Trends In Managed Care And Managed Competition, 1993–1997

We are in the midst of a managed care revolution, but managed competition has not been widely adopted.

by M. Susan Marquis and Stephen H. Long

PROLOGUE: John Maynard Keynes once quipped that “[p]ractical men, who believe themselves to be quite exempt from any intellectual influences, are usually the slaves of some defunct economist.” And so it goes with Adam Smith, whose ideas on economic competition and free markets have become so thoroughly entrenched in the fabric of American life that policymakers are loath to abandon them, even when they exact a high sacrifice from society’s neediest citizens. In American health care, policymakers must struggle with precisely this kind of conflict: the moral imperative to allow all citizens equal access to health-preserving resources versus the political and historical imperative to maintain fidelity to abstract notions that are powerfully linked to the American heritage. This struggle has given birth to managed care and managed competition, both designed in part to ensure wider distribution of health care resources, while at the same time preserving a measure of autonomy for the private-sector actors who have made health care their livelihood.

In this paper Susan Marquis and Stephen Long examine recent trends in employers’ embrace of managed care and managed competition. The 1997 data in this paper come from the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey, part of the RWJF’s Community Tracking Study and its State Initiatives in Health Care Reform Project. Both authors have had highly distinguished careers and are expert in employment-based health insurance; they are also widely respected for the large body of health policy research that they have produced over the past two decades. Both are senior economists at RAND in Washington, D.C.
ABSTRACT: According to the recent literature, we are experiencing a managed care “revolution,” and managed competition is increasingly being embraced by private- and public-sector policymakers. Using two large employer health insurance surveys, this paper presents new estimates that both confirm and add to our understanding of changes taking place in employment-based health plans. The dramatic shifts in enrollment from indemnity to managed care largely reflect employers’ choices about the types of plans to offer. Employees are limited in the number and types of plans from which they can choose. When choice is available, it is generally not governed by managed competition principles.

Two important themes in employment-based health insurance over the past two decades are managed care and managed competition. The pace of managed care market penetration has accelerated so much that in the past few years it often has been termed a “revolution.” The influence of Alain Enthoven’s ideas about how managed competition could foster improved efficiency and quality also has grown briskly. First applied in corporate settings, these ideas later became the basis for the Clinton administration’s health reform proposal. Moreover, managed care and managed competition are interrelated because growth in managed care plans may facilitate the adoption of managed competition principles by employers, while the practice of managed competition creates opportunities for managed care plans to start up or expand.

Recent evidence on managed care. After a gradual change through most of the 1980s, the past decade has witnessed a rapid shift from traditional indemnity plans to health maintenance organizations (HMOs) and other network plans, for large and small businesses alike. The proportion of employees in large firms who were enrolled in managed care plans grew from 5 percent in 1984 to 50 percent by 1993. Also, conventional-plan enrollments fell among small firms (fewer than fifty workers) from 78 percent in 1993 to 31 percent in 1995. An especially notable trend was employers’ shifting from offering one indemnity plan to offering one managed care plan. By 1998 only 14 percent of employees in large firms (more than 200 employees) were enrolled in conventional plans.

Growth in health care costs also slowed considerably between the late 1980s and the mid-1990s. Many believe that growth in HMO enrollment played an important role in this cost trend. However, the evidence on the degree to which HMOs contain employers’ costs is mixed. Some studies have found that employers offering HMOs have lower premiums, whereas others have found that HMO premiums are not consistently lower than other premiums and that such employers face higher overall premium costs. Similarly, some studies suggest that growth in market share for HMOs produces spillover benefits in the form of lower costs throughout the health
In most multiple-choice situations, employers have not put in place incentives to reward cost-conscious plan shopping.

care system, whereas other results cast some doubt that HMO growth induces competitive responses throughout the market.9

Many have observed that a backlash against managed care is developing as employees are moved from the freedom to choose their physicians under traditional indemnity plans to the restricted choice permitted under HMOs.10 Perhaps as a result, newer managed care models such as preferred provider organizations (PPOs) and point-of-service (POS) plans have seen the greatest share of recent managed care growth.11

Recent evidence on managed competition. The theory of managed competition is to contain health care costs by stimulating price and quality competition among plans. To achieve these objectives, employers must contract with several competing managed care plans and provide workers with financial incentives to choose the lowest-price plan and with comparative information about plans’ price and quality.12

