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The Employer-Purchaser Impact on Health Care Delivery and Financing

Robert Asmussen*

Comprehensive health care benefits became commonplace during the post World War II era when American business was confronted with the challenge to behave in a socially responsible manner. Union pressures and favorable tax laws helped encourage the proliferation of comprehensive employee fringe benefit packages, including health care. These benefit packages were extended to the elderly and poor in the 1960s with the enactment of Medicare and Medicaid, essentially financially uncontrollable entitlement programs. At that time no one predicted that the cost of health care benefits would become the major problem it is today.

This paper traces the employer-purchaser impact on health care delivery and financing since the advent of comprehensive health care benefits. Because cost has become the overriding concern of employers, this paper focuses on what the employer has done or has caused to happen in health care delivery and financing in an attempt to reduce or at least stem the rate of increase in health care costs. The paper also examines what the future may hold for the health care delivery and financing system as employers continue to develop strategies to deal with the health care cost problem.

“No one predicted that the cost of health care benefits would become the major problem it is today.”

Health Care Costs

In 1985 the American health care bill reached $425 billion, 10.7% of the gross national product (GNP). Representing health spending from all sources, it amounts to $1,721 for every man, woman, and child in America. Of that amount, $1,015 or 59% was spent in the private sector, with $706 or 41.2% financed by federal, state, and local governments (1). Current projections suggest that the total health care bill will reach $821 billion by 1990, almost doubling the 1985 bill (2). To place the dramatic rate of increase in health care cost in context, 20 years ago, in 1965, the health care bill was only $41.7 billion and 6% of the GNP (2).

The specific impact on employers, as one might expect, has been equally dramatic. Health insurance premiums increased from $5.9 billion in 1965 to $55.5 billion in 1981, nearly a ten-fold increase. The projected annual increase for health insurance premiums is 15% to 20%. More specifically, in 1981 the average American company spent $6,627 per employee or 37.3% of the total payroll cost on employee benefits. Of the total benefit package, $1,037 or 6% of payroll was spent on health care, life insurance, and death benefit premiums (2). This cost translates into 24% of average corporate profit after taxes (3). Health care benefit cost has become the third largest cost element after raw materials and straight-time pay for manufacturers and the second largest cost element for service industries (3).

The magnitude of the health care cost problem can be highlighted in yet another way by looking at specific corporate experience:

- In 1982 Dupont spent over $150 million for health care benefits for 150,000 employees. In 1970, with only a slightly smaller work force, the cost of these benefits was $32 million.
- Atlantic Richfield’s health insurance benefit costs have reached $100 million a year, 5% of its labor cost and nearly 20% of its cash benefit costs.
- United Technologies spent $180 million in 1982 on health care benefits, an increase of 17% over 1981 expenditures.
- Ford Motor Company’s domestic health care costs reached $800 million in 1983, up from $763 million in 1982 (2).

A review of how the health care dollar ($425 billion) has been spent and where it came from in 1985 (1) is presented in Table 1. These data clearly demonstrate a serious problem. All indications point to ever increasing costs. The GNP is growing at an annual rate of 9.5% and health care at a rate of 12.8% (2). Medical care cost increases continue to outstrip the overall consumer price index.

The employer reaction has heightened as health care costs have risen. In 1982, in a survey of Fortune 1000 largest firms, nearly 50% identified health care cost containment as a prime concern. In a similar survey conducted in 1978, only 4% had expressed such concerns (2). The battle, therefore, has been enjoined: American business versus health care cost inflation.

Employer Responses

Comprehensive health care benefit packages coupled with cost-reimbursement methodologies for hospitals and usual and

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customary fee payments for physicians caused the health care delivery system to be relatively nonresponsive to the competitive forces in the marketplace. In fact, given the comprehensive benefit packages with few incentives for consumers to be cost-conscious and the inherently inflationary hospital retrospective cost-based reimbursement system and usual and customary fees for physicians, a literal blank check was written for health care by American business and government.

Beginning as a subject for speeches within the business community, health care cost containment has now become a major employer objective. This objective is usually expressed as 1) assuring access to quality health care, 2) control and containment, and 3) price competition in the delivery system.

Interestingly, access to quality care is still perceived as important even with the health care cost problem. However, escalating health insurance cost is only one segment of total employer health cost. Absenteeism, sick leave, replacement, and training costs and the effect of interrupted service and decreased morale are all part of the same problem. A quality health care delivery system thus remains very important to the employer.

Regarding cost control and containment, the employer believes that costs can be contained by eliminating or at least decreasing wasteful consumption of health care services and by making the health care delivery system more efficient. Neither of these two efforts is perceived by the employer to adversely affect quality of care provided.

