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Initiative 673: A Return to Unmanaged Care

Initiative 673 would reduce the ability of managed care systems to maintain quality and control costs. By requiring every health plan to include “any provider or type of provider,” I-673 would undo recent achievements in health care access, quality, and cost containment. The provision knocks out a critical element of managed care programs’ market-driven system of incentives and controls.

To evaluate the initiative, it’s important to understand managed care.

Managed care plans — for example, health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans — now dominate the health care marketplace. According to a Lewin Group analysis, in 1980, “about 92% of the employed population was enrolled in a traditional fee-for-service (FFS) health plan with only 8 percent enrollment in HMOs. By 1996, only about 25 percent of workers were covered under a FFS plan. About 33 percent were in HMOs and about 42 percent were in PPO or POS plans.”¹

Patricia Danzon, an economist and health care expert at The Wharton School, University of Pennsylvania, observes: “The growing market share of managed care plans ... implies that employees are willing to accept some restrictions on choice in return for the lower premium, the lower copayment, or more comprehensive coverage offered by managed care plans.”²

These programs control costs by influencing how medical providers practice and run their businesses, by negotiating substantial price discounts and by guarding against unnecessary use. Among the characteristics of managed care systems is the network of physicians authorized to participate and provide service through the plan. Patients may go to providers outside the network, but without plan approval they will generally pay more, often full cost.

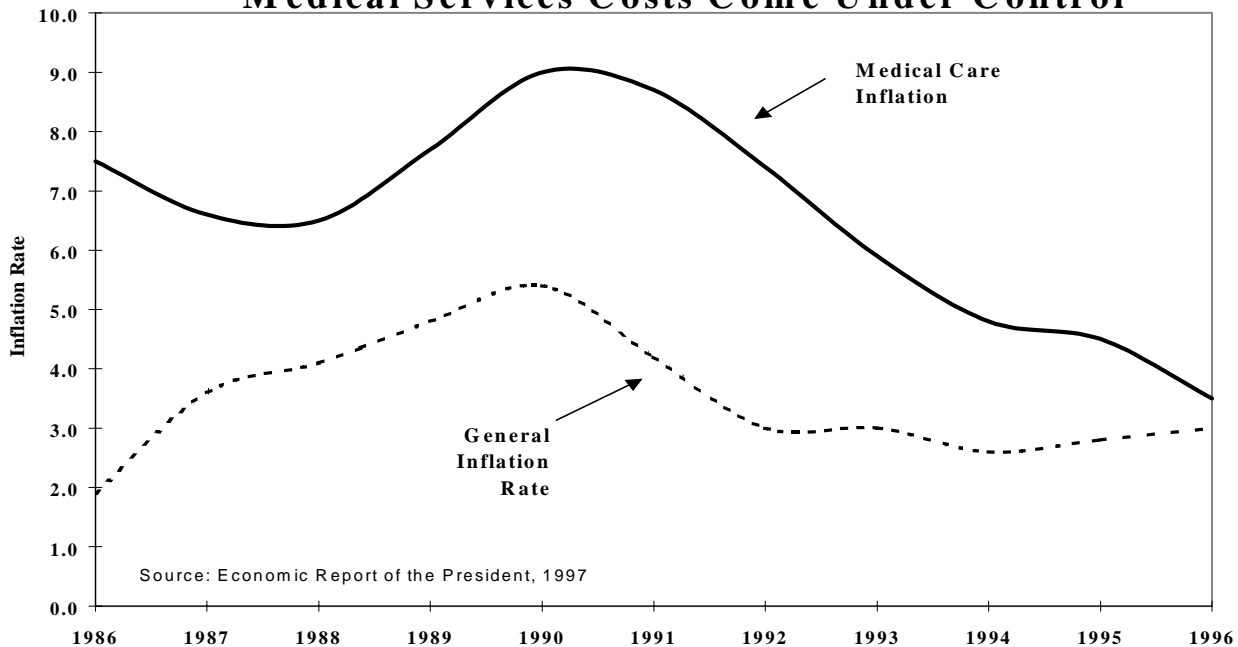
The benefits of managed care can be measured in three ways: a) the relative drop in health care inflation, b) the savings associated with managed care, and 3) the cost increases attributed to “any willing provider” legislation.

Health Care Inflation Controlled. As the following figure illustrates, after reaching a peak in the early 1990s, health care inflation has dropped dramatically. Since managed care has taken hold, the margin between the general inflation rate and the inflation rate for health care services has narrowed.

