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TRENDWATCH

What Can Medicare Learn from the Private Sector? *September 1999, Vol. 1, No. 4*

"If Medicare is not fundamentally and successfully reformed, the country will confront four choices: limiting promised benefit; reducing spending on other government programs; raising taxes; or returning to deficit spending."

- Rep. Bill Thomas (R-CA) December 1998

The future financial viability of Medicare is a key concern to legislators as cost per beneficiary rises and the proportion of the population over 65 increases. The Balanced Budget Act of 1997 (the BBA) has reduced costs in the short-term, but may have pushed the limits of efforts that focus primarily on constraining provider payment. Meanwhile, political pressure is building to expand Medicare coverage to include prescription drugs, although the method of funding this new benefit is uncertain.

In the past, Medicare has used some innovative cost containment strategies. Medicare introduced the hospital prospective payment system in the early 80's and the physicians' RBRVS in the early 90's. Between 1984 and 1991, Medicare outperformed the private sector in controlling cost increases.

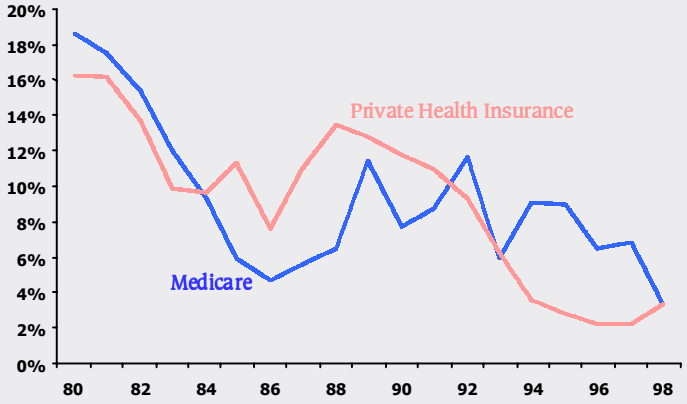
However, the private sector did a better job of constraining cost increases between 1992 and 1997. This period saw a massive shift of the employed population into managed care, the implementation of a broad range of strategies to manage costs and tremendous price competition among plans.

However, private sector cost containment efforts and increased use of managed care have troubled some consumers and led to a "managed care backlash." In response, plans and employers have eased restrictions on care delivery, leading to higher premium increases while Medicare rates of cost increases are declining.

With demographic changes projected to drive up expenditures and the predicted insolvency of the Medicare trust fund, policymakers are looking to the private sector for ideas. This **TRENDWATCH** looks at employer strategies to contain costs and asks the question, "What can Medicare learn from the private sector?"

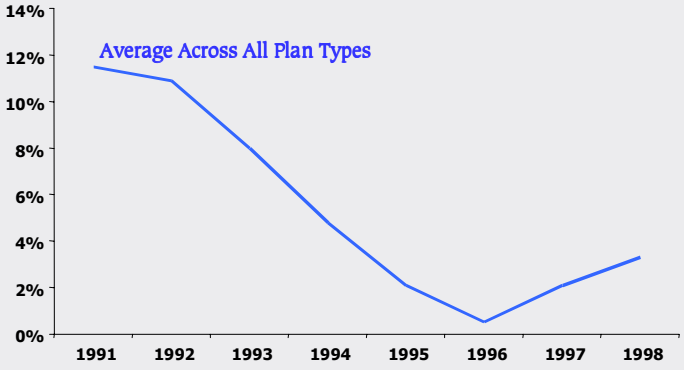
Performance of the private sector versus Medicare has varied over time.

Chart 1: Growth in Medicare spending per beneficiary versus private health insurance spending per enrollee



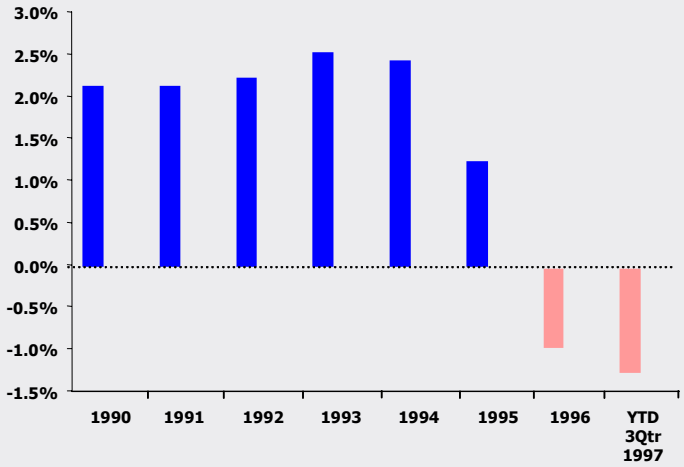
Premium increases have dropped dramatically, but are now on the upswing ...

