

ASSESSING THE IMPACT OF CALIFORNIA'S PROPOSITION 214 ON HEALTH CARE COSTS

A CRITIQUE OF THE BARENTS GROUP ANALYSIS

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Executive Summary

The HMO Patients' Rights Initiative (Proposition 214), which will be on the California ballot in November 1996, would require stricter regulation by the state of health maintenance organizations. The debate has been influenced by a recent study by the Barents Group of KPMG Peat Marwick, prepared for Taxpayers Against the Government Takeover, that assessed the cost and economic impact of both Proposition 214 and Proposition 216, the Patient Protection Act. Although ignoring important differences between these two initiatives, the Barents study estimates that, if either initiative were enacted, the cost of health care received on the job would rise 5.8% to 12.1%, and the state's costs for Medicaid and health insurance received by public employees would rise by billions of dollars.

The Barents study has serious flaws, and its estimates of Proposition 214's effect on health costs are far too large. The assessment, by (1) ignoring overheads costs, which are substantially higher in managed care plans than in fee-for-service (FFS) plans, and (2) making inappropriate assumptions about the effects of cost sharing in independent practice association (IPA) plans, overstates the hypothetical maximum amount by which costs could rise under the initiative.

The Barents study also overstates the impact on costs of various provisions of the initiative:

- It attributes a large increase in costs to the inability of plans under the initiative to negotiate price discounts with providers. However, the initiative will not restrict a plan's control over the size of its provider network, the major factor determining a plan's ability to negotiate discounts.
- Because the initiative would prohibit plans from offering providers financial incentives for denying medically indicated services, the initiative should decrease, not increase, the incidence of lawsuits challenging denials of care. Such an outcome would save money, not, as Barents maintains, raise costs.
- Requiring providers who make decisions about utilization management to be licensed in California should have a negligible effects on costs, much smaller than the amount estimated by Barents.

- Provisions of the initiative that would result in cost savings are not included in the Barents analysis.

The Barents analysis of Proposition 214

According to the Barents report, managed care plans save money over traditional fee-for-service plans in three ways: through utilization review (UR), utilization management (UM), and price discounts.’ Barents argues that the initiative will hinder the ability of managed care plans to maximally use these tools, and, as a result, health costs will rise. Barents estimates the rise in costs in a two-step procedure. First, it determines the extent to which costs in managed care plans differ from costs in traditional FFS plans.² This difference is the hypothetical upper limit on the cost increases that could occur under the initiative. (It correctly assumes that costs in managed care plans would not rise higher than in FFS plans since, if they did, people would likely switch their enrollment from managed care to FFS.) After estimating this hypothetical cap, Barents estimates the effects on costs of individual provisions of the initiative; the sum of the effects of all the initiative’s provisions cannot exceed the cap. While this could be a reasonable method for examining possible cost increases, both steps in this procedure—the calculations of the caps and the estimates of the effects of individual provisions of the initiative—are flawed.

Problems with estimates of the cap

Comparing the cost of care in managed care plans requires consideration of three types of costs: the level of utilization (how many services are used), which is affected by utilization review and utilization management; price discounts; and overhead costs (administration, marketing, and profit). Barents assesses the first two of these—utilization and price discounts—but generally ignores overhead.

This is not a trivial omission, since overhead costs in managed care plans are generally higher than in FFS plans. In a “typical” FFS plan that conducts UR, overhead costs are estimated to be 13-14% of premiums. (Overhead costs would be slightly lower in a traditional FFS plan.) However, overhead in managed care plans is usually higher. For example, CaliforniaCare Health Plans, a combined IPA and group-model HMO that enrolled over 2 million people in 1995, has overhead costs of 27%.³ Both Aetna Health Plans of California (which merged with Aetna of San Diego in 1994) and Foundation Health are IPAs, with about half a million enrollees each, have overhead costs of 23%. Health Net, a combined group-model and IPA HMO with 1.2 million enrollees, has overhead costs of 20%. CIGNA Healthcare of California, a combined staff-model and IPA HMO with 630,000 enrollees, has overhead costs of 17%. The exception is the Kaiser Foundation Health Plan, a nonprofit, group-model HMO with nearly 5 million enrollees and overhead costs of just 3%.

Because Barents ignores overhead costs, its estimates of the hypothetical maximum amount that costs can rise is excessively large. For example, Barents calculates that IPAs receive price discounts of 15% and have UR/UM savings of 8%, for a total savings of 23% compared to traditional FFS plans. As a result, Barents concludes that costs in IPAs could potentially rise by 23%. However, if differences in overhead costs are included (IPA overhead costs average 20% of premiums compared to 13% in FFS plans,⁴ for a difference of 7%), the total difference in costs between the two types of plans falls to 16% (23%-7%). Thus, the Barents methodology should show the hypothetical maximum increase in IPA costs to be 16%, not 23%. (Actually, the difference is smaller than this, as will be shown below.)

