Health Care Costs and Managed Care

BACKGROUND

Unless otherwise noted, all national data presented are from 2000, and all Michigan data are from 1998; these are the latest years for which adequate comparable data are available.

GLOSSARY

Capitation
A payment method in which a managed-care plan, group of health care providers, or individual provider receives a fixed monthly fee in return for delivering certain or all health services to a single patient or family. The capitation fee is paid regardless of how many instances of care occur.

Federal poverty level
The minimum annual income required by a family to meet food, shelter, clothing, and other basic needs: in 2002, $15,020 for a family of three (the amount varies by family size); set according to formula by the federal government.

Health maintenance organization (HMO)
A type of managed-care plan; offers enrollees comprehensive coverage for specific health services for a fixed, prepaid premium.

Managed care
A broad term for a comprehensive approach to health care delivery that (1) provides care to enrollees, usually on a capitated basis; (2) coordinates care, to ensure appropriate use of services; and (3) monitors and measures provider performance, to control costs and maintain or improve care.

Medicaid
The federal-state program that pays for health care services to many low-income people, including elderly who qualify.

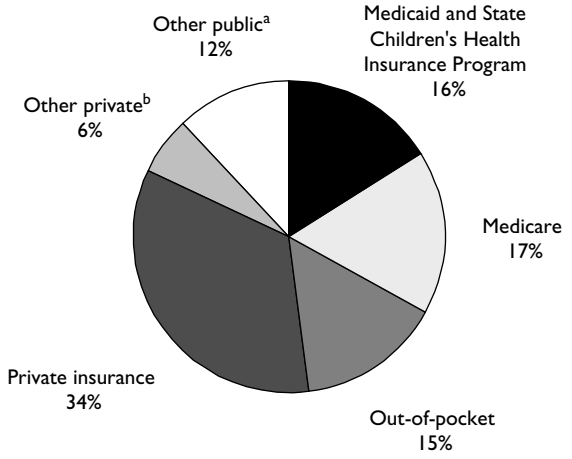
- National health expenditures reached $1.3 trillion in 2000, up 6.9 percent over 1999. Preliminary estimates place 2001 growth at more than 8 percent. The rise in 1999 and 2000 health spending outpaced growth in the gross domestic product (GDP), signaling the end of the nine-year stability of health spending's share of the GDP. Health spending now comprises 13.2 percent of the nation's economy.
- In 1998 Michigan personal health expenditures—total health expenditures less medical research and facility-construction costs—were estimated at $35.6 billion.

Programs and Payers

Exhibit 1 shows that public programs account for almost half (45 percent) of the nation's health care bill. The major public programs are

- *Medicare*, the federal program that provides a wide range of health services to the elderly, blind, and disabled; and
- *Medicaid*, the joint federal-state program that offers comprehensive health services to some adults living in poverty and to children—depending on their age—living in households at or below 185 percent of the federal poverty level.

EXHIBIT 1. National Health Expenditures, by Program, 2000



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
[a]*Includes such programs as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and state and local government hospital subsidy and school health.*
[b]*Includes industrial in-plant, privately funded construction and nonpatient revenues, including philanthropy.*

Together, these two programs make up 37 percent of Michigan's health spending and 33 percent of the nation's.

- Medicare spending amounted to 22 percent of the state's health bill and 17 percent of the nation's (national spending was $224 billion in 2000).
- Medicaid spending amounted to 15 percent of the state's health bill and 16 percent of the nation's (national spending was $202 billion in 2000).
- Other government programs (public health, health care for military personnel, and others) accounted for 12 percent of the nation's bill in 2000.

The exhibit also shows that private health insurance, much of it offered by employers to their employees, paid a third—$442 billion—of the nation's health bill in 2000. Most of the remainder ($195 billion)—for copayments, deductibles, and other health services and products not covered by health insurance—was paid out-of-pocket by patients.

The private-spending share of health expenditures grew between 1997 and 1999, offsetting public-share declines caused primarily by slower Medicare spending growth. In 2000 public and private spending grew at about the same rate. In the near future, private-expenditure growth is expected to outpace public-sector health spending because outpatient prescription drug costs, which Medicare does not cover, are rising rapidly.

