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The 1985 Health Care Cost Containment Survey of Local Public Employers in California

Public Employment Relations Board

RESEARCH AND COMMUNICATIONS SERIES

The 1986 Health Care Cost Containment Survey of Local Public Employers in California

STATE OF CALIFORNIA
GEORGE DEUKMEJIAN, *GOVERNOR*

PUBLIC EMPLOYMENT RELATIONS BOARD

August 1, 1987

Dear Public Employer/Employee Organization:

Senate Bill 922 of the 1983 legislative session, directed the Public Employment Relations Board

> . . . . to collect, analyze, and compare data on health benefits and cost containment in the public and private sectors, and to make recommendations concerning public employees. The recommendations may take into consideration health benefit cost containment issues in public and private employment . . . .

With this mandate, PERB undertook a three-year project in order to make a contribution to health care cost containment by providing information that would assist both employers and employee organizations to reduce their health benefit costs and preserve needed benefits. The three-year project dealt with the fundamental issues of organization, financing and delivery of health services.

PERB developed the data through three annual surveys and reported the findings to employers and employee organizations. It was intended that the surveys not only provide data, but would also give employers an opportunity to evaluate their costs and cost containment activities.

In addition, a guide to Preferred Provider Organizations was developed in 1984 as part of this project because of the demand by the employers and employee organizations to understand this emerging health delivery entity.

During the three years this study was being conducted, major changes occurred in health care financing, organization and delivery systems and in employer/employee activities related to employee health benefits.

This report reflects those changes over the three-year period and highlights those activities and trends that appear to be associated with reducing health care costs.

In addition, this report provides data and information on health care costs and health care cost containment activities undertaken by local public employers in 1986.

While it is not the Board's intent to promote any particular cost containment activity or strategy, we do believe that it is important to provide as much information as possible on cost containment activities undertaken by public employers and employee organizations.

The Board's objective in this research and communication effort is to assist employers and employee organizations to deal with potentially conflicting issues before they reach the bargaining table. It is a role that is educational and preventive in nature and one we hope will be of assistance to the public employer and employee organization decision-makers and those responsible for proposing and implementing organizational policy.

Sincerely,

Public Employment Relations Board

Acknowledgement

This three-year study was developed and directed by Gordon Rude, M.S., M.P.H., Health Care Consultant, and Karon Hart, Special Consultant, under the auspices of the Research and Communications Unit of the Public Employment Relations Board.

The Board wishes to thank Myrlys Stockdale and Jack Metcalf, who were interns with the Board in 1986. Each made significant contributions towards the organization and analysis of the data.

The Board also wishes to thank Dr. Paul O'Rourke, Integrated Health Management Associates, who collaborated on the development and analysis of the survey, as well as on the writing of this report.

The Board also wishes to make a special acknowledgement to Rita Lugo for her creativity in developing data programs that were necessary for this three-year study to be completed.

Inquiries regarding this report should be directed to the Public Employment Relations Board, 1031 18th Street, Room 200, Sacramento, California 95814-4174. Phone (916) 322-3088.

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HEALTH CARE COST CONTAINMENT PROJECT
CONDUCTED BY THE PUBLIC EMPLOYMENT RELATIONS BOARD
1983 to 1986

In 1983, the Legislature and the Governor instructed the Public Employment Relations Board to study the issue of the continued rise in the cost of providing health care benefits to public employees. The need for the study was a direct result of increased public employer expenditures for health care during the post-Proposition 13 era in which public budgets were being significantly curtailed.

In response to this charge, the Board developed a three-year project to collect, analyze and disseminate data on health care costs and the cost containment activities that were undertaken by public employers and employee organizations.

The first year of this study covered a period from July 1983 through June 1984. This was one year after the California Legislature had passed health care reforms that encouraged competition among health care providers in California. This policy changed the traditional open-ended fee-for-service/cost reimbursement method of paying for health services to a system of negotiated contracts with doctors, hospitals, and other health care providers at discounted rates. The policy permitted insurers and the purchasers to have greater economic control over health care providers by requiring them to compete for patients (the employees).

This project, therefore, was able to track changes in the cost and delivery of health care, and the cost containment activities undertaken by public employers during a time when dramatic changes were occurring in the health care industry due to the new policy of competition.

The project was designed to focus on collecting and analyzing data in which associations between costs and activities could be made. However, the research was not designed to control variables in such a manner that specific statistical inferences could be drawn on each cost containment action.

The response to the survey over the three years was consistently large and broadly distributed. Generalizations could be made about all public employers in California by employer size and type. We feel confident that this study accurately reflects statewide changes over the three-year period. However, because of continuing changes in health care organization, delivery, and financing, it is not possible to project what will happen over the next three years. At best, the research shows what employers and employee organizations are doing to contain costs and which activities are associated with such savings.

Public employer respondents to the PERB Survey have significantly undertaken cost containment activities since 1983, and as a result, have moderated expenditures for health care benefits.

Public employers, very often in cooperation with exclusive bargaining representatives, have taken advantage of the new competitive nature of the health care marketplace. It is apparent that public employers and employee organizations are deeply engaged in the financing and administration of employee health benefits.

The areas of greatest activity have been in restructuring the organization and financing of health benefits by employers through: self-insurance and joint powers agreements (JPAs); offering less expensive health plans (i.e., health maintenance organizations, preferred provider organizations, and self-insured/indemnity plans); incorporating or purchasing health plans which embody utilization review and rate negotiation with providers; and, adding preventive health services to plans for such problems as alcohol and substance abuse, stress reduction, and physical fitness.

EMPLOYER COSTS FOR HEALTH BENEFITS

Average Annual Expenditure Per Employee Per Year

1984	1985	1986
$1,834	$1,847	$1,996

The cost per employee per year increased less than 1% between 1984 and 1985, and increased 8.1% between 1985 and 1986. This restraint of cost was due to a general moderation in health care cost increases in the health care industry as well as specific cost containment activities undertaken by employers and employee organizations. The flattening of cost increases compared to the previous ten years of double digit inflation for health care indicates that employers and employee organizations are taking advantage of competition to moderate cost increases and are actively involved in a variety of cost containment activities.

HEALTH PLAN COSTS

Average Annual Employer Expenditure Per Employee
by Health Plan Type
For 1984, 1985 and 1986

Plan Type	1984	1984 to 1985 % Change	1985	1985 to 1986 % Change	1986
Health Maintenance Organization	$1,460	18.7%	$1,733	7.8%	$1,869
Preferred Provider Organization	N/A	-	$2,152	(7.1%)	$2,000
Self-Insured/ Indemnity	$1,670	8.9%	$1,819	14.4%	$2,081
Indemnity Insurance	$2,022	12.4%	$2,272	(.8%)	$2,254
Blue Cross/Indemnity	N/A	-	$2,102	10.3%	$2,318
Blue Shield/Indemnity	N/A	-	$2,117	15.1%	$2,437
STATEWIDE AVERAGE	$1,834	.7%	$1,847	8.1%	$1,996

From the perspective of costs by health plan type, health maintenance organizations (HMOs) consistently cost less while self-insured/indemnity (SI/I) and preferred provider organizations (PPOs) are now costing about the same. Indemnity insurance (I) plans are considerably more expensive than the other three plan types.

It appears that HMOs, PPOs and SI/Is have become more price competitive from the employer perspective in the last three years. Whether this trend will continue is unknown.

Changing health benefit plans has been a major cost containment effort during the three years of the study. It would appear that most employers are taking advantage of the competitive nature of the health marketplace by organizing and/or making less costly plans available to employees.

IMPLEMENTATION OF COST CONTAINMENT ACTIVITIES

Increasing Employee Financial Participation

Requiring an employee contribution to the health benefits plan has remained a significant cost containment activity over the three years of the project. The 1986 survey data indicates that employer costs are reduced regardless of health plan type when an employee contribution is required. Since the majority of employers do not require a premium contribution, requiring premium contributions is a trend that is likely to continue.

From the collection of information over the three years of the project, it appears that there was an emphasis in 1984 on reducing certain benefits. In the subsequent surveys, there was a decline in the reduction of benefits. Most employers acknowledge that a reduction in benefits is likely to trigger a major collective bargaining conflict at a time when other options in controlling costs can be developed by which both parties benefit.

The use of coinsurance and deductibles as a cost containment activity became a standard practice for most fee-for-service plans over the three years of the study. By 1986, more than three-fourths of the fee-for-service plans required coinsurance and deductibles.

