The Latino Coalition Foundation

725 Massachusetts Avenue, NE

Washington, DC 20002

Phone: (202) 546-0008

Fax: (202) 546-0807

A Gathering Storm in California Health Care?

Trends in Managed Care Costs, Accountability and Quality

by Naomi Lopez Bauman

The Latino Coalition Foundation

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A Gathering Storm in California Health Care?

TRENDS IN MANAGED CARE COSTS, ACCOUNTABILITY AND QUALITY

by Naomi Lopez Bauman

California employers and consumers are being asked to pay more for health care through soaring premiums and increasing co-payments, but they should not expect to receive comparable increases in benefits or quality care. Some health plans are citing factors, such as rising prescription drug costs and utilization, as the primary reasons why California's health care premiums are soaring. However, closer scrutiny does not entirely support this explanation. This study examines the factors underlying soaring premiums and why premiums will likely continue to outpace health care cost increases, how these rising premiums might affect the availability of employer-based insurance and where their health care dollar is going.

While numerous national health care studies have been recently conducted and released, this analysis reviews these data from a more focused perspective of how the documented health care changes and challenges affect the nation's largest minority community – Hispanics. In California and throughout the country, the current cost-cutting strategies threaten Hispanics' access to and level of quality health care.

Despite strong industry profits, the trend of double-digit health insurance premium increases is expected to continue. This will likely further contribute to the ranks of the uninsured and will undoubtedly affect many Hispanic workers.

According to the most recent U.S. Census Bureau statistics, the recent rise in California's uninsured is due primarily to the erosion of employer-based health insurance coverage. In light of skyrocketing health insurance premium costs in recent years, California employers face the difficult decision of whether to reduce health benefits, increase costs to employees or forgo health benefits altogether.

Since small businesses are hit first and hardest by these rising costs, workers in these firms have been far more likely to lose coverage. Of small firms that do not offer coverage, 77 percent of those with three to nine employees and 80 percent with 10 to 50 employees cite high premium costs as being somewhat or very important in their decisions.

This is an important factor in understanding why Hispanic workers, who are heavily concentrated in the service industry and in small businesses, are now at even greater risk of being disproportionately uninsured since they will have even less access to job-based coverage. Overall in California, Hispanics have the lowest rates of employer-based health insurance. Only 42.3 percent have access to this employer benefit, as compared to greater than 60 percent of African and Asian Americans and 75 percent of Whites. When offered insurance by their employers, however, Hispanics participate in health insurance at similar rates to non-Hispanic whites. Yet, Hispanics in California continue to face higher uninsured rates when compared to their White counterparts (28.3 percent vs. 8.6 percent respectively), even after accounting for factors such as income, family size, education and employment status.

Today, managed care dominates California's health care market. In fact, 99 percent of employees who receive employer-based health benefits are enrolled in managed care. Managed care was built, in part, on the idea that primary care and preventive services could improve patient health and, as a result, save money. In California, managed care is failing on both counts. Initially, managed care appeared to save money through discounting. Years later, virtually all discounts have been wrung out of the system. One of the few remaining options for saving money is to restrict access to care.

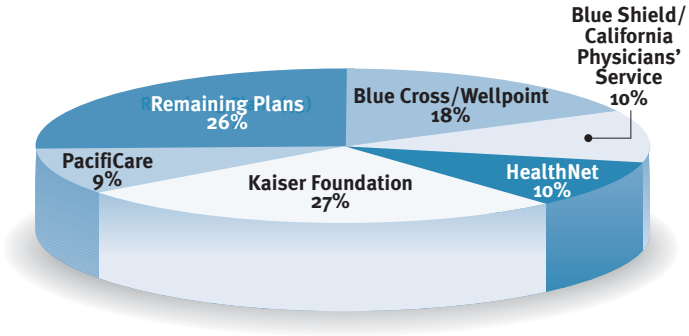
Managed care's hidden attempts to further control costs – restricting access to the newest medical treatments or delaying treatments, often without doctor involvement or patient knowledge – undermine patient care and are not necessarily cost-effective. Efforts to further ration care are particularly troublesome for the state's Hispanic population who, as a group, are more likely to suffer from chronic conditions, such as asthma and diabetes. In fact, one in seven Hispanic children have asthma and Hispanics overall develop diabetes at twice the rate of other ethnic groups. In addition, Hispanics' access to health insurance must also be considered when studying how this high prevalence of chronic illness is managed. Research has shown that nearly half of all persons with a chronic illness delayed or did not access necessary care. Nearly all these persons cited cost as the reason why they decided to forgo the care they needed. With this in mind, the "costs" of restricting access to care for these conditions ultimately lead to higher acute care costs.

Health care access, quality, choice and affordability are becoming increasingly scarce in California. That is why California employers, consumers and Hispanics in particular need to be aware of their health care options, of how much they are paying for health care and of what they are getting for their money.

Escalating health care premiums, growing market share among a small number of plans, increasing profits, additional barriers to care and overall patient dissatisfaction in recent years have intensified scrutiny of managed care. According to the U.S. Justice Department's antitrust division, health insurance companies have become an "area of primary concern."[1] Health insurers – specifically, managed care companies – exert enormous influence over the health care marketplace. The 10 largest national health insurance companies now cover more than half of all insured Americans.[2]

In California, managed care now dominates the health care market. A mere five full-service health plans cover almost three-quarters of the total number of people insured (see Figure 1).[3] With the continued demise of smaller plans, the influence of the largest plans over the marketplace will likely grow. Since November 2001, two California health plans have filed for Chapter 11 bankruptcy, one has been placed under a conservator and one will soon cease operations.[4]

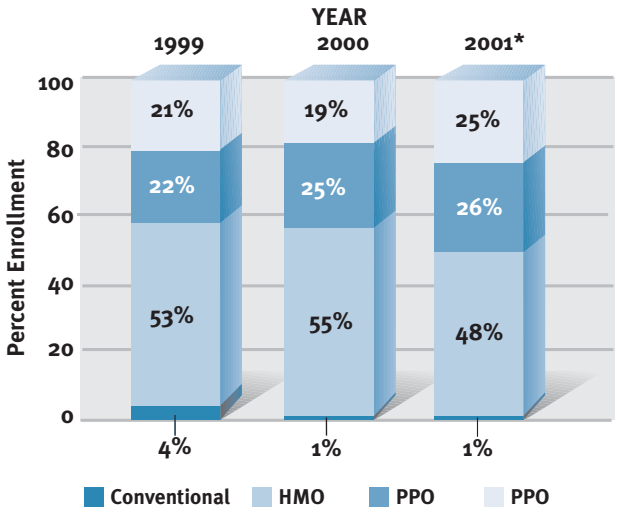
Figure 1. California's Health Care Marketplace, 2001



Source: California Department of Managed Health Care, Health Plan Financial Information for Full Service Plans as of Dec. 30, 2001.

Not only is the Health Maintenance Organization (HMO) the most restrictive prepaid health insurance arrangement, today it is the most common form of managed care in California. Since 1999, conventional health insurance has virtually disappeared in California. Ninety-nine percent of California employees who participate in employers' health plans are now enrolled in managed care.[5] In 2001, 48 percent of employees participating in employer-sponsored plans were enrolled in HMOs. Twenty-six percent were enrolled in PPO plans and 25 percent in POS plans.[6] Less than 1 percent were enrolled in conventional insurance plans.[7] See Figure 2.

Figure 2. California's Employee Health Plan Enrollment by Plan Type, 1999-2001



* Conventional coverage was < 1 percent in 2001.

Source: Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.

Despite strong industry profits (see Appendix A), the trend of double-digit health premium increases is expected to continue.[8] Health plans point to underlying health care costs, such as prescription drugs, as the primary cause for these increases.[9] But closer scrutiny does not entirely support this explanation.

In addition to showing how California's health care premium dollar is being spent, this study will examine the factors behind escalating health care costs and the relationship between those costs and health plan benefits, spending, revenues and profits. It also will explore the impact of these rising costs on Hispanics' access to health insurance and quality care in California.

1 Deputy Assistant Attorney General Deborah Majoras as quoted in Peter Kaplan, "U.S. Steps Up Scrutiny of Health Insurers," *Reuters.com*, September 9, 2002.
2 American Medical Association President-elect Donald J. Palmisano, MD, JD as cited in *Reuters.com*. See also, American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets," November 2001.
3 California Department of Managed Health Care, Health Plan Financial Information for Full Service Plans as of December 30, 2001 and U.S. Census Bureau, Current Population Survey (P60), March 2001.
4 California Department of Managed Health Care. According to the department, KPC Medical Management filed for Chapter 11 in November 2001; Maxicare filed for Chapter 11 in May 2002; a conservator was appointed to manage Lifeguard's operations on September 13, 2002; and Plan of the Redwoods will cease operations on October 31, 2002.
5 Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.
6 Preferred Provider Organizations (PPO) and Point of Service (POS) plans are somewhat less restrictive, but also are based on the prepaid health care model.
7 Kaiser Family Foundation and Health Research & Educational Trust.
8 Hewitt Associates, "2002 Health Care Expectations: Future Strategy and Direction: Survey Highlights."
9 Frank Diamond, "Premium Hikes: No Cause for Celebration," *Managed Care*, July 2002.

In response to rising costs, brought on largely by first-dollar health insurance coverage, low deductibles and cost-plus reimbursements, federal lawmakers passed the Health Maintenance Organization Act of 1973. The Act removed barriers to establishing HMOs and actually provided federal grants and loans for their creation. Furthermore, the law required employers offering health care coverage, if they had 25 or more employees, to offer HMO coverage as an option.[11] This federal law overrode laws in the majority of states that outlawed HMOs or restricted them to the point that they could not operate profitably.[12]

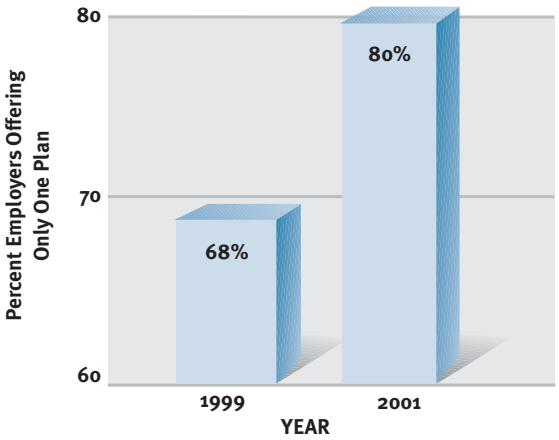
Managed care was built, in part, on the idea that primary care and preventive services could improve patient health and, as a result, save money.[13] By actively scrutinizing services, limiting patients' ability to choose doctors and services, and paying doctors a salary, it was believed HMOs would revolutionize the health care industry, both in terms of quality of care and cost. Unfortunately, managed care failed on both counts. More recently, the response of the managed care industry to ever-rising costs has been to establish additional barriers to access, especially when it comes to the newest medical innovations.

