

# Health Care Costs and Managed Care

## BACKGROUND

Unless otherwise noted, all national data presented are from 1996, and all Michigan data are from 1995; these are the latest years for which adequate 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 1998, \$13,650 for a family of three (varies by family size); set according to formula by the federal government.

### Global budgeting

A cap on all expenditures in a certain category; in discussion of U.S. health care, it refers to a nationwide limit on health care spending.

### Health maintenance organization (HMO)

A managed-care plan; offers enrollees comprehensive coverage for specific health services for a fixed, prepaid premium.

### Managed care

A broad term for any comprehensive approach to health care delivery that (1) coordinates patient care so as to ensure appropriate utilization of services, and (2) routinely monitors and measures health providers' performance so as to control cost and maintain or improve the quality of care.

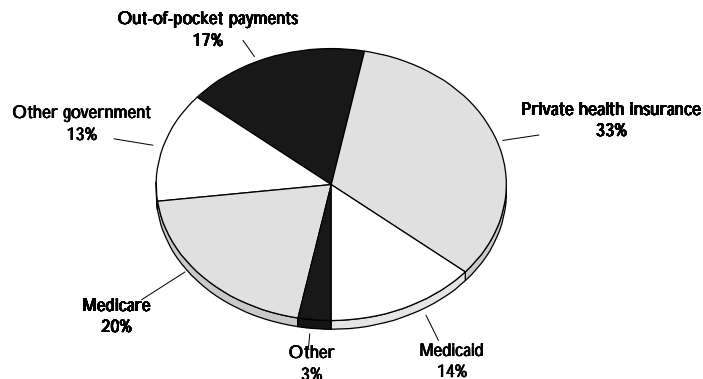
## Health Care Spending

- National health expenditures reached \$1.035 trillion in 1996. While this is an increase of 4.4 percent over 1995, it represents a significant moderation in the rate of increase from the 1980s and early 1990s, when annual increases averaged more than 10 percent.
- Michigan personal health expenditures—total health expenditures less medical research and medical facility construction costs—were estimated at \$29.8 billion.

## Programs and Payers

Exhibit 1 shows that public programs account for almost half (47 percent) of the nation's health care bill. For Michigan the figure is 40 percent.

## EXHIBIT 1. National Health Expenditures, by Program, 1996



SOURCE: Health Care Financing Administration, U.S. Department of Health and Human Services, 1997.

- Medicare (the federal program that provides a wide range of health services to the elderly, blind, and disabled) had spending of \$203 billion, or 20 percent of total costs; the Michigan figure is 21 percent.
- Medicaid (the joint federal-state program that offers comprehensive health services to many adults living in poverty and children—depending on their age—living in households at or below 185 percent of the federal poverty

level) spent \$148 billion, or 14 percent of the nation's health bill; the Michigan figure also is 14 percent.

- Other government programs (public health, health care for military personnel, and others) accounted for 13 percent of the nation's bill and 5 percent of Michigan's.

The exhibit also shows that private health insurance, much of it offered by employers to their employees, paid a third—\$337 billion—of the nation's health bill in 1996; the 1995 Michigan figure is 40 percent. Most of the remainder—for copayments, deductibles, and other health services and products not covered by health insurance—was paid out of pocket by patients.

#### **Medicaid**

*Federal/state program that pays for health care services to many low-income people, including elderly who qualify.*

#### **Medicare**

*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—that are authorized by a managed-care plan to care for the plan's enrollees.*

#### **Point-of-service plan (POS)**

*Variation of an HMO; 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 agree to furnish services to a payer's enrollees at negotiated fees, in exchange for the likelihood of increased patient volume; generally function like 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.*

#### **Rationing**

*Deciding in certain circumstances not to permit certain medical procedures to be performed.*

From 1960 to 1989, growth in public- and private-sector health spending was similar and varied only with significant expansion of public programs: the establishment of Medicare and Medicaid (1966–67) and the expansion of Medicare to people with disabilities (1973). From 1989 through 1996, however, *public* spending on health care grew at nearly the same annual rate (9.7 percent) as it did in the 1980s (10.5 percent), but *private* spending increases declined, to an average of 5.8 percent annually from 11.2 percent in the 1980s. This gap between public and private spending growth may be explained largely by private employers' aggressive attempts to control their health insurance premium costs, primarily through managed care (see below); state and federal governments have not moved to managed care as aggressively as has the private sector. Under the 1997 federal Balanced Budget Agreement, however, Medicare will be cut more than \$100 billion over the next five years. Medicaid will see more modest federal cuts, although states, including Michigan, expect to realize significant savings from new managed-care programs in which most of their Medicaid recipients must enroll. (Note: In health care parlance, savings do not mean actual declines in spending but rather cuts in expected spending increases.)