Chart 2: Average annual percent increase in premiums by employers1991-1998



... as some plans try to recoup recent losses.

Chart 3: HMO operating profit margins from 1990 to 1997



Strategy 1: Shift Employees into More Cost-effective Health Plan Types

Lessons from Medicare+Choice:

Shifting Medicare beneficiaries to managed care has been held out as a great hope for cost control. Recently, however, plans have been pulling out, citing poor margins. Forty-one contracts have been terminated, affecting 725,000 of the 6.2 million beneficiaries who have been enrolled in HMOs (Health Market Survey, July 19, 1999).

Managed care plans offer significant savings relative to conventional plans. However, much of these savings come from price discounts, not utilization control for the most currently popular insurance products. In fact, among HMOs, the staff and group model health plans that do the most effective job of managing utilization are becoming less popular during this period of "managed care backlash."

Fewer employers are offering traditional indemnity insurance products, and even fewer employees are taking them.

Chart 4: Percent employers offering traditional indemnity products

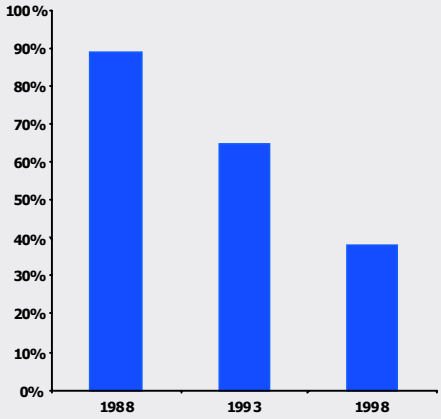
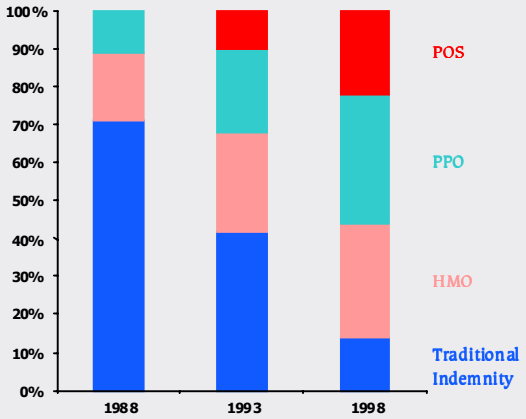
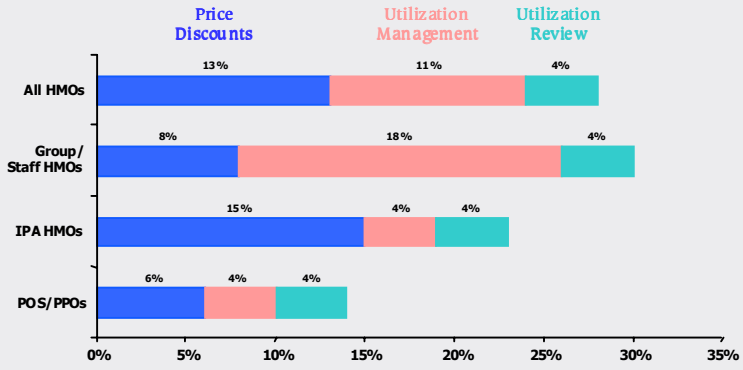


Chart 5: Percent enrollment by product type



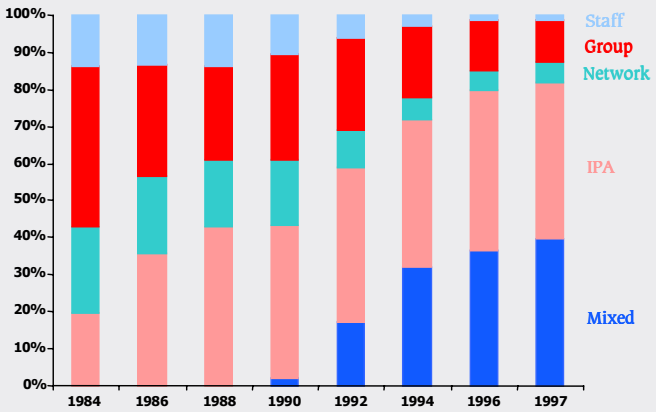
But much of managed care savings is due to price discounts ...