There has been a continued decline in the use of co-payments as a cost containment activity. Most PPOs waived co-payments in order to attract enrollees and in the 1986 survey 63.4% of the employees were in plans that waived co-payments.

A majority of the HMOs required co-payments. HMOs appear to have retained the co-payment feature because their plans are more easily marketed due to their lower cost and co-payments generate additional revenue to the HMO.

In fee-for-service plans that waived co-payments, the employer expended less when a co-payment was required. This is because PPOs (which cost less) waived co-payments and non-PPO indemnity plans (which usually cost more) required co-payments.

Restructuring the Organization and Financing of Health Care Benefits

Two of the most significant cost containment activities undertaken by respondents have been: 1) the restructuring of the employer's method of organization; and, 2) financing of health benefits or changing health plans.

Self-Insurance

A substantial number of employers have chosen to become self-insured and bear the actuarial risk of paying for health benefit claims and/or have combined with other public entities through Joint Powers Agreements (JPA) to purchase health benefits. Some employers and employee organizations have also developed health benefit trust funds that are jointly managed through employer and employee organization trustees.

There are many different kinds of organizational and financial arrangements among public employers. However, it appears that regardless of how or which health plans are purchased, becoming self-insured is a clear and continuing trend. The reasons identified for becoming self-insured:

- savings generated as a result of not being required to pay a premium tax as do commercial insurers;
- interest and investment earned on reserves that are held to pay claims or stop loss premiums (i.e., retaining the dollars that commercial insurers traditionally make as profit);
- a reduction in administrative cost and greater control of administration, cash flow and claim awareness.

In the strictest definition, a self-insuring employer assumes the actuarial risk of paying for health services for employees using a fee-for-service indemnity plan. The plan is either administered by the employer or the employer contracts for the administration with an insurer or third party. In addition, the employer usually purchases stop-loss insurance for the plan to protect against catastrophic losses.

The self-insured employer may also provide an HMO or PPO option to their employees. Should the employee elect to enroll in one of these plans, the plan assumes the actuarial risk and the employee no longer participates in the self-insured plan. The employer then only funds the employee's benefits.

Many self-insured employers offer HMOs and PPOs in addition to their SI/I plan because:

- HMOs and PPOs may cost less or they are at least price-competitive with SI/I plans; and,
- employees have greater choices of how and with which of these plans they choose to receive their health care benefits.

In the 1986 survey, 40% of the employees had selected the HMO option and 16% the PPO option over the employer's SI/I plan.

Joint Powers Agreements

The 1986 Survey revealed a continuing and significant trend among local public agencies to enter into JPAs for the purpose of purchasing employee health benefits. The reasons cited for entering into JPAs:

- to increase the purchasing power by belonging to a larger group and creating more negotiating leverage with providers;
- consolidating and reducing administrative costs;
- creating staff resources to address cost containment issues.

There are basically two types of JPAs. In the first type, premium dollars are pooled and the joint powers agency negotiates with providers and insurers for the purchasing of health benefits. In the second type, the joint powers agency becomes self-insured.

In the last three years, half of all employers in the study reported participation in JPAs.

Health Benefits Trust Funds

A health benefits trust fund is a formal agreement entered into by employers and employee organizations for the purpose of administering health care benefits. While the number of trusts established during the study was small when compared to the number of JPAs established, it is clear that trusts are a feasible option when reorganizing a benefits program and that new trusts are forming every year. Whether or not the formation of trusts will be a significant trend in the future could not be predicted from the study.

Changing Health Benefit Plans

HMOs have consistently been the health plan type in which the employer spent the least per employee per year during the last three years. More than half of all public employees are enrolled in HMOs, which accounts for the lower statewide average cost per employee per year.

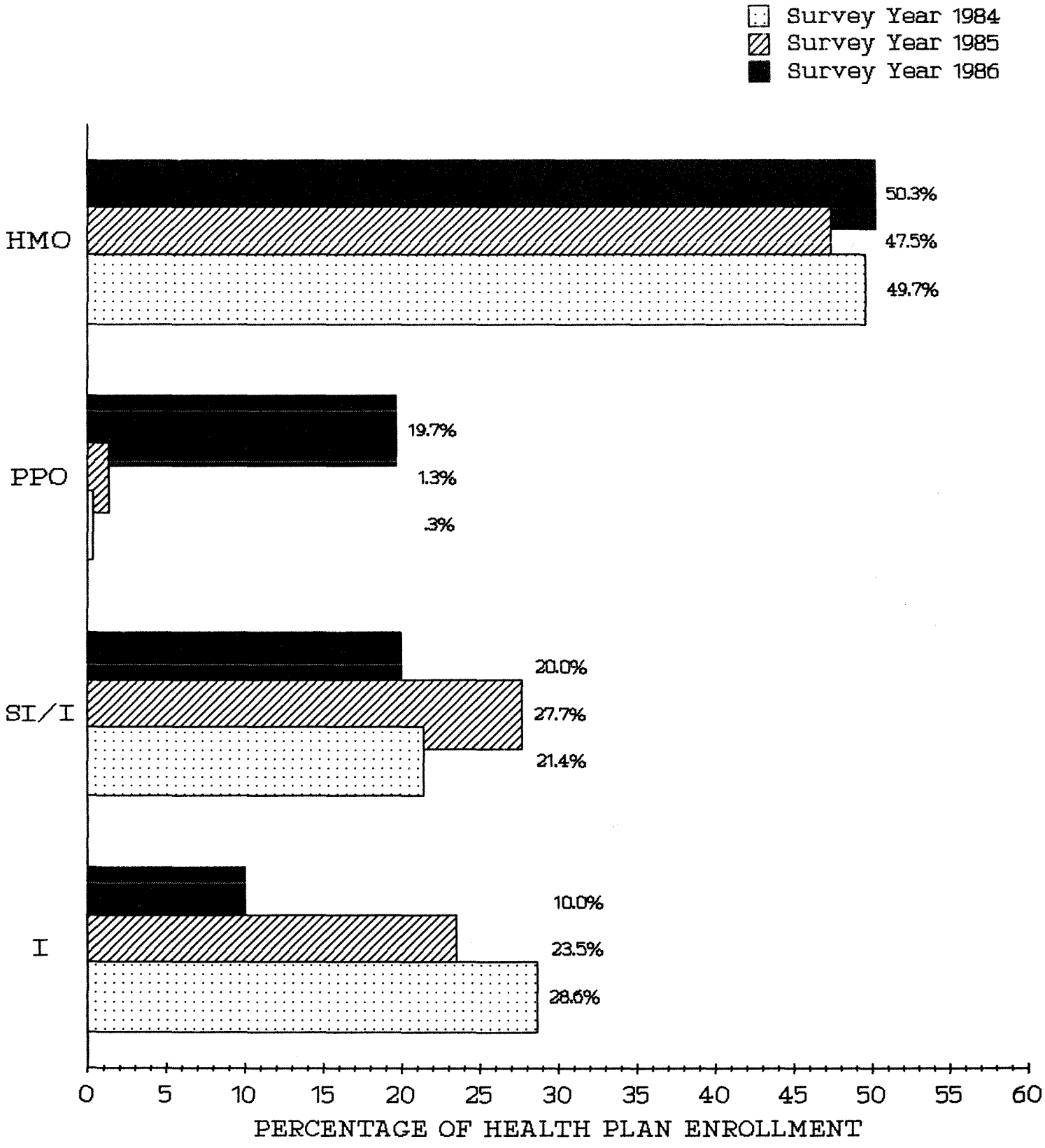
For the remaining employees not enrolled in HMOs, the most striking change in employee selection of health plan types has been the reduction in the utilization of traditional indemnity insurance plans and the rise in the use of PPOs. Indemnity insurance plans decreased from over one-quarter of usage in 1984 to approximately one-fifth of usage in 1986, whereas PPOs increased from slightly above zero in 1984 to more than one-fifth of usage in 1986.

In addition to the HMO and PPO, the SI/I plan is the other most often used health plan type. These are indemnity insurance plans in which the organization (employer, JPA, trust, etc.) is actuarially responsible for the employees' health costs and pay providers on a fee-for-service basis.

In 1986, SI/Is and PPOs had approximately the same number of employees participating in their plans.

ANALYSIS OF HEALTH PLAN ENROLLMENT

FOR SURVEY YEARS 1984, 1985 AND 1986



Utilization Review

Introducing programs structured to evaluate the utilization of health care services by employees has been a major cost containment effort observed during the three years of the study.