Introduction of price competition in health care delivery has become a major element of the employer’s objective to contain health care costs. Price competition was once thought to be inappropriate for health care because its services affected life and health. However, the attitude is changing rapidly, for as price competition policies become more prevalent in health care, the methods of health care delivery and financing are being changed.

In recent years employers have pursued three main strategies to deal with the health care cost problem: 1) altering the design and administration of health insurance coverage, 2) changing the structure of the health care system itself, and 3) promoting programs designed to improve health status and life-styles to help lower the need for health care service.

"Flexible benefit plans grow out of employers’ attempts to provide incentives to employees for cost-effective use of the health care system."

### Table 1
1985 Health Care Expenditures: $425 Billion

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital care</td>
<td>$167 billion</td>
<td>39%</td>
</tr>
<tr>
<td>Physician services</td>
<td>$83 billion</td>
<td>20%</td>
</tr>
<tr>
<td>Goods/services*</td>
<td>$85 billion</td>
<td>20%</td>
</tr>
<tr>
<td>Research, construction, administration, etc.</td>
<td>$55 billion</td>
<td>13%</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>$35 billion</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>$425 billion</td>
<td></td>
</tr>
</tbody>
</table>

*Sources:

- Private health insurance
- Direct patient payments
- Medicare
- Other state, local governments
- Other federal programs
- Federal Medicaid
- State Medicaid
- Philanthropy
- Total

*Includes dental, drugs, medical supplies, eyeglasses, appliances, and other professional services.

Strategy 1: Design and Administration of Health Insurance Coverage

This strategy for containing health care cost has been the most popular among employers primarily because such changes have an immediate and typically quantifiable result compared to programs designed to change the structure of the health care system itself. In a 1983 survey of all Fortune 500 companies and the top 250 nonindustrial companies, 75% of the respondents indicated that the primary means of corporate health care cost control was redesign of health insurance benefits and administration, and 65% of the respondents had actually changed their benefit plan in the previous five years (3).

A number of health care benefit design changes have been utilized by employers to contain at least their own health care costs. These approaches essentially create a cost shift from the employer to the employee or consumer. However, empirical evidence does indicate that more employee cost-sharing does reduce the overall use of health care services.

Specific examples in benefit redesign include 1) cost-sharing of health care by the employer and employee, 2) benefit limitations and exclusions, and 3) flexible benefit plans. Among the cost-sharing initiatives, contribution to the health care benefit premium by the employee has become the most popular alternative. In the Fortune 500 survey only 11.8% of the companies did not have an employee contribution to premium, with some as high a contribution rate as 20% (3).

Deductible and coinsurance provisions in health care benefit packages, while always a component of less comprehensive indemnity health care coverages, have become more prevalent as a revised benefit design strategy. The deductible is the favored approach of the two because it is more likely than coinsurance to discourage health care use. Deductible and coinsurance benefit design features are usually coupled with a stop-loss provision or a maximum out-of-pocket annual dollar contribution by the employee to protect against catastrophic medical problems. Maximum contributions of $1,000 to $2,000 per contract are most common.

Benefit limitations and exclusions also have been used to reduce the employer’s cost of health care. These are usually hard to achieve since they are clearly beneficial “take aways.” Examples of such limits on specific benefits are hospital days, physician services, restrictions for mental health care, and podiatric and chiropractic services.
A particularly effective device employed extensively since the mid 1970s has been the incorporation of a coordination of benefits (COB) clause in health care plans. COB clauses are designed to avoid the payment of duplicate claims when more than one health care policy is effective. Although COB does not operate to reduce the cost of services provided, it does avoid the payment of more than the total billing. COB savings are typically 5% to 6% of premiums paid for group coverage.

Flexible benefit plans grow out of employers' attempts to provide incentives to employees for cost-effective use of the health care system rather than instigating negative approaches such as premium contributions or benefit reductions. Flexible benefit programs take various forms, but usually provide a core of benefits for all employees and credits for employees to use to purchase additional benefits. The amount of credit usually depends on the employee's age, length of service, salary, and family size. The credits can be saved or used to purchase extra medical and life insurance, vacation, disability, and day-care.

Perhaps the best known flexible benefit plan was implemented in 1978 by the American Can Company. More than 100 employers now have flexible benefit programs. The concept has not flourished as much as some expected because of tax law limitations and the potential of adverse selection by employees against the various offerings. In other words, employees choose those options they plan to utilize, thereby potentially increasing the cost of the total fringe benefit package to the employer.