Today, employers and patients are growing increasingly frustrated with this approach. Individuals receiving employer-based coverage cannot seek out the coverage that best meets their needs in terms of price, quality and reputation, as they would if they were shopping for a car or a house. In fact, since their employer makes the purchase on their behalf, they are almost completely removed from the purchase of their benefits. This is particularly troublesome when an individual learns a specific procedure or treatment is not covered by his or her policy. Had they purchased health care on their own, they could have opted for or declined that specific coverage depending on their needs, preferences and sensitivity to price.

Consequently, employees are faced with fewer and fewer plan options. In California today, 80 percent of employers offering coverage offer only one plan – usually a managed care plan. This is up from 1999, when only 68 percent of firms offered just one plan (see Figure 3). Larger firms, both then and now, are more likely to offer multiple plan options.[14]

As California's economic stagnation deepens, many employers may face the difficult decision of whether to pay more for employee health care, cut employee benefits or forgo health insurance altogether. According to the U.S. Census Bureau's most recent health insurance data, the recent rise in California's uninsured is due primarily to the erosion of employer-based health insurance coverage. This would leave most workers, who obtain health care through their employers, to fend for themselves in the health insurance market, without the benefit of the special tax treatment the government extends to employer-sponsored health plans.

Figure 3. Percent of California Employers* Offering Only One Plan, 1999 vs. 2001



* Of employers offering health plans.

Source: Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.

[10] The term "managed care" is frequently used in the media, in political discourse, and by the general public. It is the method of prepaid health care in which financing and delivery is carried out for a set fee through the use of "gatekeepers" – primary doctors or caseworkers – to coordinate a patient's use of health care services.

Prepaid health plans began operating in the late 1920's. But it was some time before managed care would gain traction in the marketplace. Managed care arrangements faced enormous opposition because the financial arrangement essentially eliminated the patient in favor of the health plan's interests. In fact, for this reason, managed-care plans were illegal or could not operate in the majority of states in the early 1970s.

[11] This law remained in effect until 1995.

[12] John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis,* (Washington, D.C.: Cato Institute, 1992), p. 154.

[13] *Ibid.*, p. 524.

[14] Kaiser Family Foundation and Health Research & Educational Trust.

Tax Treatment of Employer-Based Health Care[15]

For decades, health insurance has been provided in a different manner than just about any other consumer product. Rather than purchasing health insurance in the same way we purchase car insurance, homeowners' insurance, and renters' insurance, most Americans obtain health insurance coverage through their employers. World War II created a severe labor shortage and to curtail wage inflation, the federal government forbade salary increases in the war years. Instead, the government allowed employers to provide additional fringe benefits that were not counted as income.

As a result, employers began to offer health insurance as a way to attract and retain employees. This is the main reason why health insurance benefits today are not counted as part of an employee's taxable income. Essentially, employer-sponsored health insurance is provided on a tax-free basis.

In short, the severe labor shortage brought on by World War II brought about what is considered by many experts to be the largest government intervention ever to impact health care – the exclusion of employer-provided health insurance from taxation.[16] Employers began to offer health insurance as a way to attract potential employees.

The Internal Revenue Service (IRS) issued two rulings that affected these benefits. In 1943, the IRS ruled that employers' contributions to group health insurance policies would be exempt from taxation. The second ruling, in 1953, required that employers' contributions to individual health insurance policies were taxable. In 1954, Congress reversed this second ruling by enacting section 106 of the Internal Revenue Code of 1954, making these contributions exempt from taxation. Section 3121 of the tax code also makes employers' contributions for health and accident insurance exempt from payroll taxes. As a result of these rulings, health insurance benefits are not counted as part of an employee's taxable income.

Essentially, employer-sponsored health insurance could be provided tax-free. In other words, an employer could opt to provide an employee with an additional $3,000 in salary, which would be worth $3,000 minus taxes to the employee. Or, the employer could provide a $3,000 benefit that would not be taxed. These conditions led to the widespread popularity of employer-sponsored health insurance plans and solidified the popularity of the third-party payment system, in which someone other than the consumer directly pays the medical bill. In reality, of course, health care benefits are a function of salary, and the cost of health care benefits is passed on to the employee in the form of lower wages or fewer benefits in other areas.

Those individuals purchasing health care on their own, with after-tax dollars, would likely seek major medical insurance policies (characterized by high deductibles and low monthly premiums). These policies tend to have lower premiums because the consumer is bearing a significant portion, or all, of the financial responsibility for their first-dollar health care expenses. With employer-sponsored coverage, employers are far more likely to participate in low-deductible plans or plans that provide first-dollar coverage.

While it is easy to understand why a consumer would desire low deductible, first-dollar coverage, it is more costly and is more than is necessary to protect him from unexpected, catastrophic health care costs. Employer-sponsored coverage also pays for low-cost, routine medical expenses. Consumers are insulated from the cost of health care when they directly pay for only a small portion of their care.

Health Care Demand and Costs

The high cost of health insurance paid by employers is passed on to workers in the form of lower wages and reductions in other fringe benefits. When an employer provides an employee with a free parking space, a matching 401(k) contribution or a free lunch, there is a cost associated with each of these benefits. Health insurance is no different. For every $1 an employer spends on an employee's health care, the $1 cost is ultimately passed on to the employee, often in the form of lower annual pay raises.

Those who purchase insurance on their own are paying, in some cases, up to twice what those with employer-sponsored plans pay, because they purchase health care with after-tax dollars. For example, suppose Mr. Smith, who earns $60,000 per year, receives a $5,500 employer-based health insurance policy for his family (the average annual California family's premium cost in 1999). He would have to earn far more than $60,000 to purchase the same level of coverage for his family on his own, between jobs or in a different job that does not offer this benefit. He would have to pay federal income taxes, state income taxes and payroll taxes on his wages before he could purchase a policy with after-tax dollars. In that case, he would need to earn $70,000 to purchase the same coverage on his own and maintain the same standard of living (see Table 1).[17]

[15] For an excellent history and analysis, see Grace-Marie Arnett, ed., *Empowering Health Care Consumers through Tax Reform*, (Ann Arbor, MI: The University of Michigan Press, 1999).

[16] The Health Policy Consensus Group, organized through the Galen Institute, is a task force of the nation's leading health care researchers, economists and health policy analysts at the nation's leading think tanks. The group aims to increase awareness that the tax treatment of employment-based health insurance underlies many of the problems facing the public health sector in the United States. For more information, visit www.galen.org.

[17] Calculations assume head of household filing status, four federal exemptions, and no additional withholding.

Table 1. Employer-Based vs. Not Employer-Based Health Benefits Comparison

Annual Gross Pay (with health benefits)	$60,000.00	Annual Gross Pay (without health benefits)	$70,000.00
Federal Withholding	$8,710.00	Federal Withholding	$11,410.00
Social Security	$3,720.00	Social Security	$4,340.00
Medicare	$870.00	Medicare	$1,015.00
California	$1,813.91	California	$2,743.91
CA SDI	$416.94	CA SDI	$416.94
Net Pay	$44,469.15	Net Pay	$50,074.15
		Health Insurance	$5,500
		Net Pay after Health Insurance Expenses	$44,574.15

Source: Automatic Data Processing, Inc. salary calculator estimate. Calculation assumes head of household filing status, four federal exemptions, and no additional withholding.

In addition to causing misguided incentives in the health care market, employer-based health care means individuals have little knowledge of or control over their health care plans. Even when they can select from a couple of plan options, they are still receiving one-size-fits-all plans tailored for the entire employee base; plans that are often ill-suited to employees' individual needs and preferences.

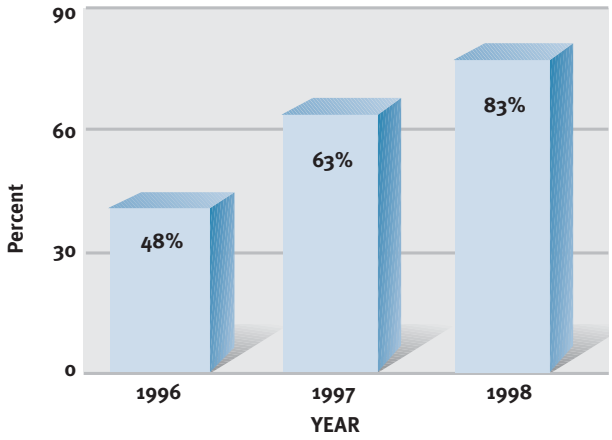
With so many Americans receiving health care through their employers, many consumers are much less sensitive to the price of medical care than they would be if they purchased it on their own. This encourages over-utilization of services, leading to higher costs for everyone. For example, if Mrs. Jones has to pay only $10 per doctor visit, she might be more likely to visit the doctor for a sore throat than she would if she were to first visit the drug store for an over-the-counter medication. If she paid the true cost of each visit (say, $75) out of her own pocket, she would be far more likely to visit the doctor only when she had an ailment that required a doctor's attention.

In the case of health insurance, health premiums will rise to cover the costs associated with increased utilization of health care services. The employer-based health care system has insulated consumers from the true cost of services. If consumers were more directly involved in negotiating and directly purchasing their health care plans, they would likely change their health care utilization patterns and opt for fewer routine benefit offerings in favor of major medical coverage.

In response to consumer pressure, some plans are offering more flexibility with regard to providers and hospitals. For example, only 48 percent of HMO plans in California allowed specialist visits or referrals without prior plan authorization in 1996. But by 1998, 83 percent of such plans were allowing the practice (see Figure 4).[18]

There is broad consensus in the health care industry that managed care spends less, on average, per premium dollar, on health care services than traditional indemnity (fee-for-service) plans do. This explains why managed care is typically a less expensive option for many employers. In recent years, however, managed care companies have faced increased scrutiny because of their practice of rationing care and often are accused of compromising patient well-being to cut costs. As a result of this political and consumer pressure, managed care plans have loosened restrictions on access to specialists and other services. This situation has contributed, in part, to increased managed care costs in California.

Figure 4. California HMO Plans Allowing Specialist Visits / Referrals Without Prior Authorization, 1996-1998



Source: UC Berkeley Center for Health and Public Policy Studies, Surveys of California Health Plans, 1997-1999.

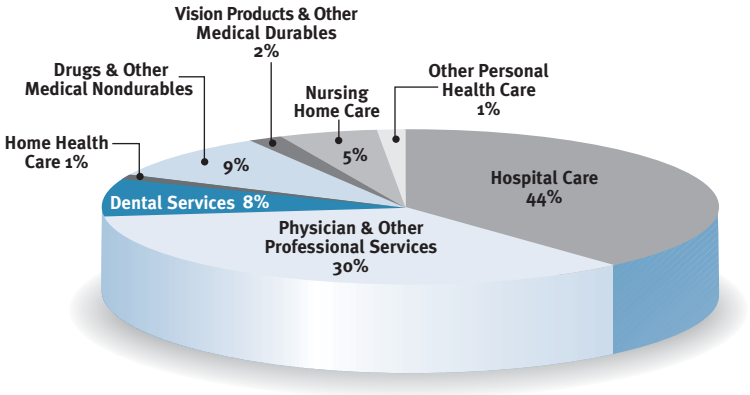
[18] UC Berkeley Center for Health and Public Policy Studies, Surveys of California Health Plans, 1997-1999.

