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Consumer Health: The Next Generation of Managed Care

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The History of Employment-Based Health Insurance: The Role of Managed Care

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The author describes the history of how the employment-based health benefits system has evolved. Specifically, he examines how we got where we are today, the success of managed care, the shortcomings of the managed care system and challenges that the managed care system will face in the future. He concludes that, despite substantial improvements in the quality of medical services provided, employers have a long way to go before they are truly purchasing the highest quality health care at the most efficient prices.

During World War II, the number of persons with employment-based health insurance started to increase for several reasons. When the National War Labor Board froze wages, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: Unions supported employment-based health insurance, and workers' health benefits were not subject to income tax or Social Security payroll taxes, as were cash wages.

Historians often suggest that the tax preference of employment-based health insurance led to the rise in its prevalence. In fact, employer interest in the health of workers started long before the tax treatment of health benefits became an issue. The early-cited examples of employment-based health programs often include the mining, lumbering and railroad industries during the late 1800s (Institute of Medicine 1993). Because employers in these industries had a practical interest in providing health services to injured or ill workers, often in remote geo-graphic regions, they frequently provided company doctors who were funded through deductions from workers' wages. In addition to work-related injuries, the early employment-based programs occasionally covered general medical care for workers, their families and the community. The concept of prepaid health care services started to spread with funding from foundations and hospitals, among others, and eventually led to Blue Cross. By 1935, prior to World War II, 15 Blue Cross plans existed in 11 states, with six more established the following year (Anderson 1975).

World War II accelerated the growth in employment-based health benefits. In 1943, the National War Labor Board ruled that employer contributions to insurance did not count as wages and, by the end of the war, health insurance coverage had tripled (Weir et al. 1988). However, it was not until 1954 that the Internal Revenue Code made it clear that employer spending on health benefits was not counted toward worker income and was tax-deductible as a business expense.

After World War II, most developed nations moved "to adopt, restructure, or complete their schemes" for providing some form of government-mandated or -provided comprehensive health care coverage (Institute of Medicine 1993). The United States obviously has taken a different path, although that is not due to a lack of effort to provide universal coverage. Legislative proposals were introduced throughout the 1940s, including one by President Truman, but they did not get very far. Even President Eisenhower proposed a government reinsurance program for poor and high-risk groups. Ultimately, the country "settled" for Medicare and Medicaid in 1965.

Today, employment-based health plans are the most common source of health insurance in the United States. Nearly 160 million non-elderly Americans are covered by the employment-based health insurance system, representing 66% of the population (Fronstin 2000). An additional 11 million elderly individuals have employment-based health insurance coverage that supplements Medicare. Employers offer health benefits to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also provide benefits in order to promote health, increase worker productivity, and recruit and retain qualified workers. Sixty-five percent of workers responding to a recent survey rated employment-based health insurance benefits as the most important employee benefit (Salisbury and Ostuw 2000).

The biggest change to employment-based health benefits occurred during the 1990s. Because of double digit increases in health care costs during the late 1980s and early 1990s, employers began to move workers into managed care plans. Between 1992 and 1999, the percentage of workers enrolled in traditional indemnity plans declined from 53% to 11% (see Figure 1). Although the movement to managed care has brought about declines in health care cost inflation, at least temporarily, it has been controversial.

The purpose of this article is to provide a history of how the employment-based health benefits system has evolved. The next section discusses how we got to where we are today. The third section discusses the success of managed care. In the fourth section, shortcomings of the managed care system are discussed. In the final section, challenges that the managed care system will face in the future are presented.

