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CONTROLLING HEALTH CARE COSTS AT GENERAL MOTORS

by Linda E. Demkovich

Prologue: “What’s good for GM is good for America,” Charlie Wilson, the corporation’s colorful chief executive officer once declared in the 1950s. Assuming that Wilson’s assertion is valid, then America’s providers of medical care should be carefully studying the quiet transformation that General Motors (GM) is undergoing in the way it finances health care. General Motors is among the vanguard of American corporations that are experimenting with a variety of new hospital and physician payment incentives. Ranging from increased employee copayments to the installation of major athletic and wellness facilities that encourage healthy lifestyles, the methods used to reduce costs are as diverse as the companies that pay the bills. GM’s alternative scheme, which it designed in concert with the United Auto Workers, is one of the more innovative; if successful, it could have profound effects on company health plans throughout the country. Called the Informed Choice Plan, the agreement gives GM employees, their dependents, and retirees a choice of three types of coverage: health maintenance organizations, preferred provider organizations, and a fee-for-service option. In this essay, Linda Demkovich, director of communications at George Washington University’s Intergovernmental Health Policy Project and the National Health Policy Forum, traces the origins of this new health package and outlines the major components of the plan which attempts to cut costs while encouraging high quality health care. Demkovich has been writing about health care issues for nearly a decade. Most of these years were spent at National Journal in Washington, D.C. where she worked from 1974 to 1985.
Detroit introduced a major design change in the spring of 1985, but it had nothing to do with automobiles. Rather, it was an innovative health insurance plan agreed to by the General Motors Corporation (GM) and the United Auto Workers (UAW)—an agreement borne out of the realization that rising health costs and the related rise in the company’s cost of providing health benefits were cheating both sides out of monies that might be more productively spent, whether on technological advancements or higher wages and “fringes” other than insurance, or used to decrease the company’s overall cost structure.

Called the Informed Choice Plan, the agreement gives GM’s 2.2 million employees, retirees, and surviving spouses and dependents a chance to select the kind of coverage that best suits their needs and builds in financial incentives to use the more cost-effective providers of care.

Under the new plan, which went into effect on April 1, 1985, GM workers have been given a choice of three types of coverage: a traditional fee-for-service plan (with strict utilization controls); health maintenance organizations (HMOs); and preferred provider organizations (PPOs). PPOs give patients who agree to see physicians on the “preferred list” a break on insurance costs—by waiving copayments or deductibles, for example, or in GM’s case, by increasing benefits such as the number of covered office visits—and guarantee the doctors who take part prompt payment and less paperwork. The plan is being administered principally by Blue Cross/Blue Shield of Michigan, but, for the first time, GM will assume the financial risk for claims by fully self-insuring. Under earlier contracts, it had used an “excessive risk” arrangement, which assigned the company most but not all of the responsibility for insuring against claims.

Goals of the plan. A primary aim of the agreement is to save the company money. In 1983, GM’s tab for employee health benefits was $2.2 billion; in 1984, it rose to $2.35 billion, with 40 million claims, some of them for as much as half a million dollars, filed annually. That translates into spending of about $3,000 per employee, $5,000 if only active workers are counted. In 1985, the spending figure had dropped to $2.1 billion. Although GM officials regard the decline as significant, they are cautious in ascribing cause and effect, crediting “good luck and national trends” in lower medical care inflation as much as the company’s own cost-cutting initiative.

All told, GM’s active workforce is 550,000, with 280,000 retirees and 1.4 million dependents. That adds up to more than 2 million people, or almost 1 percent of the US. population. Moreover, the average age of the active GM worker tends to be higher than for the country as a whole (forty-one years, compared to thirty-six elsewhere), and its retiree population is larger than the active population of all but four Fortune 500 companies. As company officials point out, older people tend to use
health services more often than do their younger counterparts.

Equally important goals are to give GM employees and their families more for their money by offering benefits not available under the traditional package—partial payment for office visits to physicians, for example—and to improve the quality of care they receive by reducing unneeded, often risky, medical and surgical procedures.