Examining where the health care dollar is spent is helpful in understanding overall spending trends. But it only begins to explain why health insurance premiums are increasing. For example, a large share of hospital costs will be covered by most health care plans. Health benefits vary dramatically by plan, making it difficult to know how much the consumer pays directly and how much is paid through health benefits for other expenses, such as vision products. In addition, some costs, such as nursing homes, will be much higher among the elderly and will compose a smaller component of health care spending for workers than for the total population. Finally, health plans are businesses that incur administrative expenses.

Where Does the Health Care Dollar Go?

California's health care dollar, as measured by the federal government, includes hospital care, physician and other professional services, dental care, home health care, prescription drugs, vision products, nursing-home care and other personal care. In 1998, most of the state's health care dollar – about 74 cents – was directed to physician and other professional services and hospital care. Combined dental care and prescription drugs made up 17 cents (see Figure 5).[19]

Figure 5. California's Health Care Dollar, 1998

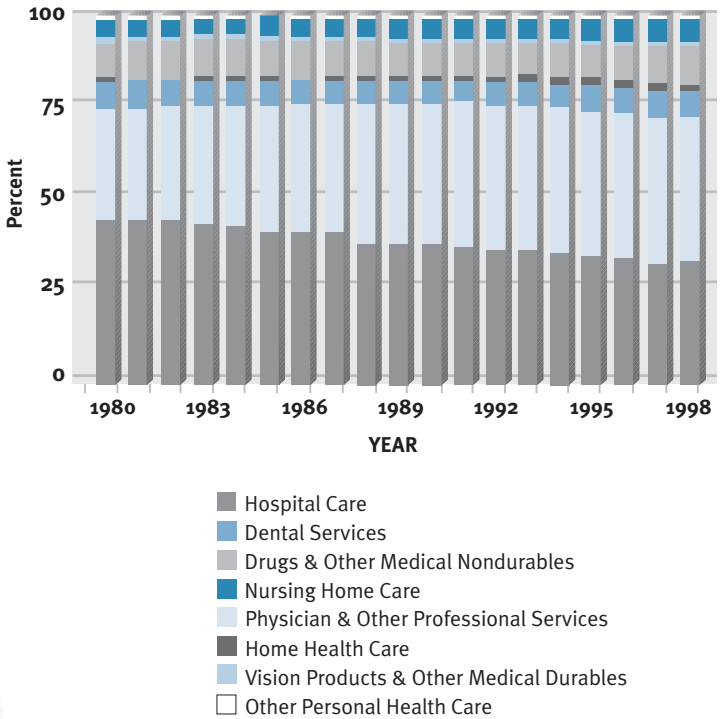


Source: Centers for Medicare and Medicaid Services, State Health Care Expenditures and Funding: 1980-1998 based on National Health Expenditure (NHE) data.

Between 1980 and 1998, the share of California's health care dollar devoted to hospital care dramatically declined by 24 percent. This dramatic shift reflects both discounting through managed care and a health care model that emphasizes outpatient procedures and services. Physician and other professional services increased by 30 percent. Prescription drugs grew by 8 percent (see Figure 6).[20]

The federal government's own actuaries at the Centers for Medicare and Medicaid Services (CMS, formerly Health Care Finance Administration, HCFA) predict health care costs will slow to an annual average of 7.3 percent over the next decade.[21] While this still constitutes robust growth, it is far lower than the anticipated premium increases California is likely to face.

Figure 6. California's Health Care Dollar, 1980-1998



Source: Centers for Medicare and Medicaid Services, State Health Care Expenditures and Funding: 1980-1998 based on National Health Expenditure (NHE) data.

[19] Centers for Medicare and Medicaid Services, State Health Care Expenditures and Funding: 1980-1998 based on National Health Expenditure (NHE) data.
[20] *Ibid.*
[21] Centers for Medicare and Medicaid Services, National Health Expenditures Projections: 2000-2010 based on historical National Health Expenditure (NHE) data through 1999.

Soaring Premiums

The trend of double-digit health premium increases is expected to continue in California. Premium increases in HMO plans averaged 19 percent for 2001 and 14.9 percent for 2000. Small group plans experienced the sharpest increases in 2001 (see Tables 2 and 3).[22] This is in addition to sharp, consecutive increases in prior years. According to a recent survey of benefit managers conducted by Credit Suisse/First Boston, California HMO premiums are expected to rise an average 17.3 percent and PPO premiums 20.5 percent in 2002 – well above California's health care cost trend.[23]

Table 2. California HMO Premium Rate Increases, 2000 and 2001, by Top Plans and Statewide Average

Plan	2001	2000
Blue Cross/Wellpoint	4.37	20.12
Blue Shield/Physicians' Services	17.99	21.81
Health Net	7.34	7.03
Kaiser	12.35	5.37
PacifiCare	3.52	7.78
Statewide	19.02	14.89

Note: Statewide averages not weighted for enrollment.

Source: MCOL, CA HMO Rate 2001 Executive Report, (Modesto, CA: MCOL, 2001).

Table 3. Average California HMO Premium Rate Increases, 2000 and 2001, by Group Size

Group Size	2001	2000
Individual	8.95	18.25
Small Group	19.99	17.12
Mid-Size Group	4.54	13.13
Large Group	7.27	8.23

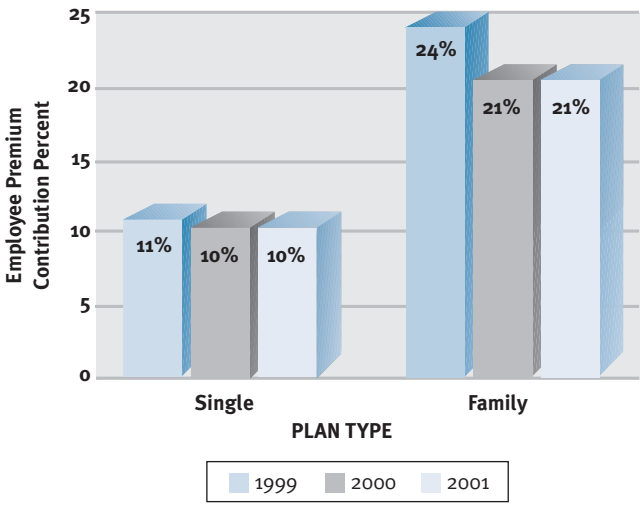
Source: MCOL, CA HMO Rate 2001 Executive Report, (Modesto, CA: MCOL, 2001).

State officials recently accepted a 25 percent HMO premium rate increase for the California Public Employees Retirement System (CalPERS) for 2003.[24] CalPERS' rate increases are viewed as a harbinger of increases throughout the state and the nation. As California employers brace for yet another year of sharp premium rate increases, it should come as no surprise should they shift a greater share of costs to their employees.

Premium Burden on Employees

Over the past two decades, there has been a dramatic shift in employer premium financing. In 1982, about 80 percent of employees nationally received full health care premium benefits provided by their employers. By 1998, only about 28 percent received full premium benefits.[25] California's employee premium contributions have followed a similar trend over the same period, but have fallen slightly in the past three years (see Figure 7).[26] As premiums increase, however, more employers will likely expect employees to pay a greater share of premiums.

Figure 7. Percent of Premiums Directly Paid by California Employees, 1999-2001



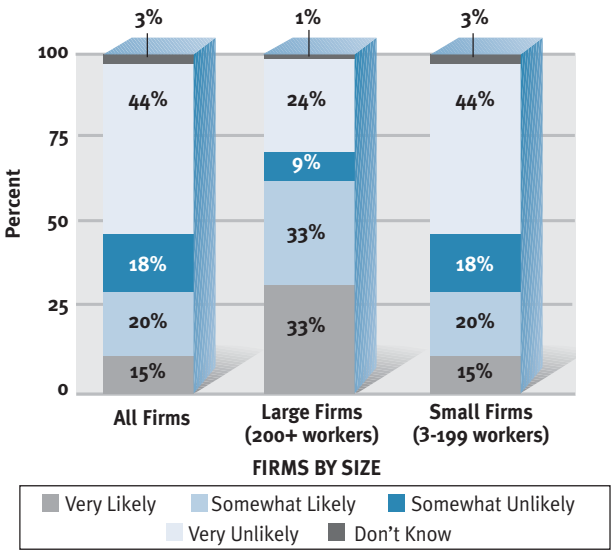
Source: Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.

According to a recent Kaiser Family Foundation survey of California employers, 35 percent of all firms, 66 percent of large firms, and 35 percent of small firms indicated it was likely or somewhat likely the firm would increase the amount employees would pay for health insurance in the following year (see Figure 8).[27]

There should be little doubt California is a latecomer to this national trend. California is fortunate in that its HMO premiums are lower than the national average.[28] This is why it is instructive to observe national cost and cost-containment approaches used by employers. Raising the amount employees pay has been the most common employer approach to controlling health benefit costs. According to a recent Towers Perrin health care cost survey, 59 percent of employers nationally changed their plan designs and cost-sharing features during the past two years. Almost one-in-five are considering adopting this approach in the future.[29]

[22] MCOL, *CA HMO Rate 2001 Executive Report*, (Modesto, CA: MCOL, 2001).
[23] Credit Suisse / First Boston, "2002 Benefit Manager Survey," Managed Care Sector Review January 15, 2002.
[24] California Public Employees' Retirement System, Circular Letter No: 600-027-02, April 26, 2002.
[25] Jonathan Gruber and Robin McKnight, "Why Did Employee Health Insurance Contributions Rise?" *National Bureau of Economic Research Working Paper*, no. 8878, April 2002. The authors found only modest impacts of increased managed care and rising health care costs on premium shifts to employees. Of six factors examined, only about one-quarter explain the rise in employee premiums between 1982 and 1996.
[26] Kaiser Family Foundation and Health Research & Educational Trust.
[27] Kaiser Family Foundation and Health Research & Educational Trust.
[28] Hewitt Associates.
[29] Towers Perrin, "2002 Health Care Cost Survey: Report of Key Findings."

Figure 8. California Firms Indicating Likelihood that Firm Will Increase Amount Employees Pay for Health Insurance by Firm Size, 2001



Source: Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.

Another important trend is how premium costs affect an employer's decision to offer health care benefits at all. There is no shortage of evidence citing cost as the top reason employers decide not to offer coverage. Of small firms that do not offer coverage, 77 percent of those with three to nine employees and 80 percent with 10 to 50 employees cite high premium costs as being somewhat or very important in their decisions.[30] Since small businesses are hit first and hardest by these costs, workers in these firms have been far more likely to lose coverage.

