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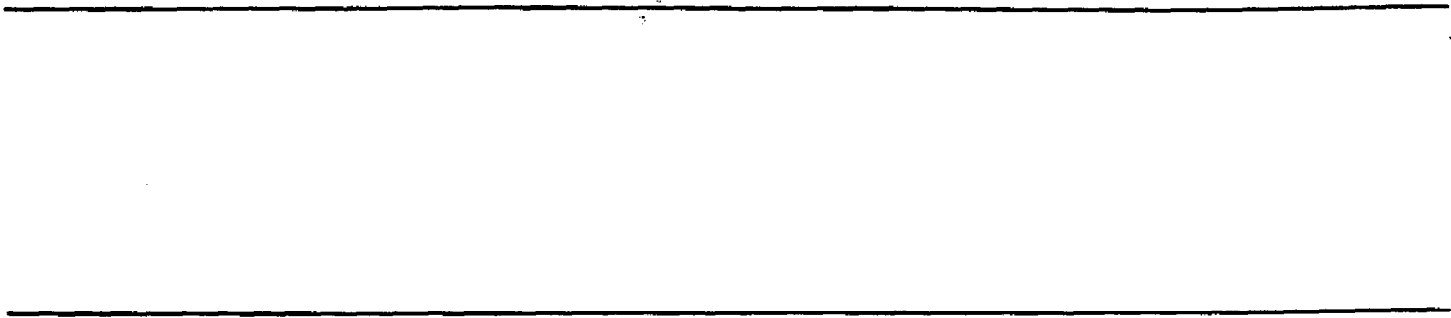
MANAGED HEALTH CARE

**Effect on Employers' Costs
Difficult to Measure**

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SUMMARY

The term "managed care" lacks a commonly accepted definition. It has been used to characterize a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. The spectrum of such plans ranges from simple preferred provider networks to more tightly structured health maintenance organizations (HMOs).

This statement presents the results of GAO's review of employers' experience with managed care.¹ We found the following:

- o Certain managed care plans have a potential for providing care at lower cost. Their ability to do so depends on the stringency of controls on price and the use of services. The extent of incentives for consumers and providers determines the degree of leverage in controlling costs.
- o Little empirical evidence exists that employers' overall health care costs have been constrained by using managed care plans. In some cases, after an initial slowing, rapid cost growth continued in subsequent years. In other cases, savings from managed care plans resulted from those plans primarily serving healthier employees. Even then, pricing policies may not have fully passed savings on to employers.
- o A major constraint on consumers of managed care is their more limited choice of physicians. To gain greater employee acceptance, employers are offering newer types of managed care plans with more flexibility but less cost-saving potential. Today, more than half of managed care enrollees are in preferred provider and point-of-service plans.

¹Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as the Subcommittee continues its deliberations on health care reform. A common feature of many health reform bills is an emphasis on managed care. At your request, GAO conducted a review of how managed care plans work and their effectiveness in constraining employers' health care costs. My testimony today summarizes our October 1993 report on employers' experience with managed care.¹

First, let me clarify what we mean by managed care, a term without a commonly accepted definition. In a sense, almost all insurance plans have some managed care features because they commonly require prior approval for hospitalization and conduct some utilization review. As used in our report, the term "managed care" refers to plans that constrain patients' choice of providers to a specific network of physicians and hospitals, control the use of services, and negotiate reimbursement with providers. So defined, about half of all insured employees are covered by managed care plans.

In brief, we found that certain managed care plans, by negotiating physician and hospital payments and controlling the use of services, have a potential for holding down costs. Lower costs for these plans, however, may not translate into lower health care spending for employers due to enrollee differences and pricing policies. In addition, we found that employees like some features of managed care plans, but many do not like having their choice of doctors limited to those in a particular network.

