Employers As Managers Of Risk, Cost, And Quality
by Robert E. Patricelli

The employee benefits manager in large U.S. corporations has fallen on hard times. Even while companies press for cost reductions and lean staffing patterns, benefits costs keep escalating. Company executives above the benefits manager demand results. The benefits manager is besieged by vendors who offer new cost-containment techniques, but has a staff too small to evaluate much of what is proposed.

While some of the techniques the benefits manager has tried seemed at least to reduce the rate of cost escalation for awhile, that rate seems to be rising again in 1987. (Insurers’ cost increases for 1987 are in the 15 percent range, up from single digits in 1985 and 1986.) The benefits manager would like to try some more dramatic measures but is concerned with allegations that quality is being threatened.

Because employers are now carrying the principal financial risk for employees’ health care costs, the benefits manager is supposed to manage risk, cost, and quality in some harmonious balance. This is a long way from simply assuring that claims are paid promptly and accurately—which was the benefits manager’s major concern just ten years ago. This Commentary explores how the employee benefits manager acquired this complex assignment and some ways to move toward sharing important parts of it with others in the health care system.

The Migration Of Risk

First, one should recognize that “insurance” has largely disappeared from health insurance, at least for most larger employers (over 250 employees). Like the old woman looking for the beef in the hamburger, one might ask, “Where’s the risk?” The answer is that, for the most part, the employer has it.

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Risk has been migrating away from health care insurers for some time. In the 1960s and 1970s, carriers moved from pooled pricing for their larger customers to experience or retro rating, so that the employers could share in any savings. There was still an insurance guarantee in that the carrier had an annual pricing risk, but, in fact, carriers that guessed wrong on price could count on recouping their losses over the next few years through higher rates.

In the 1970s, “cash-flow” products were introduced. While they still carried an insurance guarantee through an annual premium price, they gave the employer the use of the claims funds until the funds were actually spent. Under this arrangement, the insurer manages the claims payment process, debiting a zero-balance bank account that the employer establishes and funds as needed. This way, the employer receives the investment income and also avoids insurance premium taxes, but is even more clearly taking the claims risk.

In the 1980s, we have seen the flowering of self-funding or self-insurance, and here the employer is fully at risk. A new Johnson & Higgins survey of 1,329 employers of different sizes shows just 10 percent are fully insured under pooled rate programs, 26 percent are experience rated, 18 percent have cash-flow or minimum premium programs, and 46 percent are self-funded, with the carrier providing “administrative services only” (ASO). Moving up the employer size spectrum, one finds a higher percentage of ASO arrangements. Companies with over 40,000 employees are 85 percent on ASO, and virtually all of the Fortune 1,000 are ASO. The Health Care Financing Administration (HCFA) reports that more than 50 percent of all employees with health insurance participate in self-insured plans. Under these arrangements, the insurer has become an information and claims processing organization, without risk, and the employer now carries all the risk. The “beef” has migrated.

Interestingly, a few signs have indicated that the trend toward self-insurance may be abating. One health insurer has reported a few instances in which large self-insured customers-apparently beset by the confusion in the managed-care marketplace and the growing risks associated with acquired immunodeficiency syndrome (AIDS)-have requested rate quotations on a fully insured basis. Whether this is a new trend remains to be seen.

The Search For Cost Containment

To deal with steadily escalating health care costs, employers have applied successively more interventionist cost-containment techniques. Phase one was incentive arrangements that would, for example, fund outpatient surgery more generously than inpatient procedures as a means of inducing use of the lower-cost setting. Other benefit changes were
tougher, using outright exclusions such as not paying for nonemergency weekend admissions. But, added together, the impact of this type of cost containment has been minimal.

Then employers (and government, under Medicare) tried to save money by shifting costs to employees or beneficiaries through higher premium contributions, copayments, and deductibles. That has had a significant impact on employers’ costs, and, whereas just a few years ago most employer plans offered first-dollar coverage, most now have deductibles and copayments. In effect, the risk is migrating again—this time, in part, back to the employee or patient.

Benefit plan changes and cost-shifting techniques are only a partial answer, however. For the last two or three years, employers’ principal cost-containment thrust has been what has come to be called managed care—that is, not simply shifting costs or varying benefits but looking for ways to affect the price, volume, and quality of service directly. Employers want price and utilization savings and are prepared to manage health care delivery to get them. But with managed care come entirely new responsibilities for employer benefits managers. Now they are into the scary business of deciding what is the “right” level of care and who are the “good” providers.