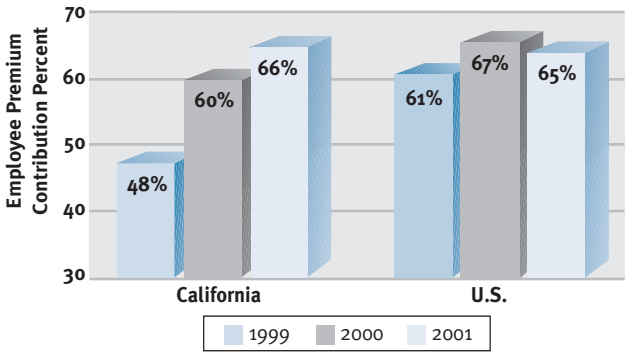
According to the most recent U.S. Census Bureau statistics, the recent rise in California's uninsured is due primarily to the erosion of employer-based health insurance coverage. In light of skyrocketing health insurance premium costs in recent years, California employers across the state face the difficult decision of whether to reduce health benefits, increase costs to employees or forgo health benefits altogether.

This is an important factor in understanding why Hispanic workers, who are heavily concentrated in the service industry and in small businesses, are now at even greater risk of being disproportionately uninsured since they will have even less access to job-based coverage. Overall in California, Hispanics have the lowest rates of employer-based health insurance. Only 42.3 percent have access to this employer benefit, as compared to greater than 60 percent of African and Asian Americans and 75 percent of Whites.[31] When offered insurance by their employers, Hispanics participate in health insurance at similar rates to non-Hispanic whites. Hispanics in California continue to face higher uninsured rates when compared to their White counterparts, (28.3 percent vs. 8.6 percent respectively), even after accounting for factors such as income, family size, education, and employment status.[32]

Employee Participation

The economic boom of the 1990s may have enticed more firms, including smaller ones, to offer health-insurance coverage as a way to compete for talented workers. In fact, the percentage of California firms offering health benefits dramatically increased from 48 percent in 1999 to 66 percent in 2001.[33] This is a particularly interesting trend given the state severely lagged in offering employer-sponsored health benefits only a few years ago and is now on par with the rest of the country (see Figure 9). Even though the current economic downturn could soon change this trend, it may not be as important to overall insurance coverage as another factor.

Figure 9. Percent of All Firms Offering Health Benefits, 1999-2001, California vs. U.S.



Source: Kaiser Family Foundation and Health Research & Educational Trust, "California Employer Health Benefits Survey 2001," February 2002.

According to a recent study, insurance take-up rates will likely decline as employee premiums increase. Harvard University economist David M. Cutler found that, nationally, the level of insurance coverage declined during the 1990s primarily because fewer workers accepted coverage when offered. This is not because fewer workers were offered insurance or were eligible for it. According to the study:

> *the share of employees offered health insurance was constant between the late 1980s and early 2000s. The share of employees declining coverage, however, rose from 12 to 15 percent… Take-up declined because the cost to employees of enrolling in health insurance increased substantially…Further, the magnitude of the effect is such that the increase in employee costs can account for all of the reduction in take-up rates in the past decade.*[34]

In California, employers' health plan offerings and employees' take-up rates have remained steady. In 1993, 68 percent of workers in firms offering health benefits were covered, compared to 67 percent in 2001.[35]

There is no doubt California has benefited from premiums below the national average. But as premiums continue to rise, California could follow the path of higher employee contributions and, as a result, lower insurance take-up rates and a higher number of uninsured workers.

[30] Kaiser Family Foundation, "Employer Health Benefits Survey 1999."
[31] E. Richard Brown, Ninez Ponce, Thomas Rice and Shana Alex Lavarreda, "The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey," UCLA Center for Health Policy Research, June 20, 2002.
[32] *Ibid*., p 20.
[33] Kaiser Family Foundation and Health Research & Educational Trust.
[34] David M. Cutler, "Employee Costs and the Decline in Health Insurance Coverage," *National Bureau of Economic Research Working Paper*, no. 9036, July 2002.
[35] Kaiser Family Foundation and Health Research & Educational Trust and U.S. Census Bureau, Current Population Survey (P60).

California health plans often point to the cost of prescription drugs as a primary cause of premium rate increases. Many employers, the media and political advocates also cite this. But upon closer inspection, actual patient spending does not entirely support this belief. If employers and consumers are being asked to pay more, they should understand what they are getting in return for higher prices.

Premium Increases

A variety of medical and non-medical factors contribute to health insurance premium prices. However, one recent study conducted by PricewaterhouseCoopers (PWC) examined many more of these factors than previous studies. In addition to health care service costs, researchers quantified the impact of government mandates and liability on health care premiums. The study estimated the average nationwide premium increase for large employers between 2001 and 2002 was 13.7 percent. Drugs, medical devices and medical advances (which did not include potential savings, such as reduced hospitalization) accounted for 3 percent – or 22 percent of the total increase. General inflation and rising provider expenses each accounted for 2.5 percent each – or 18 percent of the total increase, apiece (see Table 4).[36] The PWC report notes this estimate does not include administrative costs, nor does it necessarily reflect medical costs, which are growing more slowly than premium rates.

Table 4. The Factors Driving Rising National Costs in Health Care Premiums, 2001-2002

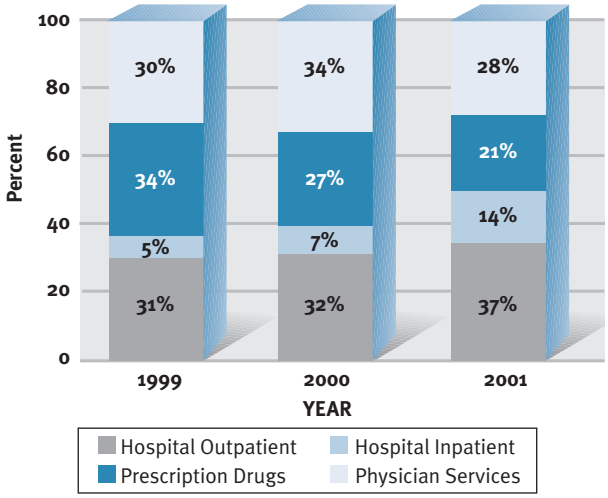
Trend Factors	Percentage Points	Percent of Total Increase
General Inflation (CPI)	2.5	18
Drugs, Medical Devices & Medical Advances*	3.0	22
Rising Provider Expenses	2.5	18
Government Mandates & Regulation	2.0	15
Increased Consumer Demand	2.0	15
Litigation & Risk Management	1.0	7
Other Categories	0.7	5
Medical Trend	**13.7**	**100**

*** This percentage does not reflect potential future savings because of drugs, medical devices and other medical advances. For example, savings in future years may include reduced hospitalizations and consumption of other health care services.**

Source: PricewaterhouseCoopers prepared for the American Association of Health Plans, "The Factors Fueling Rising Health Care Costs," April 2002.

A more recent study published in Health Affairs found that "Growth in spending on hospital services was by far the largest contributor to overall cost growth."[37] See Figure 10. The authors cite a number of factors for this growth, such as hospital wage rates and hospital industry consolidation, which may be particularly important for the California health care market. The authors also demonstrate that, for the second year in a row, the rate of growth in prescription drug spending slowed. Based on early evidence from the first six months in 2002, the authors also predict a spending slowdown in all four areas: physician services, prescription drugs, hospital inpatient and hospital outpatient.

Figure 10. Shares of Overall National Health Care Spending Growth, 1999-2001



Source: Bradley C. Strunk, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs: Growth Accelerated Again In 2001," Health Affairs Web Exclusive, September 25, 2002.

California has not been immune from rising national health care costs. In two of the top five California plans, physician cost was the primary cost driver. In only one plan did other medical costs (which included outpatient prescription drugs) prove to be the primary cost driver (see Appendix B).[38] There is no doubt medical spending is increasing, but the role of medical costs in California's premium increases may be, in some cases, a bit overstated.

[36] PricewaterhouseCoopers prepared for the American Association of Health Plans, "The Factors Fueling Rising Healthcare Costs," April 2002.
[37] Bradley C. Strunk, Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Costs: Growth Accelerated Again In 2001," *Health Affairs Web Exclusive,* September 25, 2002.
[38] Derived from InterStudy Publications Custom Database Product financial data.

Where does the California Health Care Premium Go?

Health care companies are required by California law to report on their medical and administrative expenses. But this information alone does not provide a complete picture of what employers and consumers are receiving in exchange for higher prices. While managed care plans are directing additional revenues into administration, advertising and other non-medical areas, they are also building financial reserves and shoring up profits. Unfortunately, this is not easily-accessible information for average employers and consumers.

California's top five companies reported administrative costs ranging from a high of 16 percent to a low of 4 percent of total expenses in 2001. Medical expenses ranged from a high of 96 percent of total expenses to a low of 84 percent (see Appendix B).[39]

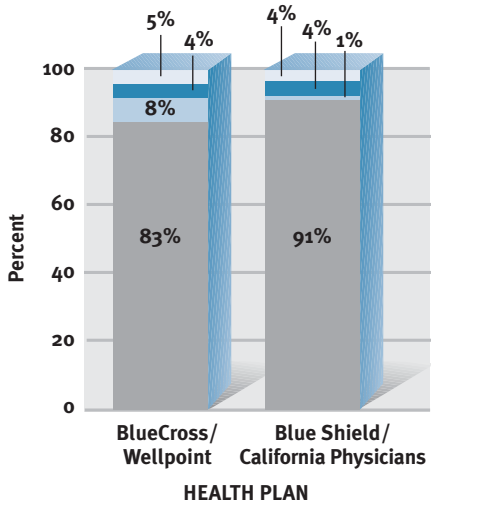
Despite an average 20 percent HMO premium rate hike in 2000[40], Blue Cross/Wellpoint had the smallest average premium rate increase per enrollee of the major providers between 1999 and 2001. Figure 11 shows how each additional dollar of the Blue Cross/Wellpoint plan's total revenue during that time was spent. About 83 cents of every additional dollar was spent on medical care, 8 cents on administration, 4 cents on marketing and advertising, and 5 cents on profit and reserves. It is also worth noting that, in 2000, the plan spent more on advertising than on outpatient prescription drugs.[41]

For Blue Shield/California Physicians' Service, which had an average premium rate increase per enrollee of 35 percent during the same period, 91 cents of every additional revenue dollar was spent on medical care, 1 cent on administration, 4 cents on marketing and advertising, and 4 cents on profit and reserves.[42]

California HMOs are credited with producing some of the strongest financial results in the country, despite a weak economy. According to Blue Cross of California's president, David Helwig:

> ***California is a very sophisticated, mature managed care market. There's a lot of management expertise in the state. That means knowing your costs, knowing your provider networks, knowing how to adequately price your products and spotting trends early and quickly.***[43]

Figure 11. How Additional 1999-2001 Revenue Was Spent, Blue Cross/Wellpoint & Blue Shield/ California Physicians' Services



Source: Author's calculations and InterStudy Publications Custom Database Product financial data.