HOW WE ARRIVED AT THE CURRENT SYSTEM:

The roots of managed care began long before the maturation of the employment-based health insurance system. In 1853, a prepaid hospital care plan was established in San Francisco by the French mutual aid society (Institute of Medicine 1993) and, in 1929, Baylor University's hospital offered a prepaid group hospitalization plan (Employee Benefit Research Institute 1997). Furthermore, in 1932, a private committee made important recommendations that supported prepaid health services. In addition, the Committee on the Costs of Medical Care (CCMC) was

established in 1927 with funding from six major private foundations. Chaired by Ray Lyman Wilbur, a former president of the American Medical Association and then president of Stanford University, CCMC recommended linking the group practice of medicine to prepayment of health services (MacLeod 1995). Physicians also introduced prepaid health services at about this time, but growth in enrollment was slow until the late 1980s. Until this time, health care providers billed patients (and insurers) largely on a fee-for-service basis.

Shortcomings of the fee-for-service system were eventually seen as one of the catalysts for managed care. Under the traditional fee-for-service system, health care providers had no incentive to provide health care services in the most efficient whatsoever to exercise any financial or economic discipline; money was "pouring in" from the Hill-Burton Act and from the Medicaid and Medicare programs. Furthermore, technological innovation, improved treatments and an aging population were all contributing to rising health care costs. In certain years during the late 1980s and early 1990s, health care costs for some employers increased nearly 20%, cost increases that many employers simply did not want to pay (Fox 1998). In 1988, for example, overall inflation was 4% according to the consumer price index (CPI), and medical cost inflation (MCPI) was 7%. However, employer spending on health benefits rose 19% (see Figure 2). Although the growth rate in employer spending on health benefits declined after 1988, it remained above 10% and continued to outpace the CPI and the MCPI. Employers quickly looked for alternatives to fee-for-service health benefits. Prepaid health care (the precursor to managed care) had existed for decades by then, though mostly in the West and Pacific Northwest. It promised to control costs through improved coordination and efficiency by reducing inappropriate or unnecessary usage of health care services, increasing access to preventive care, and maintaining and improving the quality of care. As it was intended to do, the Health Maintenance Organization (HMO) Act of 1973 also contributed to the growth in managed care. One of the major provisions of the act was a requirement that most employers offer employees a qualified HMO and, at the request of such an HMO, a traditional health plan as well. Regulations provided under the act had interpreted this provision to require that mandated employers contribute the same dollar amount to federally qualified HMOs as they contribute to their highest cost non-HMO health plan.

Responding to employer concerns about selection bias and HMO pricing, Congress enacted the 1988 amendments to the HMO Act (P.L. 100-517) on October 24, 1988. The new law relaxed some regulations applying to federally qualified HMOs and thereby allowed employers to negotiate HMO rates and coverage more easily. The 1988 law also eased the equal contribution requirement.

A third catalyst is perhaps the seminal event. Allied Signal's head of corporate benefits, Joseph Duva, forged an innovative agreement with CIGNA. Allied Signal agreed to contract directly and exclusively with CIGNA for three years at a set annual increment in premiums. Other employers quickly followed Allied Signal's innovative step toward controlling health care costs.

Plan Types

In general, managed care arrangements range from fully integrated models, such as staff and group model HMOs that tend to restrict access to a select network of providers, to less restrictive and usually more costly arrangements. The spectrum of arrangements is shown in Figure 3. Until the mid-1980s, the typical HMO model was a fairly homogeneous staff or group model. In a staff model HMO, the health plan owns its health care facility and employs salaried health care providers. Patient choice is limited, and patients are restricted to network providers. In addition, access to specialists is provided only when it is considered medically necessary and appropriate, access to specialists must be preauthorized by a primary care physician.

A group model HMO is similar to a staff model HMO, except the group model HMO contracts with a single physician group to provide services. The physician group is managed independently and is usually paid on a capitated basis. Group model HMO providers usually spend most of their time serving HMO patients, but they may spend some time in private practice.

Heterogeneous network model HMOs and PPOs have dominated expansion in managed care enrollment. Currently, there are five different HMO models: staff model, group model, independent practice association (IPA), network model and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs.