**Prior-approval screens.** To be sure, most employers do not make these decisions directly but hire various intermediaries—managed care vendors—to do it for them. For example, we are seeing widespread use of hospital preadmission certification and continued stay review organizations in the private sector. Prior-approval screening is a generic cost-containment technique widely practiced by health maintenance organizations (HMOs) that now has been “unbundled” for application to fee-for-service practice as well. Vendors of this service estimate that about 35 percent of the employer market now uses “hospital precert,” supplied either by their insurance carriers or by one of about fifty independent companies. These services can achieve about a 15–20 percent reduction in bed days, which can translate into 5–10 percent savings in claim costs.

Further, precertification can help identify potentially high-cost cases before hospitalization so that a case manager can be assigned to coordinate and manage the entire course of treatment. Since 3 percent of cases account for 50 percent of costs, good case management focusing on discharge planning and efficient aftercare can save substantially. These prior authorization techniques are now being extended beyond hospital stays to expensive diagnostic and outpatient treatment procedures with the result that doctors will increasingly have to “check first.”

**Use of PPOs.** A second managed-care technique is the use of preferred provider organizations (PPOs). Employers are putting heavy pressure on their carriers and claims administrators to set up panels of cost-effective providers with whom discounts can be negotiated. Employees are then
given incentives to use those panels by having to face higher cost sharing if they go outside the panel. At first, many thought PPOs were a flash in the pan because, unlike HMOs, they do not put providers at risk. But employers are now finding that PPOs can save them more money than HMOs can, because PPOs avoid having to provide the rich HMO benefit package, and because they do not have the higher administrative and marketing costs of prepaid plans. In its last enrollment period, for example, Chrysler saw its PPO enrollment jump from 15 percent to 29 percent of employees in sites where that choice was offered.

An important signal of things to come is that some employers now offer PPOs or combinations of PPOs and HMOs as their basic health coverage, instead of traditional insurance. Examples are Boeing Corporation and Blue Cross/Blue Shield of Illinois for its own employees. Here, employees are automatically enrolled in the PPO and face a stiff economic penalty if they go outside of the panel (unless they opt for an HMO). This amounts to preferred provider insurance, as Paul Ellwood has called it, and allows employers to maintain current indemnity deductibles and copayments with the PPO rather than having to waive them—and thereby increasing costs—to induce the use of the panel.

Use of HMOs. A third managed-care strategy is the now widespread use of HMOs as options in employers’ benefits offerings. But employers are ambivalent about the cost-saving impact of HMOs. As chairman of the U.S. Chamber of Commerce’s Health Care Council, I recently conducted an informal survey on attitudes toward HMOs among panel members. Included were benefit managers from such companies as Allied Signal, United Technologies, General Motors, Chrysler, Marriott, Bell Atlantic, and Martin Marietta. I found that most answered either “no” or “don’t know” to the proposition that “HMOs are saving my company money,” and that most thought that the HMOs were getting the better risks. At the same time, however, these managers clearly thought HMOs would remain popular; most predicted penetration levels reaching 35–55 percent of their employees by 1990.

Targeting specialty areas. A final manage-care trend is employers’ developing interest in attacking specialty areas—such as mental health, dental, and prescription drugs—using some of the same cost-containment techniques that have been applied to medical/surgical use. Hence one sees today specialized utilization review companies operating in the mental health arena, and specialized PPOs or HMOs for dental services, mental health and substance abuse, drugs, and even foot care. As in medicine, the subspecialization trend in managed care is alive and well.

Quality Of Care Issues Come Of Age

As if juggling various cost-containment and managed-care options
were not enough, benefits managers are now being asked to focus on quality measurement and assurance as well. This is a relatively new development, and many employers still regard with skepticism providers’ concerns about quality. After all, “you’re cutting back on quality” was always the physician’s cry-wolf lament from the early days of HMOs and cost containment. There has been little or no demonstrable negative impact on quality as a result of cost containment (and probably some positive impact through avoiding unnecessary hospitalization).

But new forces are directing attention to quality. First, there is ample evidence that poor quality costs money through iatrogenic (treatment-induced) illness, hospital readmissions, and simple redundancy. Moreover, employers can hardly avoid efforts at quality measurement once they adopt preferred-provider strategies that point their employees toward certain doctors and hospitals. Utilization review and prior approval procedures inevitably raise the question of what is good medical practice and how much is too much, or too little.

The Chamber’s Health Care Council, through a special subcommittee on quality, the Washington Business Group on Health, several local health care coalitions, and several large employers are all beginning to grapple with quality issues. Outside the business community, the ferment around quality is probably even more advanced, with initiatives going forward through HCFA, the Institute of Medicine, the Joint Commission on Accreditation of Hospitals, the Group Health Association of America, and the American Medical Association, to name a few. It is for the most part still in the discussion stage, but several points of consensus are emerging. First, quality cannot be optimized independent of cost. Cost-effectiveness and quality data ideally should be presented together so that the buyer can make an informed choice based on overall value. (For example, annual Pap smears for most women deliver higher-quality medicine in terms of ultimate outcomes than would testing every three years. But as David Eddy of Duke University has shown, a Pap smear every three years produces 99 percent of the benefit in actual outcomes at one-third the cost of annual testing. A cost-conscious buyer might say that testing every three years is the right calculus of value in her case.)