All of California's top five commercial health insurers enjoyed healthy profits in 2001 (see Appendix A).[44] According to Weiss Ratings, California's HMOs and health insurers had the second-highest profits in the nation, accounting for 15 percent of the total industry profits nationwide.[45] California's top five health insurers are faring well both in terms of profits and in building reserves.

Managed care is now confronting numerous and opposing challenges: meeting consumer demand for more flexibility, creating less contentious contracts with health care providers and protecting market share and profits.[46] As a result, managed care plans are in the midst of a major shift in business strategy.

[39] *Ibid*.
[40] MCOL.
[41] Allan Baumgarten, *California Managed Care Review 2002*, (Oakland: California HealthCare Foundation, 2002), p. 43 and InterStudy Publications financial data.
[42] Author's calculations and InterStudy Publications financial data. Blue Shield did not report outpatient prescription drug expenses for 2000.
[43] Quoted in Sara Selis, "Variations on a Theme," *HealthLeaders Magazine*, January 13, 2002.
[44] Derived from InterStudy Publications financial data.
[45] Weiss Ratings, Inc., "HMOs' and Health Insurers' Profits Increase 25% to $4.1 Billion in 2001," September 3, 2002.
[46] Debra A. Draper, Robert E. Hurley, Cara S. Lesser, and Bradley C. Strunk, "The Changing Face Of Managed Care," *Health Affairs*, vol. 21, no. 1, January/ February 2002.

Will Patients Pay More for Less Care?

This shift is becoming increasingly evident as HMOs take on more of the PPO's characteristics. For example, many patients now have greater direct access to specialists. While this may be long-awaited good news for consumers, it may increase pressure to control costs in the high-cost areas of medicine – impacting the state's most vulnerable populations.

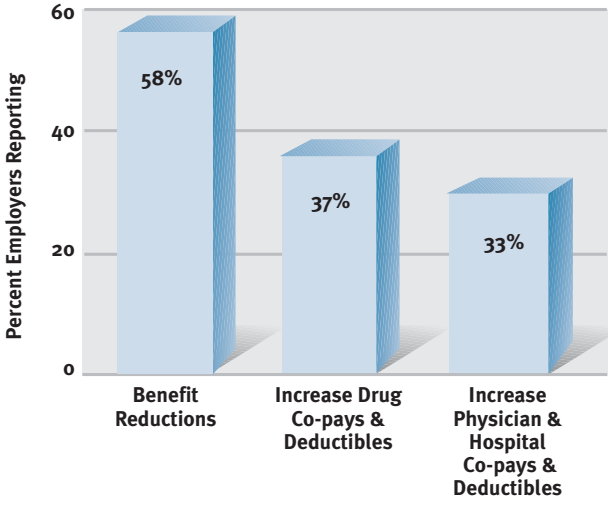
Table 5. California HMO Cost-Sharing Approaches Introduced Between Summer 2001 and Spring 2002

HMO Cost-sharing approach	Example
Separating hospitals into tiers with different levels of cost sharing	$0 copay for 1st tier hospital; $100 per day copay for 2nd tier hospitals
Annual deductible for hospital-based services and ambulatory surgery centers	$240-$1,500 per member
In-network hospital co-pay	$50-$50 per day (with 3-7 day maximum)
Deductible for brand name prescription drugs	$150-$250 per member

Source: California HealthCare Foundation, Insurance Markets, Trends & Analysis, April 2002.

California's major health plans are now imposing premium-rate increases that far outpace the expected medical-cost increases. Managed care's domination over California's health care market leaves employers and consumers in a difficult position during this transition. As previously stated, health plan choices are extremely limited in California, especially in the small-group market. HMOs are now imposing additional cost-sharing in their plan offerings (see Table 5). This is in addition to staggering premium-rate increases. Indeed, a large proportion of employers nationwide has reported increased cost-sharing this year and predicts additional cost-sharing in the near future (see Fig. 12).[47]

Figure 12. Employers Nationwide Reporting New Cost-Sharing Approaches for 2002



Source: Credit Suisse / First Boston, "2002 Benefit Manager Survey," Managed Care Sector Review January 15, 2002.

In an attempt to curb rising costs, health plans have been attempting to curb utilization. Cost-sharing, co-pays and other strategies provide a useful tool for discouraging over-utilization of services. Consequently, in California, employers and consumers have very limited choice of plans and will likely continue to pay more for the options that are available. Increased costs, either directly through premium hikes or indirectly through increased out-of-pocket expenses, may discourage employers from providing, or employees from accepting, insurance altogether.

Another important area of concern is how the managed care industry might respond to increased costs. In addition to strategies such as increased co-pays and deductibles, plans may have a stronger incentive to further contain costs among chronic patients or patients requiring expensive medical treatments.

[45] Credit Suisse / First Boston.

Efforts to further ration care are particularly troublesome for many of the state's chronic and seriously ill patients, since such cost-control strategies frequently keep the most effective treatments out-of-reach. The result could be unneeded and prolonged suffering for these patients. Ironically, many of the expensive, frequently denied treatments and persistent quality failures actually save money in the long run, alleviate patient suffering and avoid more invasive treatments.

Because of the way health care is currently organized, it does not generally have the incentive or the capacity to evaluate overall costs. Consequently, the most common method for cost evaluation is to focus on the cost of individual treatments or "component costs." Unfortunately, without evaluating overall costs – such as incidence of relapse, total medical claims, emergency room visits, etc. – efforts to achieve cost-effectiveness frequently fail.

For example, some health plans routinely delay more expensive treatments, such as surgery. A recent study by MetLife Disability of more than 15,000 short-term disability claims found that delaying treatment, postponing surgery and other cost-containment measures are more costly to employers in the long run. While the study focused on musculoskeletal claims, it provides practical insights into overall health care costs. For example, patients who had rotator cuff surgery lost 5.3 weeks of work, compared to nonsurgical patients who lost 12.2 weeks.[48] In other words, restricting access to care can have consequences that go beyond simple accounting.

Restricting access, either directly or indirectly, to certain drugs is common. Formulary restrictions, prior authorization, and higher co-pay are examples of ways to do this. In a 1996 survey for the National Pharmaceutical Council, researchers conducted a comprehensive review of 30 studies from 1972 to 1996. Taken together, these show restrictive formularies can decrease drug costs, but will increase overall costs and diminish quality of care.[49] When restrictions were put in place, costs shifted from restricted drugs to increased utilization of non-restricted drugs and other health care services. Meanwhile, the newest, most-effective drugs, while even more costly, are likely – if their use is not restricted – to reduce overall costs to a greater extent than they have up to now.

Abandoning Patients?

In what might be the most egregious example of such a restriction, Blue Cross/Wellpoint has been working since 1998 to change the status of the prescription drug Claritin to over-the-counter, since patients with allergies can, according to Blue Cross/Wellpoint, self-diagnose and treat common symptoms without advice from physicians. According to the plan's chief pharmacy officer, "At every available opportunity we believe our members should have ready and easy access to safe and effective medications."[50] In addition to Claritin, Blue Cross/Wellpoint also petitioned the Food and Drug Administration (FDA) to convert Allegra and Zyrtec, both antihistamines, to over-the-counter drug status.[51] One has to wonder whether these health plans are truly committed to empowering patients, or if they are engaged in a thinly veiled attempt to avoid providing patient care.[52]

The managed care approach to treatment has often been to establish barriers to access based on a one-size fits all gatekeeper approach, especially when it comes to the newest medical innovations. Rather than addressing individual patients' needs, managed care often ignores the importance of individualized health care.

Hispanics' Unique Health Care Needs

Obviously such decisions on the part of health plans can have an enormous impact on the health of practically any given class of patients. For example, in a variety of areas, access restrictions in California health plans have important consequences for Hispanics. In fact, one in seven Hispanic children have asthma and Hispanics overall develop diabetes at twice the rate of other ethnic groups. In addition, Hispanics access to health insurance must also be considered when studying how this high prevalence of chronic illness is managed. Research has shown that nearly half of all persons with a chronic illness delayed or did not access necessary care. Nearly all of these persons cited cost as the reason why they decided to forgo the care they needed. With this in mind, the "costs" of restricting access to care for these conditions ultimately lead to higher acute care costs.[53]

Asthma

According to the San Francisco-based Latino Issues Forum, more than one-half million Hispanics in California suffer from asthma. It is estimated the vast majority – 80 percent – of asthma treatment costs are incurred by only 20 percent of patients – those whose disease was not controlled. One-half of the total treatment costs were due to hospitalization.[54] Studies also demonstrate asthma patients receiving treatment from specialists require less acute care and have better health care outcomes, including fewer hospitalizations, shorter hospital stays and fewer emergency room visits.[55] As a result of inadequate care, many Hispanics are hospitalized for this condition at significantly higher rates than their white counterparts.[56]

[48] MetLife Disability as cited in *HealthLeaders Magazine*, "Rising Prices Come As No Surprise," July 1, 2002.

[49] Richard A. Levy, Ph.D. and Douglas Cocks, Ph.D., *Component Management Fails to Save Health Care System Costs: The Case of Restrictive Formularies*, (Reston, VA: National Pharmaceutical Council, 1996).

[50] *Managed Care Week*, "Health Plans Relieved at Shortcut Blockbuster Drugs Take to OTC," July 1, 2002.

[51] *Bureau of National Affairs Pharmaceutical Law & Policy Report*, "Claritin Would Become OTC Drug If FDA Approves Schering-Plough Request," vol. 2, no. 11, March 14, 2002. In 2001, Claritin manufacturer Schering-Plough asked the FDA to move Claritin to OTC status.

[52] Aetna, which covered almost 800,000 Californians in 2001, has also excluded Claritin and Clarinex from its formulary for 2003.

[53] Marie C. Reed and Ha T. Tu, "Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America," Center for Studying Health System Change Issue Brief, no. 49, February 2002.

[54] D. H. Smith, *et al.*, "A national estimate of the economic costs of asthma," *American Journal of Respiratory Critical Care Medicine*, vol. 156, 1997.

[55] D. Bukstein and A. Luskin, "Specialty influence on acute care resource utilization by asthma patients," *Annals of Allergy and Asthma Immunology*, vol. 80, 1998 and Health Outcomes Institute, *Update* newsletter, Fall 1997.

[56] Latino Issues Forum, "Confronting Asthma in California's Latino Communities," April 1999.

Given the overwhelming evidence demonstrating the value – both in terms of health care costs and patient outcomes – of good, ongoing treatment of asthma, there should be little doubt that employers and patients have a vested interest in access to specialized care.[57] Yet, Blue Cross/Wellpoint's efforts to restrict medical coverage for allergy and asthma patients not only trump medical specialists' recommended treatment options, they potentially threaten patients' well-being.