- o Independent practice associations. Independent practice associations (IPAs) are groups of physicians in private practice who provide some services to HMO participants, but they primarily provide services to patients not enrolled in an HMO. The non-HMO patients are treated on a fee-for-service basis. Providers working with HMOs are generally paid on a fee-for-service basis. Therefore, they do not have strong incentives to provide cost-effective care, but there has been a movement toward reimbursing IPAs on a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers employees more choice among providers.

- o Network model. In the network model, HMOs contract with two or more independent physician groups that often provide specialty services in addition to general services. The HMO typically pays these groups on a capitated basis, but these groups also spend some time in private practice on a fee-for-service basis.

- o Mixed model. A mixed model HMO will initially adapt one type of model, such as a staff model, and then expand either its capacity and/or its geographic region at a later date by adding another type of model, such as an IPA. Financial incentives within a health plan can how those

processes ultimately affect patients and the cost of providing health care. Within the network-based models mentioned above, reimbursement schemes have evolved from a salaried or capitated basis to those in which physicians share less of the risk associated with treating patients. In addition, some HMOs reimburse providers through withholding accounts and bonus programs based on quality of care or productivity. Research on the effectiveness of the various financial incentive models has recently become available.

o Preferred provider organizations/point-of-service plans. Preferred provider organizations (PPOs) and point-of-service (POS) plans have emerged as strong alternatives to fee-for-service plans and HMOs. A PPO is a panel of health care providers who individually contract with insurance companies and/or employers to offer health care benefits. A POS plan is essentially an open-ended HMO. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. Providers are usually chosen on the basis of their performance, but many plans choose physicians to fit geographic and specialty areas, often in response to employer requests. Enrollees can receive health care services from PPO providers or non-PPO providers, but they usually face higher cost-sharing requirements when receiving care from non-PPO providers. Although the PPO structure differs greatly from the HMO structure, they both combine three broad cost-management strategies: a limited provider panel, negotiated fee schedules and utilization review (UR). In addition, some PPOs have a physician who acts as a "gatekeeper" to the system.

One of the distinguishing features of a network of providers is the way the health plan selects its providers in the network. Some plans evaluate candidates against a set of predetermined selection criteria. Providers must be able to achieve the plan's goals for cost control and quality improvement by successfully managing health care delivery. Candidates can also be chosen according to their location. Providers must be able to provide health services to an adequate geographic area. Plans must be available where employees live and work. In addition, most plans require providers to agree to accept UR procedures, refer patients only to other providers in the plan and accept the plan's reimbursement procedures. Many plans also monitor their providers' practice patterns in order to identify unjustifiably high costs and then alter those patterns through education and financial incentives.

To identify potential providers for their network, some employment-based plans use objective information provided by accrediting organizations on the quality of care. Employers contract with specific networks of health care facilities for high-cost procedures such as open-heart surgeries and transplants. These facilities, known as centers of excellence, are selected according to a number of criteria, including experience, efficiency, effectiveness, and outcomes such as mortality and morbidity rates. In selectively contracting on the basis of those criteria, employment-based plans are explicitly using outcome measures for determining reimbursement.

Growth in Managed Care

As recently as 1994, traditional indemnity plans were most common among employers that offered health plans. As fewer employers offered traditional indemnity plans, participation in those plans declined, and participation in managed care plans increased. In 1999, 11% of employees participating in a health plan were enrolled in an indemnity plan, compared with 52% in 1992. During the same period, enrollment in managed care plans increased from 48% to 89%.

Although the growth in managed care has been steady in general, it has not been uniform among all types of plans. In 1998, growth in HMOs ceased, and POS plans lost market share (see Figure 1). It appears that consumers and employers are now voting with their feet. The managed care backlash and the return of health care cost inflation are in part to blame for the stagnation of HMOs and POS plans. Furthermore, the strong economy is probably affecting enrollment. As workers enjoy rising real incomes and are willing to pay more for more benefits, more are enrolling in less restrictive PPOs. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees. Locking employees into a plan that limits choice and perhaps reduces their satisfaction may not be cost effective due to its impact on an employer's recruitment and retention costs.