Potential for Savings Most Evident in Group and Staff HMOs

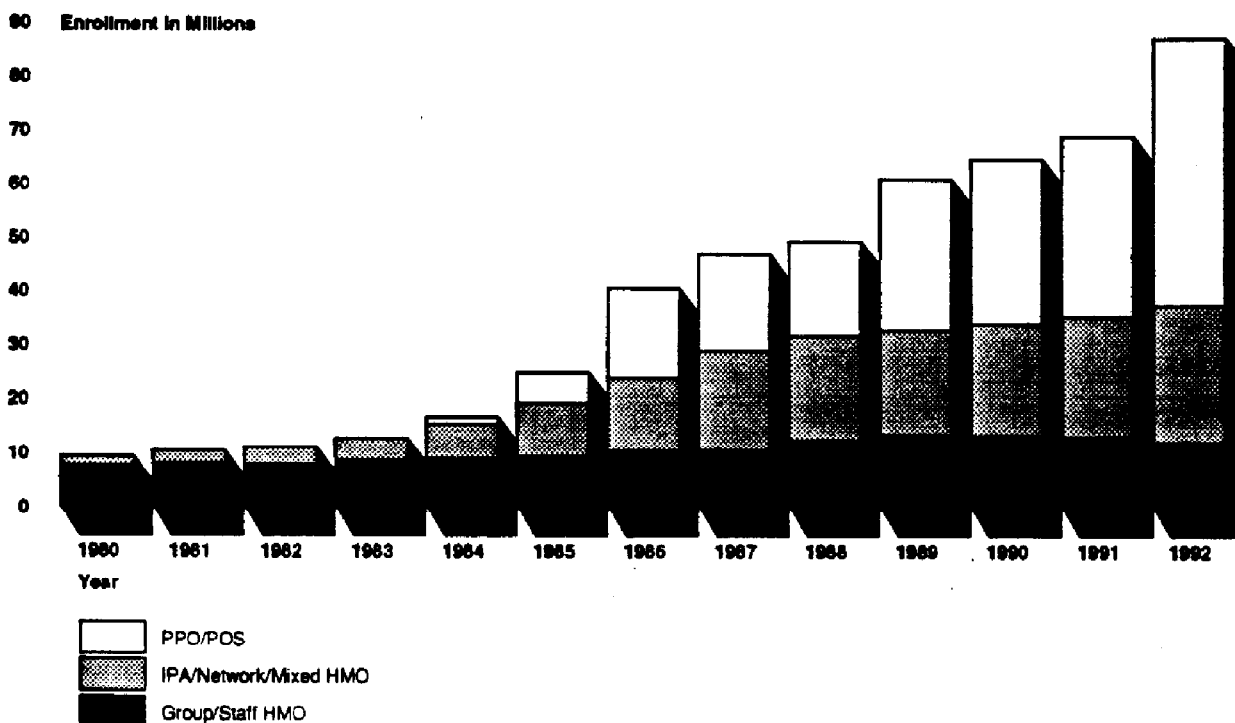
The potential for managed care plans to save money depends on the stringency of several control features. Regarding controls on consumers, for example, the greater the incentives for enrollees to seek care from network physicians, the greater the plan's potential for controlling costs. Regarding physicians, the greater the share of patients who are plan enrollees, the greater the plan's leverage to control the use and price of services.

Studies have shown that group and staff model HMOs have the greatest potential for savings. They require patients to (1) seek care from only HMO-affiliated physicians and hospitals, and (2) use a primary care "gatekeeper" to coordinate referrals to specialists and hospitals. Staff or group model physicians (1) are paid either a salary or a fixed amount per enrollee (which places the risk of expensive services and the reward of less costly care on the providers), and (2) typically treat no patients outside the HMO. Staff and group HMO enrollment grew modestly during the last decade to cover about 12 million enrollees by 1992.

¹Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Little research is available on the cost-saving potential of newer types of managed care plans, such as independent-practice HMOs, preferred provider organizations, and point-of-service plans. Consumers in many of these plans are allowed to seek care from physicians outside the plan network by paying higher out-of-pocket costs. Physicians (1) do not exclusively treat patients from any one plan, (2) are generally reimbursed fee-for-service, maintaining an incentive to provide more services, and (3) are subject to close monitoring of their practices to control utilization. As figure 1 shows, these newer types of managed care plans have grown rapidly since the mid-eighties, and now serve 75 million enrollees.

Figure 1: Managed Care Enrollment, 1980-1992



Note: HMO data include Medicare and Medicaid enrollees.
 Source: GAO estimates based on data from Interstudy, KPMG Peat Marwick, and Health Insurance Association of America.

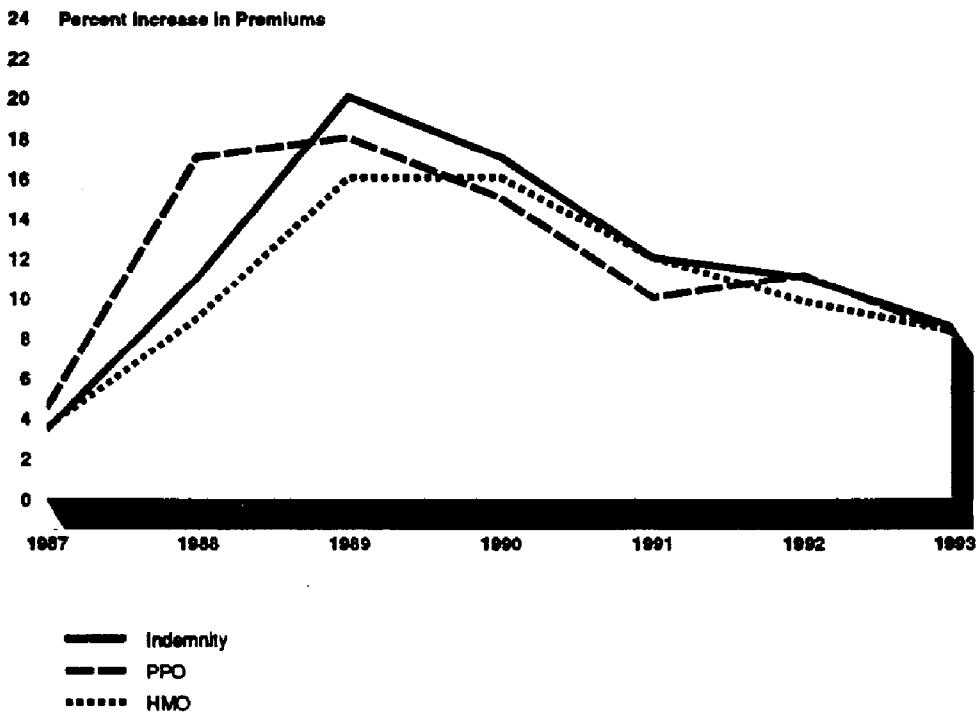
Effect on Employers' Costs Difficult to Measure

