As of 1990, 95 percent of U.S. employees and dependents were covered by one or more of the many forms of “managed care,” according to the most recent Health Insurance Association of America (HIAA) annual employer survey.1 The prevalence of managed care bears out the view that it is now mainstream medicine and that American physicians are among the most regulated in the world.

However, this statistic may be somewhat misleading. “Managed care” is used to describe everything from the most minimal, superficial utilization review program to the most actively managed staff/group-model health maintenance organizations (HMOs). Not surprisingly, considerable evidence shows substantial variation in the quality and effectiveness of utilization management and other managed care mechanisms.2

Enough employers have been involved in managed care for at least five years to ask: What are the early returns? Do employers believe managed care is making a difference? These are difficult questions to answer, because the research that might point to an answer is frequently outdated, often is based on circumstances too specialized to generalize to large groups, or has other methodological or statistical limitations. Employers—even large ones with databases and resources—must act upon anecdotal information that would be unsatisfactory to academic researchers. Further, once changes are instituted, many other factors, along with subsequent program revisions, preclude formal evaluations.

Some employers emphasize the potential of managed care to control health care costs while not limiting patients’ access to care. The annual cost trend rates of HMOs and other managed care options during the past few years have been consistently lower than for the pure indemnity option.3 Even if the resultant reductions in outlays for a few years are partly related to “prices” that carriers are charging, not to a major change

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in underlying incentives or costs, savings are real to the affected employer.

For other employers, the importance of managed care lies in improving quality of care and reducing waste, in the form of unnecessary services and excessive prices. Some of the nation’s largest employers, with the assistance of knowledgeable benefits executives, are implementing comprehensive health benefits management strategies that involve them much more than before in the delivery of care. Analysts and policymakers have long hoped that the private sector would use its purchasing power in such a way to change the health care financing system.

In this Commentary, I review trends in managed care from the perspective of three of the nation’s largest employers: General Electric, PepsiCo, and Xerox. The experiences of these three companies illustrate what corporate America is doing and what employee benefits managers believe, as reported in face-to-face interviews in July 1991. These companies reflect a larger trend toward active health benefits management by corporate executives. There seems to be a clear connection between the amount of pressure on revenues, the ability to pass costs to the customer (or taxpayer), and an employer’s willingness to spend the time, energy, and staff resources to change its health benefits strategy. Companies under pressure or determined to manage their costs are working to reduce the amount of inappropriate or excessive care for which they are paying.

As I compared the experiences of these three corporate giants, with their very different approaches to managed care, I observed several common threads. First, no one “right” answer exists for all companies. To be effective, managed care requires careful selection and proper design. Once in place, it needs continual oversight. And even in the best-managed environment, measuring its true impact will remain difficult, in a sphere of activity that is both highly complex and poorly understood. Nonetheless, managed care does offer a promising interim step that provides employers some protection from short-term cost problems. The leading-edge employers are trying to go beyond simply purchasing “off-the-shelf” managed care or leaving the problems to the medical care system. In so doing, they are struggling with the same challenges and problems that have bedeviled health policymakers for decades.

Why focus on employers? The employment-based insurance system, which has provided health coverage to most working-age Americans since the 1930s, is the object of scrutiny as the nation wrestles with its health care woes. Some critics view the system as inadequate, to which the number of uninsured or underinsured workers attests. As policymakers look to the employment-based health benefits system as a vehicle to mandate universal health coverage, they must examine how well the current system works for those who are reasonably well insured.
Corporate leaders have never been more concerned about health care costs than they are today. In a recent Fortune poll, nearly two out of three business leaders called skyrocketing medical costs one of the worst problems facing American corporations. One-third of them believed that this is the single biggest problem they would face in this decade. Some employers now want federal action to ameliorate the problems and are lobbying Congress to act, but even if Congress were to enact major health system reform by the turn of the century, employers have to deal with problems at hand now. So they are moving ahead with their own health cost containment strategies, With health benefits costs rising 17.1 percent in 1990 to $3,217 per person, on average, employers believe they have to move faster than ever to blunt the increases. If Congress is to rely on the private sector in national health system reform, that sector must prove its ability to provide care of adequate quality while curbing the cost increases eating away at its bottom line. It is at this juncture that managed care enters the discussion.