Pre-admission review (which requires prior approval of a non-emergency hospital admission) and concurrent review (which evaluates the appropriateness of care and the length of stay for the patient) have consistently been the major utilization review efforts incorporated into employer health plans.

Physician services review (which reviews physician services in the hospital) and post-audit review (which reviews provider bills after service is rendered) substantially increased in 1986.

Ancillary services review and outpatient services review also increased in 1986, but not as substantially as the other forms of review.

Utilization review in all its forms is, and will continue to be for some time, a substantial cost containment activity undertaken by insurers and purchasers of care. Employers who do not have health plans with effective utilization review built in can anticipate continued high costs.

Provider Discounts

Negotiated discounts with hospitals and physicians doubled from 1985 to 1986. This is a major cost containment activity among public employers.

In 1983, there were virtually no PPOs. In 1986, almost one-fifth of the employers reported offering PPOs as a cost containment activity. Most PPOs have obtained major discounts for service and are likely to continue doing so as competition increases.

Second Opinion for Surgery

More mandatory, rather than elective, second opinion for surgery was reported for the first time in 1986. Whether mandatory or elective, second opinion for surgery is a cost containment activity utilized by many employers.

Preventive Health Services

The introduction of alcohol and substance abuse programs has continued to be a major cost containment effort during the three years.

In the category of preventive health services, alcohol and substance abuse programs were the cost containment activities most employers implemented in 1986. Clearly, public employers and employee

organizations are acknowledging and responding to this serious problem and are recognizing the organizational savings associated with preventing these problems.

Stress reduction and physical fitness have also received considerable attention by public employers over the three-year study. This would seem to support the growing national trend of employers in promoting wellness among employees.

Smoking

What was surprising to the researchers was the lack of activity related to smoking cessation programs.

In the face of overwhelming medical information on the damaging effects of smoking to health, an increased level of disability, and organizational costs of smokers in the workforce, little emphasis seems to be placed on smoking cessation programs.

Alternative Health Services

Surgi-center, hospice, and home care programs all increased in 1986, with home care programs more than doubling since 1985.

Alternatives to hospitalization and skilled nursing home care are clearly being implemented as cost containment alternatives.

This trend will no doubt continue since services provided out of the hospital have proven to be cost effective and beneficial to patients.

PERCENT OF EMPLOYERS IMPLEMENTING COST CONTAINMENT FOR 1984, 1985 AND 1986

ACTIVITIES	1984	1985	1986
Reduce Benefits	8.6%	5.4%	4.3%
Add/Increase Employee Contribution (Co-insurance)	13.3%	8.4%	9.8%
Add/Increase Deductibles	11.6%	9.1%	6.9%
Add/Increase Co-Payment	6.5%	2.7%	3.1%
Change to Less Expensive Plan	14.5%	10.5%	8.8%
Limit Employee Choice of Plans	11.8%	6.3%	5.8%
Add Preferred Provider Organization	7.3%	7.0%	18.8%
Self-Insure	20.8%	18.6%	13.3%
Joint Powers	20.4%	15.8%	14.2%
Establish Health Benefits Trust Fund	6.1%	4.0%	3.7%
Joint Powers Agreement Utilization Review			
Pre-Admission Review	11.4%	8.8%	16.2%
Concurrent Review	9.4%	6.9%	14.0%
Ancillary Services Review	6.1%	4.0%	6.7%
Physicians Services Review	6.9%	5.6%	10.0%
Outpatient Services Review	5.9%	5.2%	7.6%
Post-Service Audit	9.0%	6.3%	10.4%
Negotiate Discounted Rates or Fees			
Hospitals	6.9%	7.0%	14.3%
Physicians	6.7%	4.9%	11.6%
Mandatory Second Opinion for Surgery	5.1%	4.7%	11.2%
Elective Second Opinion for Surgery	11.2%	7.5%	8.9%
Surgi-Center Services	6.5%	5.3%	7.6%
Hospice Services	5.1%	4.0%	7.3%
Home Care Services	7.5%	4.8%	10.0%
Alcohol Abuse Program	13.5%	8.8%	12.7%
Substance Abuse Program	12.4%	7.6%	11.6%
Smoking Cessation Program	5.7%	3.6%	5.4%
Nutrition and Weight Control Program	5.1%	4.1%	7.0%
Chronic Disease Management Program	1.8%	.6%	2.1%
Stress Reduction Program	10.0%	6.9%	8.8%
Physical Fitness Program	8.0%	9.6%	8.5%
Risk Assessment Program	6.3%	5.4%	6.0%
Cash Incentive for Spousal Insurance	2.8%	2.8%	2.1%
Participate in Health Care Cost Containment Organization	10.4%	8.3%	4.8%

1986

HEALTH CARE

COST CONTAINMENT

SURVEY

SUMMARY OF 1986 SURVEY

EMPLOYER AND EMPLOYEE CHARACTERISTICS

- The Employment Development Department of California estimates that there are approximately 1,157,200 public employees of local schools, cities, counties and special districts in California in 1986 (these estimates exclude state and federal employees).

- The survey represents 38% or 445,274 of the local public employees in California.

- The follow-up and editing procedures gave us accurate, reliable and consistent survey information.

- The size and distribution of the response to the survey permitted us to generalize about all public employers and employees in California.

- Local government expended approximately $2.309 billion on health care benefits for its employees in 1986 at an average cost of $1,996 per employee per year.

- County employers had the lowest cost per employee per year followed by school districts, special districts and cities, respectively.

- There was a difference of $517 in the employer contribution between the lowest (counties) and highest (cities) employers.

- Employers who employed between 1,001-10,000 employees paid the least ($1,822) for health benefits per employee while employers who employed between 201-500 employees paid the most ($2,236).

- There was a difference of $414 in the employer contribution per employee per year between the 1,001-10,000 size employer and the 201-500 size employer.

ENROLLMENT AND COST BY TYPE OF HEALTH PLAN

- Half of all employees (50.28%) were enrolled in HMO plans. HMOs were the health plan type in which the employer had the lowest average annual contribution per employee per year, $1,869.

- The magnitude of the enrollment in HMO plans (which were the lowest cost health plan type) had substantially reduced the statewide average employer cost. It was also the only health plan type in which the average employer cost was below the statewide average.

- PPO and SI/I plans were relatively equal in both employer contribution and level of enrollment.

Plan Type	Employer Contribution Per Employee Per Year	Percent Enrolled
PPO	$2,000	19.67%
SI/I	$2,081	19.99%

- PPO and SI/I plans were respectively $131 and $212 greater in employer contribution per employee per year than HMO plans.

- Only 10% of all public employees represented by the survey were enrolled in indemnity insurance plans or traditional Blue Cross/Indemnity (BC/I) or Blue Shield/Indemnity (BS/I) plans. These were the health plan types in which the employer contribution per employee per year was the greatest.

Plan Type	Employer Contribution Per Employee Per Year	Percent Enrolled
I	$2,254	3.87%
BC/I	$2,318	3.95%
BS/I	$2,437	2.23%

- There was a $568 difference in the employer contribution per employee per year between the health plan type with the lowest average cost (HMO) and the health plan type with the highest average cost (BS/I).

COINSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND PREMIUM CONTRIBUTIONS

- When coinsurance was required, employers spent less per employee per year for every health plan type. Reductions ranged from $116 to $378 per employee per year, depending on health plan type.

- Of all employees not enrolled in an HMO, 77.5% had a coinsurance requirement.

- When a deductible was required, employers spent less per employee per year for every health plan type, with the exception of 17 employers who had BC/I plans. Excluding BC/I plans, the reductions ranged from $165 to $426 per employee per year, depending on health plan type.

- Of all employees not enrolled in an HMO, 85.3% had a deductible requirement.

- For all health plan types, excluding HMOs, the waiving of the co-payment requirement resulted in employers expending from $161 to $587 less per employee per year, depending on health plan type. This reduction was associated with the emergence of competitive health benefit plans in the fee-for-service sector, particularly the growth of PPOs. In such competitive plans, waiving of the co-payment is an important marketing tool. Since more employees are enrolling in PPOs and other competitive plans, the data reflected employer savings in fee-for-service plans when co-payments were not required.

- The exception was for HMOs that use co-payments to increase revenue. Since HMOs were the least costly of health plans for both the employer and employee, the co-payment requirement has remained as a source of revenue for the HMOs. Employees continue to enroll in HMOs at a high rate.

- It had been a usual practice that employers paid the total cost of the lowest cost health plan and the employee paid the difference if another plan is selected. This had usually meant that the employer paid the full cost of the HMO. The data indicated that this practice is changing so that the employer contribution is no longer fixed to the lowest cost plan.