SUCCESS OF MANAGED CARE:

Managed care reduced the rate at which health care costs were increasing. According to Figure 4, between 1994 and 1997, employer costs for health care barely changed while the gap narrowed between the CPI and the MCPI. Managed care was able to reduce health care cost inflation for a number of reasons. One major factor is the way managed care plans have altered the incentive structure from a fee-for-service or cost-plus reimbursement scheme to one in which health care providers are paid a salary, a pre negotiated discount on fee-for-service charges, or on a capitated basis. In return for the new payment scheme, health care providers were guaranteed high volume levels because they would be providing health care services for a large group of subscribers. Also, health providers accepted more "risk" because of an oversupply of physicians and hospital beds. Managed care plans were also able to control health care costs by shifting some types of care from a costly inpatient setting to a less costly outpatient setting.

In general, physicians providing health care services to members of PPOs did not assume financial risk. PPOs have incorporated the UR features of managed care, such as pre certification of elective admissions, concurrent review, catastrophic case management, outpatient UR and second surgical opinion to manage costs. In general, UR programs were used on a case-by-case basis to monitor the progress and appropriateness of care and limit the volume of health care services.

The growth in managed care was coupled with new awareness and efforts to improve the quality of health care services. Organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JC-AHO), the Utilization Review Accreditation Commission (URAC) and the American Accreditation Program, Inc. (AAPI) formally assess the quality of managed care plans and award accreditation to those that meet standards. Recently NCQA reported that health plans had made significant improvements between 1998 and 1999 in all of the clinical quality measures that it tracks, but it also reported that many opportunities still exist for improving quality (National Committee for Quality Assurance 2000). These reports are based on self-reported measures provided by the health plans, and not all health plans allow NCQA to release their information to the public. Many employers, although concerned about quality, are still unfamiliar with NCQA and the health plan performance measures it uses to assess quality (Gabel et al. 2000).

ISSUES WITH MANAGED CARE:

The use of managed care is very controversial. The controversy is not over the goal of reducing the cost of providing health care. Instead, it is about some of the ways cost reductions are achieved. For instance, satisfaction levels for those with insurance coverage do not vary significantly by type of health insurance coverage, although individuals enrolled in HMOs and managed care plans with gatekeepers are slightly less satisfied than other insured individuals with various aspects of health care. Seventy-five percent of enrollees in HMOs and managed care plans reported that they were very satisfied, compared with 82.5% of individuals with other employment-based health insurance (see Table I). In contrast, individuals in HMOs and managed care plans with a gatekeeper were more likely to report that they were somewhat satisfied. Overall, enrollees in HMOs and managed care plans with a gatekeeper were almost as likely as individuals with other types of health insurance to report that they were either very satisfied or somewhat satisfied. Just over 10% of individuals in HMOs and managed care plans with gatekeepers reported that a family member had difficulty receiving needed care, compared with 7% of individuals with other types of health insurance (see Table II). The main reasons individuals gave for not receiving needed care were interesting. Individuals enrolled in HMOs and managed care plans with gatekeepers were less likely than those with other types of health insurance to report that the main reason was either the cost of care or that the insurer would not approve the treatment. Alternatively, they were more likely to report that they could not get time

off from work, that the insurer required a referral, or that the doctor refused the family's insurance. Individuals in managed care plans without a gatekeeper and in non managed care plans were more likely than HMO enrollees and enrollees in managed care plans with a gatekeeper to report that they did not get care because the insurer did not approve the treatment (26.3% vs.16.7%). However, the differences between the two groups become even smaller when including the 6.6% of the latter group that did not receive care because the insurer required a referral. The survey did not indicate whether individuals who reported the main reason as needing a referral from the insurer ever tried to obtain one.