Chart 6: Percent savings relative to traditional indemnity plans, 1998



... in the product types recently growing in popularity.

Chart 7: HMO enrollment by model type, 1984-1997

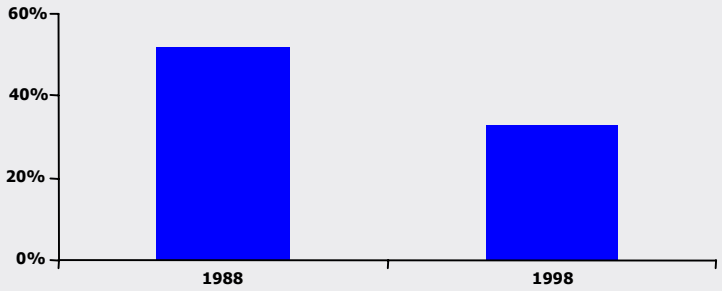


Strategy 2: Shift Costs to Employees and Reduce Choice

Increasingly, employers are requiring employees to contribute more to the cost of health insurance and are reducing the number of plan offerings. More employers are contribut-ing a fixed dollar amount to coverage so that employees bear the cost difference if they choose a higher cost plan.

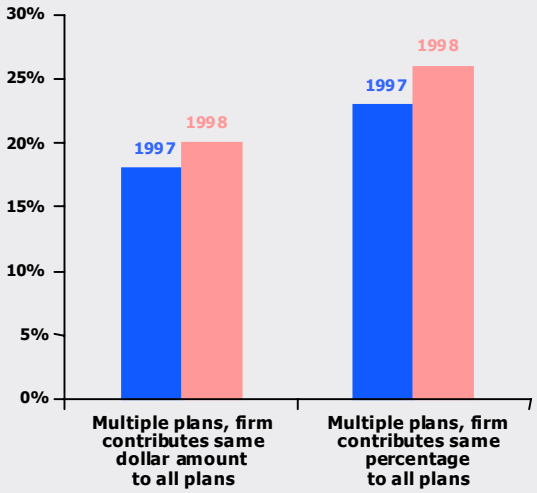
Fewer employees have all of their health care premiums paid by their employers ...

Chart 8: Percent of employees with no premium cost 1988 versus 1998



And the portion of employers contributing a fixed dollar amount or fixed percentage to the cost of insurance is increasing ...

Chart 9: Employer contribution made for workers who are offered a choice of health plans, 1997-1998



While fewer employers offer more than one health plan to chose from.

Chart 10: Percentage of employers providing a choice of health plans, national averages

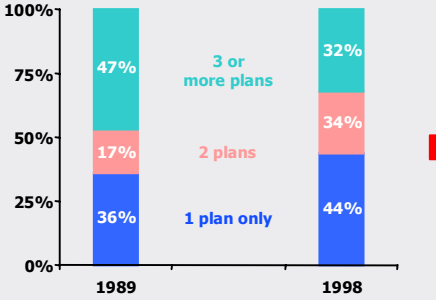
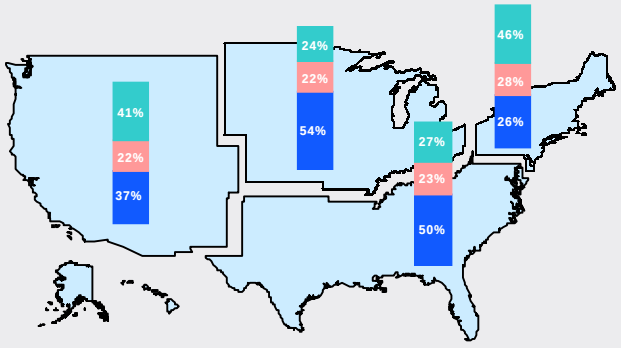


Chart 11: Choice of health plans by region in 1998



Notable Note:

Fifty-five percent of employers who contribute a fixed dollar amount to all plans set that contribution at the cost of the lowest cost plan.