- Requiring employees to contribute to the premium cost reduced employer costs in all health plan types. Reductions in employer costs ranged from $63 to $714 per employee per year, depending on health plan type.

- HMOs were the lowest cost health plan type for employers when a premium contribution was required. The health plan cost was $1,553 per employee per year, which was the lowest cost health plan type. For HMOs, the employer cost was $1,927 per employee per year when a premium contribution was not required.

- BS/I was the health plan type with the greatest variation in average cost, with a cost of $714 more per employee per year for the plan when a premium contribution was not required.

- 78.1% of all employees were enrolled in plans which did not require premium contributions.

TYPE OF SPONSORING ENTITY

- An individual public agency (single entity) was the sponsoring entity in which the employer paid the least per employee per year ($1,963). It was also the largest of the sponsoring entity types, with 366 employers and 374,519 employees. Single entities offered a larger number of HMOs (350) and PPOs (112) than other sponsoring entities. The average employer size was over 1,000 employees per employer.

- JPAs were the second least expensive sponsoring entity, with $2,089 spent per employee per year, and the second largest sponsor type, with 175 employers and 37,689 employees. JPAs offered more PPOs than HMOs. Their average employer size was slightly over 200 employees per employer.

- The sample size for health benefits trust funds and the Public Employees' Retirement System (PERS) were too small to be reliable in terms of average costs per employee per year. The sample size was approximately 2%. Our anecdotal evidence suggested that there has been a great deal of activity in this area.

- A study specific to health benefits trust funds and JPAs in regard to health plan options offered and comparative costs per employee per year would provide a comparison which is valid. This survey did not serve this particular purpose.

COMPARISON OF SELF-INSURED AND INSURED EMPLOYERS

- The number of self-insured employers was considerably lower than the number of insured employers, 271 compared to 400. However, the percentage of employees covered in self-insured programs was relatively equal between self-insured (48%) and insured (52%) employers.

- The insured employers do not offer SI/I plans as an option. Instead, they rely more heavily on HMO and PPO enrollment to contain cost. The large enrollment in HMOs and PPOs, which cost less for insured employers than for self-insured employers, accounted for the lower average cost per employee per year for insured employers (i.e., $1,962 per employee per year for insured employers as compared to $2,032 for self-insured employers).

- Self-insured employers enrolled 40% of their employees in SI/I programs, purchased HMOs for 40% of their employees, PPOs for 16% of their employees, and BC/Is, BS/Is or Is for 3% of their employees.

- HMOs purchased for employees by the self-insuring plans cost employers less than any other self-insured health plan type, $1,939 per employee per year. Purchased PPOs and the SI/I plans cost the employer virtually the same per employee per year, $2,084 and $2,080, respectively.

- Employers with insured health benefit programs reported 60% of their employees enrolled in HMOs, 23% in PPOs, and 17% in BC/Is, BS/Is or Is.

- The annual average cost for nonself-insured employers offering HMOs and PPOs was $1,823 per employee per year and $1,940 per employee per year, respectively. BC/Is, BS/Is and Is ranged $393 to $675 more than HMOs per employee per year.

- Employers expended less per employee per year by directly administering self-insured programs or using a third party administrator, rather than using an administrative services only contract with an insurer.

- The average size of the employer who directly administers the self-insurance program was 1,508 employees, third party administrator arrangements averaged 676 employees, and administrative services only averaged 930 employees.

- The number of employees covered in the administrative arrangements: administrative services only, 61%; third party administrators, 32%; and, direct self-administration, 7%.

COST CONTAINMENT ACTIVITIES

Increasing Employee Financial Participation

- Adding or increasing payroll deductions and deductibles were the activities implemented most often in increasing employee financial participation.

- Adding or increasing co-payments and reducing benefits were activities implemented least often.

- Less than 10% of the employers implemented activities increasing employee financial participation in any single category.

Changing or Limiting Employee Option

- Changing health plans was the most popular group of activities implemented to contain health care costs. Adding PPOs, self-insuring and joining JPAs were major activities that were implemented.

- The data indicated that many employers were taking advantage of the competitive nature of the health care marketplace and were changing to less costly plans, self-insuring and joining JPAs.

Utilization Review and Negotiating Discounted Rates

- Increasing utilization review was a major activity among employers, with pre-admission and concurrent review being implemented most often.

- 10% of all employers reported implementing physicians services review and post-services audit.

- Negotiating discounted rates with both hospitals and physicians were significant activities implemented. More employers reported negotiating rates with hospitals than with physicians.

Second Opinion for Surgery

- Both mandatory and elective second opinion for surgery were significant activities implemented, with more plans requiring mandatory rather than elective second opinions.

Alternative Treatment Settings

- Implementation of home care services was the most significant alternative health service activity implemented. More than 7% of the plans implemented both surgi-center and hospice services.

Employment Assistance Programs

- Alcohol and substance abuse programs were the most frequent preventive health service programs implemented.

- Chronic disease management, risk assessment and smoking cessation were the least implemented programs.

Other

- Cash incentives for spousal insurance coverage and participation in health care cost containment organizations were not major activities implemented.

DEVELOPMENT AND IMPLEMENTATION OF THE SURVEY

A survey team was brought together to analyze the surveys of the two previous years in order to simplify and redraft the 1986 survey. The survey team consisted of Gordon Rude, Dr. Paul O'Rourke, Karon Hart and Rita Lugo.

Upon completion of the redrafting process, the team felt very confident in the questionnaire and decided that a pre-test of the questionnaire was not necessary. This confidence was born out during the editing phase since fewer follow-up calls were required to complete the questionnaires than had been required in the previous years.

The questionnaires were mailed in August of 1986, followed by a reminder letter in September. Editing and encoding into PERB's IBM System 34 were completed in December of 1986.

RESPONSE TO THE SURVEY

The survey[1] was sent to 1,871 local public agencies of which 671 or 36% responded. The 36% responding employed 38% of the local publicly employed population in California. This response constitutes our 1986 data base.

Number and Percent of Employers by Type of Employer

Type of Employer	*Number of Public Employers In California	Number Of Public Employers Surveyed	Number of Public Employers Responding To Survey	Percent Of All Public Employers Responding To Survey	Percent Of Employers Surveyed Responding To Survey
City	436	436	196	45%	45%
County	58	58	33	57%	57%
School Dists.	1,177	1,177	366	31%	31%
Special Dists.	1,812	200	76	4%	38%
OVERALL	3,483	1,871	671	19%	36%

[1]See Appendix 1 for survey format.

* - Based on 1985 data. There was a small increase in public employers in 1986 which is not reflected in this table.

Number and Percent of Employees
by Type of Employer

Type of Employer	Number of Employees In California	Number of Employees Covered By Survey	Percent of Employees Covered By Survey
City	202,000	72,894	36%
County	237,200	175,510	74%
School Districts	622,500	192,210	31%
Special Districts	95,500	4,660	5%
OVERALL	1,157,200	445,274	38%

Distribution of Employees[2]
by Size of Emplcyer

Size of Employer	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	323	12,090	37	32
101-200	93	13,560	146	141
201-500	124	40,074	323	310
501-1,000	65	44,250	681	602
1,000-10,000	61	168,447	2,761	1,686
10,001 +	5	166,853	33,371	28,032
OVERALL	671	445,274	664	112

[2]See Appendices for additional analysis of response distribution.

Conclusion:

- The Employment Development Department of California estimates that there were approximately 1,157,200 public employees of local schools, cities, counties and special districts in California in 1986 (these estimates exclude state and federal employees).

- The survey represents 38% or 445,274 of the local public employees in California.

- The follow-up and editing procedures gave us accurate, reliable and consistent survey information.

- The size and distribution of the response to the survey permitted us to generalize about all public employers and employees in California.

HEALTH CARE COSTS FOR PUBLIC EMPLOYEES

The total cost of health care for public employees in California is a combination of the amount the employer contributes toward the employee's health benefit plan, the employee contribution toward the health plan, the actual out-of-pocket expense paid by the employee for deductibles, co-payments and coinsurance, and expenditures for health benefits not covered in the health service plan.

Employer Contribution to the Health Plan	+	Employee Contribution to the Health Plan	+	Employee Payments for Deductibles, Co-payments, Coinsurance and Benefits Not Covered in Health Benefits Plan	=	Total Health Care Cost

This survey was <u>not</u> designed to determine the total amount expended for public employees' health care in California. To do so would require a level of research far beyond the Board's capacity since it would have to include actual expenditures made by public employees on deductibles, co-payments, coinsurance and benefits not covered in health plans.