Although many employers that we contacted believe that they are saving money from managed care, the evidence is inconclusive about the extent to which such plans hold down employers' costs. Some employers have experienced one-time reductions in cost growth with managed care, but rapidly growing health care costs resumed in subsequent years. When managed care plan premiums have been consistently lower, savings are more likely the result of "favorable selection." This occurs when plans serve younger,

healthier, and less costly enrollees while leaving more costly people in the employers' fee-for-service indemnity plans. Favorable selection could result from the reluctance of persons receiving regular medical care to change doctors to join a managed care plan and managed care's emphasis on preventive care services.

Evidence from recent surveys conducted by employer benefits consultants is also inconclusive. Some surveys indicate that premiums are lower for managed care plans than for indemnity plans, while other surveys contradict this. A Foster Higgins' survey reveals that, for 1992, managed care premiums averaged 9 to 19 percent lower than indemnity plans. By contrast, Peat Marwick's survey found that, for 1993, managed care premiums were as much as 20 percent higher than indemnity plans. As shown in figure 2, the surveys also indicate that, during the last 7 years, managed care and indemnity plan premiums have had similar growth rates, while for most years HMO premiums grew slightly slower than indemnity plan premiums. In comparing managed care and indemnity plans, none of the recent surveys of employers' premiums adjusted for differences in enrollee characteristics or benefits covered.

Figure 2: Growth in Health Plan Premiums, 1987-1993



Sources: Health Insurance Association of America, 1987 to 1990; Peat Marwick, 1991 to 1993

Even if some managed care plans effectively lower the use of services, the plans' savings may not be fully passed on to employers in lower premiums. Some plans use a practice known as

"shadow pricing" in which they set their premiums at a rate near employers' other health plans, regardless of actual costs. Shadow pricing may enable the plan to benefit enrollees, rather than employers, by passing savings on through expanded coverage or reduced out-of-pocket costs.

Consumers Concerned by Constraints on Choice of Provider

Trends in enrollment in managed care plans show that many employees prefer more flexibility in choosing providers than traditional HMOs offer, and they are willing to pay additional out-of-pocket costs to do so. In fact, in preferred provider organizations and point-of-service plans, more than a third of claims dollars paid is for care delivered by non-network providers.

In general, enrollees in managed care plans are constrained in their choice of providers and access. New enrollees may lose continuity in their source of care because they may need to change providers if their current physicians are not in the plan's network. Also, enrollees may have to change providers when changing jobs, when doctors leave the network, or when the employer changes health plans. Enrollees also pay more to visit physicians outside the network because managed care plans provide lower or no coverage for self-referrals to specialists, requiring patients to first obtain authorization from a primary care physician or the plan.

Many employees enroll in managed care despite the limitations on choice and access to providers. When offered an option, about one-third of employees, on average, enroll in an HMO. These employees are willing to accept the restrictions on provider choice in exchange for reduced out-of-pocket costs and more extensive preventive care. HMOs generally require only minimal copayments and no deductibles. Nearly all HMOs offer well baby care and adult physicals, for example, as compared to one-third to one-half of indemnity plans.

Although research is limited, we reviewed one major study² comparing patient satisfaction with managed care and indemnity plans. It showed that, overall, patients receiving care from prepaid providers rated their care lower than patients visiting fee-for-service providers. Patients reported similar levels of satisfaction with hospital care but lower overall satisfaction with physician care in prepaid plans. Specifically, patients rated

²The Medical Outcomes Study covered over 17,000 patients and adjusted for population differences. See Haya R. Rubin et al., "Patients' Ratings of Outpatient Visits in Different Practice Settings: Results from the Medical Outcomes Study," Journal of the American Medical Association, Vol. 270, No. 7 (1993), pp. 835-840.

primary care physicians in prepaid plans lower in availability, continuity, and treatment manner but higher in affordability and coordination of care.

Employers Adding Quality Monitoring to Managed Care Efforts

Managed care arrangements are dynamic, undergoing changes as enrollment expands. Frequent changes in employers' managed care plans and the evolving managed care market have made assessing plan effectiveness difficult. Because little empirical evidence exists on the cost savings of managed care, employers are increasingly focusing on strategies to improve their ability to assess plans. They want reliable data on costs, outcomes, and consumer satisfaction so they can make meaningful evaluations. Ultimately, performance measures need to be developed that will allow employers to make informed decisions about health care plans and providers. Recognizing this growing trend in the market, many reform proposals call for expanded efforts in data collection, quality measurement, and risk measurement.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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