As part of the employer strategy to reduce its health care cost, administrative changes in how the employer makes health care insurance premium payments have long been favored. Very early in the life of health care insurance, the concept of community rating was prevalent. Every employer paid the same insurance rates for employees regardless of demographic differences among accounts. As pressure for cost containment began to mount, employers first pushed for experience rating (paying their own way) and then finally for self-insurance or variations thereof. For most sizable employer groups, experience rating was prevalent. Every employer paid the same insurance rates for employees regardless of demographic differences among accounts. As pressure for cost containment began to mount, employers first pushed for experience rating (paying their own way) and then finally for self-insurance or variations thereof. For most sizable employer groups, experience rating was the preferred employer choice in achieving cost containment because of its relative effectiveness and ease of implementation.

Utilization review programs have become commonplace in the health care system. These programs have served to police provider behavior. Originally developed as an educational tool, in recent years they have become vehicles for denying payment for services found to be provided unnecessarily. Success of such programs is obviously dependent on good utilization data. Many years have been spent deriving a data base which helps identify unnecessary utilization. These data provide employers with the necessary information to pursue cost-containment policy relating to utilization. For example, second opinion surgery programs, either voluntary or mandatory, are now commonplace in the industry as are preadmission certification for elective hospital admissions and concurrent retrospective and utilization review. Another dimension of utilization review is the program's determination of the appropriate site for treatment.

The WBGH also served to inspire the development of local coalitions. In some cases the coalitions represent only business interests; in others, representatives from health care, insurance, and other health-related organizations are asked to participate. The coalitions are engaged in many activities including cost control experiments, health promotion campaigns, education of hospital trustees, gathering and analysis of data on health care resource use, and health care planning.

Perhaps the most important contribution of the coalition movement has been the collective realization of employers that basic reform in the structure of the health care system is not necessarily accomplished only by national policy changes. It also can be significantly influenced by the private sector.

While coalitions have focused on the larger health care cost issues, a variety of cost-containment initiatives have developed at the insistence of the employers to influence the use of health care services, improve provider efficiency, and deal with the cost of the health care system in total.

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in exchange for causing employees and their dependents to use PPOs. This approach has obvious potential, particularly in markets with significant provider competition. The concept of direct contracting between employer and provider is a further extension of the PPO concept, but offers an even greater cost-containment outcome because the employer can direct all its health care needs through one health care provider system in exchange for even more favorable prices and utilization control commitments.

The most effective cost-containment mechanisms are those that have an impact on the total cost of the health care system. The health maintenance organization (HMO) or managed health care systems and reimbursement systems such as prospective reimbursement and diagnostic related groups (DRGs) have proven most successful in stemming the rate of increase in health care cost. HMOs provide care at fixed prices with no incentive to overutilize services. Employers transfer the risk to the HMO and its providers to deliver care at a fixed premium. This contrasts with traditional indemnity coverage where the employer ultimately pays for all services provided to its employees and dependents through premium payments adjusted annually to reflect the usage of the health care system by its members.

The growth of the HMO industry is reflective of its cost-containment potential. Across the country, most large employers now offer an HMO alternative to traditional fee-for-service coverage. Enrollment in HMOs has been increasing at a dramatic rate, 22% in 1984 and 25.7% in 1985. Over 21 million non-Medicare/Medicaid people now belong to HMOs. As of December 1985 there were 480 HMOs in the United States, 99 more than in 1984 (4). The Medicare and Medicaid programs are also embracing the concept of HMOs as cost-containment mechanisms. Nearly 1 million Medicare beneficiaries now belong to HMOs (4).

As mentioned earlier, the structural design of traditional retrospective cost-based reimbursement systems has been inherently inflationary. Such systems offer no incentive to contain costs. In fact, essentially whatever costs are incurred will be reimbursed. During the 1970s many states and private insurers pressured by employers introduced prospective reimbursement systems with built-in incentives for cost efficiencies. Many of them incorporated an inflationary allowance equal to the annual rate of increase in consumer price index, at that time a much lower rate than the annual medical care index itself. Dramatic reductions in the rate of increase in hospital costs resulted.

The success of these programs convinced the federal government to adopt prospective pricing or DRGs in 1984. Concerned that the usual and customary reimbursement system for physicians provided no incentives to control costs, Congress passed the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), the same act which mandated prospective pricing for hospitals, and requested that the Department of Health and Human Services examine the feasibility of applying DRGs to physician services provided in hospitals.

Physician fee schedule reimbursement programs have become commonplace in the private sector, replacing the usual and customary methodologies of the past.

