deal with whether we are going to have people trained in order to provide the services in these centers of excellence.

Thank you, Mr. Chairman.

Mr. ENSIGN. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Treat, we have talked a lot about costs being controlled by various changes in employer actions and going more to managed care. Is it your opinion that it is really not the underwriting cycle, so-called underwriting cycle, but changes in management by employers that are responsible for controlling these costs?

Mr. TREAT. Yes, sir. If you look at the underlying factors, they are still there—less so than in prior years, but they are still there. If you look at the costs for each plan type—indemnity, point-of-service, et cetera—you will see that there were increases between 1993 and 1994, but the shift in enrollment patterns from the high-cost indemnity plans to the lower-cost point-of-service and HMO plans has caused the overall cost of health care, per employee, to

drop by 1.1 percent. And it is the management of the employers in shifting employees into lower-cost plans that has resulted in the drop in costs.

Mr. HUSTEAD. I think there is a mix of things going on with health care. It is always difficult to tell. Clearly, the insurance companies and the HMO's are all pretty fat and happy these days. Blue Cross, I think, for instance, increased their reserve position by 75 percent last year. The HMO's have built to the point where they have rates that are more than adequate for their coverage; that is the way they are able to hold costs down.

At the same time, there is a shifting going on. The key question for the future is, having shifted into a PPO or an HMO or a point-of-service plan, will those operations then be able to have trends that are below average, or will they all just go back up to the same average trend?

We all hope that they will be able to not only control costs when they go to that new organization, but keep costs down, but we really don't know yet.

Mr. MCCRERY. It appears to me, looking at your charts—some of your charts, Mr. Treat, that a significant number of large employers, particularly, have carved out their drug programs. Is it possible that much of the savings that we are seeing comes from shifting, so to speak, their prescription drug benefits to a mail order program?

Mr. TREAT. In the total cost that we are measuring, that includes carved-out programs so that even though they are supplied by another vendor in a different approach, the cost is included.

Mr. MCCRERY. Yes. My question is getting back somewhat to Mrs. Johnson's question about deep discounts.

Mr. TREAT. Typically, the plans in a noncarved-out approach—prescription drugs, et cetera—would be included as subject to a deductible and subject to a coinsurance whereas in a carved-out approach, typically retail, which is a low copay, $5, $6, $10, $12, if there is a mail order program in place, typically you are getting 90-day supplies with a single copay, so in fact the benefits under a carved-out approach typically are better benefits than they were under the copay—I mean, under the deductible/coinsurance arrangement.

Mr. MCCRERY. Isn't it true that the reason there are better benefits for the employee is because of deep discounts the employer gets through a mail order or similar arrangement——

Mr. TREAT. But the deep discount is supported by efficiencies in providing the services.

Mr. MCCRERY. While that may be true, let me get back to my original question.

You said that there has been a per employee decrease in cost and that is due to better management. My question originally was, how much of that decrease might be due to shifting to a mail order drug program? How big a factor is that in the overall cost for employers?

Mr. TREAT. That is a question I don't know, and perhaps when the full survey data is available, we could see. I don't know at this point.

Mr. HUSTEAD. We find that there is not a lot to be saved in mail order; it is an efficient way of providing the service, but it is not

a major impact in the total cost. I think the management and the carving-out is what does the step.

Again, as with the other changes, the big question will be having moved to that and having achieved as much as you can through management and discounts, will you be able to keep the trend down or not.

Mr. McCrery. OK. Thank you.

Mr. Ensign. Mr. Treat, I think it was you who mentioned the POS plan, the point-of-service plans growing in cost more percentage-wise, compared to the other plans. Is that because more people in the East are now going to that?

Mr. Treat. That is correct.

Mr. Ensign. Are there any studies just in the West? Are the plans not growing as fast, percentage-wise, where they already have the plans?

Mr. Treat. There is not as significant a growth pattern in the West because that was all—it was already saturated to a greater extent with point-of-service plans. In the East there were relatively few point-of-service programs in 1993 and prior to that, and the growth has been substantial in 1994. So you are starting from a much lower base in the Northeast. Obviously, you have had a significant increase and that has diluted the effect of the lower cost on the West Coast. What you look at, it looks like an increase in point-of-service costs. In fact, it is a geographical shift.

Mr. Ensign. You also indicate in your testimony that health costs per employee actually fell about 9.7 percent in the Northeast from 1993 to 1994. Is that part of what is going on, the Northeast is going to point-of-service as some of these other plans were?

Mr. Treat. Absolutely. There has been a significant shift from indemnity plans to managed care plans in the Northeast. Unions have accepted or embraced managed care plans more readily.

Mr. Ensign. OK. When we are talking about HMO's and we are talking about some of the cost savings attributed, you hear some physicians say that this is because they are denying services because they are gatekeepers.

HMO's—in their defense, say that they are not denying, they are encouraging people to go for appropriate services, not inappropriate services, and their studies show that their quality of results—in the long run, they actually end up with better quality of results.

What is your opinion on whether HMO's are actually denying valuable services to patients or whether they are, through better management techniques and practice guidelines, actually directing patients to more appropriate treatments?

Mr. Hustead. I think I would come down on the latter, that clearly where there is no management involved, there is a lot of overuse of health care. Not only in HMO's, but other organizations have shown how much can be saved by taking a quality approach to what happens, looking to the gatekeeper. I think the evidence is that there is very little movement out of HMO's by those that join HMO's, plus the fact in the point-of-service plans that three-fourths of the care is selected in the networks suggests that the patients certainly are satisfied with the quality of care.

Mr. TREAT. You could also point to the fact that HMO's are the ones that initiated the NCQA process to measure quality. They are interested in making sure they are providing proper care.

Mr. ENSIGN. I would just like to address the IPA's versus the HMO's. And, Dr. Fronstin, I think it was you in your paper that talked about those, and the difference between saving costs, the IPA's obviously don't save the costs as some of the other plans. What is the benefit and why do you see more people choosing that?

Mr. FRONSTIN. More people tend to choose the IPA now. They provide a greater choice of physician, so when people have a better chance of sticking with their physician, once they join this type of plan, as opposed to a group or staff model HMO, that is the main difference.

Mr. ENSIGN. Do you see more companies going to that, offering that as an option to their employees, or do you see that because it is not saving or decreasing the costs?

Mr. FRONSTIN. That is the recent trend. Studies have shown that as IPA physicians treat more and more of the—IPA is just a form of an HMO—as they treat more and more HMO patients, the cost savings actually increase, there are some economies of scale. That seems to be the place where people are going, so I could see that—employers offering that on a wider basis.

Mr. ENSIGN. OK. Mr. Houghton, you had a question.

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman. I am sorry I wasn't here earlier, and I may be a little redundant; and if I am, you have just got to bear with me.

I have a chart here by the CBO which shows the trends in private health care insurance, out-of-pocket Medicare costs; and as I read the chart, with the exception of a couple of blips—one was in 1973 and the other is in 1980—the Medicare costs, Medicare expenditures and the private health insurance were about on a parallel until about 1991, then something happened in 1991. So that is point number one.

Point number two is that I understand that the thrust of this hearing is to review the approaches that people like yourselves have taken, and also the lessons which can be garnered from these approaches in the Federal Government. So without trying to belabor something which you have already possibly expressed, for each of you gentlemen, would you share with me the single most important lesson that we can learn from what you have done and apply it to our thinking.

Mr. TREAT. Our survey over the last several years has shown that a shift from nonmanaged programs to managed programs has produced a significant decrease in the cost of employer-sponsored health care. The lesson learned, I guess, is to continue to push and to make sure that the care provided under a managed environment is, in fact, quality care. And that push is going along in a parallel fashion with an emphasis on quality measurement processes being implemented.

Mr. HOUGHTON. I don't know what the percentages are in the country, but if I remember the percentages in California, about 20 percent of the people are under managed care programs. That is pretty high, isn't it?

Mr. TREAT. It is significantly higher than that. Depending on how you define "managed care," if you include——

Mr. HOUGHTON. But you would say the major driving force has been the managed care programs?

Mr. TREAT. Yes, sir.

Mr. HOUGHTON. Could the rest of you gentlemen just share with me your thoughts.

Mr. HUSTEAD. I think the differences between the trends in the two, the Medicare and the private sector, can be overemphasized. Taken over any long period, they are about the same. Each one has its different ways of responding. A large single Medicare Program cannot respond as effectively or quickly as managed care in situations like an employer can do.

I think, in general, the idea of moving to managed care will be of help; but keep in mind that Medicare has already taken many of the steps that would be involved in management such as the DRGs and relative value schedule. So I cautioned at the beginning that solutions that work in the private sector may not work in Medicare, and vice-versa.

Mr. HOUGHTON. What would be the primary issue you think that we ought to latch on to when we are rethinking this whole Medicare cost deal here?

Mr. HUSTEAD. I think to continue to try to get somebody involved in the decision between the patient and the doctor, other than those two people. And if that can be done through more managed care, that could achieve savings, but they will be fairly slow savings. Medicare is a glacial program.

Mr. FRONSTIN. I think the single most important lesson is that people are generally satisfied with their managed care plan, with their HMO, their POS plan, and the ones that tend to be unsatisfied with it generally don't understand the system. That is what one employer has shared with us, that there is a learning process involved with moving individuals into the managed care arrangements and there is a time commitment involved.

I think one of the reasons why the point-of-service plan premium increased data from A. Foster Higgins was higher in the Northeast than in the West was because of this learning process, the time it takes to implement the system to people opposed.

Mr. HOUGHTON. I can't hear you.

Mr. FRONSTIN. Part of the reason why the data on our point-of-service premiums were higher in the Northeast than in the West was because of this time adjustment people need, the time that people need to make the adjustment to managed care arrangements. There is a learning process people need to go through, and I think people on Medicare will have to go through that same learning process.

Mr. HOUGHTON. OK. Can you say that in one sentence?

Mr. FRONSTIN. If we move individuals in Medicare into managed care, there is going to be—you are going to need some time for people to make the adjustment to the different system.

Mr. HOUGHTON. So the direction is, right, time; we have got to be patient on that, and we have got to have proper understanding and education in the process.

Mr. FRONSTIN. It may be more effective to—the nonelderly are moving into managed care, and they are used to the system; and as they move into Medicare, they are more likely to accept the managed care than the current Medicare population.

Mr. HOUGHTON. Thank you.

Mr. ENSIGN. Mr. McCrery has another question.

Mr. MCCRERY. Thank you, Mr. Chairman.

There is nobody on any of the panels today from companies that have gone to a MSA-type structure or plan, but there are a lot of people who contend that we are never going to get the growth rate in health care costs down unless we get the individual more involved in the costs, the true costs of providing health care, and managing his own costs, managing his own health care. They see MSA's as a way to do that though I am not talking about the Medicare population right now; I am talking the non-Medicare population.

In your studies, have you looked at any of the companies that have gone to these type plans? Some of them have gone to them—even though they are not tax favored, they have gone to them anyway, and the experience—as we have been told, has been significant savings.

Have you looked at any of those and could you comment on those, and if you agree with those experts who say we have got to get the individual involved in the cost, whether it is enough just to have a managed care plan where you have got a gatekeeper and that kind of system.

Mr. HUSTEAD. I have chaired the American Academy of Actuaries work group on MSA's. We recently completed our work, and involved actuaries from all aspects of—those who work with MSA's and those who don't.

We see that they are cautiously optimistic on what MSA's might do. Where an individual is in a typical fee-for-service plan and there are no controls in place, there can be savings achieved. However, we have to question if you take an employee from an HMO or a managed program and put them on their own in a high-deductible plan we are not sure they can each achieve the savings that are there now.

In our study we asked these companies that have reported significant savings to open their books to us and tell us how they have done. We have heard a lot of headlines and a lot of numbers being thrown around, but the ones that did respond to us had very little and very inconclusive data; and the larger ones that have talked a lot about it just have refused to respond. We tried to get their data, so we could really study it, and it was not forthcoming.

So we are cautiously optimistic. If it does happen, if MSA's are enabled and they are successful, they will achieve that success very slowly. I would guess if you enacted MSA's this year, maybe by the year 2000, 5 percent of the people in the country would have MSA's and high-deductible plans.

Mr. MCCRERY. Does either of the other two gentlemen want to comment?

Mr. TREAT. I agree with those comments. I am concerned that—where the threshold might be, where you create a perverse incentive for someone looking at cash and a buildup of an MSA versus

receiving proper care and problems developing later on for care not received. So your premise that the individual needs to be involved in his or her own care is absolutely correct, but should not be the only individual involved in his or her own care; and I think at some point you reach a point where you create some danger.

Mr. FRONSTIN. I think it really depends on how individuals view the MSA, if they view it as an extension of their insurance plan, or if they view it as just savings that they could roll over from year to year or cash out at the end of the year.

If they choose to view it as saving and forgo interventive services, it may create additional problems down the line where, by the time they seek care, they are sicker than they would have been otherwise.

Mr. MCCRERY. Do you have any evidence that people will forgo health care for savings?

Mr. FRONSTIN. I couldn't understand you.

Mr. MCCRERY. Do you have any evidence or do you think people might forgo health care?

Mr. FRONSTIN. People might. It depends on how they view their MSA. If they view it as insurance, they would just——

Mr. MCCRERY. You are not aware of any data that supports that?

Mr. FRONSTIN. No. No.

Mr. MCCRERY. Thank you.

Mr. ENSIGN. I would like to thank the panel for your excellent testimony.

We call the next panel up. We have Paul Fearer, senior vice president of human resources at Union Bank, on behalf of the Pacific Business Group on Health Negotiating Alliance, San Francisco; Michele French, director of health and welfare benefits, Office of the President, University of California, Oakland; and James R. Wrocklage, chief executive officer, Health Care Network of Wisconsin, Brookfield, WI.

Each one of you will have 5 minutes. Proceed as you see fit. The amber light will go on when there is 1 minute left.

Mr. ENSIGN. Mr. Fearer.

STATEMENT OF PAUL FEARER, SENIOR VICE PRESIDENT OF HUMAN RESOURCES, UNION BANK, ON BEHALF OF PACIFIC BUSINESS GROUP ON HEALTH NEGOTIATING ALLIANCE, SAN FRANCISCO, CA

Mr. FEARER. I am here today representing the Pacific Business Group on Health Negotiating Alliance [PBGH], which is a coalition of 30 employers that are headquartered in California and represents nearly 3 million employees, dependents and retirees. PBGH has as its reason for being, improvement in the quality and efficiency of health care delivery.

I also personally serve in a human resources management capacity at Union Bank and, among other things, oversee the bank's benefits programs for its 8,000 employees and 1,500 retirees.

By way of background, my own employer, Union Bank and other members of the Pacific Business Group on Health experienced explosive growth in health care costs in the mid- and late-1980s; at that time, most of us used a variety of techniques to manage these costs.

We implemented managed care programs for our employees, and we created incentives to encourage employees to enter such plans.

We also, later in the 1980's and into the early 1990's, consolidated our health plan offerings. Many of us had been offering more and more choices to our employees, but we found that we needed to increase our leverage, that is, our purchasing power in terms of price and quality.

We also increased the employee share of cost through higher premiums, copays and deductibles.

Finally—and you have heard much about this already—we implemented new forms of managed care, such as point-of-service plans, which are basically a hybrid design combining aspects of an HMO and the traditional fee-for-service plan. For most of us, these initiatives helped to at least moderate the rate of growth in health care costs. But we began to run out of techniques that were effective and we needed more information and we needed more expertise to manage these costs. To that end, a number of employers formed PBGH, the Pacific Business Group on Health. Its initial activities were focused on information-sharing and research in the areas of cost control, benefit plan design, and employee satisfaction, that is, employee satisfaction with their plans. We developed, initiated and implemented a series of annual surveys of employees' satisfaction.

Our early experiences were favorable. We found there was enormous value in pooling our expertise, and it became immediately clear that there were numerous opportunities for win-win situations, that is, ways in which we could both improve quality and reduce long-term costs.

A few examples of our early activities: We spent a lot of time in the area of wellness and preventive care in researching plan design and also initiating some activities—data collection, research, et cetera—in the area of best practices.

In 1992, we saw an opportunity to manage costs and improve quality through more aggressive techniques, to engage in collective negotiation with the health plans that we offer to our employees. We realized that, given our bargaining power, we could readily identify win-win situations for both our employees and ourselves as employers.

With 2 years of preparation, we successfully completed our first round of negotiations with 17 HMO's last year. The result was a 10-percent price rollback with multiyear caps on future premium increases and performance guarantees, with a percentage of premium at risk in order to meet those guarantees.

There was enormous effort behind this result. We had to design a common benefit plan. We had to develop quality and performance standards that were common to all of us. We needed to develop contractual relationships between employers. We needed to seek the concurrence of the Department of Justice in terms of this purchasing approach, and we also needed to develop a negotiating strategy.