There is limited, mixed evidence about the success of managed competition based on several natural experiments in private and public employment settings. The studies consistently find that employees who are offered a multiple choice of plans prefer the lower-price plans when they must pay out of pocket for the full price difference among plans.13 However, adverse selection was significant in a number of these groups—sufficient to drive some plans out of the market.14

In contrast, experience is mixed with respect to cost savings. Some studies show savings, although mostly of a one-time nature followed by long-run growth rates matching those experienced by similar employers.15 In another study, even when cost-conscious plan choices by employees were induced, no effect on costs relative to the market was observed.16

Advocates for managed competition claim that this strategy has not been adequately tested, because in most multiple-choice situations, employers have not put in place incentives to reward cost-conscious shopping.17 According to a 1995 survey, only 12 percent of businesses with 200 or more workers that offered a choice of health plans gave their employees a level-dollar contribution rule, as prescribed under managed competition. On an employee basis, one-quarter to one-third of those offered a choice of plans were presented with this incentive.18 However, where managed competition
incentives were used, annual premium growth was lower. Some observers argue that adverse selection is the fatal flaw in managed competition and the reason why many multiple-choice arrangements have failed to contain costs. In multiple-choice situations, it is argued, plans compete to attract the healthiest members rather than seeking ways to provide care more efficiently. Instead, critics argue, employers could contain costs by offering HMO networks as employees' sole choice. Some employers may be unwilling to limit choice to HMO networks only, because employees' satisfaction with their health care plan—including their managed care plan—is greater when they have a greater choice of plans. A number of employers try to manage adverse selection while preserving choice by contracting with one insurance carrier but offering a choice of products from that carrier. However, this does not stimulate competition among health plans as a way of disciplining costs.

Nearly all of the literature on national estimates of the shift toward managed care and the prevalence of managed competition has been based on a single series of employer health insurance surveys, first conducted by the Health Insurance Association of America (HIAA) and then continued by KPMG Peat Marwick. This paper complements and extends this literature by presenting new estimates based on two large national surveys of employers, providing data for 1993 and 1997. We examine recent trends in employers' decisions about the design of their health insurance programs, the role of managed care in them, and their adoption of managed competition principles. We also look at the relationship between various employer health benefit models and cost.

**Study Data And Methods**

We compare estimates for 1993 from the National Employer Health Insurance Survey (NEHIS) and estimates for 1997 from the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey. The two surveys were comparable in sample and measurement design, administration, and processing.

**Sample design.** The sampling frame for both surveys was the Dun's Market Identifiers national census of employment establishments. The nationwide NEHIS sample was stratified by state and within state by firm and establishment size. The RWJF drew a sample of establishments in the continental United States, stratified by geographic area and size of the establishment. It oversampled businesses in the sixty communities followed by the Community Tracking Study and in twelve states with significant small-group rating reforms. The NEHIS completed interviews with 34,604 private employers with one or more employees, for a response rate of 71
percent. The RWJF survey interviewed 21,545 employers and achieved a 60 percent response rate.

Sampled establishments in each study were weighted to account for different sampling probabilities and for nonresponse. The weighted samples represent all private employment establishments that have at least one employee. For our comparisons, we have adjusted the weights for the NEHIS sample so that the distribution of establishments categorized by their size and the size of the larger firm—for establishments that are part of a multi-establishment firm—is the same in both the NEHIS and the RWJF samples. We also restricted our analysis of the NEHIS sample to establishments in the continental United States because this was the population covered in the 1997 RWJF survey. Although the establishment is the unit of observation for most analyses in this paper, we also used sampling weights to make estimates for employees enrolled in their employer-sponsored health plan.

Survey administration. The surveys used similar questions and definitions. Both collected information from employers using computer-assisted telephone interviews. Both interviews were conducted with the person or persons in each establishment most knowledgeable about health benefits and the characteristics of the firm and its workers. The NEHIS survey was administered during 1994 and asked respondents to report characteristics of coverage as of the end of 1993. The RWJF survey was administered during 1997, and employers were asked about coverage as of the date of the interview. The databases were subjected to similar algorithms to edit data for consistency and to impute missing data.

Measurement. We measured the change between the two surveys in the market shares for different types of health plans, the number of employers offering a choice of plans and the mix of plans offered, and the costs for different design choices. Health insurance plans were classified as HMOs, POS plans, PPOs, or conventional indemnity plans based on the respondent’s self-assessment of the plan type, aided by complete definitions as needed.

Employers were classified as “offering a choice of plans” if they offered two or more plans, whether of the same or different types and whether through the same or different carriers. In the 1997 survey we asked whether the various plans were all from the same or different insurance carriers, and we report how many employers in 1997 offered a choice of carriers as well as a choice of plans.