**Strategy 3: Promoting Good Health**

Whereas most employers have concentrated on redesign of benefit and administration of insurance programs and restructuring of the health care system as their major cost-containment strategies, promotion of good health is gaining in popularity as an important strategy. As recently as 1983, large American corporations were spending a total of only 0.117% of net profits on health promotion programs compared to 24% of net profits for health insurance (5). Today most major employers provide or sponsor health promotion programs for their employees. It is now recognized that risk factors related to life-style can be addressed by comprehensive health promotion programs which serve to reduce the need for the health care services and thus the cost of care.

The three most popular programs, according to a study of major American corporations, are regular physical exams, alcohol and drug control, and smoking cessation. Counseling, stress management, fitness, weight loss, and hypertension control are other programs offered by many companies (5). Employers are finding that reduced absenteeism and increased employee fitness and ability to cope with stress help reduce health care claim dollars per employee over time and potentially lower workmen’s compensation and liability coverage expenditures.

**Specific Employer Cost-Containment Strategies**

Having examined the three basic employer strategies to control health care cost (benefit design and administration, altering the delivery system, and health promotion), it is interesting to see how employers have actually implemented these strategies in their own organizations.

In a survey of Fortune 500 companies conducted by Market Pulse Measurement Systems in January 1985 (6), employers were asked what cost-containment strategies were presently operating within their companies. The results are presented in Table 2.
The Future

Concern over health care cost has intensified to where it is causing an evolution in the health care delivery and financing systems in the United States. What we are seeing is movement toward the integration of the financing and delivery of health care systems, with the delivery system being influenced more and more by financing. Specifically, purchaser initiatives in the design and administration of health care coverages and their impact on changing the structure of the health care system have sparked this trend.

This shift in health care policy moves the health care system from a scientific to an industrial orientation. In the past, financing of health care was designed to support the development and application of scientific principles and knowledge, with quality and quantity being more important than cost. Now the industrial orientation is prominent with the objective to relate cost of production to the price of service and then reduce the cost of producing those services.

This occurs because employers have become the new and powerful fourth party in health care delivery and financing. The employer has joined the provider, the patient, and the public and private insurers. If the current trend continues, there may be two parties: the governmental or business purchaser of health care, and the deliverers of health care.

The so-called industrial orientation has come forth in the form of competition. DRGs provide the best example of the evolving new strategy to compare costs of services among the various providers of those services. HMOs market a set of health care benefits on a cost-competitive basis. Preferred provider organizations provide an opportunity to negotiate prices of various health care services. Freestanding provider entities are competing on a price basis with existing health care institutions.

The "new" competition is causing a major transformation in both delivering and financing of health care. This transformation will take the form of a wide array of economically based delivery systems that will be truly competitive and deregulated. As HMOs and PPOs (managed health care systems) proliferate, the traditional and uncontrolled fee-for-service system will be replaced by the competitive model which will control utilization, insure quality, and restrain pricing.

Predictions are that patterns of health care will flip-flop within this century with managed health care assuming as much as 95% of market share. This may come in the form of an experience rated triple-option financing mechanism which gives the employer/employee the ability to select among the HMO, PPO, and traditional delivery alternatives.

A triple-option plan is attractive to the employer because it serves to limit the cost impact of adverse selection among benefit plans offered. For example, younger, healthier members may choose the comprehensive benefits offered by the HMO while older, sicker members may choose fewer benefits in exchange for freedom of choice of physician in a traditional indemnity plan. Similarly, the employees have an advantage when they can choose among the HMO, PPO, or indemnity package, if these options are offered and underwritten by different health financing carriers, the employer could be paying more premium in total than if a composite rate is obtained from a single carrier. This may come in the form of an experience rated triple-option financing mechanism which gives the employer/employee the ability to select among the HMO, PPO, and traditional delivery alternatives.

Evidence of this transformation is beginning to emerge in the form of megacorporate health care delivery systems. These health care corporations will own, finance, organize, deliver, and compete for all forms of health care. They will offer alternative packages of services, from "wellness" programs through

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organ transplantation to hospice services at competitive prices to purchasers. A number of these organizations are already under development. Major hospital systems, HMOs, and indemnity insurance companies have joined to respond to the future needs of major purchasers.

As one views what has transpired in health care delivery and financing over the last 20 years and looks toward the future, a major conclusion is apparent. The health care purchaser—government and the private sector—has moved from a silent payor of health care services to the major architect of the future health care delivery and financing system. Their influence on the system will continue to intensify. What remains to be determined is the impact this new balance of power will have on access to quality care and cost.

References