We are pleased with the outcome, and we are now expanding into other areas, into Medicare plans for retirees and into other types of health plans other than HMO's. Workers compensation is

another area of activity; we are also considering initiatives in the small employer market.

In conclusion, the challenge ahead for us is to improve the quality of care while pressuring plans and providers to reduce inefficiency, to wring out excess capacity, to quickly disseminate and adopt best practices, and to reduce the prevalence of inappropriate and/or unnecessary care, which is both expensive and harmful to the health of our employees. We firmly believe it is possible both to reduce costs and to improve quality, and that improved quality of care is the primary avenue to effective cost control.

Thank you.

[The prepared statement and attachment follow:]

TESTIMONY OF PAUL FEARER
PACIFIC BUSINESS GROUP ON HEALTH NEGOTIATING ALLIANCE

Mr. Chairman and members of the Subcommittee, I commend you for conducting this hearing on employer health care initiatives. I am delighted to have the opportunity to speak with you today.

My name is Paul Fearer and I am the Senior Vice President of Human Resources at Union Bank. My responsibilities include oversight of the benefit plans offered to the Bank's 8,000 employees and 1,500 retirees. Prior to joining Union Bank in 1990, I worked at Stanford University in human resources for fourteen years.

I am here today representing the Pacific Business Group on Health (PBGH) and its subsidiary, the PBGH Negotiating Alliance, of which I serve as Chairman. I joined the coalition shortly after its inception, and participated in its growth from a loose organization of like-minded businesses to a major force shaping California's health care market.

WHY A LARGE EMPLOYER COALITION?

As the Subcommittee is well aware, over the past two decades rising health care costs have made this benefit one of the most important cost centers of any business. As an example, Union Bank's total health care costs are approximately $30 million. From the mid-1980s through the early 1990s our medical inflation was sometimes in excess of 20 percent. Although the Bank derived some short term benefit reductions from the pace of annual health care inflation -- primarily through redesigning benefits and increasing employees' share of the costs -- we ultimately recognized that more fundamental reform was needed. Such reforms could only be accomplished through the combined efforts of a number of employers. The Pacific Business Group on Health is the preeminent large business coalition in California, and one of the country's most active employer coalitions. The nonprofit coalition was founded in late 1989 by two executives from Wells Fargo and Bank of America to improve the quality of health care and moderate rising costs.

PBGH (formerly the Bay Area Business Group on Health) expanded its membership from ten to nearly thirty member companies -- and continues to grow rapidly. Today, the coalition represents 2.5 million employees, dependents, and retirees, and *$3 billion* in annual health care expenditures. Membership in the group is open to both private and public sector purchasers if they have at least 2,000 California benefits-eligible employees and are not in the health care business (see Attachment A). Public sector members include the California Public Employees' Retirement System (CalPERS), the University of California, and the Federal Reserve. Most member companies have a workforce dispersed throughout California; many employ workers in multiple states, and some are international. On average, *two-thirds* of PBGH's California employees and dependents are enrolled in health maintenance organizations (HMO). Our annual employee surveys reveal that HMOs rank highest in terms of overall satisfaction.

The remaining one-third of California employees is enrolled in a point-of-service (POS) health plan, or in some cases such as Union Bank, a preferred provider organization (PPO). Very few employees are enrolled in traditional indemnity insurance health plans.

THE NEGOTIATING ALLIANCE; MOVING TOWARDS VALUE-BASED PURCHASING

Initially, PBGH primarily concentrated on standardizing health data collection and benefits across member companies. Recently, however, the organization has taken a significantly more active role by negotiating with health plans on behalf of interested members. In 1994 eleven of (at that time) nineteen members participated in an Alliance to negotiate premiums, benefits, and performance measures with managed care plans through a process of competitive bidding. The members of the Negotiating Alliance represented 300,000 actives and early retirees and $400 million in premium with HMOs. Participants in the Negotiating Alliance are bound to an agreed upon model plan design and the negotiated rates and performance measures. However, plan contracts are held by the individual employers. In this sense, each employer decides independently whether to renew, add, terminate, or freeze enrollment in a given health plan.

The Negotiating Alliance proved to be a great success for its members. In 1995--the first year in which bargained premiums took effect-- PBGH negotiations achieved actual *reductions* from 1994 HMO premiums approaching 10 percent, or *savings of $37 million*. In addition, caps on rates were established for 1996 and 1997. From a Congressional budgetary point of view, savings were even higher -- expected increases in premium were eliminated and actual decreases in real costs were obtained. Under the Alliance, Union Bank saved more than $1.5 million off of our roughly $15 million in 1994 HMO expenditures. Several companies experienced double digit decreases.

In addition to negotiating on price, an equally important component of the Alliance process focused on establishing measures and targets for evaluating health care quality. Each HMO agreed to place a portion of their premium "at risk" for performance across two dozen uniformly defined measures for customer service, quality, and the provision of data (see Attachment B). Targets demonstrating improvement for each measure and the amount of money at risk across the standards were negotiated with each plan.

Success in 1995 brought six additional large companies into the Negotiating Alliance for the plan year starting January 1996 - a total of seventeen large employers. Last year's efforts have expanded to add POS performance measures (e.g., timeliness of out-of-area claims payments) to the negotiated package. More important, PBGH is negotiating HMO rates and benefits for 40,000 Medicare-eligible retirees. (Early retirees are included with actives.) PBGH companies are eager to offer their retirees continuity of care with HMO plans through Medicare risk arrangements. Many of these plans provide more generous benefits than fee-for-service plans at no cost to the retiree.

CREATING A CLEAR BENEFIT AND RISK PACKAGE

PBGH is interested in creating competition on a level playing field. Many health plans historically competed on the basis of their ability to attract healthier enrollees through subtle differences in benefit design. For example, we discovered one health plan that did not cover insulin - an obvious disadvantage for diabetics. Similarly, if each plan was able to define customer service and quality in a slightly different fashion, purchasers could neither (a) fairly compare them nor (b) know whether such differences biased performance results. PBGH addressed these important issues by standardizing the content of our benefits and creating consistent definitions to evaluate plan performance. Most important, consumer confusion related to the overwhelming array of benefit design differences and incomprehensible performance data was eliminated. Further administrative efficiencies were created through a single RFP on behalf of all Alliance participants.

Under the managed competition model, another critical component is to appropriately adjust health plan payments to reflect differences in risk. In other words, a health plan with a relatively high risk population should receive more monies to deliver services than a health plan that has a relatively low risk population that requires fewer services. PBGH employers have expended considerable effort studying these differences. We have a three-year grant from the Robert Wood Johnson Foundation to advance and test tools for risk adjustment purposes.

In 1993, when employer health premiums were examined in an uncompetitive marketplace, we saw large differences in prices for the same health plan across employers. These price differences were evident after we adjusted for any employer risk and benefit design differences. Surprisingly, the biggest companies did not have the best prices and the "low risk" companies with young single populations did not have the best prices. Differences in benefit design and or risk accounted for only twenty-five percent of the significant price differentials! Seventy-five percent was unexplained. These findings encouraged the large employers to join forces and request one price for all on a standard benefit plan. Although for now we have postponed implementation of any risk adjustment mechanism, we will continue to evaluate the need for one as pricing becomes less arbitrary. We would never want health plans to compete on the basis of selecting healthier people than their competitors.

The last feature to creating competition in the health care market involves explicitly linking the amount of employer contribution to the least cost -- eventually the "best value" -- health plan.

Fifteen of the seventeen companies participating in this year's negotiations provide a financial incentive for employees to select the least cost plan offered to them. This approach encourages employees to act as partners in selecting health plans which offer the best value for the money.

NO COST SHIFTING: WHERE DO PRICE REDUCTIONS COME FROM?

A key part of the negotiations was an agreement by all HMOs that any cost reductions given to PBGH companies would not result in increases to other employers or populations. While it is difficult to monitor whether or not this in fact occurs, we do know anecdotally that other companies in California last year experienced a downward trend.

In this year's negotiations we are asking each managed care plan to describe how they are supporting cost reductions through efficiencies in medical management and administration. California has more than five hundred hospitals which are only half full, and more than 80,000 physicians, one per approximately 400 people (the average primary care doctor has roughly 2,000 patients). Seventy percent of the physicians are specialists. More than 30 HMOs are licensed by the California Department of Corporations, and there is tremendous overlap in managed care provider networks. As purchasers, we do not want to sustain the cost of this unnecessary capacity. We will continue to put pressure on health plans and providers to restructure, to eliminate excess capacity, to adjust physician mix to better meet the needs of enrollees, and to reengineer processes of delivering care. Not only will significant cost savings be achieved through these efforts, quality of care will be improved and consumers will be better off.

EMPLOYER COMMITMENT TO QUALITY

PBGH employers are very concerned that health care payments are not reduced to the point that quality of care is compromised. For the past several years, PBGH members have worked collaboratively with health plan medical directors and representatives of hospitals and medical groups to gauge the quality of health care. Key accomplishments include two published consumer report cards (see Attachment C) on: (a) employee survey results measuring satisfaction with health plan coverage, service quality, and costs, and satisfaction with physician and hospital care, and whether or not prevention/health promotion services were received; (2) chart review data to determine the delivery of population-based preventive services, such as prenatal care, cholesterol tests, and pap smears. Where available, national measures, such as those published by the National Committee on Quality Assurance (NCQA) are followed.

PBGH works with researchers at the University of California at Berkeley, San Francisco, and Santa Barbara, as well as RAND, the New England Medical Center, and the Health Outcomes Institute, and the Federal and state governments, to assure that all studies are of the highest research caliber.

As a strong demonstration of their commitment to advance health plan and provider performance measures and data collection, PBGH employers established a Quality Improvement Fund totaling over $1 million. Monies are also being used to research consumer perspectives on report cards and disseminate decision support tools for them. A key criterion for Fund projects is that they benefit all Californians, not only the employed insured population.

STRATEGIC ALLIANCES/FUTURE GOALS

St. Louis and Denver business coalitions are replicating the PBGH model in 1995. Strategic alliances are also being formed with regional employers in Seattle and Portland. The successes of PBGH can be transferred readily to other communities, especially those where purchasers, in both the public and private sectors, are eager to increase enrollment in managed health care plans.

In addition to expanding its large employer membership, future plans for PBGH in California include transferring the successes in group health to workers' compensation and disability, integrating data across all benefits, and exploring the inclusion of medium/small businesses in the Alliance.

CONCLUSION

Chairman Thomas, I am honored to be here today. Thank you for the opportunity to present the unique market driven approach to health care reform that we have undertaken in California. PBGH's track record of success demonstrates that private and public sector purchasers can leverage their dollars and volume to bring more rationality to our health care system. This approach is certainly not the entire solution for our problems; however, it can make a significant contribution toward a better health care system.

- ATTACHMENT A -
Member Companies

MEMBER COMPANIES

Atlantic Richfield Company

Automobile Company of Southern California

Bank of America

Bank of the West

Bechtel

California Public Employees' Retirement System

Charles Schwab

Chevron Corporation

Federal Reserve Bank of SF

Fireman's Fund Insurance

First Interstate Bank

GTE

Lockheed

Longs Drug Stores

LSI Logic

McKesson

Mervyn's

Pacific Telesis

PG&E

Ross Stores

Safeway, Inc.

Southern California Edison

Stanford University

Transamerica

Union Bank

University of California

Varian Associates, Inc.

Wells Fargo Bank

- ATTACHMENT B -
1996 Performance Standards

NEGOTIATING ALLIANCE

90 New Montgomery Street, Suite 818, San Francisco, CA 94105
Tel 415-281-8660 Fax 415-281-0960

PBGH 1996 Performance Standards

Customer Service

Measures which have penalties attached

Claim turnaround time -15 days & 30 days
ID card turnaround
EOC and member material distribution
Average speed to answer by live voice
Telephone abandonment rate
Time to respond to written correspondence
Member notification of PCP disenrollment & group notification of medical group change

Measures which are reported only (no penalties are attached)

Claim financial accuracy
Claim transaction accuracy
Claim pending
Initial call resolution rate
Identification of member services calls
New member contact
Identification of written correspondence

Quality

Measures which have penalties attached

Plan satisfaction
Plan dissatisfaction
Satisfaction with physician
C-section rate
Mammography rate
Pap smear rate
Childhood immunization rate
Prenatal care rate
Diabetic retinal exam rate
Cholesterol screening rate
Wellness program communications

Measures which are reported only (no penalties are attached)

PCP turnover rate
Open PCP/member ratio
PCP / specialist ratio
Formulary compliance rate
Generic substitution rate

Provision of Data

Additional HEDIS measures
Encounter data capture
Third party management
Smoking cessation

- ATTACHMENT C -
PBGH Report Cards

Bay Area Business Group on Health: 1994 HMO Consumer Satisfaction Report Card

CALIFORNIA HEALTH PLAN	Satisfaction with Aspects of the Health Plan		Satisfaction with Physician Services			The Health Plan's Preventive Care Performance		
	Coverage	Service Quality	Convenience	Medical Treatment	Personal Treatment	Screening	Health Promotion	Counseling
Health Maintenance Organization (HMO)								
Aetna HMO	C	B	B	B	B	B	B	B
Blue Shield	B	B	B	B	B	A	A	B
CIGNA	C	C	B	B	C	B	B	C
California Care	A	B	B	B	B	A	C	C
FHP	B	B	B	B	B	A	A	B
Foundation	B	B	A	B	A	B	C	B
HP of Redwoods	A+	A+	A	A	A+	B	B	A+
Health Net	B	B	B	B	C	A	B	B
Kaiser North	B	C	C	C	B	C	A+	A
Kaiser South	B	B	C	C	B	B	A+	B
Lifeguard	B	A	A	A	A	B	C	B
Maxicare	C-	C	C	C	C	B	B	C
Omni	A+	A	B	A	A	B	C	A
PacifiCare	B	C	C	C	C	C	B	C
QualMed	C	B	B	B	B	C	B	B
TakeCare	B	B	B	B	B	B	B	B
ValueCare	A+	A	A	A	B	C	B	A
Point-of-Service (POS) Avg.	C-	C-	C	C	C	B	C	C
Preferred Provider Organization (PPO) Avg.	C-	C	A	A	A	B	B	B

Satisfaction with Aspects of the Health Plan	**Coverage**: Coverage for doctors' office visits, hospitalizations and mental health **Service Quality**: Paperwork as well as with the plan's process for paying claims and approving care.
Satisfaction with Physician Services	**Convenience:** The location of the doctors' office, the hours when appointments are available and the length of time spent waiting. **Medical Treatment:** The length of time the doctor spends with an individual, the doctor's skills and the quality of specialists. **Personal Treatment**: The doctors' explanations, the courtesy of the office staff and the care provided by nurse practitioners.
The Health Plan's Preventive Care Performance	**Preventive Screening**: The plan's provision of blood pressure screenings, cholesterol screenings, mammograms and pap smears. **Health Promotion**: Consumer participation in health promotion programs and whether they helped the individual make lasting changes. **Counseling**: Counseling in such topics as nutrition, exercise, smoking cessation and sexually transmitted diseases.

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Bay Area Business Group on Health: 1994 HMO Consumer Satisfaction Report Card

The Bay Area Business Group on Health 1994 Consumer Satisfaction Report Card is based on the results of the 1994 Employee Medical Plan Satisfaction Survey. This survey was mailed to nearly 60,000 employees and early retirees of ten large organizations. Approximately 27,000 individuals, or 46%, responded to the survey. **Grading:** HMO scores were ranked together from high to low. HMOs scoring above the top 25th percentile were given an A. HMOs scoring below the lowest 25th percentile were given a C. Unusually high HMO scores were given an A+ and unusually low HMO scores were given a C- based on statistical criteria. All other HMOs were given a B (no B+ or B- scores were given). POS and PPO plan average grades were assigned in the same way.