While persons in employment-based health plans are generally satisfied with their experience with health care providers, there are larger differences when it comes to the actual health plan. In general, persons with employment-based health insurance are generally satisfied with their health plan. However, persons enrolled in managed care plans appear to be less satisfied with their health insurance than persons enrolled in fee-for-service plans. Persons in HMO-type plans are significantly less likely than persons in PPO-type plans or traditional fee-for-service insurance to be extremely or very satisfied with their health insurance, yet they are significantly more likely to be some-what satisfied with their health plan. Specifically, 35% of persons in HMO-type plans were extremely or very satisfied with their health plan, compared to 50% among PPO-type plan enrollees and 56% among fee-for-service enrollees (see Figure 5). Although HMO-type enrollees appear to be more likely to be dissatisfied than persons enrolled in other types of health plans, these differences are not statistically significant.

Satisfaction with health insurance has been found to be correlated with quality. According to a recent report on quality in managed care plans, plans that scored in the top 25% were more likely to have members rating their health plan either 8, 9 or 10 out of 10 (63%) than plans rated as poor clinical reporters (53%) (National Committee on Quality Assurance 2000). Members were also far more likely to give their plans high marks in such areas as ability to get care, customer service and claims processing.

Managed care plans have been criticized because of the way they are able to operate under the Employee Retirement Income Security Act of 1974 (ERISA). Under traditional fee-for-service plans, the most prevalent type of plan at the time ERISA was enacted, the denial of a claim is typically not as critical as it is in a managed care setting. That is because claims are generally paid or denied after treatment has taken place. In a managed care setting, the dominant form of health plan enrollment today, most claims decisions are made prospectively through the utilization review process. This leads many to believe that a denial of coverage by a plan is the denial of care. Courts appear to be making distinctions between determination and administration, which are preempted by ERISA, and a medical decision outside of a benefit determination, which has increasingly not been preempted (although the courts have not settled the issue).

Critics of ERISA believe that denial of coverage is the denial of care, and that administrators of health plans make medical decisions and therefore should be held responsible for those decisions through malpractice liability. Once health plans are held liable, critics argue that the quality of care provided will improve. Sponsors of health plans counter that when a health plan makes a benefit determination, it is interpreting a contract between the health plan and the participant on

what benefits are covered under that contract. The health plan is not preventing the participant from receiving care or telling the participant not to get the care; the plan is simply stating whether the contract covers the benefit. Therefore, malpractice law does not apply.

FUTURE CHALLENGES:

As the nation begins the 21st century, the health care financing and delivery system faces many challenges. First, the population is aging. Demand for health care services will continue to increase. New technology will be demanded along with the latest available medicines. Second, costly technology will continue to be developed. Third, public policy discussions will continue to include debates about patient protection legislation. Although the proposed changes will improve quality of health care for some individuals, others may be left out of the system altogether if new legislation increases health care costs. Finally, quality of health care will continue to be one of the most important, if not the most important, health care issues. Despite substantial improvements in the quality of medical services provided, employers have a long way to go before they are truly purchasing the highest quality health care at the most efficient cost.

Endnotes:

1. MacLeod (1995) provides other examples of some of the early prepaid practice plans.
2. The Hill-Burton Act is actually known as the Hospital Survey and Construction Act of 1946. It was named for its sponsors, Senator Hill of Alabama and Senator Burton of Ohio. The act provides funding for hospitals in exchange for the provision of uncompensated care for persons without health insurance coverage.
3. In a withholding account arrangement, a percentage of the payment is withheld until the end of the year. Premiums are set aside in a referral fund that is used to pay for the services of primary care physicians, specialists, hospitals and outpatient testing. If the referral fund runs a surplus, physicians receive the amount that accumulated in the withholding account. If the referral fund runs a deficit, nothing is returned to the provider.
4. NCQA uses the Health Plan Employer Data and Information Set (HEDIS) to measure health plan performance.
5. These differences may also have to do with the fact that the longer a person is enrolled in a health plan the higher his or her satisfaction, and managed care enrollees have been with their health plans for less time than fee-for-service enrollees.

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