From 1992 to 1996, employer-based private health insurance premiums rose an average of 3.8 percent annually, a significant reason for the moderation in private spending in this decade. Some large companies were able to negotiate even lower rate increases with insurers. At the same time, employers have increased the *employee* share of the premium by an average of 7.2 percent each year from 1992 to 1996. In other words, workers are bearing a growing proportion of their health insurance costs, a mark of the devolution of responsibility for health care payment. This is borne out in a spring 1997 article in *Health Care Financing Review*, in which the authors (Cowan and Braden) explain who ultimately pays what share of the health care bill. They show that in 1995

- government paid for 38 percent of health services and supplies,
- households paid for 34 percent,
- businesses paid for 26 percent, and
- the remaining 2 percent were nonpatient revenue.

## HEALTH CARE COSTS AND MANAGED CARE

In other words, health care cost distribution is different, depending on whether one looks at it by program or payer.

- *By program* The share of premium that employers and employees pay is counted as *private* health insurance payments. Employer and employee Medicare payroll tax payments are counted as *public* health insurance payments.
- *By payer* The employee's share of the premium is counted as *household* spending and so are his/her Medicare payroll tax payments; the employer's share of the payroll tax is counted as *business* spending (because it is seen as "paying" for a portion of Medicare).

### Providers

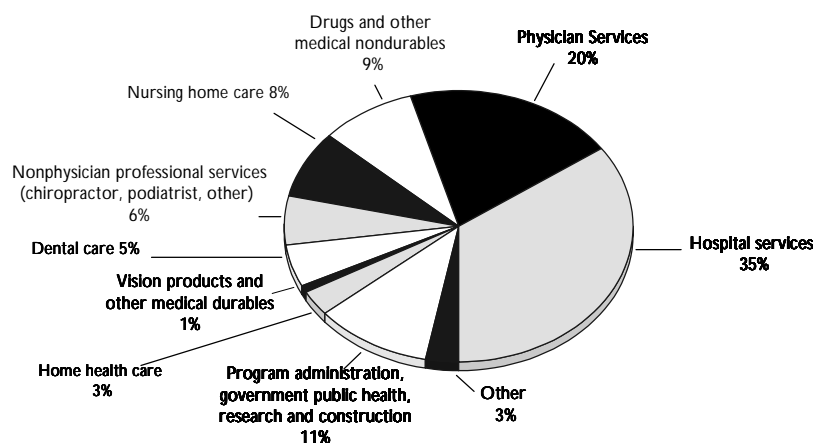
Health care expenditures also may be broken down by provider, as shown in Exhibit 2. Nationally, more than half of the health care dollars go for hospital services and physician care (35 percent and 20 percent, respectively); these shares of the nation's health care spending have not changed much since 1960. Declining in the last four decades have been the shares taken up by dental care and drugs, the latter dramatically. Nursing-home and home-health care, and other professional services have grown significantly in the same period.

In Michigan in 1995, hospitals received 42 percent of health care dollars, down from 48 percent in 1980. Physicians received 20 percent, drug and medical supplies 11 percent, nursing home 7 percent, other professional services 7 percent, dental services 6 percent, home health care 3 percent, eyeglasses and other durable medical equipment 2 percent, and other personal health care 2 percent.

### Managed Care

Managed care is a broad term for any comprehensive approach to health care delivery that (a) coordinates patient care so as to ensure the appropriate utilization of services, and (b) routinely monitors and measures the performance of health providers so as to control cost and maintain or improve the quality of care. Managed-care plans almost always practice *selective contracting*, that is, they ask only some physicians, hospitals, pharmacists, and other providers in a geographical area to join their *panel* (the group that the plan authorizes to care for the plan's enrollees). Many plans also require that all enrollees choose a *primary care* physician, who is in charge of all aspects of the enrollee's care, including referral to a specialist (such plans will not pay for specialist treatment unless the patient was referred by his/her primary care physician).

**EXHIBIT 2. National Health Expenditures, by Provider, 1996**



SOURCE: Health Care Financing Administration, U.S. Department of Health and Human Services, 1997.

- *Health maintenance organizations* (HMOs) are the best-known example of managed-care plans. They offer plan 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.
- A variation of the HMO, the *point-of-service plan* (POS), allows enrollees to seek care outside the panel without having to pay the entire cost. POS plans are growing in popularity because many view them as a way to preserve a wider choice of providers than the conventional HMO.
- The third major example of managed care is a *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.