CALIFORNIA HEALTH PLAN	Overall Consumer Satisfaction With...			
	The Health Plan	Doctor Seen Most Frequently	Care Received at Hospital	Plan's Health Improvement Programs
Health Maintenance Organization (HMO)				
Aetna HMO	C	B	A	B
Blue Shield	B	B	C	B
CIGNA	B	B	B	B
California Care	B	B	C-	C
FHP	C	B	B	B
Foundation	B	A	B	B
HP of Redwoods	A+	A	A	A
Health Net	B	B	B	B
Kaiser North	B	C	C	A
Kaiser South	B	C	B	A
Lifeguard	A	A	A	C
Maxicare	C	C	C	B
Omni	A	B	B	C
PacifiCare	C	C	B	B
QualMed	B	B	A	C
TakeCare	B	B	B	B
ValueCare	A	A	B	A
Point-of-Service (POS) Average	C-	C	C	C-
Preferred Provider Organization (PPO) Average	B	A	B	C

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California Cooperative HEDIS Reporting Initiative

A Collaboration Among Purchasers, Health Plans and Providers in California

Overview of 1993 Health Plan Performance

Health Plan	Preventive Services: Childhood Immunization	Cholesterol Screening Age 40-64	Breast Cancer Screening	Cervical Cancer Screening	Prenatal Care	Diabetic Retinal Exam
Aetna North	*	○	◒	◒	◒	○
Aetna South	◒	◒	◒	◒	◒	◒
Aetna San Diego	○	◒	◒	◒	◒	◒
Blue Shield HMO	◒	N/A	◒	◒	◒	*
CaliforniaCare	◒	◒	◒	○	◒	◒
CareAmerica	◒	◒	●	◒	◒	◒
CIGNA North	○	●	●	◒	○	◒
CIGNA LA IPA	◒	◒	◒	◒	◒	◒
CIGNA LA Staff	◒	◒	◒	○	◒	○
FHP, Inc.	◒	◒	◒	○	◒	●
Foundation Health Plan	◒	◒	◒	◒	◒	◒
Health Net	◒	◒	◒	○	◒	○
Health Plan of the Redwoods	●	◒	◒	○	◒	●
Kaiser Permanente Northern California	○	◒	◒	◒	◒	○
Kaiser Permanente Southern California	○	◒	●	◒	◒	○
Lifeguard	◒	◒	●	●	◒	◒
Maxicare	◒	◒	○	◒	◒	○
MetLife	●	◒	●	◒	●	*
OMNI Health Plan	●	○	◒	◒	◒	◒
PacifiCare	*	◒	●	◒	◒	*
PruCare	●	N/A	◒	◒	●	◒
TakeCare	○	○	◒	○	◒	○
ValueCare	●	◒	○	◒	*	●

○ Above Average
◒ Average
● Below Average
* Insufficient data submitted by the plan
N/A Not Applicable[1]

[1]Health plan was not operational for length of time required for the study.

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Mr. ENSIGN. Ms. French.

STATEMENT OF MICHELE E. FRENCH, DIRECTOR, HEALTH AND WELFARE BENEFITS, OFFICE OF THE PRESIDENT, UNIVERSITY OF CALIFORNIA, OAKLAND, CA

Ms. FRENCH. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to talk to you today.

I am going to tell you a little bit about the University of California, give a snapshot of where we were in 1993 and then tell you what we have done to reduce costs since then.

The University of California is the second largest employer in California. We have nine campuses, five teaching hospitals, and three research laboratories, and in addition, we have widespread agricultural and remote research locations.

We have about 96,000 employees who work 20 or more hours per week and are eligible for career benefits; 99 percent of that group is enrolled in some kind of a medical plan.

We have another 4,900 that are part-time employees, that we cover for catastrophic medical care. We automatically enroll them unless they decline coverage, and we have about 70 percent of them in our health plan.

We have another 33,000 retirees who receive career medical benefits. That is a growing group, both in terms of size and cost, over time. There are also 40,000 to 45,000 student employees who have access to coverage through student services programs at each campus.

I am going to talk about the employee population. We provide medical coverage to nearly all of our employees through a choice of various plans. We have six HMO's, a point-of-service plan, and a preferred provider indemnity plan in addition to the catastrophic coverage. We contribute to those plans for the employees plus their family members. And retirees have access to the same coverages with the same contribution available to them.

We require Medicare enrollment as retirees and spouses age into the program, and we contribute to the cost of their part B premium.

Historically, the university's contribution was based on the average of the four largest health plans. Those were not necessarily the most cost-effective plans; they were the most popular plans, so we had had a couple of very special expensive programs in that mix. This meant that our—that several of our plans really did not have to compete on the basis of price. They only had to stay slightly below the maximum available university contribution.

Since we have about 75 percent of our population in HMO's, that became a fairly costly strategy. Since they weren't competing on the basis of price, HMO's, in particular, competed on the basis of slight variations in coverage, things like zero copays for office visits or low prescription drug costs. They also used subtle variations in coverages to direct more expensive-type patients to other plans—things like higher copays on infertility services.

In 1993, we were looking at the third year of budget cuts, so we needed to develop some more economies in the area of benefits. While we wanted to offset our cost trend and, hopefully, reverse it, we also wanted to maintain a range of choices for our members and

we wanted to keep the quality of the program, so we adopted a managed competition strategy.

We set the maximum contribution at the level of the most cost-efficient plan. We standardized the HMO copayments. We added a point-of-service program. We set caps on the increases for 1995 and 1996.

We have also put the carriers at risk for a percentage of their premium for performance guarantees; and we have implemented Medicare risk plans for our retirees who are enrolled in HMO's.

In that 2-year period, our costs have declined by $63.5 million, or about $624 per employee or retiree. Most of that reduction is from the cost competition among the HMO's. Rather than passing those costs on to their members, they chose to reduce their premiums; some of them dropped premiums as much as 10 percent in a single year.

In a 2-year period, our total decrease in medical plan costs is about 17 percent. The second largest savings is in implementation of Medicare risk plans. We dropped our retiree cost about 5 percent by implementing that for the two largest plans.

In 1995, our average cost per employee is $2,847. That compares to the 1993 national average of $3,358. We have done this without any major reductions in coverage, and the premiums paid by the employees are modest. An HMO member will pay anywhere from zero to $45 a month for family coverage, and our point-of-service family plan is $11 a month charge. So we think we have achieved some sustainable cost efficiencies without compromising either the benefits or the quality of care that we provide to our members.

Thank you.

Mr. ENSIGN. Thank you.

[The prepared statement follows:]

TESTIMONY BY MICHELE E. FRENCH, FOR THE UNIVERSITY OF CALIFORNIA
MAY 16, 1995 MEETING OF THE SUBCOMMITTEE ON HEALTH OF THE
HOUSE WAYS AND MEANS COMMITTEE

Mr. Chairman, members of the Subcommittee on Health of the Committee on Ways and Means, I would like to thank you for the opportunity to testify before you on cost-control and quality improvement in employer medical plans.

My name is Michele French and I am the Director of Health and Welfare Benefits for employees of the University of California system.

The University of California is the second largest employer in California, with nine campuses, five teaching hospitals and three research laboratories plus various agricultural and remote research locations.

> Of the 96,200 working 20 hours or more and eligible for "career" benefits; almost 99% are enrolled in a medical plan.
>
> 4,900 part-time employees are eligible for "catastrophic" medical coverage and almost 70% are enrolled. The remainder have declined University coverage because they have coverage elsewhere. (The University automatically enrolls these employees in the catastrophic plan unless they sign a form waiving coverage.)
>
> 33,000 retirees receive the "career" medical benefits.
>
> 40-45,000 student employees have access to medical coverage via student services programs at each campus.

Medical coverage is provided to nearly all employees through a choice among 6 HMOs, a point-of-service plan, a preferred-provider indemnity-style plan or a catastrophic plan. The University contributes towards these plans for employees, their spouses and their dependent children. Retirees have access to the same medical plans and are eligible for the same maximum contribution amount as is available to employees. We require Medicare enrollment for retirees and their spouses when they become eligible and pay the "Part B" as part of the maximum University contribution.

Historically, this contribution was based on the weighted average cost of the four largest plans. These were the most popular, not the most cost-effective plans so the averaging method included some of the most expensive programs. Given this contribution strategy, many of the medical plan carriers did not need to compete on the basis of price, they only needed to keep their cost below the maximum available University contribution.

Since they were not competing on price, HMOs, in particular, competed on the basis of slight variations in benefits - such as zero copayments for office visits or low prescription drug costs. There also were subtle variations in coverage that might encourage those with more expensive conditions to select other plans; for example, higher copayments for infertility services.

In 1993, the University was faced with the third year of budget cuts and the necessity to develop more economies in the area of benefits. While we wanted to reverse or, at least, slow the cost trend of our medical plans, we also wanted to maintain quality, a full menu of choices and stability in the programs. To this end, we adopted a "managed competition" strategy by:

- setting the maximum contribution at the level of the most cost-efficient plan;
- standardizing the HMO plan copayments;
- adding a "point-of-service" plan to our options;
- requiring second and third year caps on premium increases;
- putting the carriers at risk for meeting agreed-upon performance standards, implementing Medicare "risk" plans for retirees enrolled in HMOs.

The University's medical plan costs have declined by $63.5 million, or $624 per employee/retiree since 1993, despite the increase of almost 4,600 primary lives in the same period. Most of the reduction comes from the effects of setting the contribution at the lowest cost plan, thereby forcing "market competition" among HMOs. Rather than passing the costs to members, these plans reduced their gross premiums, some by as much as 10% in a single year. The total decrease in the medical plan premiums since 1993 was almost 17%. The second largest single source of savings was implementation of the Medicare risk plans in 1995 for two of our largest HMOs, in addition to the two plans already converted to risk-style benefits. This saved $4 million dollars, reducing the 1995 retiree cost by approximately 5%.

The University's 1995 average cost per employee is $2,847, compared to the 1993 national average of $3,358. This has been achieved without any major reduction in coverage. And the premiums paid by employees are generally modest. For HMO coverage, the employee cost ranges from $0 to $45 per month for a family plan. The cost for a family enrolled in the point-of-service program is not quite $11 per month.

We believe we have achieved sustainable cost-efficiencies without compromising the quality of benefits or care for our plan members.

ATTACHMENT TO TESTIMONY BY MICHELE E. FRENCH - UNIVERSITY OF CALIFORNIA
MAY 16, 1995 MEETING OF THE SUBCOMMITTEE ON HEALTH OF THE
HOUSE WAYS AND MEANS COMMITTEE

The following summarizes the medical plans available to employees and retirees of the University of California:

PLAN	DESCRIPTION
FEE FOR SERVICE	
CORE	Catastrophic coverage, primarily for part-time employees $2,000 deductible 20% coinsurance $1 million maximum lifetime benefit
High Option	Major Medical coverage with a preferred provider network (PPO) $200 deductible 20% coinsurance (10% with PPO) $2 million maximum lifetime benefit
POINT-OF-SERVICE PLAN	Triple option with 3 benefit tiers - choice of tier each time care is received HMO tier - $5 copays for office visits $0 copays for prenatal/pediatric visits $0 copays for inpatient care PPO tier - $250 deductible/20% coinsurance Non-network - $500 deductible/40% coinsurance $2 million maximum lifetime benefit for PPO plus Non-network services; no limit on HMO services Drug card program - $12 copay, mail order service Mental Health/chemical dependency from exclusive, specialty network
HEALTH MAINTENANCE ORGANIZATIONS (HMOS)	
	Benefits standardized across 6 plans $5 copay - office visits $5 copay - drugs $0 copay - hospital inpatient care $0 copay - prenatal, well-baby care; pediatric office visits

Mr. ENSIGN. And Mr. Wrocklage, please.

STATEMENT OF JIM WROCKLAGE, CHIEF EXECUTIVE OFFICER, HEALTH CARE NETWORK OF WISCONSIN, BROOKFIELD, WI

Mr. WROCKLAGE. Thank you, Mr. Chairman, members of the subcommittee. My name is Jim Wrocklage, and I am chief executive officer of the Greater Milwaukee Health Care Purchasing Plan, which does business in Milwaukee and southeastern Wisconsin as the Health Care Network [HCN] of Wisconsin.

I hope that my testimony today will convey to you our message that the value of health care, which is a function of both cost and quality, can best be enhanced through employer-led, community-based reform which is market driven.

Our organization was created in the fall of 1986 by 10 major employers, and the mission was to arrange for, promote, and otherwise encourage programs and activities which are designed to promote the general health of the community, promote access to quality care in the most appropriate setting, and contain the increase in costs of health care.

We originally started on July 1, 1987, serving 10,000 employees of eight private employers and two public employers. All 10 of these were self-funded. We represented 10,000 employees. Today we represent 51,900 employees through 250 self-funded employers and another 47,100 through another 2,900 employers who buy insurance contracts through 10 insurance carriers. In total, we represent 247,000 covered lives in the greater Milwaukee metropolitan area.

Through 1989, HCN only served the self-funded employers, but in the interest of wanting to serve as many employers as possible in our community, HCN sought out insurers who were interested in offering the network to their insured clients generally, small to medium in size. Today, whether insured or self-funded, employers ranging in size from 2 to 200 employers represent 50 percent of our business clients.

As a demonstration of controlling costs, for the 7½-year period ending December 31, 1994, HCN had processed $596 million of hospital charges. However, its negotiated contracts permitted reimbursement of $438.4 million, so that a difference of $157.6 is the economic savings derived on behalf of all of our participating purchasers. This equates to a 26.5 per year weighted average savings for all hospital costs.

As implied by the title of this hearing, quality is as essential to HCN as cost, and as such, we have undertaken several quality initiatives of varying scope with providers in our community. These have varied from doing simply pure data analysis, identifying complication rates which are unexplainable, to serving on joint work committees of employers and providers in order to reduce administrative costs and complexity within the health care system.

Within the last few months, it has become clear to us that the following principles must guide the extent and type of our involvement in future community-based quality initiatives. Those who deliver care are the only ones who can truly manage it. Therefore the

purchaser involvement should be focused at the highest level feasible, given the scope of the project.

Patient outcomes are improved by managing the delivery processes that drive the outcomes, and before an endeavor is undertaken, thought must be given to the impact it will have on the entire community and the industry of health care. Valid data is a prerequisite to improvement. In order to promote the use of valid data, HCN encourages the use of strong operational definitions that are consistently applied and exercise due diligence in the manner with which it accepts data from providers and other community sources.

It is our concern for the consistent application of operational definitions that forces it to approach comparative data for the selection of providers with great caution. HCN is aware of interpretive differences that occur during the coding of medical records. In order to mitigate the effect of these differences, we prefer to stimulate quality improvement in our community by studying the data from each institution over time, rather than to make selection decisions based on interinstitutional comparisons.

And we have also acknowledged that the gain through these quality initiatives should be shared in the community, not hoarded.

Although we recognize that our operational structure and degree of success are not necessarily replicable throughout the United States, we do view HCN as a prime example that community-based, employer-driven market reform works. And having established a community presence, which we think is the most important thing, by consolidating a fragmented purchasers' set into a critical mass which negotiates lower prices and encourages quality improvement initiatives, we will continue to take catalytic-type action which impacts the underlying structure of the local delivery and financing of health care. When doing so, we recognize that reactions by providers, insurers, and managed care organizations in response to our actions or as part of our activities has a positive effect on our community.

Given the changes currently occurring in our community, it is highly likely that our activities will continue to create other structures which enhance the working of an organized market, create competition between clinical caregiver systems organized around efficient and effective delivery, not consolidated provider cartels. We would also empower employees as consumers and purchasers of health care, promote personal responsibility, and promote user-friendly information regarding health care value.

Given the limited time available to prepare for this hearing, I offer the attached letters as documentation of the value attributed by our board of director, employers, and participating insurers who were able to respond within the given time frame. I thank you for the opportunity to testify and I would be glad to answer any questions you may have.

[The prepared statement and attachments follow:]

TESTIMONY OF JAMES R. WROCKLAGE
HEALTH CARE NETWORK OF WISCONSIN

Mr. Chairman, and members of the Sub-Committee, my name is Jim Wrocklage and I am chief executive officer of the Greater Milwaukee Health Care Purchasing Plan, Inc. which does business in Milwaukee and southeastern Wisconsin as Health Care Network of Wisconsin (HCN). I want to begin by thanking you, Mr. Chairman, for calling this hearing today and for inviting me to testify.

I hope that my testimony today will demonstrate our organization's experience in controlling costs and improving quality on behalf of our employer clients in Southeastern Wisconsin. Most importantly, I wish to convey the message that the Value of health care (cost/quality) can best be enhanced through local community based reform which is market driven.

MISSION

After almost one year of planning, the Greater Milwaukee Health Care Purchasing Plan, Inc. was founded in the fall of 1986 by 10 major Milwaukee employers, almost all of whom continue to serve on its voluntary Board of Directors. The organization's mission is "to arrange for, promote, and otherwise encourage programs and activities which are designed to promote the general health of the community, promote access to quality care in the most appropriate setting, and contain the increase in costs of health care." To date, the mission of this Wisconsin non-stock corporation has been accomplished under the name of Health Care Network of Wisconsin (HCN), a broad network of hospitals, physician, and ancillary providers offered to self-funded and insured employers as a preferred provider overlay to their indemnity health plan.

EVOLUTION OF CLIENT MIX

On July 1, 1987, HCN began serving 10,000 employees of eight private employers and two public employers. HCN now serves 51,900 employees of 250 self-funded employers and another 47,100 employees of 2,900 insured employers who obtain insurance coverage through 10 carriers. These two groups of employees and their dependents represent approximately 247,000 covered lives in the greater Milwaukee metropolitan area and southeastern Wisconsin. HCN participating employers continue to include public employers such as municipalities and school districts.

Through 1989, HCN served only self-funded employers. However, in the interest of wanting to serve as many employers as possible in our community, HCN sought out insurers who were interested in offering the HCN provider network to their insured clients, generally, small to medium in size. Whether insured or self-funded, employers ranging in size from 2 to 200 employees currently represent 50% of our business.