Second, employers should be reviewing the HMOs, PPOs, and utilization review firms they employ on both quality and cost-effectiveness grounds. General Motors has developed a questionnaire on quality issues that its HMO must complete, and a few independent firms have begun to offer auditing services to employers who want this type of review.

Third, data can be gathered from claims forms to profile providers, particularly inpatient providers, on certain quality criteria. These data—especially if adjusted to reflect severity of illness—can be used to identify possible outliers—hospitals and physicians that are clearly better or worse than the pack in medical outcomes for certain procedures. These
outliers should then be subjected to more detailed chart reviews to help employers, HMOs, and PPOs decide whether or not to include providers in their preferred panels.

Fourth, the Health Insurance Association of America, Blue Cross and Blue Shield Association, and HCFA need to work together to amend the standard claims forms to add some additional data sets that would permit better quality assessment through outcome measurement.

Sharing The Burdens

Shifting risk to consumers. It is time for corporate America to share its burdens in the tricky business of balancing cost and quality in health care. But to do that requires more migration of risk—in this case back to employees and providers (where it was, in any case, before the advent of group insurance). After all, decisions should properly belong to those who pay for them in dollars or medical consequences. Fortunately, this is happening. As already noted, employers have been shifting costs to employees through premium contributions, deductibles, and copayments as a means of reducing company costs. At the same time, employees are being presented with many new options in the form of HMOs and PPOs as alternatives from which they can choose.

The logical consequence of this is flexible benefits plans. Here employers offer a defined contribution—a flat amount of money—and give employees a range of benefits choices. There were only fifteen “flex” plans in 1981, but they grew rapidly in popularity to about 880 by 1986. HCFA, through its proposals for a Medicare voucher and the new Private Health Plan Option, is recommending the same idea—a defined contribution from government with the elderly and employers who fund retiree benefits bearing most of the risk.

Employers who adopt defined contribution arrangements for their health care costs can give employees a broad range of choices to permit them to make the cost, quality, and access tradeoffs that best meet their needs. These decisions simply are too complex and the impacts too personal for employers to try to make such choices on behalf of the workforce. A currently missing element necessary to make such a system work is better employee education and information. Employers, unions, insurers, providers, and consumer groups all can play a role in helping to give employees and other health care consumers the information they need to make informed choices.

Sharing risk with providers. Risk also needs to be shared with providers, and that too is happening. HMOs and other capitated arrangements in effect push back onto providers the job of deciding what is good medical care in a system of constrained resources. But two things are needed for capitated systems to function properly.
First, health care researchers need to develop and refine systems for adjusting capitation payments for risk. The research in this area is promising; it needs to be accelerated. Lack of risk-adjusted payment gives capitation a bad name with providers, as indeed it sometimes should. A capitated primary care provider typically does not have a broad enough pool of HMO patients to take the risk that it will not be selected against by sicker patients. But beyond this, there is an underlying issue of supreme importance that should be of special concern to providers and employers alike. That is the issue of efficacy in health care, or, put another way, what does and does not work.

**Medical efficacy.** Without better scientific measurement on the efficacy of diagnostic and treatment procedures, quality and utilization management are shooting in the dark. I have heard several of the leading researchers in this field say that there is no scientific proof as to the efficacy of over half of the procedures used in medicine. Every year, new studies show that what was commonly accepted practice in some area has now been proved to be useless, or, even worse, harmful. Even disregarding those procedures that we can accept as efficacious without scientific studies, an enormous backlog of studies remains to be undertaken and catalogued in the area of medical efficacy. There is simply not yet an acceptable knowledge base of appropriate clinical standards and procedures to give scientific support to the utilization management, quality review, and capitation techniques that are being used.

I applaud in this regard the recently announced move by the Blue Cross and Blue Shield Association, in cooperation with the American College of Physicians, to issue new guidelines for the appropriate use of 90 percent of all hospital tests. There was an immediate challenge from the College of American Pathologists that the proposed limits were a degradation of quality. Ultimately, one can hope that the decision will be made on the basis of solid scientific studies of health outcomes to determine the costs and benefits of these tests. Cost containment and managed care require a much better knowledge base of accepted clinical practices so that we can be sure that quality is not compromised.

This is the "emperor has no clothes" problem of American health care. Providers have known about it all along. As new managed care arrangements develop that place providers at financial risk, they can no longer afford to ignore it. We need to take a major national effort to define better what constitutes appropriate health care so that all who share risk—employers, consumers, and providers—can make informed choices about what they spend and buy.