- Health Benefits, KPMG, 1998

Quote from the field ...

"Employees have to be involved in the financing of health care. They have to have some incentive to discourage unnecessary utilization," says Bob Eicher, a principal with A. Foster Higgins & Co., benefits consultant in New York.

- Business & Health, August 1993

Strategy 3: Exert Leverage and Direct Patient Volume

Medicare Participating Heart Bypass Center Demonstration:

HCFA conducted a demonstration to assess the feasibility and cost implications for coronary artery bypass graft (CABG) surgeries in seven hospitals designated as centers of excellence. Physician and hospital payments were bundled to align provider incentives to manage costs.

Results of Study ...

- **Medicare saved approximately 10% of expected costs**
- **Inpatient mortality rate was lower than the national average**
- **Patient satisfaction was higher**
- **Hospitals felt well prepared to negotiate bundled payments with managed care organizations**

However ...

- **Volume and market share did not compensate providers for reduced payment rates.**

Pooling purchasing power or directing patient volume are other strategies employers use to reduce costs. Centers of excellence programs direct patient volume to designated high quality providers for specific diseases or procedures, such as organ transplants. Promising volume allows purchasers to secure price discounts. Benefit "carve-outs" funnel volume through vendors experienced in managing care for selected high cost areas. These programs focus on both price discounts and utilization controls.

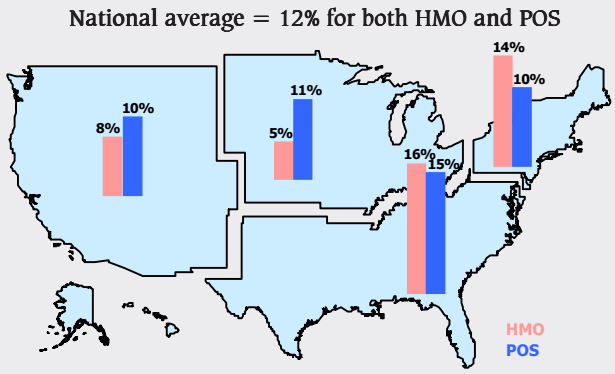
Employers have formed purchasing groups to exert pressure on health plans and providers.

Table 1: Examples of industry-leading health care buying groups

	Number of Firms	Number of Covered Lives (1998)
Buyers Health Care Action Group (BHCAG); Minneapolis, MN	28	150,000
Pacific Business Group on Health (PBGH); California	32	3,000,000
Memphis Business Group on Health (MBGH); Memphis, TN	43	115,000

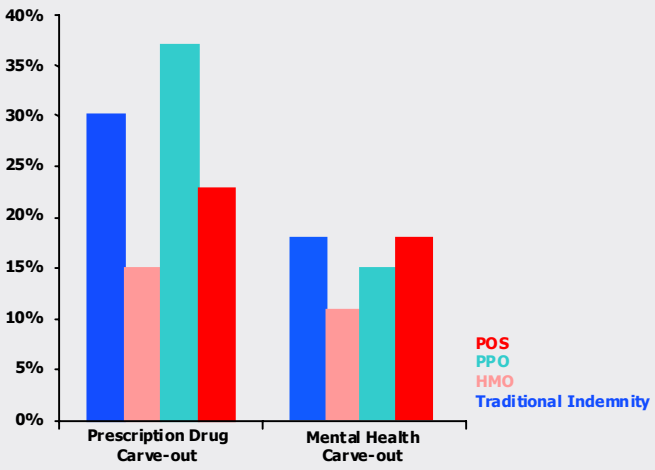
Direct contracting secures discounts for employers and purchasing groups ...

Chart 12: Percent of employers who contract with doctors and hospitals in their HMO and POS plan, by region, 1998



And carve-outs target utilization and costs for specific services.

Chart 13: Percent of employer health plans with prescription drug and mental health carve-outs, 1998



Strategy 4: Seek Value in the Cost and Quality Relationship

Limiting employee choice of plans and providers puts more of an onus on employers to ensure quality of service and care delivery. The National Committee on Quality Assurance (NCQA) collects quality and satisfaction data on plans, and many employers require their health plans to be NCQA accredited. Purchasing groups sometimes use report cards to provide employees with the information required to make their own cost-quality decisions.