Without question, managed care is the driving force in the evolution of the U.S. health care system. Most employers and federal and state governments see managed care as the means by which health care costs can be brought under control without sacrificing the quality of care that patients receive. The growth in managed care has been brisk in recent years.

- In 1996, 63 percent of the nation's population were in an HMO, POS plan, or PPO, up from 40 percent in 1992.
- As of July 1, 1996, 63 million Americans (approximately 23 percent of the population) were enrolled in an HMO, up from 35 million in 1990.
- The 1997 KPMG Peat Marwick national business survey found that 73 percent of employees were in managed care: 28 percent in an HMO, 25 percent in a PPO, and 20 percent in a POS plan.
- In Michigan, as of June 1997, 22 HMOs served almost 2.3 million members (approximately 23

percent of the state's population). State Medicaid and Medicare beneficiaries also are enrolling in HMOs in growing numbers. Michigan has been rapidly moving most Medicaid eligibles into HMOs, beginning with Wayne, Oakland, Macomb, Washtenaw, and Genesee counties in late 1997 and early 1998; the remaining 78 counties are following in 1998.

## DISCUSSION

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Health care costs rise for several reasons.

- *Inflation and population growth* These factors are persistent and, for the most part, outside the control of the health care sector.
- *Health price inflation* This exceeds general inflation and annually contributed 3 percent to health care cost increases in the early 1990s but little in recent years.
- *Frequency and intensity of use of health care services* The higher the use, the higher the expenditures. The use of services is increasing within certain age groups (for example, 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 when they do not fully replace other methods for diagnosing and treating illness and injury.

In the past 3–4 years, managed care has limited the growth of the latter two reasons largely by negotiating fee discounts with providers, limiting unnecessary care, and requiring cost-conscious decision-making by providers. Two questions arise: Can managed care continue to suppress the growth of health care costs? In its efforts to control costs, does managed care compromise the quality of care delivered to patients?

In reply to the first question, most experts agree that recent years' modest growth in health care costs will end in 1998. They offer several reasons.

- To gain market share, managed-care plans have accepted lower revenue/profits; they cannot continue this practice and remain strong.

## HEALTH CARE COSTS AND MANAGED CARE

- Managed-care plans have forced providers (mainly hospitals and physicians) to accept reduced reimbursement for several years; providers no are longer willing to accept these reductions and are strengthening their negotiating leverage by forming their own groups (physician-hospital organizations, physician organizations, and provider-sponsored organizations).
- The backlash among the public and providers against certain cost-control practices is leading (1) managed-care plans to alter their practices “voluntarily” and (2) lawmakers at the state and federal level to press for legislation that limits how plans are permitted to cut costs.
- Advances in medical technology—such as new AIDS drugs and progression in artificial limbs, valves, and organs—are expensive and life prolonging; few people want any limit placed on their development and appropriate use.
- The population continues to age, and an older population uses more health care services.

In reply to the second question—about how cost controls affect the quality of care—some observers argue that managed care will continue to 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 will help cut costs, as will 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, unnecessary care better can be identified and reduced and quality enhanced.

Nevertheless, controversy continues about whether managed care can control costs without compromising quality. In its December 22, 1997 front page article, *The Wall Street Journal* summed it up:

It is becoming ever harder to get consumers, doctors, employers, and regulators to agree on what changes, if any, would constitute an im-

provement for everyone. . . . HMOs, once hailed as a solution to [drawing the line on medical spending], are being squeezed between contradictory goals, trying to reconcile what consumers want and what employers and governments will pay for.

Many consumers want a wide choice of providers, particularly physicians, whom they may see without paying a financial penalty. Many managed-care plans, however, view restricting their provider panel as essential to controlling costs; only then can they steer patients to cost-effective hospitals and physicians. The rapid growth of POS plans (nationwide enrollment more than tripled from 1992 to 1996) suggests that managed care is attentive to consumers’ demand for greater choice. It remains to be seen whether this demand will continue after health insurance premiums rise and employers ask consumers to pay a greater share of their premium. Even so, several of the managed-care consumer-protection bills introduced in Congress and state legislatures (including Michigan) require managed-care plans to offer a POS option.

In fact, legislative debate about health care is centering 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

- give certain patients direct access to specialists;
- prohibit “gag rules”—that is, managed-care plans would be proscribed from limiting what physicians may tell patients about alternatives for treatment of illnesses and conditions;
- 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 (the proposals instead favor a “prudent layperson” definition of an emergency—that is, if such a person, using reasonable judgement, deemed an ER visit to be called for, the HMO would have to pay for it);
- prevent 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., including certain indicators of quality, how the HMO selects providers for its panel, and any financial incentives the HMO offers to providers);
- require a consumer ombudsman within the plan to act as a patient advocate;
- require coverage of some experimental treatments; and
- require that members have access to a sufficient number and mix of specialty physicians and other providers.