Does managed care save money? One need look no further than the trade press and benefits surveys to see what is happening among employers. Managed care premium increases for 1991 were reported to be one-half of the increases for traditional indemnity plans. HMO premiums were in the 10–15 percent range, versus 20–25 percent for indemnity-type insurance. Plans with a preferred provider organization (PPO) option were estimated in the 15–19 percent range. Blue Cross/Blue Shield reported that premium increases would range from 7 to 20 percent, depending on the number and type of managed care features.

Employers tend to compare their own increases to those of other firms or to other published statistics. Beyond mere numbers, however, they look for evidence of quality enhancement or preservation from statistics on questionable admissions and procedures, patient satisfaction data, and monitoring of complaints. Employers who are installing “managed care” programs are doing so partly because they perceive that their costs for those programs are at least slightly lower than their costs for their unmanaged fee-for-service plan. However, it appears that the more tightly constrained an employer’s outlays are because of reduced revenues or other competitive pressures (including from the global economy), the more willing that employer is to limit employee choices and select the less costly managed care option.

In short, although data point to cost savings connected with managed care plans, it is still not clear that they can save employers as much as one might hope. Administrative costs, so-called network access charges, and other elements of managed care plans can easily end up costing nearly as much as the fee-for-service indemnity plan. Also, costs in the second and
third years can rise again if the administrators ("vendors") are not continually monitored and held accountable and if the underlying incentives to use care are not changed. The trade press is full of stories touting the advantages of managed care, especially point-of-service plans, but there is far less talk about failures. There are little hard data of any type, but employers have the flexibility to continually refine ideas and approaches. If one action begins to look like it is not going to produce any savings, within limits, it is possible to not make the change, or make other changes right away. As a result, we will continue to operate with few definitive research results. This is a remarkably dynamic environment.

**Managed Care Strategies Of Three Corporations**

General Electric, PepsiCo, and Xerox are three corporations with different corporate cultures, business strategies, and managed care strategies. All three have been involved with managed care since the early to mid-1980s. They illustrate broader trends among a growing number of large and medium employers. Common to all of these employers is the belief that employers have to take steps to ensure that their employees have the option of selecting high-quality managed care and that they have the information and opportunity to be wiser health care decision-makers on their own behalf. Other fine examples exist, notably Southern California Edison, whose elaborate delivery system model includes eight primary health clinics that have been surveyed and accredited by the Joint Commission on Accreditation of Healthcare Organizations. I chose these cases, however, because they illustrate the diversity of approaches possible as companies go about trying to implement managed care concepts, what their strategies are, and what they believe are the results.

**General Electric.** GE spent over $800 million on health care for its employees in 1990, $3,414 per employee for medical care alone. However, costs per employee have risen 38 percent in the past three years and are estimated to increase 13 percent annually. The latter figure, high for any single expense item, is in the low moderate range for health benefits. By national standards, GE’s benefits are very generous. The company prides itself on comprehensive benefits programs used as a tool to attract and retain top employees. GE has been involved in managed care since the early 1980s. Charles Buck, staff executive for Health Care Management Programs, was a senior health care executive hired specifically to manage health care costs, a step taken by some other large employers as well. According to Buck, GE’s overall cost containment strategy, which has been evolving over the past ten years, can be divided into three categories: utilization review for the fee-for-service, freedom-of-choice plan;
incentives to use carefully selected PPOs within the medical plan; and development of enrollment-based managed care options, called Preferred Medical Plans.

GE sees utilization review as a necessary first step, given the significant amount of unnecessary medical care documented in the research literature. GE would rather not be in the position of coming in or paying others to come in late in the medical care process in an “inspect” method of control. This is the least desirable and probably the least effective approach, according to Buck. GE prefers to ensure quality and efficiency as in the industrial model, he explained, by “moving upstream in the quality assurance process: helping the patient navigate the health system, partly by educating and facilitating a questioning process by the patient.”