The Buyers Health Care Action Group (BHCAG) formed in 1988 and began contracting directly with provider groups or care systems in 1997. In 1998, the BHCAG began measuring enrollee satisfaction by health plan. Beginning in 1998, enrollees were able to choose health plans based on cost and quality measures.

Satisfaction ratings include:

- Clinic
- Quality of Care and Service
- Accessibility to Doctors
- Visit Length
- Attention Received
- Medical Explanations

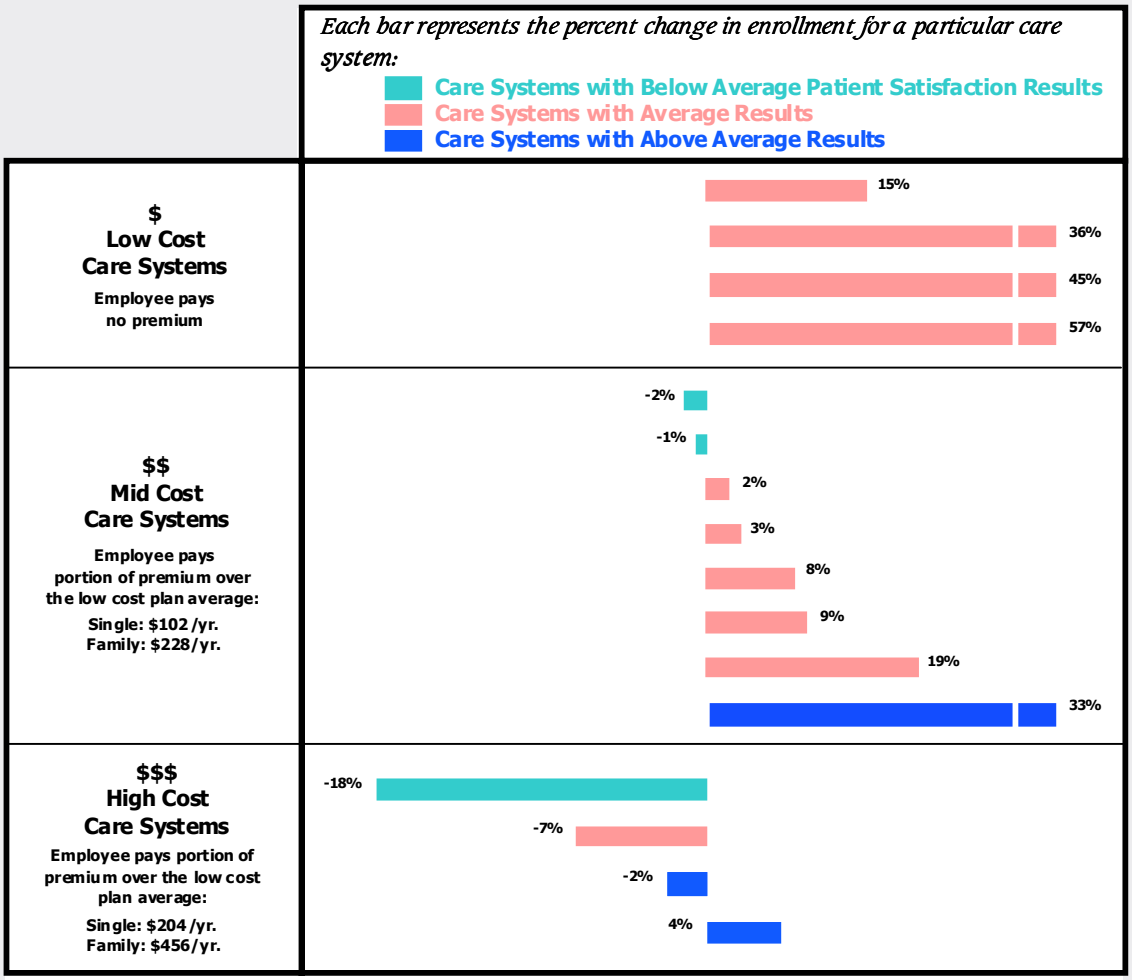
Quote from the field...