Failing to include overhead costs is not the only problem with Barents’ estimates of the caps. There is also a shortcoming in the way Barents estimated the effects of UR, UM, and price

discounts. The study compares four types of managed care plans to traditional unmanaged FFS: group- and staff-model HMOs, IPA HMOs, preferred provider organizations (PPO) and point-of-service (POS) plans, and FFS plans that practice UR. Barents uses an analysis by the Congressional Budget Office (CBO) to estimate the savings from UR in all types of plans and for UM in group- and staff-model HMOs (Barents Group, B-3). However, it does not use the CBO estimates for UM for IPAs; instead, it uses estimates from the consulting firm Lewin-VHI. While the CBO found that IPAs reduce costs by 3.6% through a combination of both UR and UM (CBO, 9), Barents used Lewin's estimate of 8%. The difference in these estimates arises from the way in which the two analyses treat the effects of IPAs' low cost-sharing levels on utilization.

Both the CBO and Barents/Lewin studies compare utilization in FFS plans and IPAs. Utilization is affected by UR and UM and also by the level of cost sharing, which in IPAs is generally low but in FFS plans usually substantial, often 20% for outpatient services. (Hospital cost sharing is usually lower.) The Barents/Lewin assessment "controls for" differences in cost sharing in order to separate the effects on utilization of a plan's UM and UR activities from those that result from differences in cost sharing. This means that Barents/Lewin assumes that cost sharing in IPAs is similar to that in FFS plans. This assumption is an appropriate technique to determine the effectiveness of the IPA's UR and UM tools in reducing utilization compared to actions by an FFS plan, but it does not give an accurate picture of the relative costs of the two types of plans because, in actual experience, cost sharing as well as UM and UR affect utilization. Low cost sharing generally is associated with higher levels of utilization and high cost sharing with lower levels. Therefore, the effects of UR and UM in reducing utilization in an IPA will be offset, in part or in whole, by the higher utilization associated with low cost sharing. Thus, the CBO's analysis, which considered the effects of cost sharing on utilization as well as UR and UM, rather than the Barents/Lewin assessment, which ignored the effects of the differences in cost sharing, is the correct approach. This means that the upper limit on the hypothetical increase in IPA costs that could occur because of the effects of the initiative on UR and UM is 3.6%, not 8%.⁵

Problems with assessments of individual provisions

The second stage of Barents' assessment, which looks at how the various provisions of the initiative would affect costs, is also flawed.

Restrictions on provider networks

There are two clauses in the initiative that would affect the current, largely unlimited freedom of plans to establish networks of providers. The initiative prohibits plans from terminating a contract with a physician or other health care provider because the provider "advocat[ed] in private or in public on behalf of patients or...report[ed] any violation of law to appropriate authorities." In addition, providers cannot be terminated except for "just cause." According to the initiative, "Examples of just cause include, but are not limited to, proven malpractice, patient endangerment, substance abuse, sexual abuse of patients, or economic necessity."

The initiative protects providers from contract termination for speaking out and acting in the patients' best interests. It also protects health plans by allowing them to terminate incompetent providers and adjust staffing levels as needed to cover fluctuations in the number and type of enrollees.

Barents claims this restriction will raise costs significantly: 4-9% for HMOs and 3-5% for PPOs/POSSs. These estimates account for well over half of the total increases that Barents calculates will occur as a result of the initiative. However, these estimates are grossly overstated.

Currently, plans may engage in selective contracting, i.e., they may select the providers with whom they contract and also determine the total number of providers. By limiting the number of providers, plans can offer large volumes of patients to each of their providers. In exchange for a large volume of patients (which means large revenues for the provider), a provider is expected to agree to a reduction in fees. According to Barents' estimates, these price discounts account for a

TABLE 1
Estimates of Savings by Plan Type, Barents and CBO

	Barents					CBO
	UR	UM	UR & UM	Price Discounts	Total	UR & UM
Managed FFS	4%	0%	4%	0%	4%	4.0%
POS/PPO	4	2	6	6	12	na
All HMO	4	a	12	13	25	12.8
IPA	4	4	a	15	23	3.6
Group & Staff HMO	4	18	22	a	30	21.9

large share of the total savings achieved by managed care plans. For example, Barents estimates that 15 percentage points of the 23 percentage-point difference in costs that it finds between IPAs and FFS plans can be attributed to price discounts at IPAs. On average among HMOs, it attributes 13 points of the 25 percentage-point reduction in costs to price discounts. For PPO/POS plans, 6 of 12 percentage points are price discounts (See Table 1).

Contrary to Barents' claims, the initiative will not affect a plan's ability to limit the number of providers in its network. Plans are not required to contract with any physician. As enrollment rises, a plan can increase its number of physicians as it wishes. If a plan finds itself with too many physicians (due, for example, to declining enrollments), it may terminate some of its contracts for reasons of "economic necessity." This is specifically allowed in the initiative. Therefore, there is no reason why plans would be less able to negotiate price discounts with providers, yet the Barents Groups maintains that this provision is a major cause of cost increases.

Limiting the number of providers with whom a plan contracts can result in lower administrative costs. Generally, the fewer the providers in a plan's network, the lower such costs. Yet the Barents report cites increased administrative costs arising from limits on a plan's ability to do selective contracting as another reason why costs would rise under the initiative (Barents Group, C-6). Since plans will be able to control the number of doctors with whom they contract, administrative costs under the initiative should be unchanged.