COST CONTROL

As a demonstration of controlling costs, I can report that during the time period of July 1, 1987 through December 31, 1994, HCN on behalf of all of its clients has processed 55,700 inpatient hospital claims totalling billed charges of $397,000,000 and 534,900 outpatient claims totalling billed charges of $199,000,000. Through its negotiated contracts, HCN's allowable reimbursement for this $596,000,000 of hospital charges was $438,400,000. The difference of $157,600,000 is the economic savings derived on behalf of all our participating purchasers. The HCN Board of Directors believes that this weighted average savings of 26.5% per year for all hospital costs over seven and a half years is an example of superb performance.

QUALITY

As implied by the title of this hearing, quality is as essential to HCN as cost. As such, HCN has undertaken several quality activities of varying scope with providers in our community. These have varied from pure data analysis identifying unexplained complication rates to full participation on joint employer/provider work teams oriented towards reducing administrative cost and complexity.

Within the last few months, it has become clear to us that the following principles must guide the extent and type of our involvement in future community based quality initiatives:

1. Those who deliver care are the only ones who can truly manage care. Therefore, purchaser involvement should be focused at the highest level feasible given the scope of the project.

2. Patient outcomes are improved by managing the delivery processes that drive the outcomes.

3. Before an endeavor is undertaken, thought must be given to the impact it will have on the entire industry.

4. Valid data is a prerequisite to improvement.

   In order to promote the use of valid data, HCN encourages the use of strong operational definitions that are consistently applied and exercises due diligence in the manner with which it accepts data from provider and other community sources.

   It is HCN's concern for the consistent application of operational definitions that forces it to approach comparative data for the selection of providers with caution. HCN is aware of the interpretative differences that occur during the coding of medical records. In order to mitigate the effect of these differences, HCN prefers to stimulate quality improvement by studying the data from each institution over time, rather than to make selection decisions based on interinstitutional comparisons.

5. Knowledge is meant to be shared.

CONCLUSION

Although we recognize our operational structure and degree of success are not necessarily replicable throughout the United States, we do view HCN as a prime example that community based, employer driven market reform works.

Having already established a community presence by consolidating a fragmented purchaser's set into a critical mass which negotiates lower prices and encourages quality improvement initiatives, HCN will continue to take catalytic type action which impacts the underlying structure of the local delivery and financing of health care. When doing so we recognize that reactions by providers, insurers, and managed care organizations in response to or as part of our activities has a positive effect in our community.

Given the changes currently occurring in Southeastern Wisconsin, it is highly likely that HCN's future activities will:

- Create other structures which continue to enhance the working of an organized market.

- Create competition between clinical care giver systems organized around efficient and effective delivery -- not consolidated provider cartels.
- Empower employees as consumers/purchasers of health care.
- Promote personal responsibility.
- Promote user friendly information regarding health care value (cost/quality).

Attachments

Given the limited time available to prepare for this hearing, I offer the attached letters as documentation of the Value attributed to our community activities by those HCN Board of Director employers and participating insurers who were able to respond within the given time frame.

Vice President

May 5, 1995

Mr. James Wrocklage
Chief Executive Officer
Health Care Network
250 Bishops Way
Suite 300
Brookfield, WI 53005-6222

Dear Jim:

You asked for a statement regarding Firstar's participation in the Health Care Network for testimony to the House Ways and Means Subcommittee on Health. As a charter member and continuing with representation on the board of directors, Firstar Corporation remains committed to the philosophy and objectives of HCN. Participation in HCN has enabled us to better control and manage our self-insured health care expense in the greater Milwaukee area. You should know that Firstar's self-insured cost for 1995 is 5% below 1994 cost levels. In addition, participation has given us the opportunity to communicate to providers about the concerns that all employers face with respect to cost and quality of care.

I hope this information is of value to you as you prepare for your appearance before the Subcommittee.

Sincerely,

Jack R. Chmiel

Badger Meter, Inc.

4545 W. Brown Deer Road, P.O. Box 23089
Milwaukee, WI 53223-0089 (414) 355-0400

May 12, 1995

James Wrocklage
Health Care Network of Greater Milwaukee
Suite 300
250 Bishops Way
Brookfield, WI 53005-6222

Dear Jim:

As a member and participant of Health Care Network (HCN) since its inception, Badger Meter, Inc. cannot over emphasize the positive impact HCN has had in helping control our employee health care costs in Milwaukee.

The average cost per employee in the Milwaukee HCN plan has increased less than twenty five percent (25%) since 1988 through 1994. Few companies can make this claim in an environment which saw double digit inflation for each or most years in that seven year period. The value of those health care dollars spent during this period has also been enhanced.

Educating employees and making them more conscious purchasers of quality health care through the HCN provider network has contributed greatly in controlling our costs. With 475 employees based in Milwaukee, these cost controls have, in part, contributed to Badger Meter's continued financial strength and maintained its market position as a leading manufacturer of flow measurement products worldwide.

As the health care delivery system has and continues to change, HCN has been able, through its flexibility and foresight, to change and help provide for cost effective quality care for our employees. HCN has added value to health care in Milwaukee.

Sincerely,

Ronald H. Dix
V.P. - Adm./Human Resources

Allen Bradley Company, Inc.
Headquarters
1201 South Second Street
Milwaukee, WI 53204 USA
414.382.2000
Fax 414.382.4444
Telex 4311018

Rockwell Automation
Allen-Bradley

May 12, 1995

Mr. James Wrocklage
Executive Director
Health Care Network
250 Bishops Way Suite 300
Brookfield, WI 53005-6222

Dear Jim:

We feel that, as a major self funded employer with a large number of active and retired employees in the greater Milwaukee area, our participation in the Health Care Network has had a meaningful impact in controlling our health care cost increases. We have participated in HCN since its inception and have found that health care costs at locations where employees have an indemnity plan available have generally increased at a faster rate than we've experienced in the Milwaukee area.

We feel it is important however, that all employers, both large and small, have the opportunity to participate in purchasing initiatives of this nature. The cooperative environment in which HCN developed has proven beneficial for our community as a whole and not necessarily a select few.

Very truly yours,

Roger J. Freitag

Roger J. Freitag
Manager-Employee Benefit Programs

DEPARTMENT OF HUMAN RESOURCES

Milwaukee County

GARY J. DOBBERT • DIRECTOR
JOHN H. GIVENS, III • DEPUTY DIRECTOR

JAC R. AMERELL
Retirement
CYNTHIA A. BARNES
Policy Procedures
JAMES M. EGGERS
Compensation
ROBERT A. KIEFERT
Information Systems
JERTHA RAMOS
Employment & Staffing
RONALD A. STANNY
Recruitment
PATRICIA A. VILLARREAL
Employment Relations
JOHN S. WOJTECKI
Budget

VIA FACSIMILE - 784-2976

May 12, 1995

Mr. Jim Wrocklage
Executive Director
HCN Health Care Network of Wisconsin
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

Dear Jim:

Milwaukee County government, as a board member of Health Care Network of Wisconsin and a large employer with a self-insured indemnity medical plan, is happy to provide confirmation of the benefits realized through the "Network's" successes in controlling health care costs.

Through direct provider discounts (hospitals, physicians and other ancillary medical care providers), "Centers of Excellence" services, guaranteed "package" rates, etc., Milwaukee County has achieved substantial medical cost savings. There have been favorable responses from our employees who now just pay their co-insurance without fear of being billed for amounts above, "usual, customary and reasonable" fee schedules. Also, with the growth of the Network, providers have been more willing to cooperate with payers in quality of care and cost containment efforts.

Such successes by the Network in acting as a catalyst in eliminating unnecessary cost and in suppressing the amount of medical cost increases ultimately benefit the taxpayers of Milwaukee County who pay for the salaries and benefits of our public employees.

We support your efforts on our behalf through your testimony to the House Ways and Means Subcommittee on Health.

Sincerely,

Gary J. Dobbert
Director of Human Resources

GJD:vo

BRIGGS & STRATTON CORPORATION

May 12, 1995

Mr. James Wrocklage
Health Care Network of Wisconsin
250 N. Bishops Way
Brookfield, WI 53005-6222

Dear Jim:

"For the largest group of Milwaukee active employees under its self-insured plan, Briggs & Stratton's current cost per employee per month is virtually the same* as it was 3 years ago, when the plan was changed to incentivize use of the HCN network. As there have been no other significant plan changes during that period, Briggs & Stratton attributes its participation in HCN, and the collective purchasing power of its employer base, as being the principal reason for the leveling of that cost."

*less than a 1% increase

Sincerely,

BRIGGS & STRATTON CORPORATION

R. C. Reynolds
Manager, Group Insurance & Employee Benefits

RCR:bkd
cc: file

JERRY BURG
Director - Human Resources
(414) 299-3430

Northwestern Mutual Life

May 12, 1995

Mr. James Wrocklage
HCN
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

RE: HCN PPO Savings

Dear Jim,

Northwestern Mutual Life Insurance Company has participated in HCN's network since its inception in 1989 and participated as a founding employer organization. We firmly believe in the savings potential available to us and to our employees as a participating member of HCN.

The benefit of participating in HCN is twofold. First, as an employer, our total claims cost is less as a result of being able to take advantage of discounted negotiated fees with providers. Second, our employees share in the savings by receiving a higher benefit and having a lower out-of-pocket cost on services received from HCN participating providers.

As you can see on the enclosed exhibits:

- Over the 5-year period of time from 1990 to 1994, we recognized an average savings of 8% for hospital expenses.
- This translates to an average savings of $330.82 per employee per year or $132.33 per covered member per year.
- As employees have become more aware of the benefits of the HCN PPO and as HCN has expanded its network, our savings have continued to grow and remain strong.

I would like to add two last important points:

1. The savings shown on the exhibits are "NET" savings after subtracting out our cost to participate in HCN.
2. The exhibits only reflect savings realized on hospital expenses. They do NOT include savings as a result of fees that have been negotiated for office visits, lab and x-ray work, medical supplies, etc. Therefore, our true savings are even greater than shown on the exhibits.

If you have any questions on the information enclosed, please call me.

Sincerely,

Jerry Burg

GE Medical Systems

General Electric Company
P.O. Box 414, Milwaukee, WI 53201

May 15, 1995

Jim Wrocklage
Health Care Network Of Wisconsin
250 Bishops Way, Suite 300
Brookfield WI 53005-6222

Dear Jim:

As you are aware, General Electric has been a participating employer in HCN since its inception. It is clear to us that our participation in HCN over the past seven and a half years has had a meaningful impact on controlling our health care costs in Milwaukee while providing access to quality providers desirable to our employees.

Sincerely,

Thomas C. Larche
Manager, Employee Health and Benefits

/rk

MILLER BREWING COMPANY

May 12, 1995

Mr. James Wrocklage
Executive Director
Health Care Network
250 Bishops Way Suite 300
Brookfield, WI 53005-6222

Dear Jim:

We feel that, as a major self funded employer with a large number of active and retired employees in the greater Milwaukee area, our participation in the Health Care Network (HCN) has had a meaningful impact in controlling our health care cost increases. We have participated in HCN since its inception. We have found that health care costs at locations where employees have an indemnity plan available have generally increased at a faster rate than we've experienced in the Milwaukee area.

We feel it is important however, that all employers, both large and small, have the opportunity to participate in purchasing initiatives of this nature. The cooperative environment in which HCN developed has proven beneficial for our community as a whole.

Very truly yours,

John R. Van Vliet
Corporate Benefits Manager

JRV/tm

13M.doc

May 12, 1995

Mr. James Wrocklage
Health Care Network of Wisconsin (HCN)
250 Bishops Way, Suite 300
Brookfield, WI 53005-6222

Dear Jim:

I welcome the opportunity to summarize the very tangible benefits of the partnership that WPS and HCN have had over the past three years. This partnership, using the HCN provider network, has provided our customers with a successful private sector, market driven, approach to controlling medical costs, utilization, and outcomes.

The availability of Health Care Network of Wisconsin (HCN) provides our small employer clients (2-100 employees) access to a broad network of providers that offers quality health care services on a cost effective basis The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium and medical trend differential as shown in the following paragraph. As can be seen, using the HCN network has provided substantial savings to our insured small business clients over the years, and has done so much sooner than otherwise would have been possible.

Compared to our standard, non-managed indemnity product, the HCN PPO and Point of Service (POS) provides a legitimate 12% savings on the physician component, 36% savings for in-network hospital stays, and 20% savings for in-network outpatient. Over the three year period these discounts translate into a medical trend differential of 6% for the HCN network products compared to our indemnity product. We expect this differential to widen in the future. Taking the arithmetic to the final level, i.e., what does this mean to the customer paying the premium bill, the HCN managed care products provide a 8-14% lower premium compared to our indemnity products for similar or better benefits.

The final proof of the HCN offering is the sales and retention levels for the WPS/HCN products in the three county metro-Milwaukee marketplace. Currently, WPS insures

roughly 35,000 people in this market, which makes the WPS/HCN product a primary insurance product in this three county area.

WPS and our customers are very satisfied with the price, product, and medical quality of the HCN managed care operation. The numbers, whether they be sales, loss ratio, or premium charged, certainly speak highly of the HCN approach to delivering quality, affordable health care.

Sincerely,

Lon Sprecher
Corporate Senior Vice President
Market Services

LS:jy

Midwest Security
INSURANCE COMPANIES

Health Care Network of Wisconsin Product

The availability of Health Care Network of Wisconsin (HCN) provides our Midwest Security small employer clients (2–100 employees in size) access to a broad network of providers that offers quality health care services on a cost effective basis. The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates the opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium differential as shown in the following history. As can be seen, this has provided substantial savings to our insured small business clients over the years, and has done so much sooner than would otherwise have been available.

	HCN Premium Rates				Traditional Indemnity Premium Rates				
Date	Single	Limited Family	Full Family	Average Increase	Single	Limited Family	Full Family	Average Increase	Premium Differential
1/1/90	74.09	173.50	239.24		76.34	177.86	249.48		-4%
1/1/91	81.00	187.00	261.00	9%	84.30	196.00	276.00	11%	-5%
1/1/92	89.00	203.00	288.00	10%	99.30	228.00	331.00	19%	-12%
1/1/93	109.00	222.00	318.00	10%	119.30	257.00	377.00	14%	-15%
1/1/94	106.00	226.00	324.00	2%	130.30	281.00	417.00	11%	-21%
1/1/95	113.00	242.00	350.00	8%	138.30	297.00	442.00	6%	-20%

	HCN Medical Inforce Data		
Date	Number of Employers	Number of Employees	Avg. Size of Group
1/1/89	0	0	
1/1/90	62	577	9.3
1/1/91	129	1212	9.4
1/1/92	247	2322	9.4
1/1/93	366	3404	9.3
1/1/94	426	3943	9.3
1/1/95	491	4631	9.4

David J. Jacobs, FSA, MAAA
Vice President and Chief Actuary
05/12/95

BENEFIT DIFFERENCES IN THE HCN AND TRADITIONAL INDEMNITY PRODUCTS

A comparison of current HCN and Traditional Indemnity benefits is given below; $250 Deductible is assumed for each.

BENEFIT	HCN		Traditional Indemnity
	In Network	Out of Network	
Coinsurance	90%/10% next $2500 after deductible	80%/20% next $2,500 after deductible	80%/20% next $2,500 after deductible
Physician/Clinic Office Call	$10 Copayment 100% thereafter includes x-ray and lab	$20 Copayment 100% thereafter x-ray and lab are subject to deductible and coins.	Subject to deductible and coinsurance including x-ray and lab
Emergency Room	$25 Copayment Then subject to deductible and coins.	$25 Copayment Then subject to deductible and coins.	Subject to deductible and coinsurance

NOTES:
HCN copayments do not help to satisfy the deductible and coinsurance.
Emergency room copayments are waived if the patient is hospitalized.

The Mutual Group (U.S.)
Employee Benefits
Mutual Life
401 North Executive Drive
Brookfield, Wisconsin 53008-0980
tel: 414 797-3000
fax: 414 797-5035

HCN HISTORY

The availability of Health Care Network of Wisconsin (HCN) provides our small employer clients (1-100 employees) access to a broad network of providers that offers quality health care services on a cost effective basis. The availability of this network to the small business insured market has allowed our small employers to share in the purchasing power generated by this larger employer coalition and creates opportunity for the small employers to benefit directly from controlled costs. The savings are reflected in the premium differential as shown in the following history. As can be seen, this has provided substantial savings to our insured small business clients over the years, and has done so much sooner than otherwise would have been available.