"With the cost of care more comprehensible to employees and the sticker price of higher priced coverage more of a direct hit to their pocket-books, many enrollees reacted just like K-Mart shoppers: they opted for the lowest priced deals."

- Frank Jossi on "Money Matters: A BHCAG Update from the Twin Cities," Business & Health, 1998

With information, employees shift out of higher cost, low performing care systems.

Chart 14: Percent change in enrollment by metro area care system due to the new BHCAG cost sharing and plan



Implications for Medicare Reform

Quote from the field ...

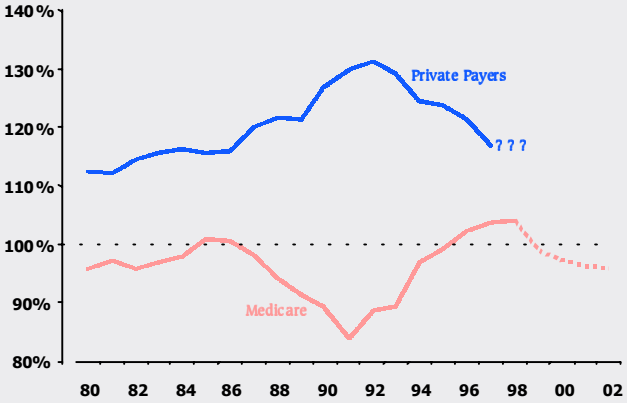
"It is impossible to reduce provider payments enough to extend the life of the Medicare Trust Fund for any significant length of time."

- Plan to Strengthen and Modernize Medicare for the 21st Century. National Economic Council/Domestic Policy Council, The White House

- Exacting deeper price concessions from providers may be difficult in the near term, whether Medicare does so directly or by contracting with insurance plans that rely upon discounts as their principal cost containment tool. Even so, maintaining the solvency of the Medicare trust fund will require more than provider payment reductions.
- Shifting more costs to Medicare beneficiaries is the most politically unattractive option, given the proportion of Medicare beneficiaries' incomes already devoted to health care costs.
- Medicare could gain some savings within the traditional system by selective contracting, centers of excellence or benefit carve-outs. Volume pricing could increase Medicare's leverage. However, HCFA would need to consider the impact of potentially large shifts in patient volume.
- As premiums in private insurance plans rise markedly again, market resistance to some managed care programs - with limited choice and access plus aggressive care management - may dampen. While this would create a new window of opportunity to promote such plans, any such strategy applied to Medicare must consider that:
  - Beneficiary satisfaction with traditional Medicare is much higher than with HMOs and health insurers.
  - Medicare, as a purchaser, will have to accept more accountability for plan/provider quality.

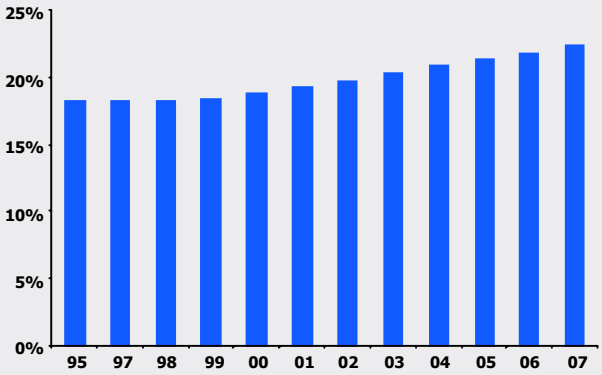
The private sector has paid the cost of Medicare losses in the past.

Chart 15: Payment to cost ratios for Medicare and private payers, 1980-1997, 1998-2002 projected



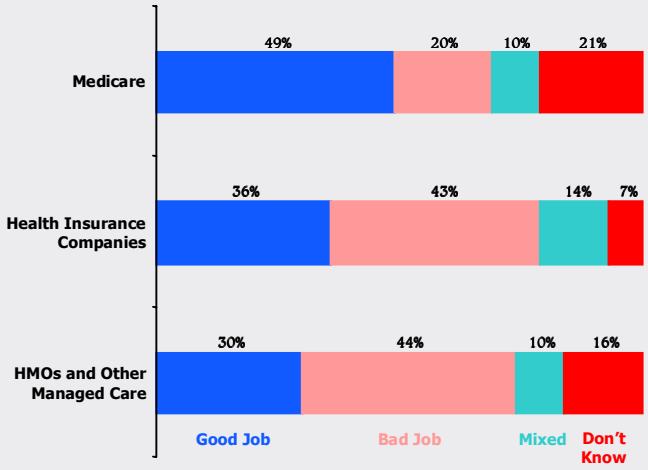
Under current program policies, Medicare beneficiaries will spend 22% of their income on health care by 2007.