It is a “win-win” situation for both labor and management, GM’s employee benefits director Richard F. O’Brien told a meeting of the National Health Policy Forum in July 1985, in one of the first public sessions to air details of the agreement. “The union didn’t give up any benefits and in fact, got more,” he said, “and we gained more control over the way our health dollars are spent.” O’Brien gets no disagreement from the man who sat on the other side of the negotiating table. “We were falling victim to out-of-control health costs,” David C. Beier, administrator of the UAW’s benefits plans section in its GM department, told the Forum’s audience, “and we were not getting our money’s worth.” The new package addresses both those concerns, he said.

Although there are no firm figures on savings, the trends so far seem encouraging and an initial assessment “indicates that we are on the right track,” O’Brien said in a follow-up interview. In the first nine months, enrollment in what the Informed Choice Plan literature calls the “managed care” alternatives increased significantly. HMO enrollment among GM employees and retirees rose from 70,000 to an estimated 123,000, while PPO enrollment—nonexistent before the contract—climbed close to 75,000. Add in an estimated 330,000 dependents and the total equals nearly 24 percent of the company’s total workforce. That is a considerably larger percentage than for the country as a whole. Nationally, estimates show that about 12 percent of the population belongs either to an HMO (18 million) or PPO (10 million). The most recent enrollment effort occurred last October. Future enrollment drives will take place every fall, with January of the following year as the effective start-up date.

The two sides are so convinced of the concept of managed care that 6,000 prospective employees at GM’s new Saturn plant, which is scheduled to open in Spring Hill, Tennessee, in 1989, will not even be offered traditional fee-for-service benefits but rather will be given only the option of joining either an HMO or a PPO.

**Paving The Way: The Building Blocks**

Keenly aware of the toll that escalating health costs were exacting on the economy in general and the automobile industry in particular, GM and the UAW had begun laying the groundwork for the new health package well before formal negotiations got underway in July 1984. Key
to those efforts was creation of a Corporation-Union Committee on Health Care Benefits. Although the committee was written into the bargaining agreement in 1979, it was not until 1982, when rising health costs collided with poor economic conditions in the auto industry, that it was pressed into action.

Pilot programs. The first significant payoff grew out of a series of pilot programs implemented by the committee beginning in 1983—programs that are expected to net the company between $21 million and $26 million in savings annually. The first two pilots—a prior authorization program implemented in Flint, Michigan, on April 1, 1983, and an ambulatory surgery initiative put in place throughout the rest of the state on July 1—were aimed at encouraging employees to use less costly outpatient services. Together, the two programs, which have since been folded into the Informed Choice Plan, were expected to save as much as $10 million a year.

The following May, a second opinion program, requiring employees to seek a consultation from a second doctor for ten specified inpatient surgical procedures, was put into operation, again in Michigan where an estimated 45 percent of the eligible population resides. In November 1983, the committee started a maximum allowable cost program, requiring substitution of less costly generic drugs for brand name products—a step that could save as much as $800,000 annually. In April of 1984, it launched a nationwide mail order prescription drug program, enabling the company to take advantage of its size to order in bulk and also substitute cheaper generic products where they are available. In the first six months the program was running, some 95,000 claims were submitted to the two mail order houses; in 1985, total claims climbed to 880,000.

Finally, the following July, the company expanded the services of dental HMOs, already available to employees in California, Illinois, and Wisconsin, to its Michigan workers.

Utilization data. The second—and perhaps the key—element in the joint committee’s drive to contain costs, however, was getting its hands on utilization data. The data proved invaluable and served as the catalyst in convincing both sides that something out of the ordinary needed to be done.

To start, GM engaged Health Data Institute (HDI), a Newton, Massachusetts, firm to collect and analyze the claims data. Paul M. Gertman, HDI’s chairman and chief scientist, explains how the data-gathering process worked and why it was so critical. The first step, he said, was to pool claims data from Michigan Blue Cross-Blue Shield; then, the data had to be “edited,” as a step toward identifying utilization problems. As the process moved from the first to the second to the third year, Gertman said, “the scope of what we were able to do improved. We were able to
look at patterns of illness over time, such as alcoholism, and evaluate the
cost, look at complications and recidivism rates. The purpose was really
to see whether there were significant patterns in unnecessary utilization,
[to make] a comprehensive assessment of past experience to ascertain
what the problems are.”