HCN Employer Premium
(PPO Plan)

	Premium**			
Date	Single	Limited Family	Full Family	Ave. % Change
Jan 92	$63	$138	$297	
Jan-93	$75	$163	$316	16.1%
Jan-94	$74	$161	$312	-1.3%
Jan-95	$81	$176	$342	9.8%

WI Traditional Indemnity Premium
(CMO Plan*)

	Premium**				
Date	Single	Limited Family	Full Family	Ave. % Change	Differential
Jan-92	$71	$158	$301		-11.3%
Jan-93	$84	$183	$356	18.1%	-11.3%
Jan-94	$88	$181	$352	-1.0%	-11.5%
Jan-95	$91	$199	$387	9.8%	-11.5%

HCN Medical Inforce Data

Date	Number of Employers	Number of Employees	Ave. Size of Group
Jan-92	236	1,558	6.55
Jan 93	246	1,626	6.61
Jan-94	227	1,251	5.52
Jan-95	233	1,805	8.89

*In addition to the premium savings, the PPO Plan has a better benefit, due to a lower coinsurance cost to the insured if network providers are used.

**Premiums shown are for a Single Male Employee, age 36, a Single Male Employee with one child, and a Male Employee, Age 30 with a spouse and two children, as of the date shown. The rates shown are for Milwaukee, Zip 532. The plans shown have a deductible of $500 and a Stop Loss level of $5,000. The PPO plan has a coinsurance of 90% in-network and 80% out-of-network. The CMO plan has a coinsurance of 80%. Maternity coverage is included.

Name: James B. Meyers
Title: Executive Director, Managed Care Development

Mr. ENSIGN. I would like to thank the panel.

Before I turn it over to Mr. McCrery, Ms. French, you mentioned some savings at the University of California by implementing some of the ideas that you have outlined. You mentioned $65 million, $624 per year per enrollee. Would you consider that those savings—if somebody was asking you, would you consider that a cut in your employee services?

Ms. FRENCH. No, as a matter of fact, I wouldn't. The bulk of that savings really came from the price of the gross premium, not from shifting that cost to employees.

Mr. ENSIGN. The reason I mention that is because you hear a lot up here on Capitol Hill about our attempt to save Medicare by implementing some of the ideas that you have outlined in your testimony that we will be cutting Medicare, we will be slashing Medicare's budget.

If we are able to save $300 billion over the next 7 years because we are able to implement some of the changes that you have implemented, would you consider those a cut or a slash in the Medicare budget?

Ms. FRENCH. I think you have to look at the costs to the member versus the cost of the program as a whole; and when you compare those two things in our environment, the cost to the member has not increased very much at all, only about 2 percent in that period of time. So the cost savings that we are talking about, the 17 percent off the gross premium, has really come out of the plans.

So in answer to your question, no. If your relationship works like that, I would not consider that a cut in the program.

Mr. ENSIGN. In your opinion, do you think that what you have implemented at the University of California would be applicable to the Medicare population?

Ms. FRENCH. I think the Medicare population is a little more difficult to deal with. It is largely still in a fee-for-service environment. It is moving slowly into an HMO or managed care environment. One of the earlier panelists remarked that there is an educational or a learning curve involved there. I think it can be done. I have seen it happen in our population, but it takes time.

Mr. ENSIGN. Thank you.

Mr. McCrery.

Mr. MCCRERY. Ms. French, let me just follow up on that. I thought I heard you say that you have experienced significant savings among your Medicare population; is that correct?

Ms. FRENCH. That is correct.

Mr. MCCRERY. How have you done that?

Ms. FRENCH. We are moving in through Medicare risk programs.

Mr. MCCRERY. What do you mean by that?

Ms. FRENCH. By that, I mean, if they are in an HMO, that they will receive all of their care from the HMO. They will no longer be available to opt out and use Medicare on a fee-for-service basis outside the HMO.

Mr. MCCRERY. Anything else?

Ms. FRENCH. That plus the gradual shift of that entire population into HMO's per se.

Mr. MCCRERY. How are you shifting that population to the HMO's?

Ms. FRENCH. That has been driven primarily by the price. The traditional indemnity program has become extremely expensive as it compresses into higher utilizers and a smaller population, so gradually people are moving out of that program into the managed care programs.

Mr. MCCRERY. Explain to me how if your retiree population is eligible for Medicare, how have their prices increased?

Ms. FRENCH. Excuse me?

Mr. MCCRERY. How have their prices increased if they are in Medicare?

Ms. FRENCH. The population that is in Medicare can be priced one of two ways. It can remain in a fee-for-service environment, which is more expensive even though they are less expensive as a group than the employees—if you compare the retirees who are in the fee-for-service programs to retirees in the HMO's, straight line, the ones in the HMO's or the managed care products are running at a lesser cost.

Mr. MCCRERY. Yes, but when your folks retire, you say that you help pay their part B premiums?

Ms. FRENCH. Yes, we do.

Mr. MCCRERY. Is that all you do? Are they in the Medicare system?

Ms. FRENCH. They are in the Medicare system.

Mr. MCCRERY. And the only assistance you provide them is helping with their part B premium?

Ms. FRENCH. No, that is not the case. They still maintain the opportunity to stay in a university-sponsored health plan in addition to Medicare.

Mr. MCCRERY. OK. And you control the prices on the university plan?

Ms. FRENCH. That is right. I don't control Medicare.

Mr. MCCRERY. Correct. So for those employees who choose to stay in the university plan, it is their choice to go into an HMO?

Ms. FRENCH. Yes. They have the full range of choices that we offer to employees. In that sense, they are treated no differently.

Mr. MCCRERY. To your employees you only offer them, fully paid, the low-cost plan?

Ms. FRENCH. That is correct.

Mr. MCCRERY. Which is an HMO, I presume.

Ms. FRENCH. It is an HMO. However, the level of cost of that HMO for an employee is still above what it costs to provide a Medicare risk program; let's give you an example.

We pay about $140 a month for a single party plan. That is available to a retiree as well. If that retiree is in a Medicare risk plan, the cost for the risk plan is probably around $40 a month, so we can also pick up the cost of their Medicare B and still be within that budget allowance.

Mr. MCCRERY. So can you translate that or can you think about it for a second and give us some guidance as to how to change the Medicare Program at the Federal level to exact some of the same type of efficiencies?

Ms. FRENCH. I think the difficulty is in the approach to the delivery of service. The Medicare Program has been traditionally embedded in fee-for-service with self-referral and very little manage-

ment of access to care. I am not sure that always gets you the best quality of care, but I think you are talking about an educational issue as much as a money issue when you are dealing with Medicare members.

It is certainly a lot easier for us to work with the Medicare members of our population who have already been in an HMO setting. They understand the delivery. They understand how the system will work for them, and they are not frightened, if you will, by the thought of some utilization management.

Mr. MCCRERY. Thank you.

Mr. ENSIGN. The last panel—and I appreciate the question. Maybe we will open it to the rest of the panel on Mr. McCrery's question; and that is, some of the ideas that have worked in the private sector, the basis for this panel discussion today is how do we incorporate some of those ideas into the Medicare Program.

You mentioned education. How do we convince seniors that this can work because especially as you age, change becomes less attractive. I think when you are in your teenage years, change is inevitable, it is just part of life, and you accept it. But as you age, you like things the way they are, you don't like to change, so education is certainly more important.

How do we educate, but also which of these programs do you think that we should bring into Medicare? Should we have a list of choices similar to what Federal employees have, similar to what the University of California has, whether that is fee-for-service or whether that is HMO's and point-of-service plans and on down the line?

Does anybody else care to comment?

Mr. FEARER. I agree with Michele French that the primary issue is the health care delivery system itself, and that we need to find ways to eliminate excess capacity. Hospitals, for example in California, are 50 percent full and we are paying for that overhead; Medicare is paying for that overhead. There is still a significant problem of inappropriate and unnecessary care and solving this problem is important to controlling cost.

Preventative care is vital, particularly for the elderly, and early intervention in disease management is also critical. The best managed care programs are effective at that, but managed care programs are not all created equal. Some are more effective than others.

I also agree that consumer education is important. In fact, I believe that Medicare has begun a program with contracts in each State and is now beginning to roll out a pilot program of consumer education for Medicare eligibles. I don't know how well that will work, but I think it has the potential to be helpful.

There also needs to be, in general, a cost-benefit approach to treatment. It may be that the most expensive treatment has a 99-percent success rate and another treatment has a 98-percent success rate, but only costs half as much. We need to think whether we can always afford the most expensive method.

I think the real issue is health care delivery, not design of the plans themselves.

Mr. WROCKLAGE. I was going to comment that I think if you could create a system where there is a defined contribution for each

Medicare recipient, and then in a given community they saw the multiple options of the delivery systems, the widest to the most narrow, and there were quality service and satisfaction measurements, then that individual retiree could make a decision as to which health plan they want to choose, knowing that if they chose the more expensive health plan, the difference would become a cost to them.

I did not talk about a program that we have—that we are creating where we are trying to create an employer alliance, a purchasing alliance for health insurance where the employer would define their contributions and the individual employee would make a health plan choice much like they are doing in California for the small employer programs. And again, I think this incorporates the idea that an employer is paying the cost or a significant portion for a good plan, but then the employee is actually making the decision on the health care delivery system they want on their own. And if they want the more expensive option, I think they must realize that that is a cost that they have to bear. And if we could give them good quality and satisfaction and service information, I don't think this would be such a difficult decision for people to make.

Mr. ENSIGN. Mr. Wrocklage, you mentioned that half of your coalition covered lives or employees of small businesses, under 200 employees. How are you able to include these small businesses into your organization? Has this helped stabilize insurance coverage for small businesses in your region and has including small businesses in your coalition improved your purchasing power?

Mr. WROCKLAGE. We have done it because Wisconsin has a very high penetration of self-funded employers, even down to employers as small as 50, so a large number of our self-funded employers are premium from 50 to 200 lives, so they came into the program under the initial phase which was to serve self-funded employers.

Many small employers don't want to take that self-funding risk and so they look to insurance carriers, and what we did was find a contractual way to provide our network of hospital doctors and physicians to insurance carriers who wanted to offer it to small employers. And what we have done is taken almost two different segments, employers who are self-funded ranging from 50 to 6,000 and then also another group of employers who are looking for an insured product—and I gave you the numbers in my testimony—and we almost had—50 percent of our business is for people who need insurance and are less than 200 in size and work through insurance carriers.

But we are the negotiators for all of those people. We are their community representative when it comes to sitting at the table to bargain on quality and cost.

So, in effect, my large employers do believe that their buying power have been enhanced by the lives that are represented by the small employer, and the small employers see their buying power enhanced. And the interesting thing, they get access to the same doctor-hospital network and the same price per unit, and so there is not this cost-shifting from one segment of the population to the other.

Mr. ENSIGN. I would like to thank the panel.

We do have a vote. We will reconvene after the vote. Thank you.

[Recess.]

Mr. ENSIGN. I would like to call the panel forward: Jon R. Reiker, vice president for benefits, General Mills Restaurants, Inc., Orlando, FL; James P. Spence, senior manager, Corporate Insurance Benefits and Medical/Wellness Services, Storage Technology Corp., from Louisville, CO.

Mr. Reiker.

STATEMENT OF JON R. REIKER, VICE PRESIDENT FOR BENEFITS, GENERAL MILLS RESTAURANTS, INC., ORLANDO, FL

Mr. REIKER. Thank you. My name is Jon Reiker. I am vice president of benefits for General Mills Restaurants. I appreciate the opportunity to testify today regarding our company's demonstrated successes in using managed care programs, and principles to control health care costs and quality in our company and the communities in which we operate.

With more than 126,000 employees, General Mills is one of the 25 largest private-sector employers in the United States. Our restaurant operations—Red Lobster, the Olive Garden, and China Coast—employ over 115,000 workers in 49 States and in Canada.

Unlike many U.S. corporations, our employment has grown sharply. We have added 20,000 new jobs in the past 2 years and more than 60,000 new jobs since 1988. It has been critical to our continued growth that we find a way to offer high-quality, competitive benefit programs which are affordable to both the company and to our employees. The collective changes which I will cover in this testimony have resulted in a reduction in cost per participant of over 50 percent since the introduction of managed care in 1992.

These savings have been accomplished without any increase in employees' premiums or any cutback in benefits, and with a significant reduction in employees' out-of-pocket costs.

I think to fully understand the programs and the process of installing those, I need to give a little background. I can tell you, that our decision to venture into managed care was not an easy one. We felt strongly that health care should be bought on the basis of quality and not discounts and that long-term solutions would have to be based on outcomes.

We initially had concerns about the impact that managed care would have on our employees, the quality of their health care, and the logistics of a plan that could reach the majority of our 200-plus markets in which we operate. But like most companies in 1991, the promise of significant cost savings was a driving consideration.

Since 1986, we have been actively involved in an extensive and relatively successful war on the cost of health care benefits for both the employee and the company. Under the banner of "Teaming Up to Tackle Health Care Costs," General Mills Restaurants initiated steps based on a theme of shared responsibility and shared savings. The group health plan was simplified so participants could better understand how to use it. We introduced MediCALL, a program of company-employed registered nurses who serve as patient advocates, assisting employees through their health care encounters by providing health care education, arranging second opinions, and counseling on how to maximize the use of the benefit plans.

Surveys consistently indicated high satisfaction with MediCALL. It was seen as a nurse in the family. We benefited by having hands-on awareness of employee health care issues. We made some minor plan changes to improve and address problems and opportunities as they appeared. We put in automated health care data systems for patient tracking and reporting and, rewarded employees for discovering and correcting billing errors. We became fully self-insured and self-administered, got very involved in community and government reform efforts, but still all of that was not enough.

In 1991, we faced again double-digit health care inflation, and cost-shifting in the health care community caused further premium and expense increases. Holding the line had become almost impossible. It seemed that our employees and the plan were the last ones in America paying retail for health care services. So, in 1991, we joined the move to managed care.

The selection of our managed care partner was critical. We conducted a nationwide search of HMO and PPO programs along five criteria.

First was network coverage. With our broad expansion, we needed a program that could cover, we felt, at least 75 percent of our employees.

We wanted an emphasis on quality that was demonstrated by a strong commitment to measuring and ensuring the highest quality of care.

Projected cost savings: We had repriced the plans to make sure that savings would be there.

Utilization control, a strong retrospective review of network providers for utilization and billing patterns.

And a program that would be customer driven.

After careful review, we chose CAPP CARE Preferred Network as our managed care partner. To introduce the plan—and this is, I think, something that was significant—we employed what we would liken in the restaurant industry to a soft opening. Essentially, minimum changes were made to the benefit plan in the first year except to forgive a hospital admission deductible when an employee chose a CAPP CARE hospital. The emphasis was placed upon discussing the advantages for employees. This included referrals to providers that had been prescreened for quality, lower out-of-pocket expenses, and providers who would accept assignment of benefits with no upfront payment.

Initially, only about 15 percent of our employees chose the network providers. However, that demonstrated a higher satisfaction and lower costs than other employees.

Specific employee testimonials were shared with the message "think what would happen if everybody used CAPP CARE providers." Today our network coverage has grown to 90 percent through aggressive expansion.

Through the end of the first year of the partnership, over $3 million had been saved in reductions from billed charges, not to mention savings from improved utilization patterns. For the first time, there would be no increase in employee premiums. Basically, 4 years later, we are still in a position with no increase in employee premiums and reduced out-of-pocket expenses, as I mentioned; phy-

sicians are paid at the CAPP CARE rate, allowing full choice to employees, with them just paying the difference.

I have in the written testimony several other examples of ways that we have worked into the MediCALL program, but in summary, just let me say that we are convinced by actively managing an employee health care plan, you can accomplish the seemingly contrary goals of lower costs, improved quality, and increased satisfaction.

For General Mills Restaurants, managed care is more than selecting a network of providers, it is the blending of the highly personal touch of our MediCALL program and CAPP CARE's leading-edge practice guidelines and health information systems. It is incorporating eligibility and improved data reporting and coordinating the broad spectrum of care to address managed care opportunities presented by workers' compensation and disability. Perhaps most importantly, it is about giving employees the information and support they need to make good health care decisions within a managed framework of quality providers.

Thank you.

Mr. ENSIGN. Thank you, Mr. Reiker.

[The prepared statement follows:]

Testimony Of Jon R. Reiker

Vice-President, Benefits, General Mills Restaurants, Inc.

Committee on Ways And Means

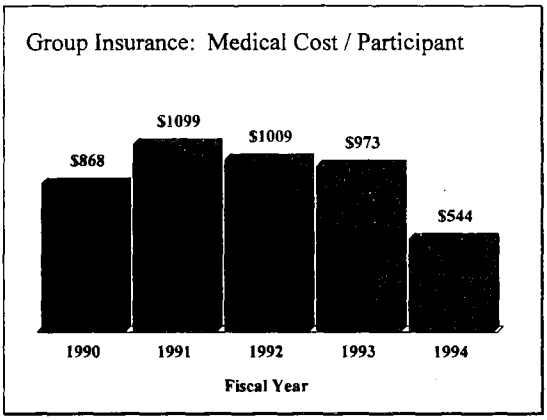
Subcommittee on Health

May 16, 1995

Introduction

Good Morning, Mr. Chairman; members of the subcommittee– my name is Jon Reiker. I am Vice President of Benefits for General Mills Restaurants. I appreciate the opportunity to testify regarding our company's demonstrated successes in using managed care programs and principles to control health care costs and quality in our company and in the communities in which we operate.

