



Policy Brief

Stanford Institute for Economic Policy Research

Can Employers Lead America to a Sustainable Market-Based Health Care System?

By Alain Enthoven

Overview

Next year will be the third consecutive year of approximately 15% annual growth in employment group health insurance premiums. There is little on the horizon to mitigate this growth. Costs per average employee will approach \$7,500. Many family premiums will exceed \$10,000. What is new and different now is that annual increases in health care expenses are equaling or exceeding affordable increases in total compensation, forcing employers to seek to shift costs to employees or to drop health insurance altogether. This is leading to labor strife, disappointed employees, and painful decisions for employers.

Figure 1 shows Stanford's experience with increasing employee health care costs. The increases are fairly typical.

Figure 1.

Total¹ Stanford Annual Family² Health Insurance Premiums and Growth 1999-2004³

Plan Type	1999	2004	CAGR ⁴
PPO ⁵	—	\$16,794	32%
POS ⁶	\$6,530	\$13,920	16%
Health Net HMO ⁷	\$5,188	\$10,592	15%
PacifiCare HMO ⁸	\$5,135	\$ 9,746	14%
Kaiser Permanente HMO ⁹	\$5,016	\$9,651	14%

¹ Employer plus employee cost.

² Coverage for a couple with child(ren).

³ There have been some changes in "plan design" over these years: increasing co-payments, patient co-insurance rates, and deductibles to help contain costs. So the actual underlying health cost growth trends are greater than suggested by these figures.

⁴ Compound annual growth rate.

⁵ Preferred Provider Organization (PPO) is a fee-for-service arrangement in which participating providers accept negotiated fees and patients who go to them get substantially better terms than if they go to non-participating providers. The growth rate shown here is since 2002, the inception of this plan. The main local provider for this plan is Stanford University Medical Center.

⁶ In the Point of Service (POS) or Triple Option Plan, patients initially receive care from their primary care group through an HMO-like arrangement in Tier I. If they want to access a wider network of physicians not in their primary care group, they may do so by paying a deductible and a substantially higher share of the cost. Tiers II and III are the two tiers of a PPO.

⁷ A Health Maintenance Organization (HMO) is an insurance organization that receives a premium to cover a comprehensive set of services for an enrolled population and accepts the obligation to deliver or arrange and purchase all medically necessary services, either directly with its own staff or through contracts with providers. Typically, the networks are much narrower than PPOs, and patient cost-sharing is in the form of fixed co-payments for doctor visits. Typical co-payments in Stanford HMOs now are \$20 per visit. The main local provider for Health Net and PacifiCare is the Palo Alto Medical Foundation.

⁸ See footnote 7.

⁹ The providers are The Permanente Medical Group, which contracts exclusively with Kaiser Foundation Health Plan, and Kaiser Foundation Hospitals.

The crux of the problem is that our health system does not contain incentives to deliver economical care. There are few, if any, feedback loops to drive innovation to make care more affordable. Most doctors practice fee-for-service medicine. They get paid when they deliver services. As a result, innovation to make their services less needed reduces income. Relatively few doctors are in prepaid group practice or similar models that reward disease prevention, chronic disease management, and best use of resources for the populations for which they are responsible.

One outcome of this is overuse of medical services. RAND Corporation studies have documented large amounts of inappropriate surgery and found that 25% of hospitalizations are inappropriate.

Causes of Expenditure Increase

Some causes of these increases will not change: rapidly improving and diffusing medical technology, an aging population, and higher incomes and expectations. We are now receiving a great deal of valuable care with new technologies. But these factors cannot explain the annual increases we are seeing now.

Some causes can be and need to be changed: provider monopolies, a flawed system of medical justice, the breakdown of managed care, and a cost-unconscious financing and delivery system. Much work needs to be done to correct these factors.

Inflationary Employer Policies

The growth of organized delivery systems accountable for quality and cost is inhibited by a very important and fundamental factor, one that could be corrected: the inflationary way most employers pay for health care for their employees.

The employers of over 75% of employed insured Americans offer their employees a single source of health insurance; i.e., a single carrier. They do this out of reluctance to change or concern over administrative costs or adverse selection, or because they are too small to offer choices. But single-source managed care is ineffective at controlling costs. Most of it is in the form of wide network preferred provider organizations (PPOs); i.e., discount fee-for-service, which means incentives to do more, whether or not more is necessary or beneficial for the patient.