Chart 16: Average out-of-pocket spending for Medicare beneficiaries as a percent of income



Consumers say they are more satisifed with Medicare than the private sector.

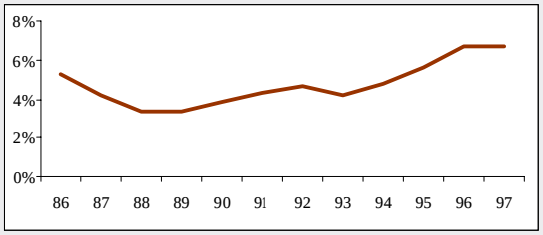
Chart 17: Percent who say how well each is serving health care consumers



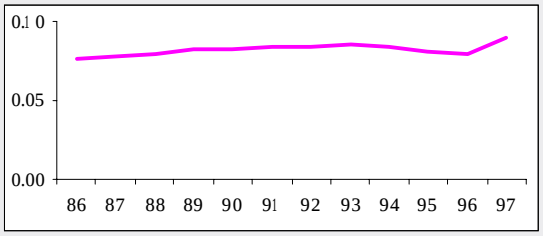
Stats to know

Hospital Sector

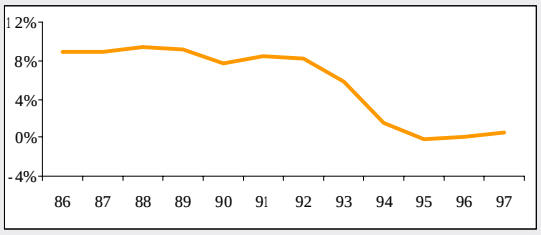
Total Margin: 86 to 97 Trend	1995	1996	1997
	5.6%	6.7%	6.7%



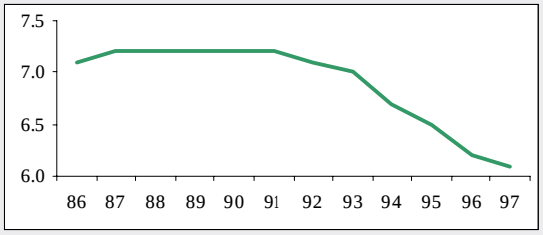
FTE per Adjusted Admission: 86 to 97 Trend	1995	1996	1997
	0.08	0.08	0.09



Percent Change in Cost per Case: 86 to 97 Trend	1995	1996	1997
	-0.2%	0.2%	0.6%

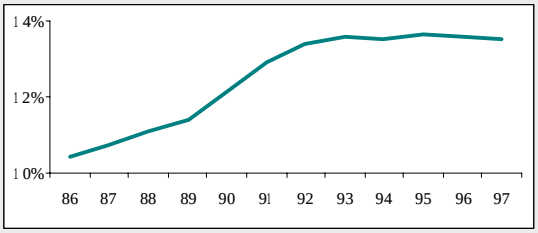


Average Length of Stay (in Days): 86 to 97 Trend	1995	1996	1997
	6.5	6.2	6.1

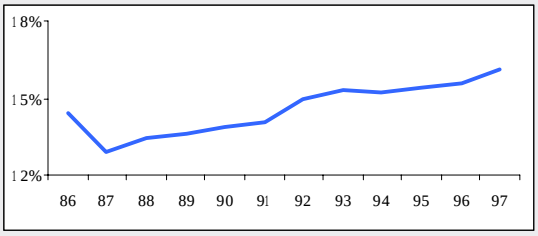


Healthcare Industry

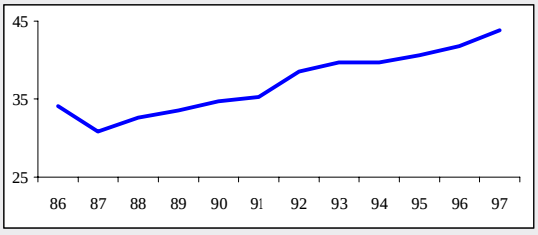
National Health Expenditure as a % of GDP: 86 to 97 Trend	1995	1996	1997
	13.6%	13.6%	13.5%