More recent data on employer-based health insurance show that after five years of record low inflation (1994–98), health insurance premiums rose dramatically in 1999, 2000, and 2001. In fact, premiums increased 11 percent between the spring of 2000 and 2001. Smaller businesses—those with fewer than 100 employees—saw higher increases (12.5 percent on average) than did large firms (10.2 percent). When employer and employee shares of health insurance premiums are combined, the average cost of individual coverage was $221 a month ($2,652 a year) in 2001. Family coverage averaged $588 a month ($7,056 a year).

As premiums rose, employers increased the employee share of the family premium from $122 to $150 a month, on average, between 1996 and 2001, but the proportion of the premium paid by employees stayed about the same (27–28 percent). Employers have been requiring employees to pay higher deductibles and copayments, however, which means that workers are bearing a growing proportion of their health insurance costs.

Medicare
The federal program that pays for many health care services for people who are blind, disabled, or aged 65 and older.

Panel
The group of providers—physicians, hospitals, pharmacists, others—authorized by a managed-care plan to care for the plan's enrollees.

Point-of-service plan (POS)
An HMO variation that allows enrollees to seek care outside the plan's panel of providers without having to pay the entire cost.

Preferred provider organization (PPO)
A group of providers that agrees to furnish services, at negotiated fees, to a payer's enrollees in exchange for the likelihood of increased patient volume; functions similarly to POS plans, but PPOs contract with HMOs and insurers rather than acting as insurers themselves.

Primary care provider
The physician in charge of all aspects of a patient's care, including referral to specialists.

Qualified health plan (QHP)
An HMO that meets certain state requirements; QHPs are used by the state to serve most of the Medicaid population.

Providers

Health care expenditures also may be broken down by provider, as shown in Exhibit 2. Nationally, more than half of health dollars go for hospital services and physician care (32 percent and 22 percent, respectively); these portions of the nation's health spending have not changed much since 1960. Declining in the last four decades have been the shares taken up by dental care and drugs, the latter dramatically despite rising drug costs in recent years. Nursing-home and home-health care and other professional services have grown significantly in the same period.

In Michigan, hospitals received 41 percent of health dollars in 1998. Physician and other professional services received 26 percent, drug and other medical supplies 14 percent, nursing homes 7 percent, dental services 6 percent, home health care 2 percent, eyeglasses and other durable medical equipment 2 percent, and other personal health care 2 percent.

Although drugs' share of the national and state health dollar has declined in recent decades, it is likely to start growing—perhaps significantly—in the years ahead. The

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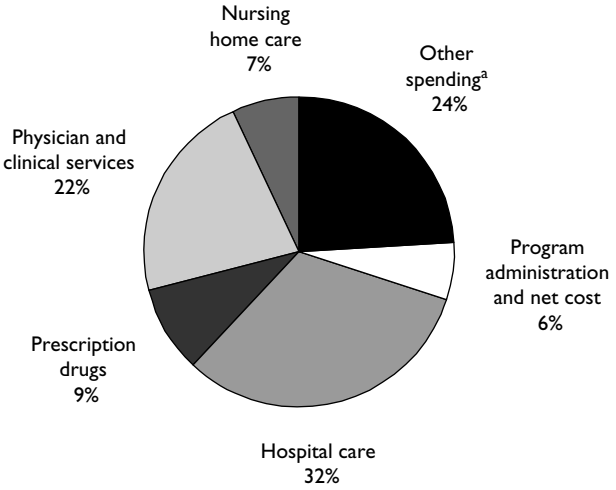

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
[a]Includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction.

average yearly cost of prescription drugs per person nationally in 1993 was $195; by 2000 it was $417. Drug costs are rising primarily for three reasons.

- More people are taking prescription drugs and those who already were taking them are taking more of them.
- Newer, more expensive drugs are entering the market, replacing older, less expensive counterparts.
- Prices are rising on existing drugs.