We measured the current level of costs by the premium for single coverage. In both surveys premiums for single and family coverage were reported for each insurance plan. We computed an average single premium for the establishment by weighting the premium for
“Enrollment of employees in traditional indemnity plans fell by 60 percent during 1993–1997, among businesses of all sizes.”

the separate plans by the number of enrollees. In our analysis we report the 1997 single premium as well as the change in this premium between 1993 and 1997. In addition, we compare the change in total health plan costs per enrollee between 1996 and 1997 reported by businesses included in the 1997 RWJF sample.

We explore the extent to which employers use managed competition’s prescribed financial incentives and provide comparative data on the quality of plans offered in 1997. Employers in the 1997 survey who offered more than one plan were asked to describe how they set their premium contributions for single coverage. Large employers (500 or more employees) offering a choice of plans also were asked about the kinds of information they provided employees to assist them in making plan choices. We report the number of employers who indicated that they provided comparative quality information, including enrollee satisfaction ratings or plan performance measures such as Health Plan Employer Data and Information Set (HEDIS) measures.

Although the sample unit and the primary analysis unit is the establishment—the physical location of business—for many analyses we categorize establishments according to the size of the firm, which includes employees at all locations nationwide. We do this because insurance decisions typically are made at a regional or national level for firms with several establishments.

Results

- **Enrollment shifts.** The dramatic shift to managed care apparent in our 1993–1997 study period accords with findings in the literature from the KPMG employer surveys. Enrollment of employees in traditional indemnity plans fell by 60 percent during this time—from 46 percent to 18 percent (Exhibit 1). This substantial shift occurred among businesses of all sizes. Overall, enrollment gains among the three types of managed care plans were of similar magnitude. However, in firms with fewer than fifty employees, almost 60 percent of the shift from conventional plans was to HMOs. In contrast, in the largest firms the shifts were to POS and PPO plans.

- **Consumer choice.** Only a minority (one-fifth) of employers offered a choice of plans in 1997 (Exhibit 2). Choice varied greatly with the size of the firm, however. Fewer than 10 percent of establishments of firms with fewer than fifty employees offered a choice...
in 1997, whereas about 35 percent of establishments of the largest firms did so. Consequently, the proportion of enrollees who were offered a choice of plans was larger than the proportion of employers that provided a choice. Nonetheless, in 1997 only 43 percent of health plan enrollees worked for an employer that offered a choice of plans.

EXHIBIT 1
Employee Enrollment In Health Insurance Plan Types, By Firm Size, 1993 And 1997

<table>
<thead>
<tr>
<th>Firm size</th>
<th>Type of plan</th>
<th>1993</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO</td>
<td>POS</td>
<td>PPO</td>
</tr>
<tr>
<td>All establishments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>24%</td>
<td>4%</td>
<td>26%</td>
</tr>
<tr>
<td>1997</td>
<td>33</td>
<td>15</td>
<td>34</td>
</tr>
<tr>
<td>Fewer than 50 employees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>20</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>1997</td>
<td>38</td>
<td>7</td>
<td>36</td>
</tr>
<tr>
<td>50–499 employees</td>
<td></td>
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<tr>
<td>1993</td>
<td>26</td>
<td>4</td>
<td>29</td>
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<td>1997</td>
<td>41</td>
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<td>1993</td>
<td>26</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>1997</td>
<td>26</td>
<td>21</td>
<td>33</td>
</tr>
</tbody>
</table>

NOTES: HMO is health maintenance organization. POS is point-of-service. PPO is preferred provider organization.

EXHIBIT 2
Establishments Offering And Health Plan Enrollees Offered A Choice Of Plans, 1993 And 1997

<table>
<thead>
<tr>
<th>Firm size</th>
<th>All establishments</th>
<th>Fewer than 50 employees</th>
<th>50–499 employees</th>
<th>500 or more employees</th>
</tr>
</thead>
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<tr>
<td>Establishments</td>
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<td>11</td>
<td>21</td>
<td>43</td>
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<tr>
<td>Offered plan choice, 1993</td>
<td>17</td>
<td>9</td>
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<td>Offered 5 or more plans, 1993</td>
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<td>5</td>
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<td>3</td>
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<td>Offered choice of carriers, 1997</td>
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<td>4</td>
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<td>Health plan enrollees</td>
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<td>61</td>
</tr>
<tr>
<td>Offered plan choice, 1993</td>
<td>43</td>
<td>12</td>
<td>34</td>
<td>59</td>
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<tr>
<td>Offered 5 or more plans, 1993</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Offered 5 or more plans, 1997</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Offered choice of carriers, 1997</td>
<td>23</td>
<td>5</td>
<td>18</td>
<td>32</td>
</tr>
</tbody>
</table>