GE is developing specifications for a prototype telephone-based “patient decision support system,” known as Nurseline. GE employees and their dependents will be encouraged to call registered nurses for information about health care or health problems. In time, Nurseline will integrate with traditional utilization review, second surgical opinion, and the local provider network (purchasing) strategy. For example, if a patient who has been told he needs prostate surgery would call Nurseline, he would be given information about options and alternative outcomes that he might want to review with the urologist. The nurse might also suggest a local urologist who has an excellent record of conservative practice and good interpersonal skills for talking with patients.

A newsletter for employees aimed at health care decision making is another component of this program. This newsletter is intended as a tool to help both patient and provider be much more informed about medical options. In creating and publishing it, GE has gone considerably further than most other large employers. Its format and information, which includes sophisticated discussions of health care treatment decisions written for a lay audience, differ from some of the better wellness-oriented or health promotion newsletters.

A key to successfully implementing a new health benefits strategy is to make that strategy consistent with the corporate culture that already exists in a company. GE has done this in several ways. First, it regularly runs focus groups to test ideas and approaches. Employees are encouraged to invent solutions to problems they perceive in their health benefits plan. Their concerns can be as specific as needing help finding a physician or deciding about surgery, or as general as knowing what works and what does not. Second, as part of its efforts to understand and influence the health care system, GE is attempting to “map” the health care process, using a management tool already used throughout GE. “Process mapping” involves key participants in the process to produce a flow chart showing
every step in the process under examination, no matter how small. This reveals steps that do not add value and allows GE to manage an operation from start to finish.8

Another component of GE’s health strategy is what GE calls Preferred Medical Plans—network-based alternatives that employees can elect outside the GE plan, with carefully selected physicians, hospitals, and other providers. The company already has Preferred Medical Plans in three cities and plans to develop eighteen more in the next three years. These plans are implemented in a variety of ways, not by a single national carrier, thus enabling the company to be flexible in meeting local needs. A number of criteria, including quality measures, enter into the selection of the best care options in each city. Another part of the scheme is the option of treatment in nationally recognized “centers of excellence.” If the patient accepts treatment in one of these centers, GE pays for not only the medical costs but also expenses for transportation, meals, and lodging for the patient and one immediate family member.

In the long run, GE’s Buck is betting on enrollment-based options—that is, health plans that must be selected at the beginning of the year and that take responsibility for the care of the enrollee. The preferred model is one in which the patient chooses a primary care physician. Based on this ongoing relationship, the physician and the system have a chance to fulfill their responsibilities for continuing care. This is especially valuable for patients with chronic care needs; it permits an emphasis on wellness, health promotion, and early diagnosis and treatment.

Overall, GE’s early returns show added value in what they are purchasing. Annual increases in the low double digits, which are lower than those of other employers, seem to back that up. But because GE is making so many changes at once, it is difficult to quantify which intervention makes the difference. The company has evidence that it is providing more services yet slowing down the rate of cost increase. GE has also learned that it cannot ever let up.

PepsiCo. Although different from GE in both corporate culture and health benefits strategy, PepsiCo shares common elements with GE. One of these is a benefits executive with a great deal of health care–related experience. Dave Scherb, vice-president of benefits for PepsiCo, has both health insurer and HMO management experience.

Although PepsiCo is one of the country’s largest employers, a number of its locations employ only a handful of people. With divisions that include Pepsi-Cola, Frito-Lay, KFC, Pizza Hut, and Taco Bell, PepsiCo’s geographic distribution, diverse work force, and demographics make health cost containment a challenge, particularly when it comes to building managed care networks.
The corporate culture of PepsiCo fosters innovation, rapid decision making, and the kind of direct accountability that would make less risk-taking types nervous but can certainly inspire the imaginative. The company thrives on individual choice, accountability, and change. Its chairman believes that one of the worst business advisory statements ever made was, “If it isn’t broken, don’t fix it.” The company’s ongoing success reinforces its strategy of devising new ideas each year to improve upon the last year’s performance. As far as benefits are concerned, PepsiCo builds in so much individual choice and annual benefit changes that employees view them as normal. PepsiCo has had a flexible benefits plan in place for over a decade—one of the oldest such plans in the industry.