What the survey does provide is an accurate assessment of the employers' contribution to health premiums, as well as identification of the extent to which coinsurance, deductibles and co-payments exist in public employee health plans. This survey was confined to medical/hospital benefits and did not address dental, vision and workers' compensation benefits.

EMPLOYER CONTRIBUTION TO HEALTH PLANS

The average cost per employee for public employers in California was $1,996 per year. There was a variation in average cost by employer type and size and health plan type.

Average Annual Cost of Employer Contribution[3]
Per Employee by Type of Employer

Type of Employer	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
CITY	$2,216	$2,108
COUNTY	$1,699	$1,776
SCHOOL DISTRICT	$2,178	$2,265
SPECIAL DISTRICT	$2,204	$2,005
STATEWIDE AVERAGE	$1,996	$2,164

Average Annual Cost of Employer Contribution
Per Employee by Size of Employer

Type of Employer	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	$2,234	$2,209
101-200	$2,119	$2,164
201-500	$2,236	$2,204
501-1,000	$2,130	$2,120
1,001-10,000	$1,822	$1,979
10,000 +	$2,051	$2,133
STATEWIDE AVERAGE	$1,996	$2,164

[3]See Appendices for additional analysis of employer contribution by size and type of employer.

Conclusion:

- Local government expended approximately $2.309 billion on health care benefits for its employees in 1986 at an average cost of $1,996 per employee per year.

- County employers had the lowest cost per employee per year followed by school districts, special districts, and cities, respectively.

- There was a difference of $517 in the employer contribution between the lowest (counties) and highest (cities) employers.

- Employers who employed between 1,001-10,000 employees paid the least ($1,822) for health benefits per employee while employers who employed between 201-500 employees paid the most ($2,236).

- There was a difference in the employer contribution of $414 per employee per year between the 1,001-10,000 size employer and the 201-500 size employer.

ENROLLMENT AND COSTS FOR DIFFERENT TYPES OF HEALTH PLANS

The study assessed the percent and number of enrollees by health plan type and the average and median contribution by the employer per employee per year. The following comparison is by health plan type.

The following definitions describing health plan types are quoted from the questionnaire:

> HMO - A health maintenance organization (HMO) provides health benefits through a selected group of providers and is financially at risk for providing benefits.
>
> An HMO may be a staff model HMO, such as Kaiser, or an independent practice association (IPA) in which providers have agreed to participate in the HMO.
>
> PPO - A preferred provider organization (PPO) is an arrangement in which a group of providers have entered into a contractual agreement to provide services to a sponsoring entity at a negotiated discounted rate. Employees who use PPO providers usually pay lower rates, or have no co-payments or deductibles. Employees may use other providers but they usually have to pay co-payments and/or deductibles. Insurers may offer PPO plans such as the Blue Cross Prudent Buyer Plan and the Blue Shield Preferred Plan.
>
> Self-insuring organizations that are single entities, joint powers agreements or trusts, may also negotiate discounts with some or all of the providers that provide health benefits for their employees. They may directly negotiate the discounts or a third party may negotiate the discounts on their behalf, or a provider, or group of providers, may offer the discounts.
>
> For the purposes of this question, if any providers have negotiated discounted rates through an insurer, directly, through a third party, or through an offering of local providers, then the health plan type is a PPO.
>
> BC/I or BS/I - Blue Cross and Blue Shield offer a diverse array of health plans and services. BC/I or BS/I refer only to those health plans where Blue Cross or Blue Shield assumes the actuarial risk of paying for health benefits of employees and pays the community rate for physician services and actual charges for hospital care.
>
> Blue Cross also offers the Prudent Buyer Plan and Blue Shield offers the Preferred Plan which are preferred provider organization plans (PPOs). For the purpose of this question, DO NOT USE the BC/I or BS/I designation if your plan is the Blue Cross Prudent Buyer Plan or the Blue Shield Preferred Plan.

Blue Cross and Blue Shield also administer the health benefits programs of organizations that are self-insured through contractual agreement with the organization. The employee usually retains the Blue Cross or Blue Shield card, but the self-insuring organization assumes the actuarial risk for health benefits for employees. DO NOT USE the BC/I or BS/I designation if Blue Cross or Blue Shield is only administering your self-insured plan through an administrative services only, ASO, contract.

I - An indemnity insurance plan is a plan in which the insurer assumes the risk of paying health benefits for employees and dependents. The employer pays the insurer a premium for this function and the insurer pays providers on a fee-for-service/cost reimbursement basis.

SI/I - For the purposes of this question, a self-insured indemnity plan is a plan in which your organization assumes the actuarial risk of paying for employee health benefits, but continues to use an insurer for administrative services. If a self-insured indemnity has negotiated rates, it should be recorded as a PPO.

Number of Plans/Enrollees
Percent of Enrollees and Employer Contribution
by Type of Plan

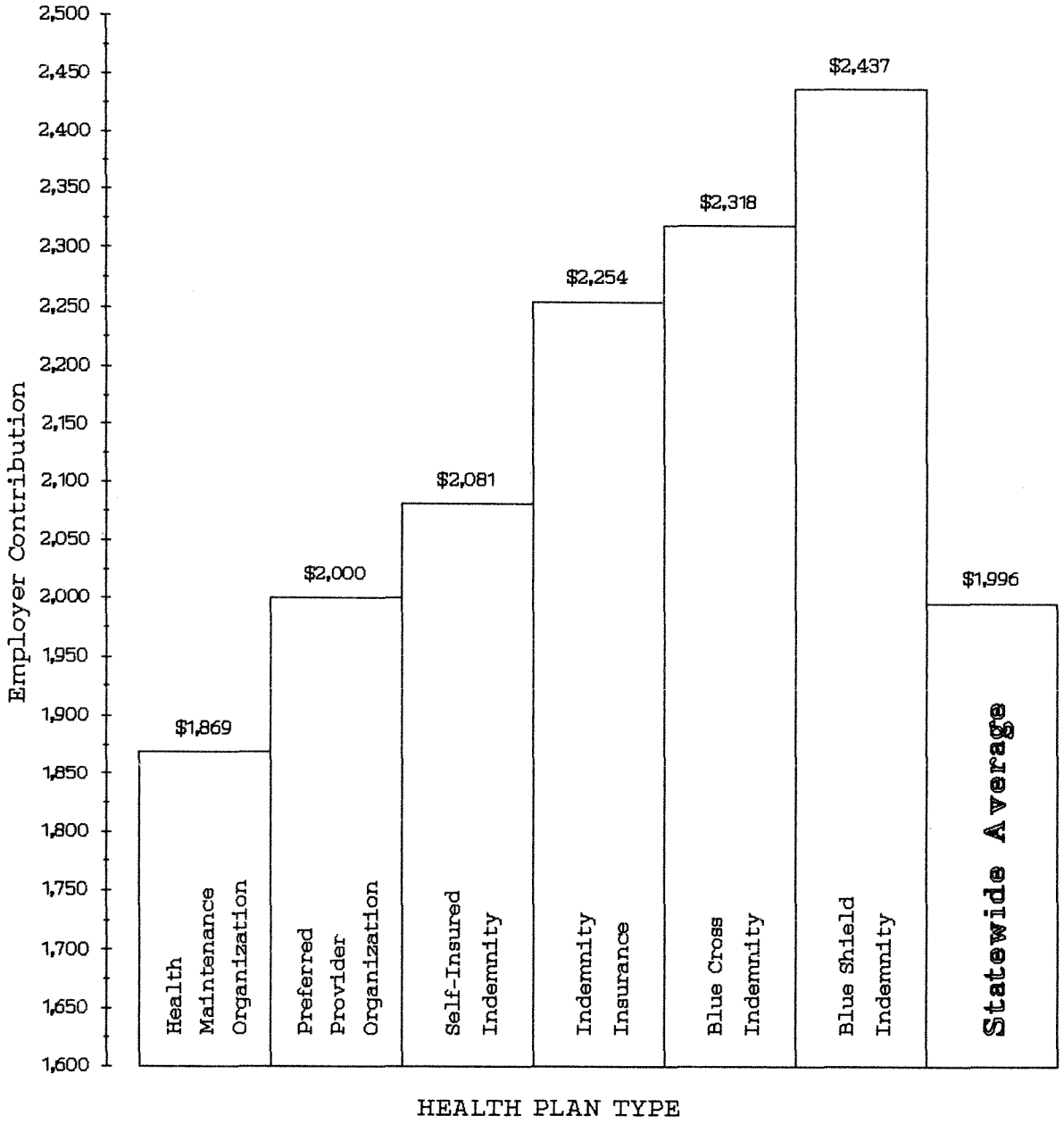
Plan Type	Number of Plans	Number of Enrollees	Percent of Enrollees	Average Employer Contribution Per Enrollee	
HMO	621	217,711	50.28%	$1,869	
PPO	297	85,176	19.67%	$2,000	
SI/I	127	86,549	19.99%	$2,081	
I	120	16,771	3.87%	$2,254	
BC/I	155	17,117	3.95%	$2,318	
BS/I	72	9,674	2.23%	$2,437	
	1,392*	432,998**	99.99%	$1,996	STATEWIDE AVERAGE

* - Number of plans exceeds the number of employers because most employers offer more than one plan.