NOTES: Employers were classified as offering a choice of plans if they offered two or more plans. When offering a choice, employers were classified as offering a choice of carriers if the plans were from at least two insurance carriers. In 1997, 63 percent of establishments belonged to firms with fewer than 50 employees, 17 percent belonged to firms with 50–499 employees, and 20 percent to firms with 500 or more employees. The corresponding distribution for health plan enrollees was 20 percent, 27 percent, and 53 percent, respectively.
In addition, only about half of those who were offered a choice of plans could choose among products of various carriers. Eight percent of employers offered a choice of products from various carriers, while 9 percent offered a choice of products from a single carrier. Among enrollees, 23 percent had a choice of products from various carriers, while 20 percent were offered a choice of products from a single carrier.

Despite interest in managed competition’s potential, consumer choice is not increasing. In fact, our results suggest a decrease between 1993 and 1997 in the number of large establishments that offered a choice (Exhibit 2). The number of health plan enrollees offered a choice, however, did not decline by a statistically significant amount. A trend toward fewer choices among larger employers is also evidenced by a consistent decrease in the numbers of employers and enrollees with five or more plan choices. However, this estimate is imprecise and not statistically significant.

**Types of plans offered.** Because consumer choice is limited, the enrollment shift to managed care largely reflects changes in the types of plans employers are offering. About half of all businesses offered only indemnity plans in 1993, but this fell to only 19 percent by 1997 (Exhibit 3). In contrast, the percentage of employers offering only HMOs more than doubled, and the percentage offering only one type of managed care product nearly doubled. Although similar changes are seen among firms of all sizes, larger employers are more likely than smaller firms are to offer both a managed care product and an indemnity product.

Only 27 percent of health plan enrollees had the opportunity to enroll in a traditional indemnity plan (as the only choice or in combination with a managed care product) in 1997, compared with 59 percent in 1993, and more than half were offered only one type of managed care plan in 1997.

**Impact of cost.** Cost and employers’ decisions about the type of health plan to offer may be related. Single premiums for employers offering an HMO alone or an HMO and another managed care plan were about 6–10 percent lower ($160–$164 versus $175–$178) than were premiums for other employers in 1997 (Exhibit 4). Similarly, the increase in total premiums between 1996 and 1997 reported by employers offering HMOs alone or in combination with another managed care plan was lower than for other employers. The same pattern of slower growth in premiums for employers offering HMOs is seen in comparing average single premiums reported in the 1993 and 1997 surveys by the type of plans offered, but the differences in premium changes among employers offering various types of plans are not statistically significant. The lower HMO premiums and their
slower growth may have been factors leading employers to shift to these plans from the indemnity plans they previously offered.

On the other hand, cost and offering a choice of plans do not appear to be related. Premiums for single coverage do not differ between employers offering a choice of plans or of carrier and those that do not (Exhibit 4). The change in costs between 1996 and 1997 also did not differ significantly between employers offering a choice of plans or carriers and those that did not.

Spread of managed competition. The spread of managed competition practices among firms that offer a choice of plans remains limited. In 1997, 28 percent of establishments offering a choice contributed a fixed-dollar amount for single coverage to all health insurance plans, thereby requiring their employees to pay the full price difference between more and less costly plans out of pocket (Exhibit 5). Another third paid a fixed percentage of the single premium for all plans, thereby requiring employees to pay a part of the difference in cost between plans and the employer to pay the

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**EXHIBIT 3**

Types Of Plans Offered, By Firm Size, 1993 And 1997

<table>
<thead>
<tr>
<th>Firm size</th>
<th>HMO only</th>
<th>POS only</th>
<th>PPO only</th>
<th>Indemnity only</th>
<th>Managed care and indemnity</th>
<th>Other combinations</th>
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<tbody>
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<td>Establishments</td>
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<tr>
<td>All establishments</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>13%</td>
<td>2%</td>
<td>21%</td>
<td>51%</td>
<td>9%</td>
<td>4%</td>
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<td>21</td>
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<td>25</td>
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<td>Health plan enrollees</td>
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<tr>
<td>All establishments</td>
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</tbody>
</table>

**SOURCES:** National Employer Health Insurance Survey; and 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

**NOTES:** HMO is health maintenance organization. POS is point-of-service. PPO is preferred provider organization.
rest. Thirty-eight percent of employers fully subsidized the cost difference by paying the full premium for single coverage for all plans or by setting a fixed-dollar contribution from employees.\textsuperscript{15} Large employers are more likely than small ones are to require that employees pay at least a part of the cost difference if they choose a more expensive plan. However, even among large employers, only 36 percent had a fixed-dollar contribution policy in 1997.