At PepsiCo, a disciplined budgeting process, which has been used successfully since the introduction of flexible benefits in 1980, determines the timing for new managed care programs. Each year, in the first quarter, the benefits staff examines data on prior experience and presents alternatives and estimates of the impact of various options in the second quarter. They decide what to implement in the third quarter and develop communications to “roll out” the changes. In the fourth quarter, employees enroll in their choices, and the cycle begins again.

Some of PepsiCo’s most effective managed care programs were developed out of that process, including the high-risk pregnancy program, managed mental health and chemical dependency programs, and HMO and PPO networks. Several years ago, data analysis demonstrated that premature newborns helped make maternity PepsiCo’s fastest-growing expense. PepsiCo contracted with a utilization review firm to identify potentially high-risk pregnancies and provide intensive case management through a pilot program for one division. Given the relatively small number of cases and the statistical and measurement problems, Scherb is cautious about offering empirical evidence of the pilot programs effectiveness. Hard data over enough years will soon be available, but in the interim, he can cite the following statistics: Of forty problem newborns identified in the first year of the pilot, twenty were in the new maternity program. Those in the program had medical costs that averaged one-half the costs of the others. (Costs are markers for a number of problems, including pain and suffering of the families.) Based on its apparent success, PepsiCo made the program available throughout the company last year. Employees value the program, as evidenced by positive comments in surveys and their 80 percent voluntary participation rate.

In the analysis and budgeting process, PepsiCo also saw serious problems with psychiatric care. It hired a specialty mental health and substance abuse managed care firm, added case management, and used an employee assistance program (EAP) to encourage early assistance and
follow-up help. It also hired another specialty mental health/substance abuse firm with a network for Frito-Lay. In both cases, within two years of implementing these changes, the average length-of-stay went from thirty-six to eighteen days. Psychiatric costs declined by 18 percent within one year of adopting managed care with network providers. Claims costs were almost back to 1987 levels.

Believing that this is still too high, PepsiCo decided to put in a thirty-day inpatient limit, primarily as a tool for case managers. The thirty-day limit can be waived if active case management is present. This shifts the burden of proof from the utilization review firm and case manager to the provider, who must make the case that the care is needed. With limits, Scherb said, “the provider has to show that the care is medically appropriate and necessary. This makes a big difference and also starts the discussion at a more affordable level.”

Until PepsiCo began introducing some management, mental health and substance abuse claims were rising at a rate consistent with those of other large employers. After PepsiCo made the changes, their mental health/substance abuse claims costs became third highest, no longer at the top of the list. Maternity occupies that spot, but the data suggest that length-of-stay and cesarean section rates are actually lower than the norm. Nonetheless, in PepsiCo fashion, the benefits staff is tracking the data, ready to act if problems arise.

PepsiCo, as do many employers, offers HMOs throughout the country. The geographic dispersion of PepsiCo employees requires the use of national networks (both HMO and PPO) to gain buying power at the local level. However, believing that it had far too many HMOs to exercise adequate management control, PepsiCo began a systematic consolidation of the number of HMOs it offered, using a formal request-for-proposal (RFP) process. At the same time, it developed national PPO networks. PPO and HMO networks, provided mostly by insurers, are an essential part of a long-term, comprehensive strategy for managing care. PepsiCo believes it is approaching its limits on the costs employees can be expected to share. Through networks, PepsiCo can use its leverage and health care knowledge to help employees get high-quality health care without necessarily increasing their share of the bill. Scherb believes that, over time, the quality of network providers will be the incentive for employees to use network services. That is why PepsiCo has not used negative incentives such as benefit cutbacks to steer employees to its networks.