Managed Care

Managed care is a broad term for any comprehensive approach to health care delivery that (1) provides care to enrollees usually on a capitation (fixed monthly fee) basis (2) coordinates patient care so as to ensure the appropriate use of services, and (3) routinely monitors and measures the performance of health providers so as to control costs and maintain or improve care.

Managed-care plans almost always practice selective contracting—that is, they ask only some physicians, hospitals, pharmacists, and other providers in a geographic area to join their panel (the group that the plan authorizes to care for its enrollees). Many plans also require enrollees to choose a primary care physician, who is in charge of all aspects of their care, including referrals to a specialist (the plan will not pay for specialist treatment unless the patient was referred by his/her primary care physician). There are three common types of managed-care plan.

- *Health maintenance organizations* HMOs are the best-known type of managed-care plan. They offer enrollees comprehensive coverage for specific health services for a fixed, prepaid premium. If enrollees obtain health care from a provider not on their plan's panel, they must pay the full cost for the care out of their own pocket.
- *Point-of-service plan (POS)* This is an HMO variation that allows enrollees to seek care outside the panel without having to pay the entire cost. POS plans are becoming more popular because many view them as a way to preserve a wider choice of providers than with a conventional HMO.
- *Preferred provider organization (PPO)* PPOs are groups of providers that agree to furnish services to a payer's enrollees at negotiated fees in exchange for the likelihood of increased patient volume. PPOs generally function like POS plans—with enrollees required to pay more for a service if they use a non-PPO provider—but they usually do not monitor provider costs and performance as closely as HMOs do.

Managed care is a driving force in the evolution of the U.S. health care system, but it no longer is viewed by most employers and federal and state governments as the primary means by which health care costs can be brought under control. The past two years have shown that health care costs can rise significantly even as managed-care enrollment rises. As the numbers below illustrate, many more employees are in less restrictive health plans (PPOs and POS plans, sometimes called "managed care lite") than are in HMOs, which makes it more difficult for employers to control health care costs.

In 2001, 93 percent of the nation's workers were in an HMO, POS plan, or PPO, up from 40 percent in 1992. Only 7 percent of workers with employer-sponsored health insurance were in traditional indemnity plans.

- HMO enrollment peaked in 1996 at 31 percent of the working population; in 2001 the figure was 23 percent.
- PPO enrollment has risen from 28 percent in 1996 to 48 percent in 2001.
- POS plans covered 14 percent of workers in 1996 and 22 percent in 2001.

- In Michigan, as of September 30, 2001, 29 HMOs served almost 2.7 million members (more than one-quarter of the state's population). Medicare beneficiaries enrolling in HMOs have declined in recent years, as many health plans withdrew from the federal program because of inadequate payment for services. In Michigan in 2001, about 79,000 beneficiaries were enrolled in Medicare HMOs; the number is projected to be lower in 2002. Michigan has moved most Medicaid beneficiaries into qualified health plans (QHPs), HMOs that meet certain state requirements; as of December 2001, 742,000 are enrolled in a QHP—90 percent of those eligible for a QHP and almost two-thirds of the total Medicaid population.

DISCUSSION

Why Health Costs Rise

Health care costs rise for several reasons.

- *Inflation and population growth* These factors are persistent and, for the most part, outside the health care sector's control. As the huge baby boom generation (those born between 1946 and 1964) ages, its use of health care services will drive up costs dramatically.
- *Health price inflation* This exceeds general inflation and annually contributed an average of 3 percent to 1999–2001 health cost increases.
- *Frequency and intensity of use of services* The higher the use, the higher the expenditures. Use of services is increasing within certain age groups (e.g., the elderly), which may be compounded by the increase in the size of the age group (again, the elderly are an example). New technologies and drugs also contribute to rising costs, especially when they do not fully replace other diagnosis and treatment methods.

In the mid-to-late 1990s, managed care was successful in limiting the growth in two of the factors above—inflation and utilization—largely by negotiating fee discounts with providers, limiting unnecessary care, and requiring cost-conscious decision-making by providers. There are limits to such actions, however, and in recent years there has been a resurgence in health cost increases. Most experts agree on several reasons for accelerated health spending in 1999–2001.