The data teams turned up some interesting patterns. For instance, GM
employees in New Jersey were hospitalized much more frequently and
were staying in the hospital longer than the population at large. HDI
concluded that 32 percent of the costs and 30 percent of the days were
questionable. They found that in southeastern Michigan, in the counties
surrounding Detroit, the cost of podiatry services was 6.5 times greater
than in other urban areas of the state, including Lansing, Grand Rapids,
and Kalamazoo. Also in Michigan, 25 percent of pregnant woman were
having cesarean deliveries, compared to 16 percent nationally, and their
average length-of-stay was considerably longer as a result. They also
found a disturbingly high recidivism rate among alcohol and drug abus-
ers, with some employees going through treatment centers dozens of
times. O’Brien lays part of the blame for that situation at the company’s
door, for not paying more attention to the “revolving door” syndrome
and ensuring that proper treatment was provided.

With those kinds of black-and-white numbers in hand, it was hard for
the company and the union to disagree on the facts of the case. That did
not, however, guarantee agreement on a solution, and at first, the two
sides adopted significantly different approaches to the problem.

GM’s preference was to require greater cost sharing by employees, by
imposing higher copayments and deductibles—a strategy that O’Brien
says the company still believes in. As a survey by Hewitt Associates
released in late 1984 showed, cost sharing has become increasing popu-
lar among employers trying to combat rising health costs. Since 1982,
according to the survey, there has been “a significant shift away from
first-dollar coverage for inpatient hospital service and surgical charges,
toward the use of front-end deductibles,” on the part of larger industrial
firms in particular. In 1982, for example, only 19 percent of such compa-
nies required employees to pay a deductible for inpatient hospital ser-
VICES; by 1984, 68 percent imposed such a requirement. Moreover, the
size of the deductible has been getting larger, with deductibles of $150 or
more increasing by 29 percentage points between 1982-84.

The UAW flatly opposed the cost-sharing strategy. Its position was
that it was physicians, not union members, who were responsible for
admitting patients to hospitals and deciding how long they would stay
and what procedures would be performed. It was there, officials argued,
that controls should be imposed. “Doctors thought it was a VISA card,”
Beier said of the fee-for-service system. It was obvious that the utilization
of health services was out of control and that it not only was costly but
also “was not good quality care.”

Gertman affirms that sentiment. Most overutilization, he said in an interview, “is bad quality medical care.” There are direct risks, from needless exposure to x-rays, for instance, as well as indirect risks such as contracting an infection during a hospital stay. The attitude most people adopt is, “What are a few more days in the hospital, a few more tests and procedures?” But in fact, he said, “they all add up and put people at risk. Hospitals are not safe places for people who don’t need to be there.”

With the union holding firm against higher copayments and deductibles, contract negotiations could have become bogged down. However, the two sides finally agreed to experiment with what has come to be called the managed care approach. Thus was born the Informed Choice Plan.

Giving Employees Options: The Concept Of Managed Care

Despite the surge of interest nationally in competitive delivery systems—HMOs, PPOs, and the like—fee-for-service physicians are the mainstay of the U.S. health care system. In general, the GM-UAU experience since April 1 affirms that basic pattern, with about 24 percent of eligible employees now enrolled in either HMOs or PPOs and the rest opting to stay with traditional coverage. Nonetheless, the company and the union are hoping to exert influence on the fee-for-service sector by building in features of the “managed” care concept to guard against inappropriate and unnecessary use of services.

The major effort on that score is a new “predetermination review” procedure applied to all nonemergency and nonmaternity hospital admissions. Patients (except those enrolled in Medicare) who fail to follow the proper procedures may end up paying the first $100 of covered hospital expenses and an additional $100 of surgical costs, plus 20 percent of the charges they incur (up to a maximum of $750 per person and $1,500 per family per year). For emergency admissions, the predetermination review requirement is waived for twenty-four hours; any additional services provided after the first twenty-four hours, however, must be approved in advance. The plan includes a special toll-free number, embossed on employees’ identification cards, that members can call if they do not have time to submit a written admission request in advance.

The HMO option. HMOs, a familiar option to many GM employees, continue to gain in appeal, HMO membership has reached the 123,000 mark, following another surge during the fall 1985 enrollment period. Part of the draw, obviously, is a more generous benefits package. In addition to services covered under the traditional plan, HMO enrollees are insured for routine office visits, physical examinations, immunizations and allergy tests, and also generally pay a lower percentage of pre-
scription drug costs.