PepsiCo has had very good success with managed care, Scherb believes. “Second surgical opinion saved a little, but precertification saved a great deal more. . . . Now, with the addition of more sophisticated case management programs and networks, we’ve continued to hold our annual
costs down to single-digit increases.” PepsiCo has seen savings of 6–12 percent of hospital and physician charges through the use of networks, but the combination of many actions, not networks, has held down costs. Looking forward, Scherb said:

In the 1990s, carriers will have to continue to prove that they have high-quality, efficient providers as measured by ever more sophisticated methods. Our networks are using the credentialing and quality assurance methods known today, but we want providers to continue to prove with solid statistics and outcomes data that their doctors and institutions are better and that they are continuing to reduce unnecessary use. As the state of the art expands, we’ll expect our networks to remain at the cutting edge of the quality movement.

Xerox. Xerox purchases health benefits for 55,000 U.S. employees, retirees, and their eligible dependents. Like GE, Xerox has long provided comprehensive, competitive benefits, a policy that is valuable in recruiting and retaining top scientific and technical people in communities such as Rochester, New York, and throughout California. But as have all employers, Xerox has been challenged to blunt the health cost spiral. (Xerox health costs grew 51 percent between 1987 and 1990.) Xerox concluded that shifting more costs to employees was not an acceptable option and that cutting benefits was not desirable.

Xerox employees are clustered in several locations, some of which have a tradition of older, stable HMOs. When Xerox began its most active cost management program, at least 40 percent of its employees—many of them in Rochester—were already enrolled in HMOs. Employees in these communities had considerable choice among HMOs. Thus, the Health-Link HMO network, which Xerox offered for enrollment in 1990, is built on an existing tradition of familiarity with HMOs.

For more than six years, Pat Nazemetz, director of benefits at Xerox, has been developing and fine-tuning a bold, imaginative strategy for health care cost management, based on HMOs and nationwide in its scope. The plan was to create a national network of well-managed, high-quality HMOs, applying to the purchase of health benefits the same “Total Quality Management” business strategy that helped Xerox win the prestigious Baldridge award.

Through a lengthy competitive process with twenty-two possible HMO managers, Xerox spelled out in detail its health services requirements. In effect, Xerox asked HMOs if they would not only provide the kind of care Xerox demanded but also help manage other HMOs. Xerox wanted to develop the kind of long-term supplier relationship with their HealthLink HMO managers and HMOs that the Japanese use with such success and that is becoming popular in the United States.

According to Nazemetz, “We were willing to pay a fair and reasonable price. Xerox is a major player in its communities. We always want to be
a good corporate citizen. We were not looking for discounts because we did not want to negatively affect the providers that served its employees, and because a long-term, quality-oriented relationship could not be built on simple discounts.” At the same time, Nazemetz wanted to ensure that each service area offered competition and a choice for employees. Although Nazemetz continues to refine the original approach, the broad policy direction has remained unchanged.

The components of HealthLink are in place, with Kaiser, Blue Cross/Blue Shield of Rochester, FHP, PruCare, HMO Group, and U.S. Healthcare serving as the six national managers. All billing and reporting will be consolidated under the managers. These managers have already done the thorough on-site surveying and evaluating that permit HMOs to be a part of HealthLink.

Beginning in 1991, new Xerox employees will not be offered health coverage outside the HealthLink HMOs. Any Xerox employee hired before that time can remain in the Xerox fee-for-service indemnity plan, but the individual’s out-of-pocket costs in this plan can be quite high, thus providing a financial incentive to switch to the managed care option. For example, the annual deductible for the fee-for-service plan is 1 percent of pay (previous year), and the out-of-pocket maximum is 4 percent of pay or $4,000, whichever is lower.

Xerox has gone further than other large employers to exercise its collective purchasing power in identifying high-quality managed health care providers and designing and implementing a nationwide strategy. In so doing, Xerox has accelerated the demands on HMOs to be responsive to employers and directly accountable through detailed, quantitative measures of utilization, quality of care, program effectiveness, and costs.