Diabetes

Hispanics also are at a higher risk for diabetes than is the general population. In fact, an amazing 10.2 percent of all Hispanic Americans have diabetes.[58] Yet, fewer than half of California's health plans rated by HealthScope received a "good" score for helping patients control blood sugar. Even more surprising, not a single plan received above "fair" for controlling cholesterol among such patients, even though this is considered standard medical care.[59]

Part of the explanation may be found in the efforts of many of health plans to restrict the use of some of the most effective drug treatments for these conditions. For example, Lipitor (atorvastatin calcium) is a drug commonly used to block cholesterol production in the body. Unfortunately, many California health plans restrict access to this drug, through prior authorization requirements, step therapy rules, limits on the number of days the drug is covered or simply by not covering it at all.[60]

According to a recent study in the New England Journal of Medicine, metfomin (brand names: Glucophage and Glucophage XR), which is used to regulate blood sugar levels, was shown to reduce the risk of getting type two diabetes by 31 percent. When study participants added exercise to their treatment, their risks were reduced even further.[61] Yet, this drug is similarly restricted by many California health plans.[62] According to the National Committee for Quality Assurance (NCQA), a large portion of diabetes treatment costs is attributable to disease complications, such as heart disease, blindness, kidney disease, stroke and even death.[63] Employers and health care consumers should be aware the cost of restricting access to care often leads to higher acute-care costs, not to mention patient suffering. They should also be aware that managed care practices should be continuously scrutinized.

Quality Care?

There is no doubt managed care is, in response to consumer demand, slowly expanding health care access and choice in some areas. The National Committee for Quality Assurance (NCQA), a national HMO accrediting group, reports that, for the fifth consecutive year, HMO quality has improved.[64] But a recent study published in the Journal of the American Medical Association challenges the validity of NCQA findings. The study's authors reveal that, between 1997 and 1999, health plans with lower scores were far more likely to withdraw their plans' quality scores from public disclosure. For example, 49 percent of the plans withdrew from public disclosure in 1998. The authors conclude that, "Compared with HMOs receiving higher quality-of-care scores, lower-scoring plans are more likely to stop disclosing their quality data. Voluntary reporting of quality data by HMOs is ineffective; selective nondisclosure undermines both informed consumer decision making and public accountability."[65] Other studies continue to find wide variation in managed care quality.

In a review of 79 studies published from 1997 to mid-2001, researchers found HMOs tend to use fewer hospital resources, such as shorter length of stay and fewer intensive care unit services, and other expensive treatments, especially for the frail elderly and chronically ill. Furthermore, according to the authors, "HMO enrollees report worse results on many measures of access to care and lower levels of satisfaction, compared with non-HMO enrollees."[66] This may explain why consumers in California continue to press for further legislative reforms.

Despite the many state reforms efforts enacted in 1999, California's managed care industry continues to face strong patient discontent, as evidenced by continued legislative actions to further regulate the industry. California Governor Gray Davis recently enacted a new package of managed care reforms. Patients with certain life-threatening illnesses are now guaranteed access to prescription drugs, if they are already covered by HMO drug coverage. The Department of Managed Care is now authorized to regulate HMO quality. Health insurers, including HMOs, may not change their premiums or out-of-pocket costs after the start of an open enrollment period or after receiving a premium payment for the first month of coverage.[67] Eleven bills were signed into law.

Even though managed care may be slowly evolving to meet consumer demands, many questions remain: What are consumers' alternatives? Will higher costs drive more people into the ranks of the uninsured? What costs – in terms of both money and patient well-being – are being incurred in the meantime?

[57] See, for example, C.R. Westley, *et al.*, "Cost effectiveness of an allergy consultation in the management of asthma," *Allergy Asthma Proc*, vol. 18, 1997; K. Sperber, *et al.*, "Effectiveness of a specialized asthma clinic in reducing asthma morbidity in an inner-city minority population," J Asthma, vol. 32, 1995; and A. G. Weinstein, L. McKee, J. Stapleford, D. Faust, "An economic evaluation of short-term inpatient rehabilitation for children with severe asthma," *J Allergy Clin Immunol*, vol. 98, 1996.

[58] National Diabetes Information Clearinghouse, National Institutes of Health at www.niddk.nih.gov.

[59] HealthScope health plan quality ratings at www.healthscope.org/Interface/health_plans/default.asp. HealthScope is a public information source provided by the San Francisco-based Pacific Business Group on Health.

[60] California Internet Formulary Reference at ca.mcodrugs.com. Site sponsored by Citizens for the Right to Know. Data from MediMedia.

[61] Diabetes Prevention Program Research Group, "Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin," *New England Journal of Medicine*, vol. 346, no. 6, February 7, 2002.

[62] California Internet Formulary Reference.

[63] National Committee for Quality Assurance, *The State of Health Care Quality 2002: Industry Trends and Analysis*, (Washington, D.C.: National Committee for Quality Assurance, 2002).

[64] National Committee for Quality Assurance.

[65] Danny McCormick, MD, MPH; et al., "Relationship Between Low Quality-of-Care Scores and HMOs' Subsequent Public Disclosure of Quality-of-Care Scores," *Journal of the American Medical Association*, vol. 288, no. 12, September 25, 2002. Recently, a new rule prevents health plans that do not agree to public disclosure from keeping their accreditation. The authors also point out that in 1998 a mere 4 percent of HMO applications for accreditation were rejected.

[66] Robert H. Miller, Harold S. Luft, "HMO Plan Performance Update: An Analysis of The Literature, 1997-2001," *Health Affairs*, vol. 21, no. 4, July/August 2002. The authors' pattern of findings were more favorable to California HMOs for quality of care than elsewhere. Overall, the authors found quality of care for HMOs comparable to non-HMOs.

[67] Office of Governor Gray Davis, "Governor Davis Expands California's Landmark Patient's Bill of Rights," Press Release, September 22, 2002.

Managed care was created in the belief it would revolutionize the health care industry by improving quality and controlling costs. It has failed on both counts. In recent years, managed care has erected additional barriers to access, especially when it comes to the newest medical innovations.

A better approach – both for employers and employees – is to allow workers more control over their own health care decisions. More health plan choices would be a good start. Arkansas and North Dakota recently enacted mandate-relief laws that allow insurers to offer "no-frills" insurance at a lower cost.[68] This would allow for the return of major medical insurance policies (characterized by higher deductibles and lower monthly premiums) in California.

A recent IRS ruling allowing employees to set up Health Reimbursement Arrangements (HRAs) also could provide California employers with much-needed help with health care benefits.[69] From now on, money provided by employers for employees' out-of-pocket medical expenses will not be subject to taxes, and any unspent funds can be rolled over from year to year. When the employee retires or switches jobs, he or she also can receive residual funds in a lump sum. Basically, this abolishes the "use-it-or-lose-it rule" for employer contributions to health care.

Rather than purchasing first-dollar coverage for employees, employers can now purchase high-deductible policies and use the cost difference to fund medical spending accounts, similar to a medical savings account. Under an HRA, patients can choose their own doctors and prioritize their own health care needs and preferences. According to the Wall Street Journal, Humana saw an expected 19 percent increase in health care costs drop to less than 4 percent when it offered this plan to its employees.[70] Beginning in 2003, the Federal Employees Health Benefits Program will begin offering an HRA option.[71] The option will include major medical health coverage, with a personal health care account of $1,000 for individuals and $2,000 for families.

The most important aspect of this approach is that it creates transparency in the health care system. It would prevent managed care's hidden attempts to control costs – restricting access to the newest medical treatments or delaying treatments, often without doctor involvement or patient knowledge – which undermine patient care and are not necessarily cost-effective.

[68] Betsy McCaughey, "States Look to Cut Red Tape to Ease Crisis of Uninsured," *Investors' Business Daily*, March 15, 2002.
[69] Internal Revenue Service, Health Reimbursement Arrangements, *Internal Revenue Bulletin*, Notice 2002-45.
[70] *Wall Street Journal*, "Three Cheers for the IRS," July 2, 2002.
[71] Galen Institute, *Health Policy Matters*, September 20, 2002.

The Golden State has the best available medical treatments anywhere. It is home to some of the world's best academic research institutions, leading hospitals and innovative medical companies. Unfortunately, health care access, quality, choice and affordability are becoming increasingly scarce in California.

The current health care market is dominated by managed care "gatekeepers" that take away important health care decisions from patients and their doctors. Managed care's hidden attempts to further control costs – restricting access to the newest medical treatments or delaying treatments, often without doctor involvement or patient knowledge – undermine patient care and are not necessarily cost-effective.

Efforts to further ration care are particularly troublesome for the state's Hispanic population who, as a group, are more likely to suffer from chronic conditions, such as asthma and diabetes. Restricting access to care for these conditions often leads to both higher acute care and patient suffering.

That is only one reason why California employers and consumers need to be aware of their health care options, of how much they are paying for health care and of what they are getting for their money. As premiums continue to rise, California could follow the path of higher employee contributions and, as a result, lower insurance take-up rates and a higher number of uninsured workers – especially Hispanics.

Since small businesses are hit first and hardest by these costs, workers in these firms have been far more likely to lose coverage. Hispanic workers, who are heavily concentrated in the service industry and in small businesses, are disproportionately uninsured and susceptible to additional premium increases.

A better approach – for both employers and employees – would be to allow workers more control over their health-care decisions. Increased transparency and choice in the health care market are needed to reduce health insurance premium costs and allow patients to prioritize their health care needs and preferences. By restoring these decisions to consumers and their doctors, California employers, lawmakers, insurance companies and health care providers could restore accountability to the health care system and put patients first.

Health Plan Finances and Membership Summary, 2001

	Kaiser	Blue Cross/ Wellpoint	Cal. Physician Services/ Blue Shield	Health Net	PacifiCare
Members	6,433,296	4,389,159	2,001,299	2,471,553	2,065,998
Net Income Before Tax	$120,257,000	$535,420,000	$61,189,000	$172,262,606	$67,116,845
Total Revenue	$14,887,411,000	$7,273,347,000	$4,311,646,000	$4,870,894,640	$6,499,640,425
- Premiums	$9,755,489,000	$6,111,530,000	$3,584,660,000	$3,197,346,630	$2,657,512,725
Total Expense	$14,767,154,000	$6,737,927,000	$4,250,457,000	$4,698,632,034	$6,432,523,580
- Marketing	$160,753,000	$375,901,000	$256,078,000	$25,387,876	$140,181,933
- Admin*	$399,713,000	$976,759,000	$527,862,000	$408,198,333	$535,549,722
- Physician Services	$6,257,576,000	$2,246,717,000	$1,451,739,000	$1,882,955,584	$2,397,517,248
- Inpatient	$4,128,755,000	$2,387,056,000	$1,403,287,000	$1,616,808,190	$2,174,707,616

* Expense- Admin includes Compensation, Aggregate Write-ins and the previously-listed Marketing. It does not include Interest Expense or Occupance, Depreciation & Amortization.