Gains from such “preventive care” services could be considerable, especially in keeping members out of the hospital. GM’s own statistics show that while the general trend is toward fewer hospitalizations, HMO members have consistently averaged fewer days than have people enrolled in the traditional plan: 532 versus 1,032 days per 1,000 population in 1980; 420 versus 700 days per 1,000 in 1984.

As of January 1, 1986, UAW members had access to ninety plans, (fifty-six group practice models and thirty-four independent practice associations, or IPAs); salaried workers had been offered membership in 128 plans (seventy-eight group models and fifty IPAs).

Like some other large employers, GM has in some cases felt victimized by what is called “shadow pricing”—HMOs pricing their services at rates roughly equivalent to fee-for-service rates, despite their reputation for being more cost-efficient. Even so, officials have not publicly expressed dissatisfaction with the prepaid arrangements, expecting that the squeeze being put on traditional providers will force down HMO rates as well.

The only major concern the company has heard so far about HMOs has come from the “snowbirds,” retirees from the north who winter in the south. Those who have joined HMOs are concerned with reciprocity, or being able to get coverage while out of the HMO service area.

For those enrolled in a Blue Cross/Blue Shield HMO, the problem has already been solved through a network arrangement called HMO USA, which guarantees coverage wherever the plan member happens to be. Most of those enrolled in other HMOs are covered out of state only for emergency services, but O’Brien said that efforts are underway to put reciprocity agreements in effect in those plans as well.

The PPO option. The most phenomenal growth, however, has been membership in the preferred provider arrangements. Before April 1, 1985, GM employees had no such option. By the beginning of January 1986, there were twenty-two PPOs serving virtually every location the company has large concentrations of workers (there are only three zip codes in the country that do not have at least some GM workers or retirees), and 75,000 people had enrolled. Measured another way, PPOs are now an available option for 80 percent of GM employees. In Michigan, where the largest concentration of employees resides, 7 percent of hourly enrollees and 13 percent of those on salary - including GM’s chairman of the board Roger Smith- had elected PPO coverage as of the beginning of 1986. In neighboring Indiana, 19 percent of the hourly workforce and 30 percent of salaried employees enrolled during the August 1985 sign-up drive.

As is the case with HMOs, PPO membership offers a wider range of benefits than does traditional fee-for-service coverage; those benefits include partial payment for office visits, “well baby care,” and immuniza-
tions for preschool children. Unlike HMOs, however, PPO members are not “locked in” to a limited group of doctors and will be responsible for paying only 20 percent of the charges for services rendered by nonparticipating physicians. For the first year of the contract, Blue Cross of Michigan and Metropolitan Life Insurance Company have been handling all the arrangements involving PPOs. That includes selecting the hospitals and doctors to participate, although a labor-management committee reviews all bids and can veto all or part of any proposal that is submitted. Cost is only one factor in the final decision, officials familiar with the bidding and selection process say. The other criteria include providers’ accessibility, the strength of their organization, and the quality of the care they deliver.

Predictably, the process has ruffled a few feathers. Soon after the preferred providers were designated, for example, the Indiana Hospital Association, on behalf of eighty-six hospitals in the state, sued Blue Cross, charging that the agreements violated antitrust laws. Blue Cross won the first round. Half of the hospitals that were party to the suit then appealed the judgment, but again, the ruling went against them.

The situation at St. John’s Medical Center in Anderson, Indiana, where 80 percent of the population is GM-related, illustrates the problem some hospitals were facing. St. John’s, one of two hospitals in Anderson, was not given a PPO contract, allegedly because of its high costs. Hospital officials say those costs stem not from inefficiency but from St. John’s status as a tertiary-care facility that serves more severely ill patients as well as provides two-thirds of the community’s indigent care. Now, GM workers enrolled in a PPO must either be referred to St. John’s by their doctor (with Blue Cross approval), make up the difference in cost between the two local hospitals, or travel as many as thirty miles to Indianapolis if they need services the other hospital in town does not provide.