** - Number of enrollees is less than total number of employees covered by the survey because some employers offer more than four plan options.

AVERAGE ANNUAL EMPLOYER CONTRIBUTION

PER ACTIVE EMPLOYEE BY HEALTH PLAN TYPE



HEALTH MAINTENANCE ORGANIZATION (HMO)

Employers expended $1,869 per employee per year on employees enrolled in HMO plans. This was less than any other health plan type and $127 per employee per year below the statewide average. This study confirmed that HMOs, when they are available, continued to be the least expensive health care delivery mechanism.

HMOs were also the health plan type in which most public employees (50.28%) were enrolled. This high level of enrollment contributed significantly to lower the statewide average cost per public employee per year. Individual employers with high HMO enrollment levels had less total expenditure for health benefit programs.

PREFERRED PROVIDER ORGANIZATION (PPO)

With an average expenditure of $2,000 per employee per year, PPO plans were the second least expensive health plan type offered by employers. This was very close to the statewide average of $1,996 per employee per year.

Nearly 20% (19.67%) of the enrollees covered by this survey were in some type of PPO arrangement in which discounts had been negotiated with health care providers.

SELF-INSURED/INDEMNITY (SI/I)

SI/I plans in which the employer assumes the actuarial risk for service was the third least expensive health plan type with an average expenditure at $2,081 per employee per year. SI/Is and PPOs were closer in employer expenditure, with only an $81 per employee per year difference, than other health plan types and about the same number of employees were enrolled in SI/Is (19.99%) as were enrolled in PPOs (19.67%).

INDEMNITY INSURANCE (I)

I plans were fourth in order of least expensive to most expensive and were exceeded in employer expenditure per employee per year only by BC/I and BS/I plans. Employers expended an average of $2,254 per employee per year for I plans and less than 4% of all employees were enrolled in such plans.

BLUE CROSS AND BLUE SHIELD INDEMNITY (BC/I and BS/I)

BC/I and BS/I plans were the most expensive health plan types with an average employer expenditure per employee per year of $2,318 and $2,437 respectively. However, less than 4% of all employees were enrolled in BC/I plans; slightly more than 2% were enrolled in BS/I plans.

Conclusion:

- Half of all employees (50.28%) were enrolled in HMO plans. HMOs were the health plan type in which the employer had the lowest average annual contribution per employee per year, $1,869.

- The magnitude of the enrollment in HMO plans (which were the lowest cost health plan type) had substantially reduced the statewide average employer cost. It was also the only health plan type in which the average employer cost was below the statewide average.

- PPO and SI/I plans were relatively equal in both employer contribution and level of enrollment.

Plan Type	Employer Contribution Per Employee Per Year	Percent Enrolled
PPO	$2,000	19.67%
SI/I	$2,081	19.99%

- PPO and SI/I plans were respectively $131 and $212 greater in employer contribution per employee per year than HMO plans.

- Only 10% of all public employees represented by the survey were enrolled in indemnity insurance or traditional BC/I and BS/I plans. These were the health plan types in which the employer contribution per employee per year was the greatest.

Plan Type	Employer Contribution Per Employee Per Year	Percent Enrolled
I	$2,254	3.87%
BC/I	$2,318	3.95%
BS/I	$2,437	2.23%

- There was a $568 difference in the employer contribution per employee per year between the health plan type with the lowest average cost (HMO) and the health plan type with the highest average cost (BS/I).

EMPLOYEE COSTS

Employee costs for health benefits include all of the costs for health care not covered by the employer. Employee costs may be out-of-pocket expenditures for health benefits, services and products not covered in the employee health plan that require employee financial participation through coinsurance, deductibles and co-payments.

Financial participation by the employee in the plan is usually viewed by the employer as a method of creating employee awareness regarding the cost of the health benefits, as an incentive for the employee not to over-utilize services, and as a mechanism to reduce employer costs.

Employee organizations view required financial participation in the health plan as a cost-shift from the employer to the employee.

The following is an analysis of the employers' contribution by plan type using coinsurance, deductibles, co-payments and premium contribution as available. No attempt was made to determine the employees' level of required financial participation. However, we did denote when some level of coinsurance, deductible, co-payment, or premium contribution was required.

COINSURANCE

Coinsurance refers to an arrangement in which the employee is responsible for a stated percentage of charges billed by the provider with the insurer paying the balance. For example, the insurer may pay 80% of the hospital bill and the employee is responsible for the remaining 20%. There are many variations of coinsurance which can be structured to meet purchaser needs. Coinsurance shifts a portion of premium costs to employees without reducing benefits.

Comparison of Employer Contribution
by Coinsurance Requirements* and Health Plan Type

Plan Type	Coinsurance Not Required	Coinsurance Required	Difference In Employer Costs When Coinsurance Is Required
HMO**	$1,872	$1,739	$ - 133
PPO	$2,282	$1,904	$ - 378
SI/I	$2,205	$2,049	$ - 156
I	$2,357	$2,241	$ - 116
BC/I	$2,469	$2,248	$ - 221
BS/I	$2,622	$2,403	$ - 219

* - The level of benefit coverage and coinsurance arrangements are unknown.

** - 37 employers reported that 40 HMO plans, with a total of 5,373 employees enrolled, required coinsurance. Most HMOs do not require coinsurance.

Number and Percent of Employees Enrolled In Plans
by Coinsurance Requirement

Plan Type	Coinsurance Required: Number of Enrollees In Plan	Coinsurance Required: Percent of Enrollees In Plan	Coinsurance Not Required: Number of Enrollees In Plan	Coinsurance Not Required: Percent of Enrollees In Plan
HMO	5,373	2.5%	212,338	97.5%
PPO	63,562	74.6%	21,614	25.4%
SI/I	68,718	79.4%	17,831	20.6%
I	14,836	88.5%	1,935	11.5%
BC/I	11,646	68.0%	5,471	32.0%
BS/I	8,150	84.2%	1,524	15.8%
Total	172,285	39.8%	260,713	60.2%
- HMO*	- 5,373		- 212,338	
	166,912	77.5%	48,375	22.5%

* - HMOs were eliminated since 97.5% did not require coinsurance.

Conclusion:

- When coinsurance was required, employers spent less per employee per year for every health plan type. Reductions ranged from $116 to $378 per employee per year, depending on health plan type.
- Of all employees not enrolled in an HMO, 77.5% had a coinsurance requirement.

DEDUCTIBLES

A deductible is the amount paid by the employee before the health care coverage of the plan begins to pay. For example, some plans have a $200 deductible for non-hospital benefits (i.e. ambulatory care). This means that the employee must pay $200 during the year for non-hospital benefits, such as doctor office visits, before the plan will begin to pay for non-hospital benefits.

A deductible may be required regardless of coinsurance or co-payment requirements. HMOs do not usually require deductibles.

Comparison of Employer Contribution
by Deductible Requirements and Health Plan Type

Plan Type	Deductible Not Required	Deductible Required	Difference In Employer Costs When Deductible Is Required
HMO	$1,873	$1,675	$ - 238
PPO	$2,357	$1,931	$ - 426
SI/I	$2,217	$2,052	$ - 165
I	$2,540	$2,248	$ - 292
BC/I	$2,187	$2,335	$ + 148
BS/I	$2,636	$2,426	$ - 210

Number and Percent of Employees Enrolled In Plans
by Deductible Requirement

Plan Type	Deductible Required: Number of Enrollees In Plan	Deductible Required: Percent of Enrollees In Plan	Deductible Not Required: Number of Enrollees In Plan	Deductible Not Required: Percent of Enrollees In Plan
HMO	3,909	1.8%	213,802	98.2%
PPO	71,426	83.9%	13,750	16.1%
SI/I	71,382	82.5%	15,167	17.5%
I	16,414	97.9%	357	2.1%
BC/I	15,240	89.0%	1,877	11.0%
BS/I	9,136	94.4%	538	5.6%
Total	187,507	43.3%	245,491	56.7%
- HMO*	- 3,909		213,802	
	183,598	85.3%	31,689	14.7%

* - HMOs were eliminated since 98.2% did not require a deductible.

