



Toward Evidence-Based Health Care Reform

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What Went Wrong With Cost Containment

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)

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Annual rate increases for employer-sponsored health insurance peaked in 1985 at more than 15% a year, then dropped to less than 5% in the mid-90s, but have been climbing again. What happened? This issue of our e-memo offers one possible explanation: government regulations and most current insurance plan designs have insulated consumers and providers from the cost of care.

In the pre-HMO days, with most insurance plans, the consumer paid a deductible, then shared in costs (usually an 80-20 split), and then the carrier paid 100% above the consumer's out-of-pocket limit. HMOs came to the market in the mid-1980s with a new economic model:

1. Instead of paying providers on a "fee-for-service" basis, HMOs would prepay a fixed monthly amount (capitation) to the provider. Under this model, the capitated provider would assume financial risk and make all medical decisions with the patient. There would be no need for the HMO to "bean count" when the provider assumed the risk.
2. Because a provider was prepaid each month whether the patient sought care or not, the patient was limited to using that provider. In return for the prepayment and exclusivity, providers negotiated lower fees and accepted financial risk.
3. Patients faced minimal financial risk. There was no longer a deductible, and patients only paid a per-service co-pay (\$5, \$10). This fee required the patient to think about initiating care, but wasn't high enough to impose a barrier to early and preventive care.

Using this model, HMOs caught fire in late 80s and early 1990s because of lower premium costs and inflation trends, and high patient satisfaction with low copays. However, many patients were unhappy about not having the anytime, anywhere choice of the old plans. They were limited to one primary physician and a particular network of specialists, hospitals and pharmacies. They were limited to using the ER for only truly emergency, life-threatening problems, not for convenience.

Eventually, patients rebelled and their anger was fueled by endless HMO bashing in the press and the organized provider lobby (AMA, AHA, etc). Providers who were unhappy with assuming financial risk, or who lost patients to HMO network providers, were known to disparage HMOs to their patients. Employees pressured on their employers, who pressured the HMOs to reintroduce more choice. Legislatures and state regulators mandated HMOs to contract with "any willing provider," and to let consumers go to emergency rooms without calling their doctors for a quick triage and to self-refer to specialists. What providers and consumers wanted, in effect, was the low financial risk AND open choice of the old indemnity plans, at the low premium cost of the HMO.

This tug-of-war over cost, choice and financial risk presents an important lesson: the way we deal with health care often ignores fundamental laws of economics. Here's an example we're all familiar with --- coverage for pharmaceuticals --- that demonstrates what went wrong.

HMOs built networks of pharmacies willing to accept a lower price in return for a virtually guaranteed market of consumers. Because of these significant discounts, HMOs could keep premiums lower, and charge patients a flat co-pay (\$5, \$10, etc) rather than impose a deductible and coinsurance. In this model, the key economic

characteristics are:

- A patient has little economic barrier to getting a prescription, especially a prescription for a chronic disease, filled promptly.
- Pharmacies have an incentive to compete to provide the best discounts to the HMO, in return for being on the exclusive network.
- The HMO has an incentive to educate patients and physicians on cost effective prescribing because the HMO, not the consumer, is assuming a greater financial risk. HMO medical officers and pharmacy chiefs develop "counter-detailing" programs and formularies to guide the prescribing practices of their participating doctors to cost effective drugs, rather than respond to salespeople.
- The patient has less choice (i.e. using network pharmacies only) and is rewarded with lower out of pocket (both in co-pay and premium).

But patients didn't like being limited to the network, and pharmacists who didn't want to accept the discounts, or who were at a disadvantage to pharmacies who could buy cheaper at wholesale, went to legislatures to impose legal restrictions on the HMOs such as:

1. "Any Willing Provider" laws that require an HMO to contract with any pharmacy willing to accept the terms of the contract. In the first year after enactment of the law, all pharmacies may move down to the lower rates in the contract at the time. But in subsequent years at contract renewal, there is no incentive for any pharmacy to undercut other pharmacies because everyone ends up with the same contract anyway. Consumer pressure forced HMOs to sign up as many pharmacies as possible. Price competition, in other words, disappeared.
2. "Unitary Pricing" laws (promoted by independent pharmacies and small wholesalers) that prohibit manufacturers from charging a lower price to high-volume purchasers than they charge to low volume purchasers. This means high volume purchasers (in particular, HMOs and chain stores) are stripped of their ability to negotiate discounts, which raises costs at the retail level to the consumer.
3. "Anti-Formulary" legislation that allows physicians to override an HMO formulary when writing a prescription.

Thus, following the backlash against HMOs, plans now display the following economic characteristics:

- Fixed co-pays (\$10/\$20/\$25) that limit patient price sensitivity. While there may be a differential between generics and brands (usually no more than a \$5 or \$10 difference), there is no reason for the patient with a fixed co-pay to care about the retail price of the drug. Anything above the co-pay is the HMO's problem.
- The HMO is constrained by laws that prohibit it from negotiating deep discounts with pharmacies in return for channeling patients to them by setting up an exclusive network.
- Manufacturers and their wholesalers have no incentive to offer deep discounts to volume purchasers, because they would have to give the same price to any retailer, regardless of volume.
- The HMO is constrained by laws that prohibit it from establishing a formulary of lower cost, effective drugs for use by physicians. Physicians can prescribe at will, for example as influenced by drug company representatives, or under pressure from patients responding to advertising.

The impact wasn't just pharmacy benefits. Similar laws and rules limit how HMOs and other insurers can contain costs for hospital, physician, diagnostic and mental health services. Patient financial exposure is limited to flat, minimal copays, and provider financial exposure is unconstrained by either patient price sensitivity or contractual requirements. And everyone is angry about how fast costs are going up.

Could that be what went wrong with cost containment?