Some employers made the mistake of using a Health Maintenance Organization (HMO) as a single source. Research showed that dissatisfaction with HMOs was concentrated among people in them without a choice. People should only be in HMOs by choice.

Some employers offer one carrier with several plan designs; e.g., HMO, POS (point of service), and PPO. Typically, these plans are served mostly by the same fee-for-service solo-practice doctors, so what is on offer is not competition among efficient delivery systems.

The single-source policy leads to employee demands for ever more inclusive networks. If employees find that their doctor is not in the network, they complain, and the employer orders the carrier to add the doctor. This forces carriers to include the inefficient as well as the efficient; poor quality doctors as well as good ones. In effect, through this policy, employers have re-invented the “any willing provider” principle that they fought so hard to overturn in the 1980s. (Unfortunately, 21 states, under political pressure from organized medicine, have re-enacted “any willing provider” laws.) Doctors and hospitals that know they must be included in the network have no reason to offer significant price concessions. Such wide networks are not cohesive provider organizations capable of truly managing care.

The worst thing about the single-source policy is that it blocks market entry and growth of efficient, selective organized delivery systems. Because selective systems do not include all or most doctors and hospitals, these systems are not suitable candidates for the role of single source.

A significant minority of employers—those of 20-25% of insured employees—does offer their employees choices of carrier and delivery system. Among these, the largest group contributes a fixed uniform high percentage of the premium of the carrier of the employee’s choice, usually in the range of 80-100%. Employees are left with little or no financial incentive, as far as premium is concerned, to make an economical choice. Worse yet, in this environment, the carrier and participating doctors have little or no incentive to restrain or reduce cost. A higher premium does not lead to a loss of subscribers. A recent study found that only 9.6% of Fortune 500 employees were offered a choice of carrier and a fixed dollar contribution that allows employees to keep all the savings from joining a less costly plan.

Many employers pay a flat 80% of the premium. That means that the employer pays systematically more—80% of the difference—on behalf of the employees who choose the more costly alternatives. They shouldn’t be surprised if few of their employees choose the least costly plans. If the low-priced plan were to restrain its premium by a dollar, the prospective enrollee would see only 20 cents of saving. This helps to create price-inelastic demand in which there is no incentive to lower or restrain price. This is made worse by the fact that employees can pay their premium share with pre-tax dollars. All of these policies make it very difficult if not impossible for a would-be efficient organization to enter this market and prosper.

Rational Incentives For Quality And Cost-Effectiveness

Employers who pay for the bulk of health insurance coverage in the United States have the power to change the situation and stem the rapidly increasing cost of health care by changing the incentives. To create a competitive, efficient, and cost-contained health care system, employers should follow the examples of Wells Fargo Bank, Hewlett-Packard,

and a few other companies; Stanford and Harvard universities and the University of California; the federal government; and the State of California:

- Offer employees a wide range of choices from selective HMOs to POS plans to PPOs, and
- Earmark for the employee's purchase a fixed dollar amount that does not exceed the price of the low-priced plan (i.e., let the employee keep the savings), and
- As some of the above-mentioned employers are doing, adjust the prices employees pay to correct for the effects of biased selection in the health risks that choose one or another plan, so that health plans are not penalized for enrolling and caring for patients with costly chronic conditions. (Tools are available to do this now.)
- In addition, they should insist that the quality of care delivered to the populations enrolled in the different alternatives be measured systematically and results made available to employees.

This policy has several important advantages for employers:

- The employer outlay is keyed to the least costly and least inflationary component of the health care system.
- The employees have incentives to choose value for money.
- The most economical plan gains market share and is rewarded for being economical.
- Employee preferences are respected.
- The model creates economic pressures (i.e., loss of patients) on the most costly alternatives to innovate to contain and reduce cost.

This policy will not transform the whole health care system unless a large majority of employers follow it. There is a collective action problem. Business leaders who want to see change must create a movement among employers. But there is an incentive for employers to follow this trend, as they can save money and provide their employees with more choice and better incentives.