- To gain market share, managed-care plans had accepted lower revenue/profits, but they could not continue this practice and stay in business.
- Managed-care plans had forced providers (mainly hospitals and physicians) to accept reduced reimbursement for several years, but providers no longer are willing to accept this and are strengthening their negotiating leverage through consolidation.
- Health care is labor intensive, and significant shortages of professionals, particularly nurses, mean that to attract and keep sufficient numbers of these professionals, health care employers have had to increase compensation.
- Public and provider backlash against certain cost-control practices is leading (1) managed-care plans to alter their practices "voluntarily" and (2) state and federal lawmakers to press for legislation limiting ways that plans may cut costs.
- Advances in pharmaceutical and medical technology—such as new biotechnology drugs and improvements in artificial limbs, valves, and organs—prolong life, but they are expensive and few people want any limit placed on the development and appropriate use of such advances.
- The population continues to age, and an older population uses more health care services.

Managed Care

Some experts contend that managed care can control costs without jeopardizing the quality of care. They point out that when working properly, managed-care plans and providers are rewarded financially for keeping people healthy, which limits cost increases and improves quality. They add that managed care's greater use of preventive services and patient education helps to cut costs, as has the development of clinical guidelines that allow physicians to forgo costly procedures that have little likelihood of improving a patient's health. As medical science is able to define more precisely what works and what does not, they assert that unnecessary care can be identified and reduced and quality enhanced.

Supporters of health plans also note that through the National Committee for Quality Assurance (NCQA), HMOs voluntarily may seek accreditation—an indicator of a certain level of quality and financial stability. NCQA reviews are rigorous on- and off-site evaluations, conducted by physician teams and managed-care experts. The reviews assess such clinical quality indicators as frequency of regular breast-cancer screening and childhood immunization, advice to smokers to quit, first-trimester prenatal care, and use of appropriate medication following a heart attack. To receive accreditation, an HMO must meet specific standards in clinical care, prevention of illness and injury, patient satisfaction, and financial stability. An increasing number of employers are requiring HMOs to have NCQA accreditation before they will contract with them.

Health plans are enmeshed in a complex battle among health care interest groups. Critics of managed-care plans, including some consumers/employees and providers, argue that their practices threaten quality. They contend that most health plans focus primarily on the bottom line and that to do so means that they must deny care that physicians and other caregivers deem necessary. Other critics, including some employers, believe that managed-care plans have not succeeded at controlling costs.

The call in recent years for federal and state "patient bill of rights" legislation confirms that there is conflict among health plans, employers, consumers, and providers. Many consumers want a wide choice of providers, particularly physicians, whom they may see without financial penalty. Many managed-care plans, however, view restricting their provider panel as essential to controlling costs—it is the only way that they can steer patients to cost-effective hospitals and physicians. The rapid growth of POS plans suggests that managed care is attentive to consumers' demand for greater choice, but it remains to be seen whether this demand will continue as health insurance premiums rise and employers ask consumers to pay a greater share of the premium.

Current legislative debate about health care centers on many practices of managed-care plans and government's role in regulating them. Congress and almost every state have proposals or new laws to toughen HMO regulation. The most common initiatives would

- expand patients' legal recourse if they believe an HMO has denied or delayed necessary care;
- give certain patients direct access to specialists;
- prohibit "gag rules"—that is, proscribe managed-care plans from limiting what physicians may tell patients about treatment alternatives;
- prevent HMOs from denying payment for emergency services because the HMO determines after the fact that the patient's symptoms did not warrant an ER visit;
- prohibit routinely discharging new mothers and/or their newborns from the hospital in less than two days (normal delivery) or four days (caesarean section);
- prevent outpatient surgery for mastectomies;
- require that certain information about the plan be disclosed to plan members (e.g., certain indicators of quality, how the HMO selects panel providers, and any financial incentives the HMO offers to providers to keep costs down);
- require a consumer ombudsman within or outside the plan to act as a patient advocate; and
- require that members be afforded access to a sufficient number and mix of specialty physicians and other providers.