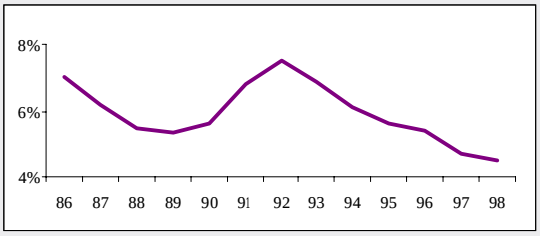
Percent Uninsured: 86 to 97 Trend	1995	1996	1997
	15.4%	15.6%	16.1%



Number Uninsured (in Millions): 86 to 97 Trend	1995	1996	1997
	40.6	41.7	43.7



Percent Unemployed: 86 to 98 Trend	1996	1997	1998
	5.4%	4.7%	4.5%



Sources:

Chart 1: Medicare growth rates from the Health Care Financing Administration (HCFA) and private spending growth from the National Health Accounts data. The growth in per capita Medicare spending in 1998 is 1.5 percent, which is in part due to delays in claims processing attributed to new fraud and abuse checks. To correct for this distortion, we used the growth in incurred costs for 1998, which was estimated to be about 3.3 percent.

Chart 2: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 7, Figure 2.

Chart 3: Decision Resources, Inc., InterStudy Publications. (August 1998). *The InterStudy HMO Trend Report 1987-97*, 87.

Chart 4: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 30, Figure 25.

Chart 5: The Henry J. Kaiser Family Foundation (August 1998) *Trends and Indicators in the Changing Health Care Marketplace*, 18, Exhibit 2.4.

Chart 6: American Medical Association, Center for Health Policy Research (1999), 24, Exhibit 6.

Chart 7: The Henry J. Kaiser Family Foundation (August 1998) *Trends and Indicators in the Changing Health Care Marketplace*, 23, Exhibit 2.11.

Chart 8: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 53, Text.

Chart 9: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 37, Figure 34.

Chart 10: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 31, Figure 26.

Chart 11: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 33, Figure 28.

Chart 12: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 92,94, Figure 77, 79.

Chart 13: KPMG Compensation & Benefits Health Care Group, *Health Benefits* (1998), 70, Figure 58; 73, Figure 62.

Chart 14: Jossi, F. *Money Matters: A BHCAG update from the Twin Cities* Business & Health (April 1998), 44.

Chart 15: The Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program* (July 1998), 26. Medicare projections based on *The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Payment Cuts*, The Lewin Group (May 1999).

Chart 16: The Lewin Group Analysis, *Medicare Benefits Simulation Model*, Version 2.0.

Chart 17: The Henry J. Kaiser Family Foundation/Harvard School of Public Health Chart Pack, *National Survey on Medicare: The Next Big Health Policy Debate?* October 20, 1998.

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Other Sources:

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The Lewin Group/American Hospital Association, *The Balanced Budget Act and Hospitals: The Dollars and Cents of Medicare Payment Cuts* (May 1998).

Sources for "Stats to Know":

Total Margin: AHA Annual Hospital Survey, 1986-1997
FTE/Adjusted Admission: American Hospital Association Annual Survey, 1986-1997
Percent Change in Cost per Case: American Hospital Association Annual Survey, 1986-1997
Average Length of Stay: Hospital Statistics, 1999 Edition, Healthcare Infosource, Inc.
National Health Expenditure as a Percent of GDP: Compiled by HCFA on www.hcfa.gov/stats/nhe-oact/tables/t09.htm
Percent Uninsured: Compiled by Bureau of the Census on www.census.gov:80/hhes/www/hlthins.html
Number Uninsured: Compiled by Bureau of the Census on www.census.gov:80/hhes/hlthins/hlthin97/hi97t8.html
Percent Unemployed: Compiled by Bureau of Labor Statistics on http://stats.bls.gov:80/cpsaatab.htm#empstat

TrendWatch is a quarterly report produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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