Conclusion:

- When a deductible was required, employers spent less per employee per year for every health plan type, with the exception of 17 employers who had BC/I plans. Excluding BC/I plans, the reductions ranged from $165 to $426 per employee per year, depending on health plan type.

- Of all employees not enrolled in an HMO, 85.3% had a deductible requirement.

CO-PAYMENTS

A co-payment is an amount paid by the employee as partial payment for a specified service. For example, if the doctor's office visit is $25 and the employee is required to make a $5 co-payment toward the visit, then the health plan will pay the other $20.

A co-payment may be required independent of requirements for coinsurance or deductibles.

Comparison of Employer Contribution
by Co-Payment Requirements and Health Plan Types

Plan Type	Co-Payment Not Required	Co-Payment Required	Difference In Employer Costs When Co-Payment Is Required
HMO	$1,893	$1,851	$ - 42
PPO	$1,921	$2,508	$ + 587
SI/I	$2,026	$2,556	$ + 530
I	$2,219	$2,438	$ + 219
BC/I	$2,263	$2,424	$ + 161
BS/I	$2,315	$2,732	$ + 417

Number and Percent of Employees Enrolled In Plans
by Co-Payment Requirement

Plan Type	Co-Payment Required		Co-Payment Not Required	
	Number of Enrollees In Plan	Percent of Enrollees In Plan	Number of Enrollees In Plan	Percent of Enrollees In Plan
HMO	126,515	58.1%	91,196	41.9%
PPO	11,477	13.5%	73,699	86.5%
SI/I	9,004	10.4%	77,545	89.6%
I	2,726	16.3%	14,045	83.7%
BC/I	5,921	34.6%	11,196	65.4%
BS/I	2,835	29.3%	6,839	70.7%
Total	158,478	36.6%	274,520	63.4%

Conclusion:

- For all health plan types, excluding HMOs, the waiving of the co-payment requirement resulted in employers expending from $161 to $587 less per employee per year, depending on health plan type. This reduction was associated with the emergence of competitive health benefit plans in the fee-for-service sector, particularly the growth of PPOs. In such competitive plans, the waiving of the co-payment is an important marketing tool. Since more employees are enrolling in PPOs and other competitive plans, the data reflected employer savings in fee-for-service plans when co-payments were not required.

- The exception was for HMOs that use co-payments to increase revenue. Since HMOs were the least costly of health plans for both the employer and employee, the co-payment requirement has remained as a source of revenue for the HMOs. Employees continue to enroll in HMOs at a high rate.

PREMIUM CONTRIBUTIONS

Premium contribution is the amount that the employee contributes to the health plan premium. The employee's contribution is in addition to the employer's contribution and together constitute the cost of the premium.

Premium contribution may be utilized with any health plan type and is independent of deductibles and co-payments.

This survey did not attempt to determine the level of employee contribution to the premium.

Comparison of Employer Contribution
by Premium Contribution Requirements and Health Plan Type

Plan Type	Premium Contribution Not Required	Premium Contribution Required	Difference In Employer Costs When Premium Contribution Is Required
HMO	$1,927	$1,553	$ - 374
PPO	$2,013	$1,950	$ - 63
SI/I	$2,146	$1,957	$ - 189
I	$2,314	$2,087	$ - 227
BC/I	$2,441	$2,064	$ - 377
BS/I	$2,676	$1,962	$ - 714

Number and Percent of Employees Enrolled In Plans
by Premium Contribution Requirement

Plan Type	Premium Contribution Required		Premium Contribution Not Required	
	Number of Enrollees In Plan	Percent of Enrollees In Plan	Number of Enrollees In Plan	Percent of Enrollees In Plan
HMO	33,878	15.6%	183,833	84.4%
PPO	17,871	21.0%	67,305	79.0%
SI/I	29,717	34.3%	56,832	65.7%
I	4,418	26.3%	12,353	73.7%
BC/I	5,568	32.5%	11,549	67.5%
BS/I	3,233	33.4%	6,441	66.6%
Total	94,685	21.9%	338,313	78.1%

Conclusion:

- It had been a usual practice that employers paid the total cost of the lowest cost health plan and the employee paid the difference if another plan is selected. This usually had meant that the employer paid the full cost of the HMO. The data indicated that this practice is changing so that the employer contribution is no longer fixed to the lowest cost plan.

- Requiring employees to contribute to the premium cost reduced employer costs in all health plan types. Reductions in employer costs ranged from $63 to $714 per employee per year, depending on health plan type.

- HMOs were the lowest cost health plan type for employers when a premium contribution was required. The health plan cost was $1,553 per employee per year, which was the lowest cost health plan type. For HMOs, the employer cost was $1,927 per employee per year when a premium contribution was not required.

- BS/I was the health plan type with the greatest variation in average cost, with a cost of $714 more per employee per year for the plan when a premium contribution was not required.

- 78.1% of all employees were enrolled in plans which did not require premium contributions.

TYPES OF SPONSORING ENTITIES

The four types of sponsoring entities in local public agencies through which health benefits are provided to employees are the PERS, JPAs, health benefits trust funds and single entities.

The PERS provides the option for local public agencies to participate in the health benefits program of the system through a buy-in provision established by state statute. Employees can choose from a number of health plans offered through PERS.

A JPA is an agreement between local government authorities who join together to perform a common function such as the purchasing of health benefit coverage.

A health benefits trust fund is a formal agreement entered into by the employer and employee organization for the purpose of administering health care benefits for employees. A health benefits trust fund usually has representation from both the employer and the employees or employee organization on the governing body, although the fund may be administered by an employer, employee organization or a third party. The governing body determines how benefits are to be provided and by whom.

A single entity is any public agency that administers its health benefits program for employees and has not entered into a JPA, trust or the PERS program.

Sponsoring Entity
for Health Plan Benefits
Among Public Employers in 1986

Type of Entity	Number of Employers*	Number of Employees*
Single Entity	366	374,519
Joint Powers Agreement	175	37,689
Health Benefits Trust	23	3,673
PERS - Health Benefit Program	52	5,880

* - 55 or 8% of the employers with 23,513 or 5.3% of the employees covered by this survey are not included in this analysis because they had more than one sponsoring entity for health benefits coverage.

Type of Health Plan by Sponsoring Entity

Single Entity		Joint Powers Agreement	
Health Plan Type	Number of Plans	Health Plan Type	Number of Plans
HMO	350	HMO	78
PPO	112	PPO	105
SI/I	58	SI/I	51
I	77	I	7
BC/I	94	BC/I	30
BS/I	50	BS/I	4

Health Benefits Trust		PERS	
Health Plan Type	Number of Plans	Health Plan Type	Number of Plans
HMO	8	HMO	106
PPO	12	PPO	34
SI/I	3	SI/I	1
I	3	I	20
BC/I	3	BC/I	5
BS/I	0	BS/I	18

Conclusion:

- An individual public agency (single entity) was the sponsoring entity in which the employer paid the least per employee per year ($1,963). It was also the largest of the sponsoring entity types, with 366 employers and 374,519 employees. Single entities offered a larger number of HMOs (350) and PPOs (112) than other sponsoring entities. The average employer size was over 1,000 employees per employer.

- JPAs were the second least expensive sponsoring entity, with $2,089 spent per employee per year, and the second largest sponsoring type, with 175 employers and 37,689 employees. JPAs offered more PPOs than HMOs. Their average employer size was slightly over 200 employees per employer.

- The sample size for health benefits trust funds and PERS were too small to be reliable in terms of average costs per employee per year. The sample size was approximately 2%. Our anecdotal evidence suggested that there has been a great deal of activity in this area.

- A study specific to health benefits trust funds and JPAs in regard to health plan options offered and comparative costs per employee per year would provide a comparison which is valid. This survey did not serve this particular purpose.

SELF-INSURANCE

The survey defined "self-insured" as an organization that has assumed the actuarial risk for paying for the health benefits of employees. Under this definition an organization could be a single entity (employer), a participant in a JPA or a health benefits trust fund and be self-insured.