A.R. Wakefield, St. John’s senior vice-president for corporate development, said the hospital believes in competition but felt Blue Cross treated it unfairly by refusing to reveal its criteria for choosing participating providers. The hospital hopes to be reconsidered when the PPO contract is renegotiated in 1987. For now, however, it is clearly on the outside looking in. Although PPO enrollment in Anderson was considerably less than for the state as a whole, Wakefield said the total impact has probably not yet registered. “Even if you lose only three patients a month, you’re starting to talk about the bottom line,” he said. Although Blue Cross officials declined to discuss specifics of the St. John’s case, one characterized the situation as “the natural consequence of what is going on in the health care field. You’re seeing what happens in the competitive bidding process.”
The Future: Lessening Resistance To Change

Beier dismisses the situation in Anderson. "People are always opposed to change," he said. "We hope that in another year or two, there will be greater acceptance" of the changes the 1984 GM contract brought about. That goes for the union’s membership as well as hospitals and doctors, said Beier, who acknowledged that many workers are “not particularly happy” with the new health care package. But by the time of the next contract negotiations, he predicted, “you’ll see the majority [of GM’s autoworkers] enrolled in either an HMO or a PPO-with reciprocity” within each of the systems, he added.

While O’Brien won’t venture to estimate the numbers who will enroll in managed care alternatives, he is clearly encouraged. “The test of any plan . . . is that people who are dissatisfied will leave. Each and every year [at enrollment time] they’ll be able to vote with their feet.” And so far, he said, “very few are leaving”—only a handful of the 123,000 GM employees in HMOs have elected to drop out, and PPO enrollment seems to be increasing steadily.

Cutting costs and improving quality. As for cost, it is too soon to know with any certainty how much money the managed care alternatives will save. Some of the pilot programs, most of which were incorporated in the 1984 contract, are beginning to yield data, however. In December 1984, for example, a pilot program requiring predetermination for foot surgery was started, in the hope of eliminating excessive surgery in Southern Michigan. Almost immediately, payments for such procedures dropped dramatically.

In conjunction with the Informed Choice Plan, GM and the union have now instituted separate coverage for substance abuse for all its employees. The benefit, insured through Connecticut General, will use a “gatekeeper” approach to monitor a person’s progress and avoid the “revolving door” syndrome. Records on one employee, for instance, showed an average of 106 days of absence a year for ten years, most related to alcoholism. The cost to the company’s health plan: more than $6,200 a year. After enrolling in the program, the employee had no sickness or accident days in 1982, 1983, or 1984.

If estimating savings will be difficult, quantifying improvements in the quality of care will be an even harder task. Though most everyone agrees that the Informed Choice Plan affords GM and the UAW a unique opportunity to monitor and control quality—and indeed, better quality care was a key ingredient in selling it to the autoworkers—there are no clear guidelines by which to judge such improvements.

Leading a new trend. It remains to be seen whether other major employers and unions will follow the lead taken by GM and the UAW, although interest in experimenting seems apparent. The Informed Choice
Plan is “precedent-setting,” an AFL-CIO official commented. “Most unions are not at that point yet, although clearly it’s the direction we’re heading in.” The Ford Motor Company, for example, offers its employees the option of joining HMOs and PPOs. Unlike, GM, however, it has not attempted an all-out, universal enrollment effort and has not pushed to create such alternatives where they do not already exist. And in April 1985, the Teamsters signed an agreement with the Voluntary Hospitals of America to establish a national PPO network for its 500,000 members. Gertman reports that many Health Data Institute clients, including the Chrysler Corporation and commercial insurers and Blue Cross plans, have been asking for utilization data in order to spot trends in overuse.

Initially, the activity in the private sector to contain health costs may have been a response to the cost shifting that resulted from federal spending cuts. But according to Gertman, it now signals a shift in leadership away from the corridors of Washington and into corporate boardrooms. Before the enactment of Medicare in 1965, he said, the auto industry’s health insurance package was the “golden benchmark” against which other benefits were measured. For the next decade or more, control shifted to the government. But after Congress defeated President Carter’s cost-containment plan, employers stopped simply “going along” and once again began playing a leadership role. In the 1990s, when people look back on cost-containment efforts, he said, “the GM-UAW agreement will be recognized as one of the key turning points in that shift of power.”