General Mills' Experience



General Mills Restaurants- Annual Medical Plan Expense / Participant

With more than 126,000 employees, General Mills is one of the 25 largest private-sector employers in the United States. Our restaurant operations (Red Lobster, The Olive Garden, and China Coast) employ over 115,000 workers in 49 states and Canada. Unlike many major U.S. corporations, our employment has grown sharply. We have added over 20,000 new jobs in the past two years and more than 60,000 new jobs since 1988. It has been critical to our continued growth that we find a way to offer high-quality, competitive benefit programs which are affordable both to the company and to our employees. The collective changes which I will cover in this testimony have resulted in a reduction in cost/per participant of over 50% since the introduction of managed care in 1992. These savings have been accomplished without any increase in employees' premiums or any cutbacks in benefits, and with a significant reduction in employees' out-of pocket costs.

Background

From 1986 to 1991, GMRI had waged an extensive, and relatively successful, war on the cost of health care benefits for both the employee and the company. Under the banner of "*Teaming Up to Tackle Health Care Costs*," GMRI initiated steps based on a theme of shared responsibility and shared savings. The group health plan was simplified so that participants could better understand how to use it. We introduced MediCALL - a program of company employed registered nurses to serve as patient advocates for our employees and their families. These nurses assisted employees through their health care encounters (hospitalizations, surgeries, births, etc.) by providing health care education, arranging second opinions, and counseling on how to maximize the use of the benefit plan. MediCALL has been very favorably perceived – like "having a nurse in the family." Surveys consistently indicated high satisfaction. The company benefitted by having a hands-on awareness of employee health

care issues. Plan design changes were made to address problems and opportunities as they appeared. Automated systems were created for patient tracking and reporting. Employees were rewarded for discovering and correcting billing errors. GMRI built heroes of those employees who by example conveyed the image of smart health care consumers. Eligibility and enrollment procedures were tightened. GMRI became fully self-insured and self-administered. Community and government reform efforts took on increased priority.

But it still wasn't enough! The cost shifting in the health care community caused further premium and expense increases, our previously stable insurance costs returned to double-digit inflation. Holding the line had become almost impossible. It seemed that our employees, and the plan, were the last ones in America paying "retail" for health care services. So, in 1991, GMRI joined the rush to managed care.

Our Move to Managed Care

I will tell you that our decision to venture into managed care was not an easy one. We initially had concerns about the impact it would have on our employees, the quality of their health care, and the logistics of a plan which could reach the majority of our 200 or more market areas. Philosophically, we favored outcomes management and quality improvement initiatives over discounted fees as long-term solutions. But like most companies in 1991, the promise of significant cost savings was a driving consideration.

The selection of our managed care partner was critical. We conducted a nationwide search of HMO and PPO programs along 5 criteria:

- Network Coverage -- Our target was to cover at least 75% of our covered employees with a commitment to meet expansion needs
- Emphasis on Quality -- Strong commitment to measuring and ensuring the highest quality of care through provider selection and contracting
- Projected cost savings -- A large sample of historic claims were "repriced" to estimate our potential savings under discount contracts
- Utilization control -- Strong retrospective review of network providers for utilization and billing patterns
- Customer Driven -- Open and enthusiastic response to the development of new programs and features.

After careful review, GMRI chose the CAPP CARE Preferred Network as our managed care partner. To introduce the plan, GMRI employed a soft-opening approach. Essentially, minimal changes were made to the benefit plan except to forgive a hospital admission deductible when an employee chose a CAPP CARE hospital. The emphasis was placed upon discussing the advantages for employees. These included:

- Referral to Providers screened for quality,
- Lower out-of-pocket expenses, and
- Providers who accept assignment of benefits with no up-front payment.

Initially, only 15% of the employees chose network providers. However, those that did enjoyed far higher satisfaction and lower costs than other employees. Specific employee testimonials were shared with the message "think what would happen if everyone used CAPP CARE providers!" After six months, an employee satisfaction survey found that those employees who used the network were over 90% satisfied- higher than those in non-network areas. CAPP CARE pursued an aggressive network development campaign to bring network providers to those areas where it didn't exist. GMRI prioritized the expansion plan.

As a result, more and more employees began benefiting from the availability of preferred providers. By the end of the first year of the partnership, over $3,000,000 had been saved from reductions from billed charges, with additional savings from improved utilization patterns. For the first time in many years, there would be no increase in employee premiums. Encouraged by these positive results, GMRI made plan changes to place stronger incentives for employees to choose CAPP CARE providers. Penalties were raised for out-of-network hospitals. Physicians were paid at the CAPP CARE preferred rate thereby allowing the employee to retain their choice of physician with the requirement that, if they charged more than the PPO rate, the employee would pay the difference. Videos featured employee testimonials on how easy it was to use CAPP CARE providers and how much employees and the company could save by doing so. Employees were counseled in how to recruit their physician into the network, assuming successful completion of the stringent credentialing requirements imposed by CAPP CARE.

Impact to Costs and Quality

As seen in the earlier chart, General Mills Restaurants, Inc. has reduced its employee medical insurance costs by over 50% through managed care initiatives. Improved data meant information was more readily available to take action correcting problem areas, and led us to additional opportunities to coordinate and improve each employee's continuum of care. Preferred provider networks, outsourced utilization review, automated practice guidelines, and the integration of workers' compensation and group health insurance have all been implemented since the partnership began in late 1991.

Perhaps most importantly, we are convinced that we are seeing better quality of care provided to our employees at a more affordable price. MediCALL provided an important cornerstone on which to build. CAPP CARE's full provider referral capability was outsourced to MediCALL. When an employee contacted MediCALL, they were counseled on the best way to maximize their benefit plan by using CAPP CARE providers. They were also informed of the financial impact of going to non-network providers. Employee satisfaction with the benefit plan has never been higher. Problem calls related to group insurance issues are on the decline. Claims administration has improved -- fewer pended claims, shorter turnaround times. MediCALL is better able to focus its major case management efforts on more patients than before.

CAPP CARE is well known as a leader in the development and use of practice guidelines. In keeping with a vision of electronic coordinated care, CAPP CARE and GMRI embarked on a project to blend their full practice guidelines and utilization review program with MediCALL's patient education, counseling and case management program. Nurses now interact with the physicians prior to services being provided. This proactive approach allows patients to receive the best quality care as defined by the highest medical standards. Procedures or services suspected of being unnecessary or questionable would be reviewed with the GMRI and CAPP CARE medical directors prior to being performed. All records were fully automated and individualized letters were distributed to the patient, physician and facility provider.

Finally, CAPP CARE provided a proprietary program called VIM (Volume and Intensity Management). Practice and billing patterns were analyzed for the purpose of ensuring consistently high-quality, cost-effective care. Savings were realized from reducing the number of unnecessary C-sections, increasing the number of patients diverted to outpatient services, and reducing the length of stay for several mental health diagnoses. Equally important was the identification of problem areas. Anything showing a loss or poorer performance than prior years became the focus for corrective action. Benefit plan enhancements or improved procedures were implemented to address these issues. Innovation requires continuous evaluation and improvement.

Recent Developments

Another opportunity existed to expand the impact of managed care. Our Workers' Compensation expenses were as large as those for health care. GMRI saw a clear opportunity to better integrate the functions of group health, workers' compensation and disability insurance. Liberty Mutual has joined with GMRI and CAPP CARE in a unique pilot project to extend the value of the managed care to workers' compensation. Liberty Mutual, our workers' compensation carrier, will provide a registered nurse in the MediCALL program to assist restaurant managers in referring injured workers to CAPP CARE preferred providers. The nurse will work closely with store management to ensure the injured employee receives the most appropriate high quality treatment. The goal is to manage the medical treatment of the diagnosed condition until the employee can return to full productivity

CAPP CARE has proven the transportability of these new products - Outsourced UR and Workers Comp Provider Network - by providing them to other high profile customers such as Adolph Coors, Inc., Flagstar Restaurants and Accordia National.

The Future

Looking to the future, CAPP CARE is in the forefront of the practice guideline initiative. This year, physicians in the Orlando, Florida (home of GMRI) and Orange County California markets will serve as beta sites to begin using highly sophisticated, hand-held data managers in the day-to-day operation of their offices. These devices contain the practice guidelines and allow the physician to assure total quality of care without the level of outside intervention currently required. The Physician will be able to diagnose, prescribe treatment, make a referral, write a

prescription (if necessary), file notes to the medical record and even bill the payer -- all electronically. We view such initiatives as the inevitable future of managed care.

In Summary

We are now convinced that by actively and continuously managing an employee health care plan, you can accomplish the seemingly contrary goals of lower costs, improved quality, and increased satisfaction. For General Mills Restaurants, managed care is more than selecting a network of providers. It's the blending the highly personal touch of our own MediCALL program with CAPP CARE's leading edge practice guidelines and health information systems. It means coordinating the broad spectrum of health care from initial eligibility through claims administration and large case management to workers' compensation and COBRA. Perhaps ultimately, it is about giving employees the information and support they need, at precisely the moment they need it, to make good health care choices -- within a managed framework of quality plans and providers.

Mr. ENSIGN. Mr. Spence.

STATEMENT OF JAMES P. SPENCE, SENIOR MANAGER, CORPORATE INSURANCE BENEFITS AND MEDICAL/WELLNESS SERVICES, STORAGE TECHNOLOGY CORP., LOUISVILLE, CO

Mr. SPENCE. My name is Jim Spence. I am senior manager for corporate insurance benefits and medical/wellness services for Storage Technology Corp. I also want to mention I am a graduate of Johns Hopkins Medical School, as a physician's assistant, so I have 15 years of medical experience as well as seeing both sides of the coin from the benefits perspective.

Storage Technology is a high-tech firm that manufactures computer data storage. We employ 11,000 worldwide, 9,000 domestically, and 6,500 at corporate headquarters in Louisville, CO.

We are self-insured and introduced our managed care program in 1990, primarily to attempt to curb the rapid rise in our medical costs. Since 1990, we have offered two managed care programs to employees. We have also offered a traditional indemnity plan only where managed care networks do not exist.

The first program is a preferred provider organization, or PPO. This program offers a network of providers that have agreed to negotiated rates for services. Employees have the option of going in network or out of network, but with higher deductibles, higher out-of-pocket maximums, and a significantly reduced reimbursement level.

The second program is an exclusive provider program [EPO's]. This is similar in structure to an HMO with funding slightly different. EPO utilizes primary care providers as gatekeepers. Employees must first see their gatekeeper and receive a referral prior to seeing a specialist. Employees' expenses are covered 100 percent in this plan with no deductible. There is no coverage for care provided outside of the EPO network. And our indemnity plan is a traditional plan with 80/20 coverage.

Employee premiums are the same for the EPO product as they are for the premier PPO product. Premiums have only increased 5-percent since 1990.

Prior to introduction of our managed care plans, our total medical costs rose 11 percent in 1988 and 46 percent in 1989. With implementation of our managed care program, 1990 saw a 5-percent decrease in total medical costs. Between 1990 and 1994, our total medical costs have averaged a decrease of 2 percent per year. During this time, our population has remained relatively constant.

On the other hand, our indemnity plan has increased 11 percent a year since 1991.

As we continue to manage our costs, we are convinced that managed care is a long-term solution for the present as well as the future. We also believe that managed care is effective in controlling our medical costs without sacrificing quality of care.

Why have we been successful in controlling the meteoric rise in medical costs? I believe the reasons are threefold.

One, managed care: Managed care has clearly been the most important factor in bringing our costs under control. We have offered the PPO plan, as well as the EPO plan, and 65 percent of our employees have enrolled in the PPO plan, which is less restrictive but

at a higher cost both to the company as well as the employee; 35 percent in an EPO; and less than 1 percent in the indemnity plan. The EPO, which has tighter management controls, has kept the annual benefits paid per employee at an average of $2,600, while the PPO benefits paid per employee is averaging $2,900.

Although less expensive, we have not made great efforts to drive employees into the EPO plan. This is due to employee surveys showing that employees like some flexibility and have made efforts to receive their care in network and have been excellent consumers in controlling their health care costs.

STK, Storage Technology, views managed care as a four-legged platform. The legs are comprised of the employer, employees, providers, and a third-party administrator. And the platform itself is quality medical care. We feel that each leg must communicate with the other legs in order to be successful.

For this reason, the benefits department meets regularly with the employees through focus groups to understand their needs and satisfactions with the program. We meet frequently with Aetna, our third-party administrator, as well as with our highly utilized hospitals and provider groups. In these meetings, we discuss concerns, exchange data on utilization and costs, and develop strategies to address issues. By doing this, we feel that each party understands clearly where the other legs of the platform are focused.

As an example of this, we noted in 1991 that our largest medical expense was in pregnancy and childbirth. We met with two of the local hospitals to ask how they would help us control costs and assure us a high quality of care for our members in this area. Their response was to enhance their facilities in birthing centers, provide an educational program for pre- and postnatal care, and they participated in successful negotiations with us to provide package rates for their services. We believe this occurred because we developed an open dialog and were able to create a partnership with them in responding to our needs.

Another advantage of managed care is the ability to provide cost control measures while assuring that quality care is being delivered. As an example, the chronic passive motion machine is somewhat new technology that orthopedists use frequently on their patients after knee and hip surgery. Studies have shown that there is no advantage to using this machine over standard physical therapy and has no effect on improving outcomes. For this reason, we provide only very limited coverage.

Another example is autologous bone marrow transplant for end-stage metastatic breast cancer. We have an employee who requested this therapy, which was controversial at the time. Aetna worked with us in evaluating this last-effort treatment for efficacy. Though very experimental and risky, in an attempt to save this woman's life, treatment was approved. She underwent the treatment 4 years ago and is currently still employed as an engineer at Storage Technology.

Other advantages to network care are the ability to perform case management on high-cost, complicated claims and utilizing centers of excellence that can control costs while delivering the highest quality of care.

Employees are another key to controlling our costs. We have done extensive communication and education programs to develop our employees into wise medical care consumers. After having delivered these programs to employees, we are focusing on incentives that motivate them to be good consumers. We do this through paying them one-half the savings they find in hospital billing errors and by reporting fraud. We are currently looking at paying the employees a retrospective dividend of $100 as a way of saying thanks for actively working to control medical expenses.

Evidence that our employees are wise consumers is shown by the average number of outpatient visits but significantly lower inpatient admissions and lengths of stay than expected. This is what we call the worried well syndrome. Our plan members go to the doctor often but generally for mild problems or early-stage symptoms. We have encouraged employee usage of outpatient care because it reduces our costs through early treatment intervention and greater protection against the higher cost claims of hospitalization. This appears to be effective, shown by the low hospital usage.

In 1990, our inpatient psychiatric admissions were twice the expected rate as was the length of stay. Mental health was our second most expensive category of care. The benefits department met with our employee assistance program to provide us with a plan that would bring these costs under control. We communicated these changes to employees. The plan changes increased accessibility of outpatient mental health, increased the number of covered visits by placing a liberal cap on charges per member per year, and negotiated rates with providers and encouraged members to seek help whenever needed. We also put very restrictive coverage for inpatient care and limited it to 14 days in most cases. This change fell in line with our philosophy and that of the AMA that 75 percent of all diseases are stress related and that if focus is placed on dealing with this stress at an early stage, morbidity would be significantly reduced, thus reducing the higher cost claims.

Employees have viewed this as a positive step and have taken advantage of this coverage. Since making this change, the plan has saved over $250,000 per year.

In 1994, an employee survey showed a 94 percent satisfaction rating on their health and welfare benefits. This satisfaction rating has remained consistent since 1992. This level of satisfaction has not always been the case. Implementing managed care in 1990 was not without its travails and anguish. Employees were upset with the loss of total freedom of choice they had with indemnity, were confused about the regulations of managed care and wanted grandfather clauses for their care. In some cases, we did grandfather mental health and maternity indemnity coverage for one year. Our communication program continued through these trying times, and by 1992, most of the angst had passed and employee satisfaction quickly soared.

Is it okay to continue or do you want me to stop?

Mr. ENSIGN. That is fine. The rest of your written statement will be included in the record.

[The prepared statement and attachments follow:]

TESTIMONY OF JAMES P. SPENCE
STORAGE TECHNOLOGY CORPORATION

Storage Technology Corporation (STK) is a high tech firm that manufactures computer data storage. STK employs 11,000 worldwide, 9,000 domestically and 6,500 at corporate headquarters in Louisville, Colorado.