The large cost increases that Barents estimates would occur due to this provision appear to be based on its assessments of the costs associated with "any willing provider" (AWP) laws (see Barents Group, C-2-C-4). AWP laws, which have been passed in some states, require health plans to contract with any willing provider and may increase the number of providers under contract. But under the California initiative, plans are not required to contract with any willing provider.

Restrictions on physician payment

The Barents Group estimates that restrictions on physician payment would increase costs in HMOs by 3% (approximately 20-50% of the total increases due to the initiative). The provision in the initiative that Barents claims would result in this cost increase states that no plan shall pay a bonus or financial incentive to providers for the “denial, withholding, or delay of medically appropriate care to which patients or enrollees are entitled.” Barents agrees that “[i]n theory, this provision should not have any impact on premium costs, since HMOs’ policies are to not deny, reduce, limit, or delay medically necessary services” (Barents Group, 13). However, Barents then argues that “[i]n practice...this provision may put the burden of proof on HMOs to establish that the treatment provided [or not provided] to a patient was not a result of a bonus or withhold policy.” As a result, the report “assume[s] that HMOs will stop using bonuses and withholds rather than face potential litigation” (Barents Group, 13).

But, as Barents acknowledges, plans currently are obligated to provide all necessary medical care, and they face the risk of medical malpractice claims if they do not. There is no reason to think, as Barents claims, that such litigation would become more prevalent due to this provision. The initiative should actually lessen the number of such lawsuits, since it would reduce potential conflicts of interest between doing what is right and best for the patient and doing what might be financially advantageous for the provider and the plan.

Appropriately licensed personnel for utilization management

The initiative requires that people involved in decisions about denial of care be appropriately licensed. The Barents Group correctly interprets this provision to mean that utilization management functions that currently might be performed in a centralized location outside the state would have to be performed by people with the appropriate California licenses, probably located within California.

For plans that already perform these functions with California-licensed personnel, the initiative would have no effect. However, for a plan that uses out-of-state personnel and offices, the initiative could mean that the plan would require fewer offices and people at out-of-state sites and more people and office facilities within California. Barents estimates that using California-licensed personnel and transferring these functions into the state would raise HMO costs by 1-3% and PPO/POS costs by 1-2%, or a total of \$199 million to \$553 million annually.⁶ In other words, Barents estimates it would cost as much as an additional half a billion dollars annually to do in California what is already being done elsewhere. Moreover, these estimates are the costs for IPA and PPO/POS plans only, since Barents acknowledges that most group- and staff-model HMOs already perform these function in-state and would not be affected (Barents Group, 14). This cost estimate is highly inflated.

Disclosure of non-health care expenditures

Barents fails to assess fully the provision in the initiative that will likely have the largest effect on **reducing** costs. The initiative requires health plans to disclose the share of total premium receipts not spent on health care, for example, expenditures for marketing and advertising, profits, and administration. Barents argues that this additional administrative burden will raise health expenditures. However, Barents does not mention that this provision will strengthen the negotiating position of purchasers of health insurance, such as employers, and enable them to negotiate lower prices for health care. The California public employees health plan (CalPERS), which already requires this information from the plans with which it contracts, estimates that this information has significantly improved its ability to contain health costs.

The impact on the California economy

Finally, the Barents analysis of the effects of the initiative on employment and the state's economic output derives from its cost estimates and is based on Barents' macroeconomic model of the state's economy. If its cost estimates are too high, then the measured effects on the economy will be overstated as well. Unfortunately, no information on the macroeconomic model is provided in the report. Since results from all models of this type rest heavily on the assumptions embedded within them, the accuracy of the macroeconomic predictions cannot be evaluated.

Conclusion

The flawed report by the Barents Group provides inaccurate information with which to assess the impact of Proposition 214. The assessment, by (1) ignoring overhead costs, which are substantially higher for managed care plans than for FFS plans, and (2) making inappropriate assumptions about the effects of cost sharing in IPA plans, overstates the hypothetical maximum amount by which costs could rise due to the initiative.

The report also overstates the cost effects of various provisions of the initiative.

This critique is limited because, due to lack of independent data, many of the cost claims made by Barents cannot be confirmed or rejected. However, flaws identified in the cost estimates that *can* be evaluated do not inspire confidence in the remainder of the claims.

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Endnotes

1. Traditional FFS plans are those that do not manage care (and employ no utilization review). These types of plans are rare today. The CBO estimates that, in 1990, 47% of indemnity plans had effective UR, 47% had less effective forms of use management, and 6% were unmanaged. The movement toward use of effective UR has grown since that time.
2. All the data on overhead costs are from CMA 1996.
3. Author's analysis of CMA data.
4. The CBO examines savings due to changes in utilization only for HMOs and FFS plans; it does not examine PPO/POS plans. Therefore, there is no independent confirmation of Barents' estimates of price discounts for any types of plan or of the effects of UR and UM on utilization in PPO/POSs.
5. These are 1997 dollars.

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