Proponents of many of these provisions contend that they protect quality of care. Opponents of some measures contend that HMOs rarely engage in the practices that the bills address and therefore legislation is unnecessary. As to limiting access to specialists, experimental treatment, and emergency care, however, they argue that managed care's ability to control costs and maintain quality depends on being permitted to take these very actions.

Controlling Costs

There have been many efforts to control health care costs. Employers are starting to shift more costs onto their employees, and this probably will accelerate during the economic downturn because workers are more likely to accept the increases than to try to move to another job.

Employers, government, and health plans also are working to address rapidly escalating prescription drug costs. Employers have increased prescription copayments, often by dividing brand-name drugs into preferred and nonpreferred categories, which creates a three-tiered drug benefit: Generic drugs have the lowest copay, preferred brand-name drugs have a higher copay, and nonpreferred brand-name drugs have the highest. Campaigns to get prescribers and patients to use generic drugs more frequently when appropriate also are underway. Large employers and government long have sought to limit drug costs by bulk purchasing and, very recently, with price controls. Michigan and a few other states recently notified drug companies that their products will be excluded from Medicaid's preferred list of drugs if they do not lower their prices. The drug companies and others contend that Medicaid beneficiaries will be denied the medication they need under such an action.

Improving Quality

Most health care experts believe that the efforts discussed above will fail to control health care costs. Others add that such efforts could even threaten the quality of care. To make matters worse, the cost of new technology and drugs and, especially, the aging of the population will drive up health care costs for the foreseeable future.

To try to confront this seemingly intractable problem, health policy experts and practitioners increasingly are focusing on the issue of quality. They believe that the only way to gain control of unsustainable increases in health costs is to improve the quality of care because, they con-

tend, too much care is unnecessary or unproven. Doing this means better identification and elimination of unnecessary care and delivering only care that will benefit the patient as efficiently as possible. They argue that more must be done to

- translate into medical practice the procedures known from research to be effective in restoring patients to health and managing chronic disease (called "evidence-based medicine");
- limit the use of procedures for which there is no solid basis in research;
- reduce errors in the health care *system* that are not the fault of individual professionals but are a factor in thousands of preventable deaths every year;
- endeavor to better coordinate patient care among physicians and other professionals, especially for the millions of Americans with chronic illnesses such as diabetes, high blood pressure, and arthritis; and
- emphasize prevention of illness and injury by promoting healthy behavior (e.g., regular exercise, good nutrition, seat belt use, modest alcohol consumption, no tobacco consumption).

Perhaps the most prominent nationwide initiative to put these ideas into practice is the Leapfrog Group. Comprising many large employers—including the big three automakers, General Electric, and Verizon—the Leapfrog Group focuses on developing tangible leaps in patient safety and quality, rewarding high-quality care providers, and informing employers and consumers about these efforts. Currently, three tangible leaps are sought.

- *Computerized physician-order entry* Physicians' handwriting can be misread, leading to serious prescription errors. Hospitals would require physicians to enter medication orders into a computer linked to prescribing-error-prevention software.
- *Intensive-care-unit physician staffing* Research shows that patients do best in an intensive care unit that is staffed with intensive-care specialists.
- *Evidence-based hospital referral* Employers should direct patients and health plans to hospitals that have demonstrated high quality of care for certain common procedures.

In our state, the Michigan Health and Safety Coalition (MH&SC)—with active participation from automakers, labor, providers, insurers, state government, and others—is helping to carry out the Leapfrog initiatives and other programs to improve the quality of care.

Everyone agrees that Americans use too much health care and that the value of much of it is unproven, but there is no consensus on how to eliminate rationally and humanely the services we do not need. Leapfrog and similar efforts offer promise. What is certain is that the battles today are only a dress rehearsal for those that we will see in a decade, when the huge baby boom generation begins to reach age 65, and its health care needs intensify.

See also Aging; Communicable Diseases and Public Health; Health Care Access, Medicaid, and Medicare; Long-Term and Related Care; Mental Health Funding and Services; Substance Abuse; Tobacco Settlement; Youth at Risk.

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