We are self-insured and introduced our managed care program in 1990, primarily to attempt to curb the rapid rise in our medical costs. Since 1990 we have offered two managed care programs to employees. We also offer a traditional indemnity plan only where managed care networks do not exist . The first program is a preferred provider organization (PPO). This program offers a network of providers that have agreed to negotiated rates for services. Employees have the option of going in network or out of the network but with higher deductibles, higher out of pocket maximums and a significantly reduced reimbursement level. The second program is an exclusive provider program (EPO), this is similar in structure to an HMO. The EPO utilizes primary care providers as "gatekeepers". Employees must first see their gatekeeper and receive a referral prior to seeing a specialist. Employees expenses are covered at 100% with no deductible. There is no coverage for care provided outside of the EPO network. The indemnity plan is a traditional plan with 80/20 coverage. Employee premiums are the same for the EPO product and the premier PPO plan. Premiums have only increased 5% since 1990. Prior to introduction of our managed care plans our total medical costs rose 11% in 1988, and 46% in 1989. With implementation of our managed care program, 1990 saw a 5% decrease in total medical costs. Between 1990 and 1994 our total medical costs have averaged a decrease of 2% per year. During this time our population has remained relatively constant (see chart #1). On the other hand, our indemnity plan has increased 11% a year since 1991. As we continue to manage our costs, we are convinced that managed care is a long term solution for the present as well as the future. We also believe that managed care is effective in controlling our medical costs without sacrificing quality of care.

Why have we been successful in controlling the meteoric rise in medical costs? I believe the reasons are three-fold:

1. Managed Care- Managed care has clearly been the most important factor in bringing our costs under control. We offer a preferred provider organization (PPO) and an exclusive provider organization (EPO) which is similar in coverage to an HMO. We have 65% of our employees enrolled in the PPO which is less restrictive but at a higher cost, 35% in the EPO and less than 1% in the indemnity plan. The EPO, which has tighter managed controls, has kept the annual benefits paid per employee at an average of $2,600 while the PPO benefits paid per employee is averaging $2,900 (see chart #2 and #4). Although less expensive, we have not made great efforts to drive employees into the EPO plan. This is due to employee surveys showing us that employees like some flexibility in choosing providers, have made efforts to receive their care in network, and have been excellent consumers in controlling their health care costs.

In the EPO network- 98.4% of members utilized network providers for office visits
99.1% of members utilized network hospitals for inpatient care

In the PPO network- 75% of members utilized network providers for office visits
87% of members utilized network hospitals for inpatient care

STK views managed care as a four-legged platform. The legs are comprised of the employer, employees, providers and a third party administrator and the platform itself is quality medical care. We feel that each leg must communicate with the other legs in order to be successful. For this reason, the benefits department meets regularly with the employees through focus groups to understand their needs and satisfaction with the programs. We meet frequently with Aetna, our third party administrator, as well as with our highly utilized hospitals and provider groups. In these meetings we discuss concerns, exchange data on utilization and costs and develop strategies to address issues. By doing this we feel that each party understands clearly where the other "legs of the platform" are focused. As an example of this, we noted in 1991-92 that our largest medical expense was in pregnancy and childbirth. We met with two of the local hospitals to ask how they could help us control expenses and assure us a high quality of care for our members in this area. Their response was to enhance their facilities into birthing centers, provide an educational program for pre- and post-natal care and they participated in successful negotiations with us to provide package rates for their services. We believe this occurred because we developed an open dialogue and were able to create a partnership with them in responding to our needs.

Another advantage of managed care is the ability to provide cost control measures while assuring that quality of care is being delivered. As an example, the chronic passive motion machine is somewhat new technology that orthopedists use frequently on their patients after knee and hip surgery. Studies have shown that there is no advantage to using this machine over standard physical therapy and has no effect on improving outcomes; for this reason we provide only very limited coverage. Another example is autologous bone marrow transplant for end stage metastatic breast cancer. We have an employee who requested this therapy, which was controversial at the time. Aetna worked with us in evaluating this last effort treatment for efficacy. Though very expensive ($250,000) and risky, it appeared to be a plausible treatment and, in an attempt to save this woman's life, treatment was approved. She underwent the treatment four years ago and is currently still employed as an engineer at STK. Other advantages to network care are the ability to perform case management on high cost, complicated claims and utilizing centers of excellence that can control costs while delivering the highest quality of care for specific cases.

2. Employees control our costs and are our customers.

Employees are another key to controlling our costs. We have done extensive communication and education programs to develop our employees into wise medical care consumers. After having delivered these programs to employees we are now focusing on incentives that motivate them to be good consumers. We do this through paying them one-half the savings they find in hospital billing errors and by reporting fraud. We are currently looking at paying the employees a "retrospective dividend" of $100, as a way of saying thanks for actively working to control medical expenses.

As evidence that our employees are wise consumers is shown by the average number of outpatient visits but significantly lower inpatient admissions and lengths of stay than expected(see chart #3). This is what we call the "worried well" syndrome. Our plan members go to the doctor often but generally for mild problems or early stage symptoms. We have encouraged employee usage of outpatient care because it reduces our costs through early treatment intervention and greater protection against the higher cost claims of hospitalization. This appears to be an effective strategy as shown by the low hospital usage.

In 1990 our inpatient psychiatric admissions were twice the expected rate as was the length of stay. Mental health was our second most expensive category of care. The benefits department met with our Employee Assistance Program providers to develop a plan that would bring these costs back under control. We then communicated these plan changes to employees. The plan changes increased accessibility of outpatient mental health, increased the number of covered visits by placing a liberal cap on charges per member per year and negotiated rates with providers and encouraged members to seek help whenever needed. We also put very restrictive coverage for inpatient care and limited it to 14 days for most cases. This change fell in line with our philosophy (and that of the AMA) that 75% of all diseases are stress related and that if focus is placed on dealing with this stress at an early stage, morbidity would be significantly reduced thus reducing the higher cost claims. Employees viewed this as a positive step and have taken advantage of this coverage. Since making this change the plan has saved over $250,000 per year.

A 1994 employee survey showed a 94% satisfaction rating of their health and welfare benefits. This satisfaction rating has remained consistent since 1992. This level of satisfaction has not always been the case. Implementing managed care in 1990 was not without its travails and anguish. Employees were upset with the loss of total freedom of choice they had with indemnity, were confused about the regulations of managed care and wanted grandfather clauses for their care. In some cases, we did grandfather mental health and maternity indemnity coverage for one year. Our communication program continued through these trying times and by 1992 most of the angst had passed and employee satisfaction quickly soared.

3. In-house services are another facet that have helped to keep our costs under control. Headquarters has an on-site wellness facility that contains a 50,000 sq. ft. fitness facility, a fully staffed medical clinic and a day-care center for 80 children. The fitness facility has a utilization of over 7,500 participants a month. We track these utilizers and in the future plan to correlate medical costs of utilizers versus non-users. The medical clinic offers acute care, treatment of workers compensation injuries, emergency care, physical therapy, EAP, dental hygiene, lab and xray, as well as preventive services. The clinic provides substantial savings to the medical plan of over $1,000,000 per year. There is no charge to employees who use the clinic.

STK firmly believes that prevention and early intervention have played a significant role in controlling our medical expenses. The wellness, benefits and medical staff have developed incentives for employees to follow preventive health guidelines. As an example, our WellFlex program consists of a health risk assessment, a medical screening, a medical exam that is age appropriate, and wellness counseling. Employees can sign up for this program during the yearly benefit plan enrollment. If they agree to participate in this program, not smoke and wear their seat belts, STK will pay them $152/year. We have a 93% participation rate in this program. Through the health screen we have detected numerous silent disease processes in participants and referred them for further care. From this program we have also determined that 30% of our population have elevated lipid levels that put them at risk for cardiovascular disease. We have developed wellness programs to help employees address concerns such as this in hopes of preventing future problems that are preventable now. Again, we believe that patient education, early intervention and prevention are some of the keys to controlling patient morbidity and controlling costs.

Another wellness success story is our stop smoking program. In 1989 approximately 35% of our employees smoked. The present and future costs to the plan by increased utilization from this population were substantial, though not measured. The wellness and medical departments implemented free stop smoking programs to employees and spouses. This included distributing stop smoking patches through the medical clinic, three different types of stop smoking classes through the wellness department and ongoing group support of ex-smokers. Today only 11% of our population are smokers.

What can Medicare learn from this?

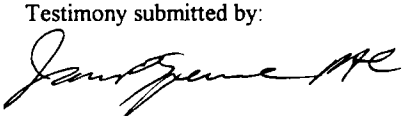
We feel we have been successful because we have empowered, motivated and provided incentives for our employees to be smart consumers of medical care in controlling costs. Given that the Medicare program has been projected to become insolvent by 2002, an important factor is to recognize the significance plan participants play in controlling costs. Any plan redesign needs to include incentives and consumer education to effectively motivate participants to manage costs.

Preventive services, early detection programs and utilization of these services should help control costs, particularly in the Medicare age population which has a significant screening yield rate.

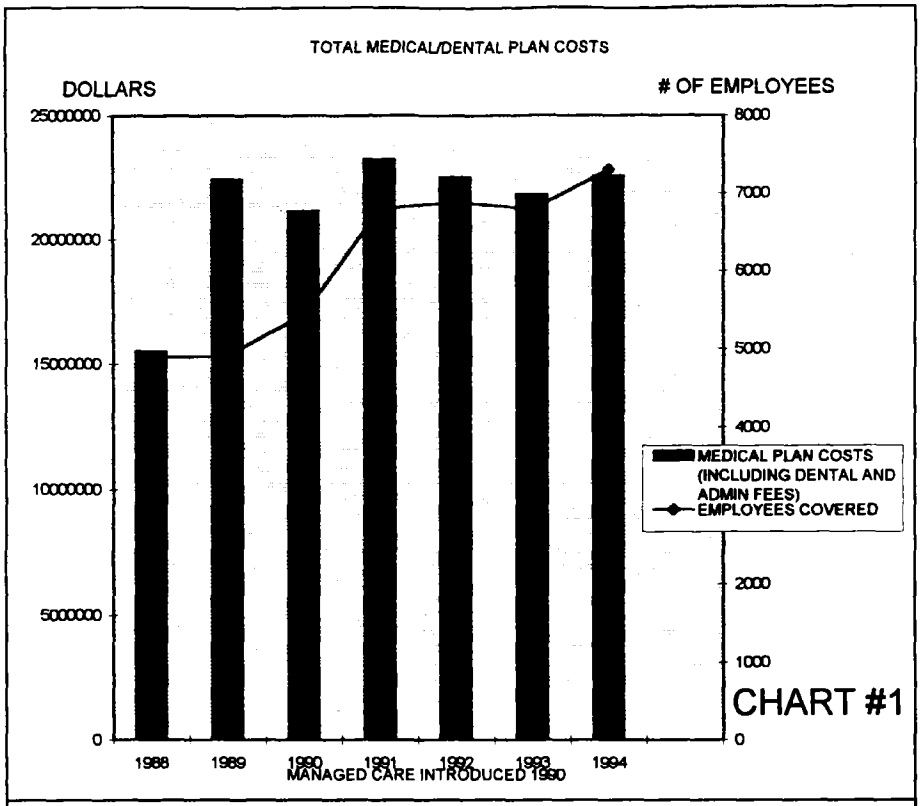
Our experience has been that the marketplace will quickly adapt to changes in enrollees' coverage while continuing to meet the needs of plan participants within the greater accountability of managed care. Enrollees may feel a loss of freedom as the program is implemented but will reasonably adjust in short order.

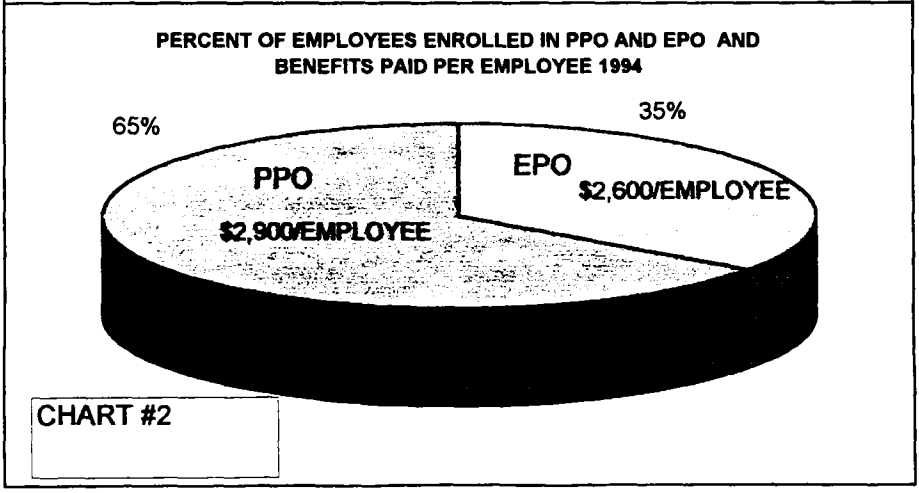
We have experienced little evidence that quality of care is hampered by managed care. In fact, most studies have shown that quality of care is improved with managed care. There is some evidence that unnecessary care is limited and controlled while preventive and early intervention care is greatly enhanced. You will hear the argument that quality of care is sacrificed due to cost controls. In reality, managed care has had to show accountability and proof of the effectiveness in delivery of medical care and treatment regimen efficacy. The outcome of this has been an impressive improvement in assessing and measuring clinic outcomes. This clearly benefits all "legs" of the "quality medical care platform". STK firmly believes managed care will provide us the means to keep our employees and their families at the top of the platform.

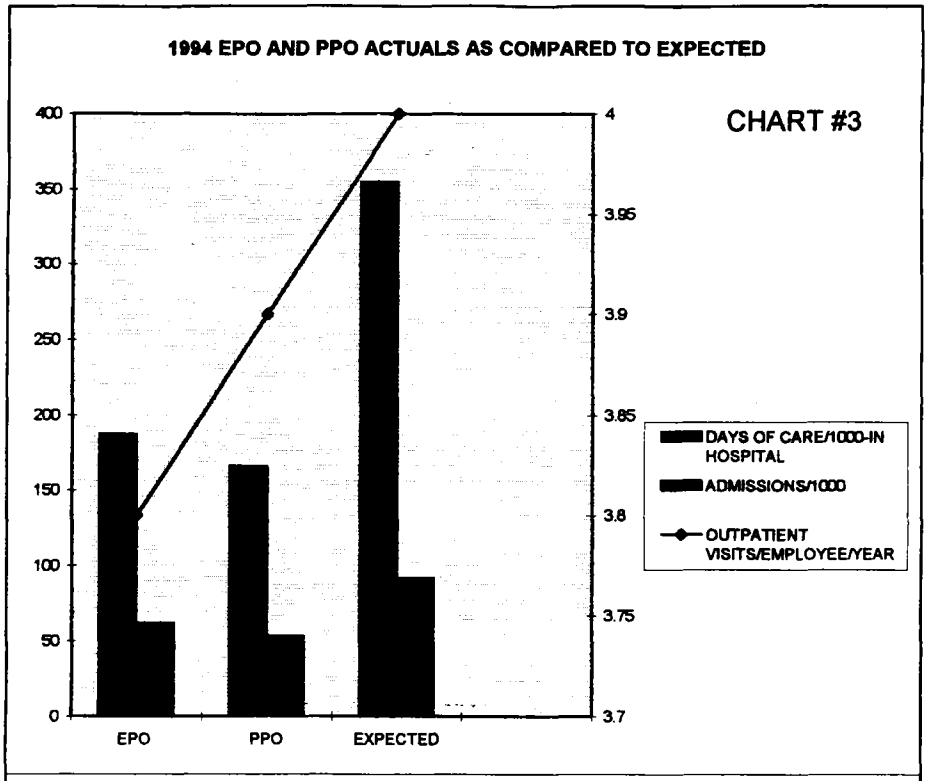
Testimony submitted by:

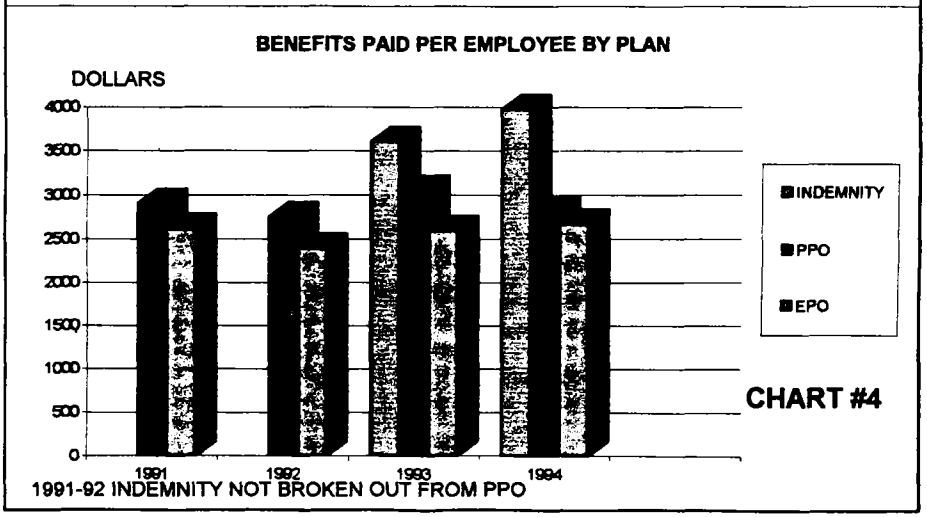


James P. Spence P.A.-C.
Senior Manager
Corporate Insurance Benefits &
Medical/Wellness Services
Storage Technology Corporation
2270 S. 88th St.
Louisville, Colorado 80028-0030
(303) 673-5314
Fax- (303) 673-4049


TOTAL MEDICAL/DENTAL PLAN COSTS
DOLLARS
OF EMPLOYEES
25000000
20000000
15000000
10000000
5000000
0
8000
7000
6000
5000
4000
2000
1000
0
MEDICAL PLAN COSTS (INCLUDING DENTAL AND ADMIN FEES)
EMPLOYEES COVERED
1988
1989
1990
1991
1992
1993
1994
MANAGED CARE INTRODUCED 1990
CHART #1


PERCENT OF EMPLOYEES ENROLLED IN PPO AND EPO AND BENEFITS PAID PER EMPLOYEE 1994
65%
35%
PPO
$2,900/EMPLOYEE
EPO
$2,600/EMPLOYEE
CHART #2


1994 EPO AND PPO ACTUALS AS COMPARED TO EXPECTED
CHART #3
400
350
300
250
200
150
100
50
0
4
3.95
3.9
3.85
3.8
3.75
3.7
EPO
PPO
EXPECTED
DAYS OF CARE/1000-IN HOSPITAL
ADMISSIONS/1000
OUTPATIENT VISITS/EMPLOYEE/YEAR


BENEFITS PAID PER EMPLOYEE BY PLAN
DOLLARS
4000
3500
3000
2500
2000
1500
1000
500
0
1991
1992
1993
1994
INDEMNITY
PPO
EPO
CHART #4
1991-92 INDEMNITY NOT BROKEN OUT FROM PPO

Mr. ENSIGN. Just a couple of quick questions. We do have another vote, and so we will wrap this hearing up.