Because a high percentage of its employees were already enrolled in HMOs and its main locations were in areas with long-standing, strong HMOs, Xerox could implement its HMO-based managed care strategy faster than some other employers could. Early evidence suggests that Xerox is on schedule in its implementation of a tough strategy, and Xerox is confident that it is moving in the right direction. Nazemetz estimates that Xerox’s HMO costs are about ten percentage points lower than those of its indemnity plan. As part of its ongoing commitment to HealthLink and to continuous quality improvement, Xerox is working with the National Committee for Quality Assurance (NCQA) and its HealthLink managers to accredit and survey all of its HMOs. In 1991, Xerox planned to complete employee surveys and obtain patient satisfaction data from a national survey. Xerox will also collect baseline utilization and quality data, which it can in turn use to monitor progress in health status.

While the main strategy has been to establish HealthLink as quickly
as possible, the indemnity plan also has new elements of managed care to
ensure that the indemnity plan’s high growth rates are moderated and
that Xerox pays only for medically necessary and appropriate care. Xerox
now requires utilization review for a hospitalization, including psychiatric
and substance abuse treatment. The latter is particularly important, given
concerns among all employers that HMO benefit packages discourage
patients with high service requirements. Xerox is determined to create a
system that takes care of people but also is affordable in the long run.

Lessons For Other Employers

As these three examples demonstrate, health cost management strate-
gies of leading-edge employers have several elements in common. First,
employers are driven by data that document problems and point to causes.
Initially, they may have reacted to annual medical claims cost increases
that became unacceptable after enough years and growing frustration
with no sign of abatement. Second, employers take significant time to
develop plans, work with internal groups or task forces, interact with
divisional or regional personnel to explore ideas, and meet with external
providers and other vendors. Some companies have chosen to, or were
forced to, accelerate some of those steps.

Third, as part of that process, employers have learned to stay involved
with their suppliers to a degree that would have been unimaginable until
a few years ago. In many instances, the employer forced the suppliers or
providers to introduce or adapt a program or product. Fourth, the steps
they took had to fit with the “corporate culture.” What works well or
easily in one organization might be counterproductive in another.

Fifth, all have come to appreciate the need for consumers/patients to
be knowledgeable and be given the tools to ask questions and make their
own health care decisions. Sixth, employers believe, as the benefits
managers here described, that high-quality health care will prove to be
the most cost-effective and, over the long term, the least costly.

Seventh, employers do not shrink from their roles as buyers of hundreds
of millions of dollars of services, which must be continually monitored
and actively managed, just like any other major expense. Cost manage-
ment and quality assurance cannot be “done” and then left to the
professionals or the vendors. Financial leverage and technical knowledge
are used aggressively to get more return on the investment of their health
care dollars. Companies gain because they are slowing the growth of
benefit costs that are eating away at their profits. Employees gain because
their out-of-pocket costs are reduced and they can get better care if it is
managed properly. Finally, and most importantly, employers believe that
for the long term, the systems that come closest to truly managing care—well-managed HMOs and gatekeeper-model PPOs—will provide the greatest promise for ensuring high-quality care at a reasonable price.

Incrementalism As Corporate Strategy

Health care in the United States is moving toward more oversight and accountability. Providers, understandably, view it as “micromanagement.” Everyone affected laments the added administrative costs due to such management, but employers are not likely to reduce their increasingly direct involvement in health care delivery because the cost management does reduce employers’ claims costs relative to their costs if left unmanaged or uncontrolled. They believe they have no choice given their approximately $200 billion annual investment in health care.

It is unknown whether the spread of managed care, with its combination of national systems and regional or local management, will occur with any degree of evenness, competence, and uniformity, or if the wide dispersion, layers of organization, and multiple units of the nation’s employers will undermine presumed advantages. Effective execution makes the difference between a shell of a program that simply adds another layer of administrative costs to an already multilayered system and a program that provides useful services to providers and patients alike.