Managed Care Savings. Managed care is not new — Seattle’s Group Health Cooperative recently celebrated its 50th year — but its growth in recent years has been phenomenal. Prof. Danzon suggests the surge in growth can be explained largely by two factors: First, advances in information technology allowed effective operation of large networks; second, the “continued increase in the absolute cost of health care” forces payers to “confront the politically and technically difficult issues of deciding what services insurance should cover,” a step leading to managed care.³



Medical Services Costs Come Under Control



As the Lewin Group reports, enrollment came about “as employers and governments sought to find ways of maintaining coverage while containing the growth in health care costs” Danzon’s analysis agrees, and she adds the important observation that “... economic theory and evidence indicate that ... employees ultimately bear the costs of employer-sponsored plans ... through lower wages or higher premium contributions. ... the level and structure of health benefits reflect employee preferences. Employers are largely intermediaries.”

In other words, the managed care programs offered by employers increase the value of the total employee compensation package. The savings benefit the employee, and the savings are substantial.

The Lewin Group prepared estimates of these savings based on alternative sets of assumptions. Nationally, total savings in 1996 ranged between \$23.8 billion to \$37.4 billion, or from 7.5% and 11.7% of baseline spending.⁴ The household impact ranges from \$375-500 for an average family with children.⁵

Any Willing Provider Cost Impacts. Often led by provider groups seeking entry to managed care networks, efforts have been mounted in many states in recent years to pass “any willing provider” (AWP) laws. Initiative 673, for example, requires the plans to accept any doctor or nurse practitioner who wants to participate so long as the care is a) within the provider’s scope of practice; b) meets standards for effective, financially responsible care; and, c) addresses a condition covered by the plan. The initiative is silent on how such standards are determined. Plans must accept doctors of psychology, chiropractic, optometry, and naturopathy, among others and may not exclude providers on the basis of experience or qualifications (other than the nebulous “scope of practice” requirement).

An analysis by Atkinson & Company for the Group Health Association of America found that HMO premiums could increase from 9% to 29% under AWP mandates. They report that HMOs typically “select providers for inclusion in the



network based on thorough reviews of the providers' background, current professional standing and practice patterns... ." AWP laws make that impossible. In addition, they increase administrative costs, complicate reviews of practice patterns, and limit the negotiating advantages of the HMO.⁶

The Coalition for Affordable Health Care (CAHC), the campaign opposing I-673, commissioned a study by Arthur Anderson LLP to evaluate the cost of the initiative. Using CAHC's estimate that plan premiums would increase 12% under the proposed AWP provision, the firm estimates a range of impacts. For 1998, they estimate the following: For households with individual insurance coverage, costs would rise about \$235 in 1998; for households with family coverage, up \$660; business costs would increase about \$455 per employee and state government costs (for employees, state-sponsored health care programs, and the Basic Health Plan) would jump about \$175 million.⁷ They observe that passage of AWP legislation "would tend to eliminate much of the cost-savings achievable through managed care."⁸

The assumption of a 12% premium increase drives the cost estimates. The assumption is plausible: it falls on the low end of the Atkinson & Company range. Further, it is consistent with the Lewin Group estimate of managed care benefits.⁹ The loss of those benefits will mean premium hikes.

While the magnitude of the cost increase may be subject to some debate, it is clear that I-673 will eliminate a primary element of the cost savings achieved through managed care networks. Costs will rise, and rise considerably.

Washington, to an extent not experienced in many states, has intensively debated health care issues in legislative, business, and public forums for at least six years. The issues addressed in I-673 were considered and rejected, appropriately, by the legislature. Within a managed care network, expanded choice for a few imposes extraordinary costs on every other member. (Arguably, by reducing the range of options available in the marketplace, the initiative is, in fact, anti-choice.) Nothing currently prevents individuals from seeking health treatment outside managed care networks.

The "any willing provider" provision of the initiative is determinative. Initiative 673 is bad public policy.

¹ The Lewin Group, Inc., *Managed Care Savings for Employers and Households: 1990 through 2000*, May 23, 1997, page 12.

² Danzon, Patricia M., "Tort Liability: A Minefield for Managed Care?" *Journal of Legal Studies*, vol. XXVI, June, 1997, page 494.

³ Danzon, page 503.

⁴ Lewin Group, page 18.

⁵ Lewin Group, page 33.

⁶ Atkinson & Company, *The Cost Impact of "Any Willing Provider" Legislation*, June 27, 1994, pages 1-7.

⁷ Arthur Anderson, LLP, *Cost Estimates Related to the Impact of an "Any Willing Provider" Provision in the State of Washington*, October 1, 1997, page 2.

⁸ Arthur Anderson, page 3.

⁹ The Lewin Group, page 42.