But being from the private sector myself, I have gone through these same changes. What was your experience and did you survey your employees as far as satisfaction with their health care coverage before these changes and after these changes, especially the managed care changes?

Mr. REIKER. We have been continuously surveying our employees for the past 5 years. And probably we had a little blip of negative response when we went to the harder approach—with the disincentives. But since we have used the soft opening approach the first year without disincentives, it wasn't very great and that went away, I would say, within the first 2 months.

We encouraged employees to have their physicians petition for membership within the network. We provided them the forms to do that. We would facilitate that where possible, made it as easy as possible. We gave them the choice to stay with their physician and just pay the difference. So it really quickly rebounded to the prechange levels, and in fact it is higher now than it ever was before.

Mr. ENSIGN. To follow that up to apply to Medicare, you know, the testimony, and you hear this all the time, is educating seniors; and both companies sound like they went through extensive communications efforts and education efforts of your employees——

Mr. SPENCE. Absolutely.

Mr. ENSIGN [continued]. To try to educate seniors on some of the benefits, some of the ways that this is actually going to be better for them than worse for them. Do you see that as the soft approach maybe the first year and the disincentives the second, third, or fourth year, whatever it is?

Mr. SPENCE. I think so, and I think the option, or one the things that you can do, that didn't make sense because of how we work, was to offer a choice of plans. We needed to put our eggs all in one basket, if you will, and so we chose only one plan. But I think to provide the seniors with a choice of plans and the ability to get their doctors to enroll in those plans; if they wanted them, let them continue to choose providers, but if they go outside, they pay the difference.

That took away all the opposition that we had; it seemed eminently fair. So I would say that to offer the choice, to educate them about the differences, I think is very valuable.

Mr. ENSIGN. One last quick question—maybe both of you could comment on it, because you both mentioned something that the Speaker has mentioned about giving seniors incentives for errors in billing or fraud as far as financial rewards. Do you have any statistics on how successful that was?

Obviously, it is well received by the employees, I am sure, but do you have any dollar amounts or anything?

Mr. SPENCE. It is not very significant from a dollar standpoint. I would say we have rewarded less than $150,000 in savings since the beginning of the plan and that is based on $50 million a year in claims. But if you used those stories in your communication, you build heroes out of those people, you get far more in terms of active consumers and people really watching the bills. And I have talked

to a lot of employers, and that has been their experience; you get few significant savings, but it really does heighten awareness.

Mr. REIKER. In terms of fraud and hospital billing errors, it has been very insignificant. I think we provide the incentives for employees to actively participate as health care consumers, and I think that has been much more successful and has greater cost savings.

Mr. SPENCE. We have put in some very sophisticated billing errors or billing problem checks, clinical logic in our claims system volume, and intensity management in our PPO system, so we pick up a lot there and refuse them, which are much more sophisticated than employees; and employees are more of a public relations thing.

Mr. ENSIGN. The reason I brought that up is because you hear that there is so much fraud in Medicare, that there are gross abuses. That is controversial. Some people think it is a very small percentage and the amount of saving that we could get with these incentives to seniors; I think I would tend to agree more with you that it will be more of a show that they actually have something to save the government and themselves money as far as the buy-in to some of these new techniques that will save us a lot more money.

I thank you both for your testimony. It was excellent.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

Testimony

Karen Shore, Ph.D., Executive Director
1966 Ashley Place, Westbury, NY 11590
516-997-3390

A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) **Recommendations:**

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependent upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.

a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.

b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) Vignettes from Managed Mental Health Care - see pages 7 & 8.

F) "Managed Cooperation:" A Medical/Mental Health Care Plan - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

(over)

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, infuding spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An idea for the future

(revised 2/14/95)

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1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

TESTIMONY OF JUDITH STORMS KRAFT, LICSW
CONSORTIUM FOR PSYCHOTHERAPY

The industrialization of Mental Health is a revolution like the one in the 19th century when capitalism exploited the masses to increase the gross national product and achieve world power. Driven by a need to cut spending on health care, our system has institutionalized violence against humane social/psychiatry services, agencies, professionals (who are guardians and providers of services), and, ultimately patients/clients/consumers.

Managed Care companies, competing for control by reducing utilization of health insurance benefits (so that insurers will be able to offer lower premiums for mutual profit,) have forced a shift in the therapeutic, confidential contract between a patient and the therapist of his choice. Therapy has changed from a fiduciary relationship of healing to factory-like piecework on an assembly line, with interchangeable therapists performing efficient, cost-effective, programmed functions to produce widgets of minimum, measureable, changed behavior, and positive outcome statistics. Confidentiality is compromised because Managed Care authorizes payment for sessions based on detailed information about the problem, symptoms, psychiatric diagnoses, strengths, weaknesses, and behavioral goals--which they enter into their computer files. The State mandated $500 Mental Health benefit is virtually eliminated by making it subject to Managed Care's determination whether therapy is medically necessary and follows their guidelines of being short-term. Some capitated contracts pay for only $400, so anything beyond that is dependent upon the therapist or agency absorbing the loss. Client self-determination is non-existant because Managed Care's policies override it, stating that long term treatment for changing personality disorders, ingrained behavior patterns, or non-medical situational problems like abuse will not be authorized. Restoration to prior level of functioning, not cure, is the recommended approach.

Professions and agencies, competing for survival, have been bullied into resigned accomodation. Initial protests were extinguished by threats of annihilation. Managed Care has monopolized 3rd party payers. If therapists don't agree, they are not empanelled as providers. If they argue, they are dropped. If they are dropped, they generate no income, and go out of business.

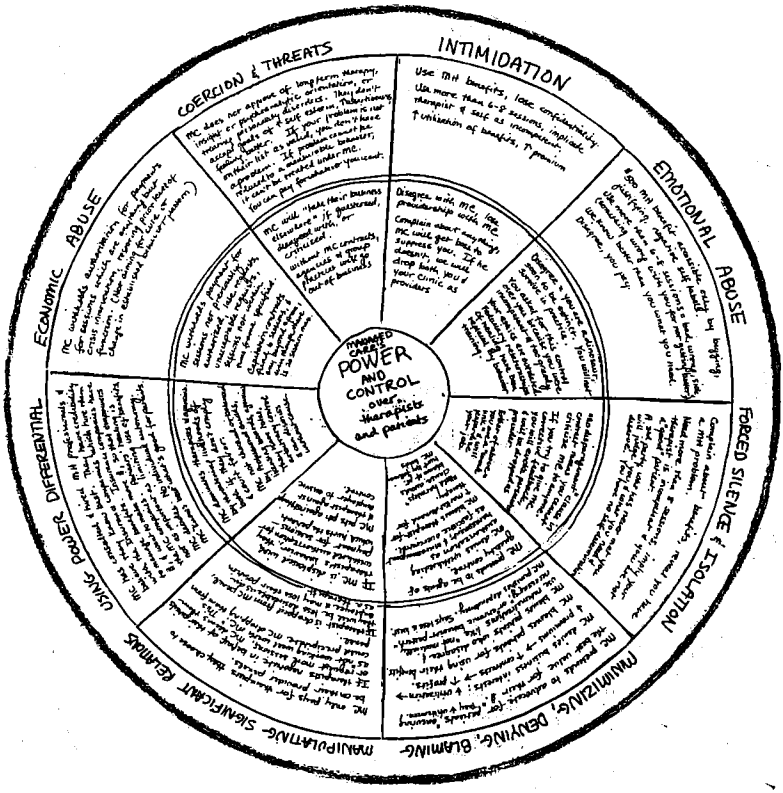
Contracts prohibit criticism of Managed Care. Contracts excuse Managed Care from liability if a bad outcome results from the treatment they authorize or fail to authorize; they are "held harmless." Therapists have to sign and uphold the contracts or they lose providership.

There are no checks and balances, since Managed Care answers only to insurance companies and business profits, not professional guilds, licensing boards, or agencies and codes of ethics. Managed Care has total, arbitrary control and can dismiss without cause. No laws govern their operations.

Professions and agencies, competing for survival, are victims of their own powerlessness under the abuse and fascistic rule of managed care. Powerlessness corrupts values and ethics. Therapists and administrators mindlessly identify with the aggressor and comply with demands. All Mental Health professionals are confounded in their thinking under this oppression. Managed Care is incompatible with Mental Health. Mental Health professionals are afraid of losing their livlihoods if they don't "ride the wave." Victims are treating victims, unwittingly participating in a pernicious mutation of Mental Health practice.

VIOLENCE AGAINST MENTAL HEALTH

Managed Care's mission is to decrease utilization of Mental Health Insurance benefits. They succeed by micromanaging therapists & double-talking patients. Any attempt to use benefits at any point automatically sets abuse in motion to curtail treatment. The forms of abuse are the same as those batterers use to gain power & control over their victims. *



* Adapted from POWER AND CONTROL WHEEL developed by Domestic Abuse Intervention Project, Duluth, MN. (See example following)

POWER AND CONTROL WHEEL

This diagram, developed by the Domestic Abuse Intervention Project in Duluth, Minnesota, indicates the different forms of abuse that batterers use to gain power and control their victims.

MANAGED CARE DOES NEITHER

by Judith Storms Kraft, LICSW
11/94

As an LICSW (M.S.W liscensed to practice independantly) with a quarter of a century of experience as a psychotherapist, I will remember the '90s as the most difficult. It isn't that the clients are harder to treat, or that the society is more violent, or that the resources are more scarce. It is because Managed Care reigns over professionalism and mental health.

Managed Care emerged as a panacea to beleagured medical insurance companies struggling to compete with Health Maintenance Organizations by offering more care options for lower rates. It was an umbrella superimposed on existing professional organizations with ethics and standards, and liscensing boards governing practice. It presented as a kind of consumer advocate, assuming that upwardly spiraling medical costs were from self serving professionals who were not accountable to their monitoring agencies, and were ripping people off. Managed Care companies hired professionals to oversee, control, and evaluate the professionals providing the care. The insurance companies, politicians, and the public put their faith in them.

In describing mental health benefits, they did not limit services to a $500/year maximum out-patient cost, but said "as much as needed", "each episode," "up to 20 visits/year." It sounded good to providers recruited to cooperate in this venture, and it sounded good to the subscribers. No one clearly established who would determine what ""needed" meant.

I have been a Managed Care provider for about 5 years. Their mode of operation is much less benign than their words convey. I have interpreted the "messages" communicated by their behavior, which contradicts what they say. Their "double messages" to clinicians, and my response to them follows below:

DOUBLE MESSAGES FROM MANAGED CARE TO CLINICIANS

1. Cover up and don't question our duplicity: We have to offer up to 20 sessions of therapy in order to compete with other HMO's. We really only want to pay for 4-6.

2. We will pretend to defer to your clinical judgement about what the problem is and how many sessions over what period of time it will take to treat it for a solution or favorable outcome. We will give you 4-6 sessions in a shorter time frame than you reguested, and ask you to repeat yourself each time you ask for more time. We hope you'll get tired of the time it takes to call

us, call us back, leave messages, fill out forms to extend authorizations for treatment. If that doesn't work, maybe the client will get tired of your cancelling appointments because you haven't received the authorization number yet, and you won"t be reimbursed for the service without it.

3. We will only accept words we want to hear in minimizing, reductionist, dehumanized terms. We won't consider anything abstract or having to do with feelings. We have to be able to quantify and measure so we can feed numbers into our computers and manipulate them for our statistics so we look like we are reducing costs for the insurance companies.

4. If you ask for more sessions, we will punish you by questioning your competence, not referring any more cases, and banning you from our panel of providers. We only want providers who "work well with managed care" (who will cover up for us, lie, not complain, who are willing to abandon themselves and their integrity in order to help us reduce usage of mental health services so we can look effective in reducing costs for insurance companies and still make a profit.

5. If you dare tell clients what is going on and are up front about how many sessions they can have without you going out on a limb for them (which will destroy you), you will be punished because we will withdraw our business from your organization.

6. If you express anger about the position you are in: double binded, powerless, oppressed, unable to advocate for clients, we will attack you by calling your boss to suppress any further outbursts. We will warn him that if he doesn"t comply by scaring you into submission that we will assume all his employees are like you--wimps, upstarts, incompetents who can't play hardball. We do not want feedback and we will interpret appropriate assertiveness as mutinous. You should be ashamed for being angry, and you seem to have a problem with authority.

7. We are so powerful that we don't have to obey the laws about paying you for services within 90 days. You just have to wait for us to get through our red tape. Too bad if that means you have to borrow money to survive. If you put your interests ahead of our interests, you don"t look like a loyal team player. (The important thing is that we cut costs for insurance companies and make money--not you.) We haven't been obeying the law, and we are getting away with it. Therefore we are right. We can do anything we want.

8. If you make any mistakes and don't meet our time schedules, you are punished by not getting paid for the service. We have the power. You don't. Therefore, we are right and you are wrong.

9. We have a cooperative relationship with our providers,not an adversarial one, so that, together we can provide better mental health care for less money.

A CLINICIANS RESPONSE TO MANAGED CARE

A. I experience Managed Care as fascistic, abusive and damaging to clinicians, and incompatible with mental health and Mental Health practice. It has the seeds of catastrophic portent. Hitler's ideas were originally appealing to the German people who wanted to preserve their culture and cut costs. He meant well.

B. I feel that I have been overpowered, intimidated and bullied by some of my professional collegues working for Managed Care who have identified with the aggressor and abandoned their humanity, compassion, and their profession.

C. If I accept this without confronting the double messages, without rejecting the role of sacrificial foil, without refusal to embody the conflicts as a scapegoat, I will abandon myself and will dis-integrate. Then I will be impaired and will not be able to function as an authentic person or a therapist.

D. I have survived by compartmentalizing the therapy, keeping it separate from seeking authorization for payment of it. The anxiety comes up in the latter, when all hangs on my ability to be clear, succinct, and compelling. My energy is being dissipated in defense mechanisms in order to do that--repression, suppression, denial, dissociation, depersonalization, identification with the aggressor, reaction formation, rationalization. This is what traumatized victims do in order to survive. I have to do this to help people?

E. Working with Managed Care, therefore, compromises the mental health, performance, and job satisfaction of the clinician providing the therapy. If I admit that I am stressed, I expose myself as weak, unfit, and will be blacklisted. Practice groups don't want to be associated with losers, so this condemns clinician-victims to silence and isolation--which is the problem we treat in our clients.

F. Staff training in brief treatment to better meet the demands of Managed Care so we will be winners (and be chosen to remain on provider panels) perpetuates the myth that the problem is in the clinicians rather than in the system, and that it can be solved by controlling the clinicians and forcing compliance with the rules made by profiteers serving

the insurance companies.

G. Mental Health professionals need a safe forum to address the process of becoming casualties in this frenzy of Managed Care and Managed Competition which has penitrated the central Massachusetts area more than anywhere else in the country. All eyes are upon us. We need to support each other and have the courage to tell it like it is, and work to find better alternatives.

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