No employer likes to tackle tasks as daunting and thankless as managing health benefits costs. Often, success does not look good enough to gain any accolades from senior management, and every step that moderates the rise in medical claims produces loud complaints. The tougher the reform strategy, such as replacing all other options with an HMO, the more grumbling there is likely to be. Thus, although employer/purchasers are increasingly frustrated by annual increases in the 15–25 percent range, they do not want to move so fast that they either hurt or alienate their employees, thus putting themselves in an uncompetitive situation for recruitment and retention. Employers believe that health coverage is one of the most important benefits they can and should provide to their employees. Because of its importance, managers want to minimize changes with adverse effects.

Yet the ability to pass on cost increases to customers or taxpayers continues to shrink, and employers have less ability to absorb premium hikes at such high levels year after year. The dragging economy has influenced the health benefits market even in the past eighteen months. The recession and the gloomy outlook for the future standard of living have accelerated these realities and made it more essential for some employers to institute more stringent cost sharing and look at capping
their outside liability, by moving into more comprehensive managed care. Even public employees—who have long had some of the most comprehensive and thus costliest health plans—are beginning to be challenged to give up some of their “first-dollar” coverage or take reductions in other benefits, wages, or jobs.

Degrees of management. Employers usually follow these steps to reduce medical claim costs: (1) increasing what employees have to pay for coverage, especially for dependents; (2) increasing deductibles and copayments; and (3) introducing new limits in special areas such as mental health and substance abuse (“inside limits”).

To date, most employers have been willing to tackle only the most blatant, unnecessary care. Employers with the highest costs and the greatest pressures on their revenues will keep looking for managed care organizations that will give them better and better results. When these methods fail, more aggressive squeezing down on discretionary care and techniques for slowing demand come next. Most employers move unhappily to that stage. Unless government enacts laws that limit price increases affecting all purchasers, employers will take even more drastic steps to limit cost increases, such as limiting their absolute contribution to health plans or providing primary care services in a tightly controlled setting. Direct contracting and purchasing (for more specialized services) will become increasingly attractive to the largest employers in an area. The growing supply of physicians will make it easier to recruit and retain physicians as managers and as clinicians, as well as to provide oversight for the employer.

Integrated plans. If an employer’s younger, healthier workers move first into the managed care programs, and the sicker or older employees stay in the “indemnity” option, an employer will have the worst possible experience. For this reason; employers are looking for integrated plans with carriers and HMOs in which employees’ movement in and out of the indemnity option (so-called antiselection) is “priced” in a way that does not cost the employer more money. Until such “integration” is more widely available, employers are pressuring HMOs to hold down their premium increases, partly because employers believe that they are “overpaying.” Employers also want evidence that documents their employees’ use of services. Since HMOs in the past have resisted employers’ demands for more accountability and reduced premiums, employers have come to believe that offering fewer HMOs will give them more leverage and reduce administrative burden. The current trend to consolidate the number of HMOs offered will, accelerate. This in turn will make it easier to move to a single option, or very small number of options.

It is not unusual for an employer to announce that it is moving to
managed care to avoid having to shift more costs to employees. Companies with the highest per employee costs and the greatest pressure on their own revenues are most likely to feel they have no other choice. Most employers—of all sizes—will go through incremental steps toward less free choice of providers or higher cost sharing if employees want to retain complete freedom of choice.

Unless the economy turns around soon, I foresee much more movement by more employers to the most comprehensive managed care with the most obvious ability to hold down costs. Employers will find it increasingly attractive to deal with one organization, with the adverse risk selection “neutralized” by the integrated plan. At the same time, most costly health care (such as inpatient operations and mental health care) provided outside of an HMO or a PPO will be reviewed by specialized utilization reviewers.

The largest companies will find themselves immersed in “micromanagement” to ensure that they get what they want. Medium and small employers will follow suit to the extent possible. The U.S. health care delivery system is so extensive, complicated, and expensive, no employer of any size can afford not to become deeply involved in finding new ways to limit its outlays. One employer said recently, “I don’t like to have to spend so much time on it, but somebody has to control the constantly running meter.”

NOTES

7. Ibid.