Employers also have shown little movement toward adopting the financial incentives prescribed by managed competition. Only 4 per-

### EXHIBIT 5
Incentives For Consumer Shopping Among Employers Offering Multiple Plans, 1997

<table>
<thead>
<tr>
<th>Type of incentive (self-only coverage)</th>
<th>Use of Incentives</th>
<th>Firm size</th>
<th>Percent of employees choosing lowest-price plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All establishments</td>
<td>Fewer than 50 employees</td>
<td>50–499 employees</td>
</tr>
<tr>
<td>Employer pays Fixed amount to all plans</td>
<td>28%</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>Fixed percent to all plans</td>
<td>34</td>
<td>18</td>
<td>34</td>
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<tr>
<td>100 percent to all plans</td>
<td>31</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td>Employee pays Fixed amount for all plans</td>
<td>7</td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>

**SOURCE:** 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
cent of employers offering multiple plans that subsidized the difference (in whole or in part) in premiums in 1996 switched to an equal-dollar contribution policy in 1997.

Employers’ contribution policies affect employees’ behavior, however. A larger fraction of employees chose the lowest-price plan in 1997 when they had to pay the full difference in costs out of pocket than when the cost was fully subsidized (Exhibit 5). On the other hand, we did not find that the average premium was lower for employers offering strong financial incentives to employees to shop for lower-price plans than it was for other employers.

Provision of information on quality. Few employers provide information to employees to help them compare plans on the basis of quality and other indicators of plan performance. Among establishments of large firms offering a choice of plans, only 22 percent provided information beyond basic plan descriptions in 1997 (not shown). Information on quality, such as results of satisfaction surveys or HEDIS measures, was provided somewhat more often by employers who offered a choice of various types of plans than by those who offered plans of one type (26 percent versus 14 percent).

Managed Care Without Managed Competition?

Even over the brief four-year period we studied, it is not an overstatement to claim that we are in the midst of a managed care revolution. The dramatic shifts in enrollment from traditional indemnity plans to managed care plans largely reflect employers’ choices about the types of plans to offer rather than voluntary choices among multiple options by employees. These changes may have been driven by cost. Costs and cost changes were lower for employers offering HMOs than for those offering other types of plans in 1997 and may have been a factor inducing employers to shift to HMO plans.

There is some evidence from recent KPMG surveys that HMOs lost market share between 1995 and 1998 among employees in firms with 200 or more employees.36 This may reflect the anti-managed care backlash and consumers’ concerns about access and quality in HMOs. Whether the consumer backlash will lead smaller employers to change their plan offerings and whether the HMO retrenchment will continue if premiums begin to rise more rapidly warrant future monitoring.

Even in workplaces where choice is provided, managed competition principles have not been widely adopted. About half of employers offering a choice of plans in 1997 limited the options to a single insurance carrier’s portfolio. This choice may
encourage consumers to shop around, but it will not stimulate competition among suppliers. Few employers provide strong financial incentives for consumers to choose a low-price plan. In cases where this approach has been taken, we see the expected shift toward the lowest-cost plan, but it is not accompanied by lower costs or slower growth in costs. In sum, these latest trends represent far more change in the form of employment-based insurance than in opportunities for consumers to exercise real choices or for competition to stimulate cost control.

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NOTES


8. For example, on lower premiums from offering HMOs, see G. Gifford et al., “A Simultaneous Equations Model of Employer Strategies for Controlling Health Benefit Costs,” Inquiry (Spring 1994): 56–66. For different views, see U.S. GAO, Managed Health Care: Effect on Employers’ Costs Difficult to Measure, GAO/ HRD-94-3 (Washington: GAO, October 1993); and R. Feldman, B. Dowd, and G. Gifford,
“The Effect of HMOs on Premiums in Employment-Based Health Plans,” 

