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 employers

… 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

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 contributing 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

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

<table>
<thead>
<tr>
<th></th>
<th>Number of Firms</th>
<th>Number of Covered Lives (1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buyers Health Care Action Group (BHCAG); Minneapolis, MN</td>
<td>28</td>
<td>150,000</td>
</tr>
<tr>
<td>Pacific Business Group on Health (PBGH); California</td>
<td>32</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Memphis Business Group on Health (MBGH); Memphis, TN</td>
<td>43</td>
<td>115,000</td>
</tr>
</tbody>
</table>

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

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

| Each bar represents the percent change in enrollment for a particular care system: |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
|                                | Care Systems with Below Average Patient Satisfaction Results | Care Systems with Average Results | Care Systems with Above Average Results |
| $ Low Cost Care Systems        | ![Graph showing percent change](chart14a.png) | ![Graph showing percent change](chart14b.png) | ![Graph showing percent change](chart14c.png) |
| Employee pays no premium       | ![Graph showing percent change](chart14d.png) | ![Graph showing percent change](chart14e.png) | ![Graph showing percent change](chart14f.png) |

<table>
<thead>
<tr>
<th></th>
<th>15%</th>
<th>36%</th>
<th>45%</th>
<th>57%</th>
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<tr>
<th>$2 Mid Cost Care Systems</th>
<th><img src="chart14g.png" alt="Graph showing percent change" /></th>
<th><img src="chart14h.png" alt="Graph showing percent change" /></th>
<th><img src="chart14i.png" alt="Graph showing percent change" /></th>
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<tr>
<td>Employee pays portion of premium over the low cost plan average:</td>
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<td></td>
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<tr>
<td>Single: $102/yr.</td>
<td><img src="chart14j.png" alt="Graph showing percent change" /></td>
<td><img src="chart14k.png" alt="Graph showing percent change" /></td>
<td><img src="chart14l.png" alt="Graph showing percent change" /></td>
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<tr>
<td>Family: $228/yr.</td>
<td><img src="chart14m.png" alt="Graph showing percent change" /></td>
<td><img src="chart14n.png" alt="Graph showing percent change" /></td>
<td><img src="chart14o.png" alt="Graph showing percent change" /></td>
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<th>$3 Mid Cost Care Systems</th>
<th><img src="chart14p.png" alt="Graph showing percent change" /></th>
<th><img src="chart14q.png" alt="Graph showing percent change" /></th>
<th><img src="chart14r.png" alt="Graph showing percent change" /></th>
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<tr>
<td>Employee pays portion of premium over the low cost plan average:</td>
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<tr>
<td>Single: $204/yr.</td>
<td><img src="chart14s.png" alt="Graph showing percent change" /></td>
<td><img src="chart14t.png" alt="Graph showing percent change" /></td>
<td><img src="chart14u.png" alt="Graph showing percent change" /></td>
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<td>Family: $456/yr.</td>
<td><img src="chart14v.png" alt="Graph showing percent change" /></td>
<td><img src="chart14w.png" alt="Graph showing percent change" /></td>
<td><img src="chart14x.png" alt="Graph showing percent change" /></td>
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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 pocketbooks, many enrollees reacted just like K-Mart shoppers: they opted for the lowest priced deals."

Implications for Medicare Reform

- 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.

Charts:

- The private sector has paid the cost of Medicare losses in the past.
- Under current program policies, Medicare beneficiaries will spend 22% of their income on health care by 2007.
- Consumers say they are more satisfied with Medicare than the private sector.
**Stats to know**

### Hospital Sector

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<tbody>
<tr>
<td></td>
<td>5.6%</td>
<td>6.7%</td>
<td>6.7%</td>
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### Healthcare Industry

<table>
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<tr>
<th>National Health Expenditure as a % of GDP: 86 to 97 Trend</th>
<th>1995</th>
<th>1996</th>
<th>1997</th>
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<tbody>
<tr>
<td></td>
<td>13.6%</td>
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<tbody>
<tr>
<td></td>
<td>15.4%</td>
<td>15.6%</td>
<td>16.1%</td>
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<tr>
<td></td>
<td>40.6</td>
<td>41.7</td>
<td>43.7</td>
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### Percent Unemployed: 86 to 98 Trend

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<tr>
<td>5.4%</td>
<td>4.7%</td>
<td>4.5%</td>
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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 4: KPMG Compensation & Benefits Health Care Group, Health Benefits (1998), 30, Figure 25.
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), 51, 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.
Table 1: Buyers Health Care Action Group, Pacific Business Group on Health and Memphis Business Group on Health.

Other Sources:
Rabinow, A. The Buyers Health Care Action Group: Creating a Competitive Care System Model. Managed Care Quarterly (1997).
Health Care Financing Administration, Office of Medicare/Medicaid, as included in Extramural Research Report. (September 1998). Medicare Participating Heart Bypass Center Demonstration.

Sources for “Stats to Know”:
Total Margin: AHA Annual Hospital Survey, 1986-1997
Percent Change in Cost per Case: American Hospital Association Annual Survey, 1986-1997
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/hlthin97/hi97t8.html
Number Uninsured: Compiled by Bureau of the Census on www.census.gov:80/hhes/hlthin97/hi97t8.html

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.