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LABOR CENTER REPORTER

Number 93
June 1983

HEALTH CARE COSTS: CONTAINMENT OR SHIFTING?

by Bruce Poyer

To cope with the inflation of health care costs (see LCR 91), the California legislature has initiated two far-reaching policies. The first was intended to check MediCal inflation rates, which averaged 18% a year 1976-1982. Beginnning last fall, the state was permitted for the first time to negotiate selectively with hospitals to provide prepaid care for MediCal patients. After six months of such negotiations, the state now has contracts with 147 hospitals, covering 9,000 hospital beds. By July, 90% of all MediCal care will be under contract, at annual savings of $85 million (estimated by the MediCal negotiator).

The second state policy change permits private health insurance companies (including Blue Cross) to negotiate in the same manner with hospitals. The theory is that hospitals will have to compete to offer the best prepaid rates for various group purchasers. The plans which result from this competitive bidding will be called PPO's, or Preferred Provider Organizations. Such plans are expected to be based on hospitals and related health care institutions, but they will soon blanket in specific providers of care as well. (MediCal will be able to contract directly with doctors and other providers beginning in July.)

In adopting the new policies, the legislature has turned its back on regulation and opted instead for competition as its primary cost-containment weapon. The competition involved is all at the sophisticated level of prepaid group coverage, and will do nothing for the unemployed or for a great many others who simply do not have group health coverage. The return to competition is regarded by some as a last-ditch effort to restrain health cost inflation in both public and private sectors. It is regarded by others as a particular challenge to the health plans which are negotiated in collective bargaining.

Special Problems in Collective Bargaining for Health Care – Negotiated coverage for 2.2 million union members and their 4 to 5 million dependents in California is highly fragmented. When health plans were originally appended to collective bargaining contracts, they took on the geographical fragmentation of union and employer and industry jurisdictions. In addition, labor-management representatives and health plan trustees in California have relied primarily on indemnity insurance plans, which still cover 60-70% of union members and dependents. There are probably more than 1,000 such plans in the state. No one even has a list of them, but they contain every conceivable mixture (a) of covered and limited and excluded services, and (b) of formulas for deductibles and co-insurance and maximum payments. Finally, negotiated plans have a great variety of administrative arrangements, and they also differ widely in such basics as dependent coverage, and loss of coverage because of lay-off.

During the past three decades, the major cost and quality control development affecting negotiated coverage in California has been the spread of HMO's, which now cover about 20% of union members and dependents in California. However, the health plans of the commercial insurance industry (including the Blues) still predominate in California, and they have been virtually open-ended for cost increases. They have also had extremely high administrative costs (national data indicates from 12 to 15% annually in recent years).

As a consequence, in the typical negotiated plan in California, only about half of the total cost of health care of the covered employee and his family is prepaid in the collective bargaining agreement. The employee or his dependent must pay the rest out-of-pocket--or find supplemental coverage in a government program. Thus, the total prepaid bill for negotiated coverage in California is now at least $6 billion annually, but the total cost of health care to union families may be as high as $12 billion annually.

In the typical indemnity insurance health plan in this state, there is no claims review procedure and no monitoring or surveillance of either the cost or quality of health care. From time to time, there may be some data on the utilization of health services covered by the plan (i.e., in hospital vs. out-patient and preventive care services; or comparative data on hospital stays and surgery rates). However, there will be no data whatever to indicate either the need for or the utilization of health care services not covered by the plan, which may nonetheless constitute half the typical family's annual health care bill. Thus there will be no way to determine the impact of any uncovered service on the total cost of covered services.

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Current Efforts to Contain Negotiated Health Care Costs in California – Many California employers have become active in cost containment coalitions, and some union representatives have joined them. However, recent employer proposals in collective bargaining have been more concerned with cost shifting--to employees--than with cost containment. The most common such proposals are to raise deductibles or co-insurance payments, or to put maximum payments on various covered services, or to exclude more services altogether from coverage. Employers are also challenging maintenance of benefit clauses, demanding that employees share increasing premium costs, and seeking more contract re-openings to deal with health care costs.

As in the government health care programs, such "take-away" proposals come from budget considerations only, and not from analysis either of health care needs, or of the cost and quality relationships between one kind of service and others. Neither labor nor management is usually in a position to evaluate the total cost impact of any of these take-away proposals--let alone the impact on quality of health care.

Both labor and management should be more concerned with the potential impact of another kind of cost shifting. If the Reagan Administration carries its proposed tax on health plan premiums over $175 per employee per month, half of all California union members will be affected, and the allocation of these additional costs, previously tax exempt, will be another big problem in collective bargaining. Further, continual cuts in services previously provided to the aged and the poor under Medicare and Medicaid result in documented cost shifts to the disadvantage of labor-management and all other private sector group purchasers.

In the long run, effective cost containment in negotiated health care programs will require bold and imaginative steps to reduce expensive and inefficient fragmentation of programs and services. Labor-management representatives at top leadership levels will have to learn how to cross traditional jurisdictional lines in order to undertake research and generate adequate data, develop more uniform coverage for broader groups of union members with the same health care needs, and limit both excessive administrative costs and profits of commercial insurers. Health care cost problems confronting negotiators today have been intensified over the years by the predominant role of cost-plus, data-deficient commercial insurance coverage--just as the same problems have been intensified in the government programs by the same groups, in their role there as "fiscal intermediaries." Today's cost problems will not be solved when the friendly commercial insurance agent calls again on labor and management with new versions of "cut rate" health care packages, nicely tailored to fit the continuing, open-ended, inflationary erosion of present benefit levels.

– Bruce Poyer

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