Effective Managed Care

The RAND Corporation did a randomized experiment with patients enrolled in Group Health Cooperative of Puget Sound, a managed care organization, and the fee-for-service sector in Seattle and found that Group Health produced equal health outcomes for 25% less resource use.

Effective managed care does not exist in some markets. One major reason for this is the market conditions employers have created. If employers created a market that was hospitable to effective managed care, many such organizations could come into existence. For example, there are over 900 multi-specialty group practices with 25 or more doctors in the United States. With appropriate incentives, many of them could team up with insurance carriers in contracts based on per capita prepayment. If market conditions demanded it, many more would do so.

These organizations are usually more efficient than solo practice, and they have the potential to improve.

What About Small Employers?

Small employers need to join "exchanges"; i.e., institutions that bring together many employers and employees and at least several competitive health care organizations. Software now exists to facilitate the management of choice. For example, broker-created California Choice now serves nearly 10,000 small employer groups with almost 140,000 members. Each participating employee can choose among eight HMO networks through six carriers and a large statewide PPO network. Employers benefit from one standard enrollment application for all participating health plans and one single itemized bill. To make the whole health care system more competitive and efficient, large employers ought to lend their resources to starting exchanges.

A very promising innovation is the "two carrier exchange" being pioneered on the West Coast by a startup company called BENU, in partnership with CIGNA, Kaiser Permanente, and Group Health Cooperative. For example, in Seattle, each participating employee has a choice of three Group Health plan designs and three CIGNA plans. The employer agrees to earmark no more than the price of the low-priced plan, and the employer receives a single unified bill. With the agreement of the two carriers, BENU handles the risk adjustment, to correct for biased risk selection, and also manages the flow of payments from employer to carriers.

Specific Recommendations

- The key to creating a truly competitive health care system is for employers, large and small, to offer their employees a responsible choice that includes effective, selective health care organizations. In many cases, this can be facilitated by exchanges that are emerging in the marketplace today.
- Employers should contribute a fixed dollar amount, earmarked for health insurance, and ensure that employees receive or pay the full difference between the contribution amount and the premium of the plan of their choice.
- The federal government should accelerate the process of competition by requiring employers to offer choices of carrier and delivery system, and to earmark for health insurance a fixed dollar amount.
- The federal government ought to override state "any willing provider" laws that block the development of selective networks. (If employers offer a wide choice, including wide networks as a choice, "any willing provider" is not needed to assure employee access to the doctors they want to see.)

If employers cannot do their part, health insurance will become intolerably expensive (if it isn't already), the numbers of uninsured will soar, and the employer-based system will have to be replaced, almost certainly by government.

About the Author

Alain Enthoven is the Marriner S. Eccles Professor of Public and Private Management, Emeritus. He is one of the nation's leading experts and speakers on the areas of healthcare and managed care. Enthoven has held a wide variety of positions in both the government and corporate worlds. These include his work as the assistant secretary of defense, an economist with the RAND Corporation, and the president of Litton Medical Products. In 1977, while serving as a consultant to the Carter Administration, he designed and proposed The Consumer Choice Health Plan, a plan for universal health insurance based on managed competition in the private sector. Enthoven was appointed Chairman of the California Managed Health Care Improvement Task Force by former Governor Pete Wilson. He is now Chairman of the Stanford University committee on faculty/staff human resources, grappling with the problem of soaring health care costs for university employees.



The Stanford Institute for Economic Policy Research (SIEPR) conducts research on important economic policy issues facing the United States and other countries. SIEPR's goal is to inform policy makers and to influence their decisions with long-term policy solutions.

With this goal in mind SIEPR policy briefs are meant to inform and summarize important research by SIEPR faculty. Selecting a different economic topic each month, SIEPR will bring you up-to-date information and analysis on the issues involved.

SIEPR Policy Briefs reflect the views of the author. SIEPR is a non-partisan institute and does not take a stand on any issue.

For additional copies, please see SIEPR website at: <http://SIEPR.stanford.edu>



SIEPR *Policy Brief*

A publication of the
Stanford Institute for Economic Policy Research
Stanford University
579 Serra Mall at Galvez Street
Stanford, CA 94305
MC 6015

NON-PROFIT
ORG.
U.S. POSTAGE
PAID
PALO ALTO, CA
PERMIT NO. 28