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

In Michigan, legislation has been drafted or introduced to address almost all these issues; enacted have been laws prohibiting gag rules and allowing a prudent layperson (not the health insurer) to determine if symptoms warrant an ER visit.

To address these and other issues related to consumers and managed care, two national efforts have been prominent. President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry—made up of representatives from government, business, labor, health providers, and health plans—released in November 1997 its "Consumer Bill of Rights and Responsibilities." The goals of the bill of rights are to

- strengthen consumer confidence by assuring that the health care system is fair and responsive to

consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health;

- reaffirm the importance of a strong relationship between patients and their health care professionals; and
- reaffirm the critical role consumers play in safeguarding their own health status, by establishing both rights and responsibilities for all participants in improving health status.

Some employers and managed-care plans contend that the commission's goals reflect a bias toward providers and consumers and that the legislation likely to follow from these goals will impede managed-care plans' ability to control costs. They fear that a health care system too responsive to consumer needs is one we cannot afford. In its final report in March 1998, the advisory commission declines to recommend legislation to carry out the Consumer Bill of Rights and Responsibilities. President Clinton, however, has issued an executive order calling for Medicaid, Medicare, and other federal health programs to comply with it by 1999.

The managed-care industry itself has taken steps to reassure the public that HMOs are not skimping on care in order to preserve profits. In fall 1997, three large HMOs and two prominent consumer groups (AARP and FamiliesUSA) called for the *federal* government to regulate managed-care plans so as to prevent states from enacting disparate regulations on their own. They propose standards that would allow direct access to some specialists, permit people to choose among health plans, require the "prudent layperson" standard for emergency care, require payment for some experimental treatments and drugs if necessary for an individual's care, require HMOs to have an ombudsman to investigate patient complaints, and prevent HMOs from paying physicians in any way that would directly encourage them to limit medically necessary care. Not surprisingly, some employers and health plans do not embrace this attempt to restore confidence in the managed-care industry.

Through the National Committee for Quality Assurance (NCQA), HMOs voluntarily can 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, prenatal care in the first trimester of pregnancy, and use of appropriate medication following a heart attack. To receive accreditation, an HMO must meet or exceed specific standards in clinical quality of care, prevention, patient satisfaction, and financial stability. An increasing number of employers are requiring that HMOs have NCQA accreditation before they will contract with them.

Legislation, the call for national standards, and accreditation all attempt to address the concern among some that managed-care plans, in their attempt to control costs, are jeopardizing the quality of care. Managed care defenders respond that anecdotes, especially those presented on television network newsmagazines, have replaced legitimate research in the public's attitude toward managed care. The September/October 1997 *Health Affairs*, a highly respected health-policy journal, presents a rigorous review of studies of managed care, to determine managed care's effect on health care quality. The authors (Miller and Luft) state that "quality-of-care evidence from 15 studies show an equal number of significantly better and worse HMO results, compared with non-HMO plans. However, in several instances, Medicare HMO enrollees with chronic conditions showed worse quality of care." They conclude that fears that HMOs provide poorer care are not supported, nor are the hopes that they improve quality. Their review was limited to research completed prior to 1992, when cost-cutting pressure in the health care industry began to intensify.

The cost of new technology and drugs and, especially, the aging of the population almost certainly will drive up health care costs in the longer term, if not sooner. While the battles over managed care have commanded the public and policymakers' attention, some contend that *rationing* (deciding in certain circumstances *not* to perform certain procedures) must be examined. They argue that limits should be set on care to the elderly because they use a disproportionate share of health care services and because many expensive, technologically intensive treatments offer the sickest among them little hope of improvement. Opponents of rationing respond that it is inhumane and arbitrary; they counter that society has a moral imperative to do all it can to keep people alive and improve the quality of their lives, no matter how old or sick they may be.

Others argue that the only way to control total health care costs in the long run is for the federal government to cap total health expenditures (*global budgeting*). Proponents contend that all other efforts merely shift costs from one payer to another, without curbing overall spending. Opponents respond that such a cap would be arbitrary, failing to take into consideration the services that people need most.

This is the crux of efforts to control costs without diminishing quality: 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. 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* AIDS and HIV Infection; Automobile Insurance; Devolution; Health Care Access; Long-Term and Related Care; Medicare and Medicaid; Mental Health Funding and Services.

**FOR ADDITIONAL INFORMATION**

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