Source: Derived from InterStudy Publications Custom Database Product financial data.

Detailed Health Plan Finances and Membership, 1999-2001

Blue Cross of California/Wellpoint

Health Plan Expenses, 2001
Health Plan Expenses, 1999-2001

Blue Shield/California Physicians' Service

Health Plan Expenses, 2001
Health Plan Expenses, 1999-2001

Health Net

Health Plan Expenses, 2001
Health Plan Expenses, 1999-2001

Kaiser Foundation Health Plan, Inc.

Health Plan Expenses, 2001
Health Plan Expenses, 1999-2001

PacifiCare of California

Health Plan Expenses, 2001
Health Plan Expenses, 1999-2001

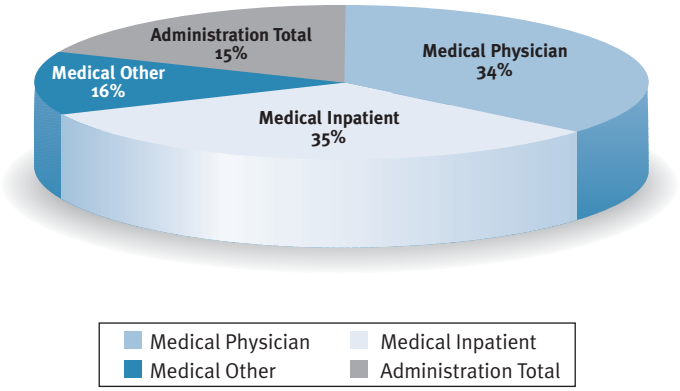
Blue Cross of California/Wellpoint

	2001	2000	1999
Net Worth Total	$886,880,000	$875,430,000	$761,276,000
Revenue - Premiums	$6,111,530,000	$5,395,745,000	$4,581,020,000
Premiums/Members	$1,392	$1,300	$1,197
Revenue Total	$7,273,347,000	$6,374,868,000	$5,332,869,000
Medical Physician	$2,246,717,000	$1,872,735,000	$1,692,928,000
Medical Inpatient	$2,387,056,000	$2,004,447,000	$1,623,333,000
Medical Other	$1,060,732,000	$946,830,000	$788,029,000
Medical Total	$5,727,956,000	$4,868,784,000	$4,125,597,000
Admin Compensation	$333,803,000	$353,846,000	$315,063,000
Admin Marketing	$375,901,000	$348,164,000	$291,823,000
Admin Write-in	$267,055,000	$174,571,000	$129,673,000
Admin Total	$1,009,971,000	$911,544,000	$772,702,000
Total Expenses	$6,737,927,000	$5,780,328,000	$4,898,299,000
Net Income Before Taxes	$535,420,000	$594,540,000	$434,570,000
Income BT / Members	$122	$143	$114
Total Members	4,389,159	4,149,950	3,827,766
Total Physician Encounters*			
Total Encounters*			
Bed Days per 1,000 Members	266	262	272
Average Length of Stay	4.32	4.31	4.18

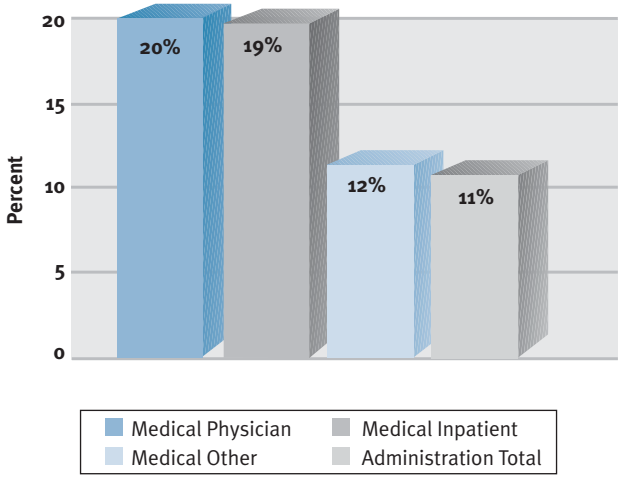
* Data not reported.

Source: Derived from InterStudy Publications financial data.

Health Plan Expenses, 2001



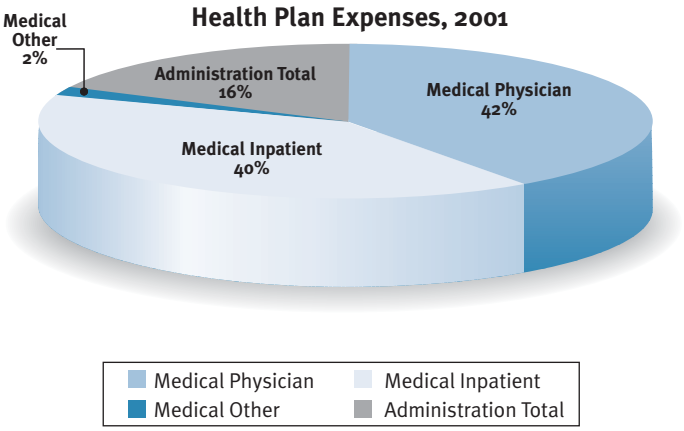
Health Plan Expense Increases, 1999-2001

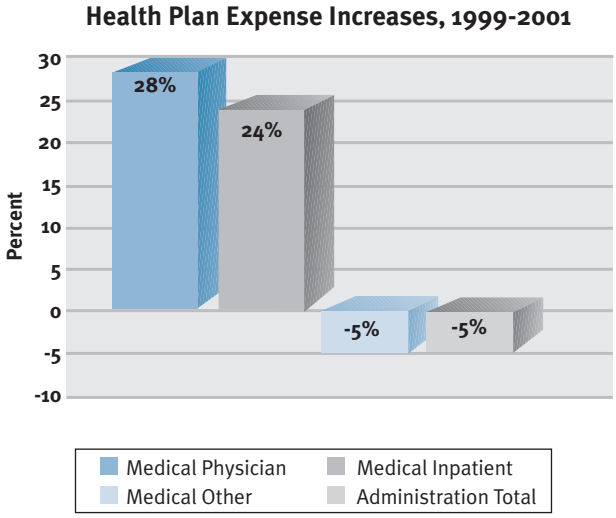


Blue Shield/California Physicians' Service

	2001	2000	1999
Net Worth Total	$605,344,000	$546,892,000	$546,650,000
Revenue - Premiums	$3,584,660,000	$2,914,052,000	$2,446,083,000
Premiums/Members	$1,791	$1,443	$1,326
Revenue Total	$4,311,646,000	$3,526,563,000	$2,975,553,000
Medical Physician	$1,451,739,000	$1,131,937,000	$974,653,000
Medical Inpatient	$1,403,287,000	$1,136,174,000	$898,515,000
Medical Other	$56,024,000	$59,041,000	$46,100,000
Medical Total	$3,680,783,000	$2,947,606,000	$2,459,060,000
Admin Compensation	$164,416,000	$131,869,000	$149,389,000
Admin Marketing	$256,078,000	$223,512,000	$203,371,000
Admin Write-in	$107,368,000	$191,557,000	$99,004,000
Admin Total	$569,674,000	$597,738,000	$500,286,000
Total Expenses	$4,250,457,000	$3,545,344,000	$2,959,346,000
Net Income Before Taxes	$61,189,000	($18,781,000)	$16,207,000
Income BT / Members	$31	($9)	$9
Total Members	2,001,299	2,019,419	1,844,465
Total Physician Encounters	12,469,495	11,353,651	9,637,354
Total Encounters	21,101,805	18,774,930	16,271,776
Bed Days per 1,000 Members	246.5	241.1	250.2
Average Length of Stay	3.8	3.8	4

Source: Derived from InterStudy Publications financial data.



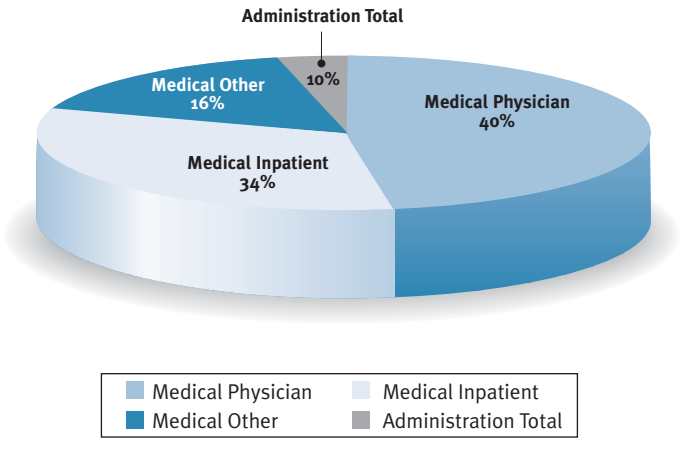


Health Net

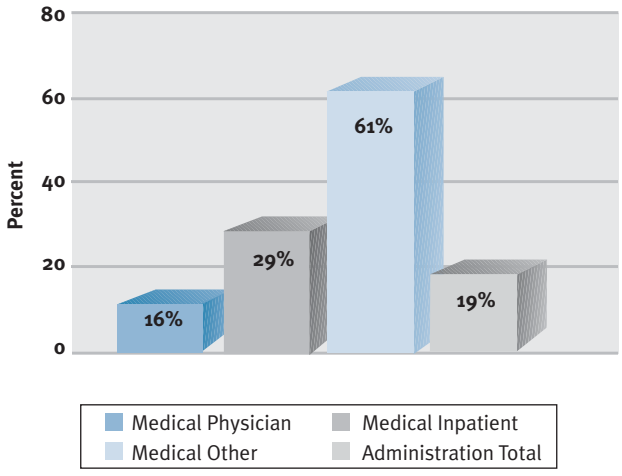
	2001	2000	1999
Net Worth Total	$500,585,310	$467,790,147	$414,250,140
Revenue - Premiums	$3,197,346,630	$2,518,116,341	$2,343,110,921
Premiums/Members	$1,294	$1,105	$1,075
Revenue Total	$4,870,894,640	$3,981,586,652	$3,678,223,909
Medical Physician	$1,882,955,584	$1,617,120,321	$1,591,455,181
Medical Inpatient	$1,616,808,190	$1,254,128,139	$1,167,592,688
Medical Other	$739,506,828	$459,518,127	$419,354,171
Medical Total	$4,239,270,602	$3,330,766,587	$3,178,402,040
Admin Compensation	$142,410,674	$156,824,280	$157,008,168
Admin Marketing	$25,387,876	$16,557,347	$16,543,529
Admin Write-in	$240,399,783	$162,419,283	$130,429,063
Admin Total	$459,361,432	$384,480,330	$334,474,673
Total Expenses	$4,698,632,034	$3,715,246,917	$3,512,876,713
Net Income Before Taxes	$172,262,606	$266,339,735	$165,347,196
Income BT / Members	$70	$117	$76
Total Members	2,471,553	2,279,319	2,180,305
Total Physician Encounters	4,952,216	5,508,238	9,862,177
Total Encounters	6,568,235	6,030,657	12,327,721
Bed Days per 1,000 Members	274.1	279.7	321.8
Average Length of Stay	5	5	5

Source: Derived from InterStudy Publications financial data.