9. On HMOs’ producing lower costs throughout the system, see J.C. Robinson, 
“HMO Market Penetration and Hospital Cost Inflation in California,” Journal 
of the American Medical Association (20 November 1991): 2719–2723; D. Gaskin and 
J. Hadley, “The Impact of HMO Penetration on the Rate of Hospital Cost 
of Managed Care Market Share and Health Expenditures for Fee-for-Service 
Medicare Patients,” Journal of the American Medical Association (3 February 1997): 
432–437. For different views, see R. Feldman et al., “The Competitive Impact 
of Health Maintenance Organizations on Hospital Finances: An Exploratory 
Baker and K.S. Corts, “HMO Penetration and the Cost of Health Care: Market 
Discipline and Market Segmentation,” American Economic Review: Papers and Pro-

10. R.J. Blendon et al., “Understanding the Managed Care Backlash,” Health Affairs 
Backlash and the Task Force in California,” Health Affairs (July/August 1998): 
95–110. and M. Brodie, L.A. Brady, and D.E. Altman, “Media Coverage of Man-
aged Care: Is There a Negative Bias?” Health Affairs (January/February 1998): 
9–25.


12. Entenohen and Kronick, “A Consumer Choice Health Plan for the 1990s;” and 
Entenohen, “Multiple Choice Health Insurance.”

Health Plans,” Journal of Health Economics (1 April 1997): 231–247; D.M. Cutler 
and R.J. Zeckhauser, “Adverse Selection in Health Insurance,” NBER Work-
ing Paper (Cambridge, Mass: National Bureau of Economic Research, 1997); 
and R. Feldman and B. Dowd, “The Effectiveness of Managed Competition: 
Results from a Natural Experiment” (Presented at an American Enterprise 

14. T.C. Buchmueller, “Managed Competition in California’s Small-Group Insur-
ance Market,” Health Affairs (March/April 1997): 218–228; and D.M. Cutler and 
S. Reber, “Paying for Health Insurance: The Trade-Off between Competition 

15. Ibid.; and S.C. Hill and B.L. Wolfe, “Testing the HMO Competitive Strategy: 
An Analysis of Its Impact on Medial Care Resources,” Journal of Health Economics 

16. Buchmueller, “Managed Competition.”

17. Entenohen, “Multiple Choice Health Insurance.”

18. Jensen et al., “The New Dominance of Managed Care;” and K.A. Hunt et al., 
“Paying More Twice: When Employers Subsidize Higher-Cost Health Plans,” 


21. Ibid.

Affairs (Summer 1995): 99–112; and A.A. Gawande et al., “Does Dissatisfaction 

Choice Be Managed to Constrain Health Care Costs?” Health Affairs (Fall 1989): 
51–59.

25. For details on the NEHIS, see A.J. Moss, Plan and Operation of the National Employer Health Insurance Survey (Hyattsville, Md.: National Center for Health Statistics, 1999).


27. Self-employed individuals with no employees are excluded.

28. These adjustments had a very minor effect on our estimates. However, because employers' decisions to offer insurance vary greatly by firm size, we made the adjustment so that differences in the estimates would not simply reflect differences in realized samples.

29. These algorithms differ from those used by the NCHS for creation of their internal analytic files. Therefore, the NEHIS estimates presented here may differ slightly from the NEHIS estimates published elsewhere.

30. We have not reported standard errors of the differences in the exhibits because this is a descriptive paper. We comment only on statistically significant results or indicate that the finding is not significant.

31. In the 1997 survey the four types of plans were named in the question. In 1993 the question named plan types HMO, PPO, conventional, and combination plans; a plan reported to be a combination of an HMO and a plan that paid for out-of-plan services was coded as a POS plan. We also compared our results using an alternative plan classification that modified the self-assessment based on characteristics of the plan—that is, whether out-of-plan costs were covered and whether the plan had a network (1997 survey). Conclusions using the alternative classification were unchanged.

32. Results for family premiums were similar to those for single premiums, so they are not reported here.

33. This finding is in contrast to that of Jensen and colleagues, who found some increase in the percentage of workers who were offered a choice of plans between 1993 and 1995. Jensen et al., “The New Dominance of Managed Care.”

34. T. Rice et al., Trends in Job-Based Health Insurance Coverage, Henry J. Kaiser Family Foundation Policy Report (Los Angeles: UCLA Center for Health Policy Research, June 1998), also found no difference in overall premiums between firms responding to the 1993 and 1996 KPMG surveys that offered and did not offer a choice of type of plan. However, the authors report that firms offering a choice tended to have lower premium increases.

35. Counting employees rather than employers, 27 percent paid the full difference in premiums, 40 percent paid a fixed share of the premium, 28 percent had no out-of-pocket payment for self-only coverage, and 6 percent paid the same amount for all plans.