Health Plan Expenses, 2001



Health Plan Expense Increases, 1999-2001

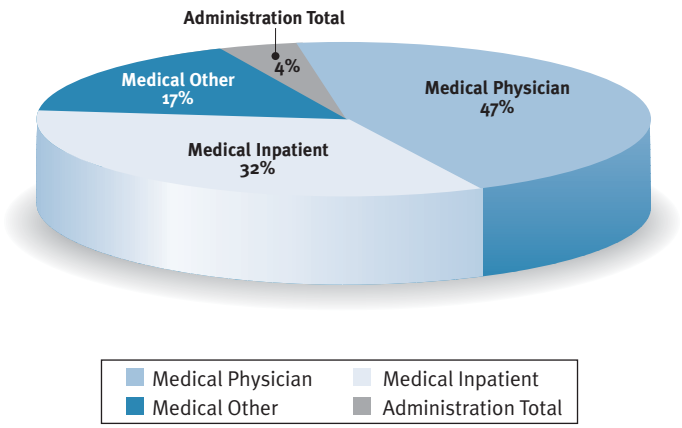


Kaiser Foundation Health Plan, Inc.

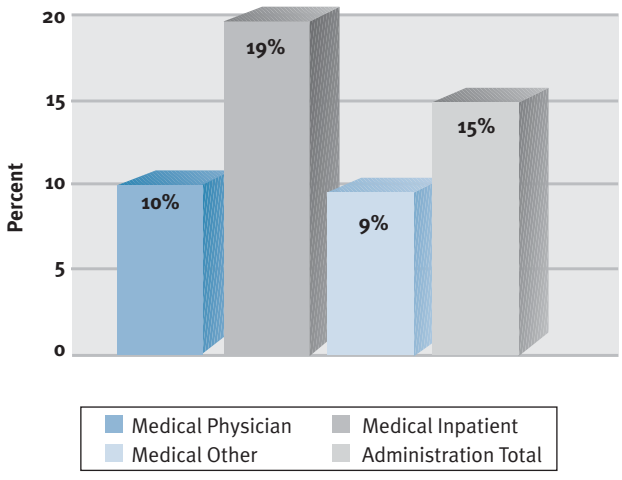
	2001	2000	1999
Net Worth Total	$1,336,058,000	$1,306,585,000	$1,176,994,000
Revenue - Premiums	$9,755,489,000	$8,514,947,000	$7,608,844,000
Premiums/Members	$1,516	$1,360	$1,238
Revenue Total	$14,887,411,000	$13,331,861,000	$11,945,443,000
Medical Physician	$6,257,576,000	$5,707,322,000	$5,285,123,000
Medical Inpatient	$4,128,755,000	$3,469,660,000	$2,998,694,000
Medical Other	$2,166,190,000	$1,979,290,000	$1,660,672,000
Medical Total	$14,284,318,000	$12,750,822,000	$11,394,981,000
Admin Compensation	$140,828,000	$135,169,000	$136,983,000
Admin Marketing	$160,753,000	$154,053,000	$134,981,000
Admin Write-in	$98,132,000	$38,063,000	$135,765,000
Admin Total	$482,836,000	$418,406,000	$524,743,000
Total Expenses	$14,767,154,000	$13,169,228,000	$11,919,724,000
Net Income Before Taxes	$120,257,000	$162,633,000	$25,719,000
Income BT / Members	$19	$26	$4
Total Members	6,433,296	6,260,026	6,145,836
Total Physician Encounters	21,548,907	21,128,028	20,089,375
Total Encounters	33,801,437	33,648,023	33,374,900
Bed Days per 1,000 Members	262	262	229
Average Length of Stay	4	3.9	3.8

Source: Derived from InterStudy Publications financial data.

Health Plan Expenses, 2001



Health Plan Expense Increases, 1999-2001

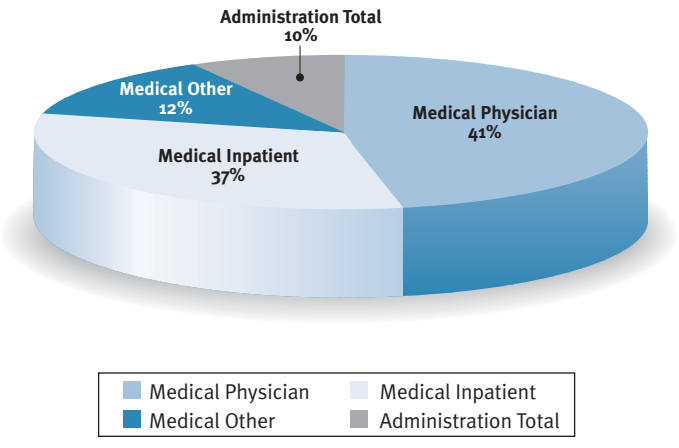


PacifiCare of California

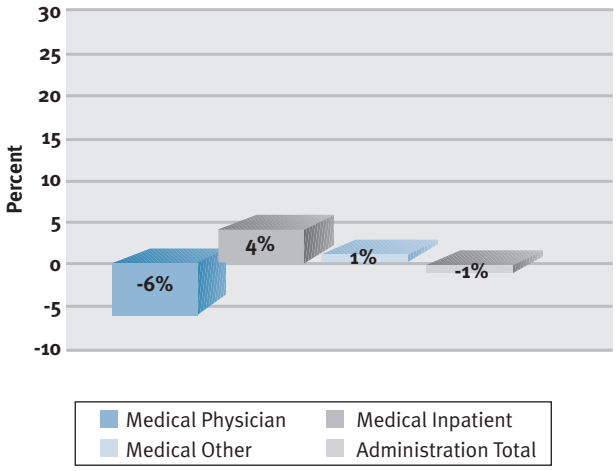
	2001	2000	1999
Net Worth Total	$293,507,453	$239,753,607	$243,430,709
Revenue - Premiums	$2,657,512,725	$2,696,040,759	$2,357,397,718
Premiums/Members	$1,286	$1,134	$1,013
Revenue Total	$6,499,640,425	$6,614,591,420	$6,244,245,678
Medical Physician	$2,397,517,248	$2,555,121,575	$2,345,806,638
Medical Inpatient	$2,174,707,616	$2,081,444,869	$2,105,860,136
Medical Other	$716,321,061	$711,553,280	$521,755,353
Medical Total	$5,872,924,283	$5,794,445,376	$5,263,515,777
Admin Compensation	$165,488,508	$164,654,084	$144,605,058
Admin Marketing	$140,181,933	$184,782,553	$187,290,213
Admin Write-in	$229,879,281	$193,540,632	$192,836,158
Admin Total	$559,599,297	$564,506,901	$550,314,006
Total Expenses	$6,432,523,580	$6,358,952,277	$5,813,829,783
Net Income Before Taxes	$67,116,845	$255,639,143	$430,415,895
Income BT / Members	$32	$108	$185
Total Members	2,065,998	2,376,801	2,328,082
Total Physician Encounters	11,159,487	12,217,735	12,013,591
Total Encounters	11,159,487	12,217,735	12,013,591
Bed Days per 1,000 Members	525	510	514
Average Length of Stay	4.24	4.34	4.38

Source: Derived from InterStudy Publications financial data.

Health Plan Expenses, 2001



Health Plan Expense Increases, 1999-2001



About The Author

Naomi Lopez Bauman is a public policy consultant. She has conducted research on federal and state health and welfare programs, children's issues, women's issues, barriers to entrepreneurship, Social Security privatization, and tax expenditure programs.

Lopez-Bauman has served as Director of both the Center for Enterprise and Opportunity and the Project on Children at the Pacific Research Institute and was a member of the California Senate Bipartisan Task Force on Homelessness. Lopez-Bauman also worked as a research associate in health care and welfare at the Institute for SocioEconomic Studies and as an entitlements policy analyst at the Cato Institute. She also served as special policy advisor to the State of Michigan's Secchia Commission, which provided recommendations for state government reform.

A frequent media guest, Lopez-Bauman has appeared on ABC's Politically Incorrect, PBS, CNN, CNBC, FOX News Channel, and MSNBC. An author of more than 80 studies and commentaries, her opinion articles have appeared in Investor's Business Daily, Los Angeles Daily Journal, Washington Times, San Diego Union-Tribune, Chicago Tribune, Houston Chronicle, and Insight. Lopez-Bauman holds a B.A. in economics from Trinity University in Texas and an M.A. in government from The Johns Hopkins University.

About The Latino Coalition Foundation

The Latino Coalition Foundation (TLCF) will research and develop policies that are relevant to Latinos' overall economic, cultural and social development while empowering individuals through the promotion of self-reliance and personal responsibility.

As its primary mission, TLCF will, on behalf of its members, closely monitor public policy at the federal, state and local levels to determine its impact on the Latino communities throughout the U.S., and engage in public education campaigns when warranted.

TLCF also will analyze and report to the public about the impact of Federal, State and local legislation, and government regulations, has on the Latino communities.

Within the Latino Community, Diversity is Key

The 2000 Census sent a shock wave across America. Corporate leaders, elected and appointed officials, and members of the media face the challenge of adapting to the new face of America. But before they can adapt, they will need to understand that Latinos are extremely diverse with different needs and concerns.

For too long, Latinos have been viewed as a monolithic community in the U.S. Nothing could be further from the truth. Hispanics living in the United States share many common traits. Most Latinos share their language, religious faith, and larger and close-knit families. However, they also have vast differences including unique cultural and colloquial idiomatic language variations; national and regional food tastes; educational and economic status, and different personal experiences leading to their migration to the U.S., to name but a few.

This diversity often times is dictated as much by current living conditions as it is by national origin or economic status. For instance, a Mexican-American family living in rural Fresno, California may have very different needs and concerns than a similar Mexican-American family living in urban Chicago, Illinois.

TLCF: Promoting a Better Understanding of the Latino Communities

TLCF will endeavor to promote a better understanding of the various Latino communities throughout the country. Through the use of ethnic research; public forums, and publications, TLCF will educate American leaders on the sensitive balance - and differences - within these Latino communities.

TLCF will serve as an archive and clearinghouse of behavioral and attitudinal research of Latinos in the U.S. The Foundation will research, analyze and report Hispanic trends based on in-house research and careful analysis of research conducted by other sources.

As part of its in-house research, TLCF will conduct regularly-scheduled policy-based public opinion studies including qualitative and quantitative research to promote a better understanding of the diverse U.S. Latino communities.

TLCF will include a number of projects designed to address the particular needs and concerns of different groups within the U.S. Latino communities. Each of the projects will have its own members and leaders in a number of states under the organizational umbrella of The Latino Coalition Foundation.