Comparison of Self-Insured and Insured Public Employers

Organizations become self-insured primarily because of:

- savings generated as a result of not being required to pay a premium tax as do commercial insurers;
- interest and investments earned on reserves that are held to pay premiums (i.e., retaining the profit that insurers traditionally make);
- a reduction in administrative costs and greater control over administration and cash flow.

The following chart compares the cost per employee per year between insured and self-insured organizations regardless of health plan type. The averages are based on an average cost calculated from the total reported costs of health plan types divided by the number of enrollees in each plan type.

It is important to note that the average cost per employee per year for self-insured organizations does not take into account organizational savings that may have accrued as a result of earned interest and/or reductions in administrative costs, if any.

	Self-Insured Employers	Insured Employers
Number of Employers	271	400
Number of Employees	214,931	230,343
Total Average Cost Per Employee Per Year	$2,032	$1,962

In the strictest definition, a self-insuring organization assumes the complete actuarial risk by establishing its own indemnity plan and pays for the health services of all employees on a fee-for-service basis. In practice, many self-insured organizations purchase health services for their employees by purchasing a health benefit plan on their behalf. In this instance, the purchased plan is actuarially at risk.

In some organizations, a self-insured plan is established for some, but not all, of the employees. In these cases, the organization is partially self-insured and at risk.

This project did not collect data that enabled the researchers to determine why HMOs and PPOs cost more for self-insured organizations than insured organizations.

Health Plan Types Utilized by Self-Insured and Insured Employers in 1986

Plan Type	Self-Insured* Employers			Insured Employers		
	Number of Plans	Number of Enrollees	Average Cost Per Employee	Number of Plans	Number of Enrollees	Average Cost Per Employee
HMO	174	85,513	$1,939	447	132,198	$1,823
PPO	136	35,123	$2,084	161	50,053	$1,940
SI/I*	126	86,429	$2,080	--	--	--
Fee-For-Service** Indemnity (I, BC/I, BS/I)	47	6,419	$2,427	300	37,143	$2,302
	483	213,484***		908	219,394	
Number of Employees in BC/I, BS/I, & I		6,419			37,143	
Percent of Employees in BC/I, BS/I, & I		3.0%			16.9%	

* - One employer (120 employees) responded incorrectly to this section. Therefore, the number of employers/employees does not equal the total numbers for plans/enrollees.

** - Analysis of the 3% of the employees enrolled in BC/I, BS/I and I plans indicate a variety of arrangements: the sponsoring agency is partially self-insured and also offers other health plan options or uses its insurance pool dollars to purchase indemnity plans.

*** - Total number of enrollees does not equal total number of self-insured employees because some employers offer more than four plan options.

Conclusion:

- The number of self-insured employers was considerably lower than the number of insured employers, 271 compared to 400. However, the percentage of employees was relatively equal between self-insured (48%) and insured (52%) employers.

- The insured employers do not offer SI/I plans as an option. Instead, they rely more heavily on HMO and PPO enrollment to contain cost. The large enrollment in HMOs and PPOs, which cost less in for insured employers than the self-insured employers, accounted for the lower average cost per employee per year for insured employers (i.e., $1,962 per employee per year for insured employers as compared to $2,032 for self-insured employers).

- Self-insured employers covered 40% of their employees in SI/I programs, purchased HMOs for 40% of their employees, PPOs for 16% of their employees, and BC/Is, BS/Is or Is for 3% of their employees.

- HMOs purchased for employees by the self-insuring plans cost employers less than any other self-insured health plan type, $1,939 per employee per year. Purchased PPOs and the SI/I plans cost the employer virtually the same per employee per year, $2,084 and $2,080, respectively.

- Employers with insured health benefit programs reported 60% of their employees enrolled in HMOs, 23% in PPOs, and 17% in BC/Is, BS/Is or Is.

- The annual average cost for nonself-insured employers offering HMOs and PPOs was $1,823 per employee per year and $1,940 per employee per year, respectively. BC/Is, BS/Is and Is ranged $393 to $675 more than HMOs per employee per year.

ADMINISTRATIVE ARRANGEMENTS OF SELF-INSURED EMPLOYERS

Four kinds of administrative arrangements of a self-insured organization were described:

Direct Self-Administration	--	the employer directly administers the health benefits fund and pays claims.
Administrative Services Only	--	the employer pays the insurer to administer the health benefits program and pays claims, although the insurer has no actuarial risk.
Third Party Administrator	--	A company is retained to administer the health benefits program and pay claims.
Other	--	Any arrangement not stated above.

Comparison of Administrative Arrangements of Self-Insured Employers*

	Direct Self-Administration	Administrative Services Only	Third Party Administrators
Number of Employers**	10	153	111
Number of Employees**	15,084	142,375	75,073
Average Cost Per Employee Per Year	$1,550	$2,118	$1,911

* - Only 1 employer had an "other" arrangement

** - Three employers had a multiple response which represents 17,601 employees.

Conclusion:

- Employers expended less per employee per year by directly administering self-insured programs or using a third party administrator, rather than using an administrative services only contract with an insurer.

- The average size of the employer who directly administers the self-insurance program was 1,508 employees, third party administrator arrangements averaged 676 employees, and administrative services only averaged 930 employees.

- The number of employees covered in the administrative arrangements were: administrative services only, 61%; third party administrators, 32%; and, direct self-administration, 7%.

COST CONTAINMENT ACTIVITIES

Employers were asked to report on cost containment activities that were implemented in 1986. The list of cost containment alternatives was compiled from alternatives undertaken or proposed by a variety of employers, employee organizations, health care providers, health economists and consultants, and others. Although there is considerable disagreement about the appropriateness or effectiveness of the alternatives among interested parties, the intent of the survey was to objectively determine what alternatives were being considered in 1986 without regard to appropriateness or effectiveness.

The survey made inquiries on the use by employers of 35 activities considered to have an impact on lowering the cost of employees' group health insurance plans.

Since employers usually offer more than one plan option, the cost containment activities reported do not necessarily apply to every plan option offered by an employer.

Percentages reported for each cost containment activity apply to the number of employers who have implemented an activity, not numbers of health plan options affected by a given activity.

INCREASING EMPLOYEE FINANCIAL PARTICIPATION

Reduce benefits

A benefit may be for a health service that is provided in a health care plan such as coverage for hospital care, physician care, hearing and vision screening, etc. A benefit may also be a product other than a service such as medical appliances, prescription drugs, hearing aids, dentures, glasses, etc. This question refers to reducing or eliminating a health care service or product. "Reducing benefits" in this question does not include requiring additional employee contributions to the plan, increasing deductibles or co-payments, or reducing the employers contribution to the plan.

Add or increase employee contributions to health plan premiums (Payroll Deduction

Payroll deduction is a deduction from the employee's check to pay for part of the health plan premium. Health plans refer to insurers such as Travelers, Cal-Western, Blue Cross/Shield, etc. or health maintenance organizations such as Kaiser Health Plan or other group of providers whose services are paid for through a premium. Premium means the amount paid on a periodic, usually monthly, basis for coverage of specified health benefits. Adding or increasing the employee contribution means that the employee would pay a greater percentage toward the premium than is now paid.

Co-Insurance

For purposes of this survey, co-insurance refers to an arrangement in which the employee is responsible for a stated percent of billed charges of the provider with the insurer paying the balance. For example, the insurer may pay 80% of the hospital bill and the employee is responsible for the remaining 20%.

Add or increase deductibles

A deductible is the amount paid by the employee before the health care coverage of the plan begins to pay. For example, some plans have a $200 deductible for non-hospital benefits (i.e., ambulatory care). This means that the employee must pay $200 during the year for non-hospital benefits, such as doctor office visits, before the plan will begin to pay for non-hospital benefits. Adding or increasing deductibles would mean that the employee would pay a greater amount for health services before the plan would begin to pay.

Add or increase co-payment

A co-payment is an amount paid by the employee as partial payment for a service. For example, if a doctor's office visit is $25 and the employee is required to make a $5 co-payment toward the office visit, then the health plan will pay the other $20. Adding or increasing a co-payment would mean that the employee would have to pay a greater fee for each service.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
REDUCE BENEFITS	61.4%	10%	18.5%	4.3%	5.8%
ADD OR INCREASE EMPLOYEE CONTRIBU-TION TO HEALTH PLAN PREMIUMS (Payroll Deduc-tion)	52.3%	15.8%	14.5%	9.8%	7.6%
CO-INSURANCE	61.7%	8.3%	5.7%	5.7%	18.6%
ADD OR INCREASE DEDUCTIBLES	53.4%	16.2%	13.4%	6.9%	10.1%
ADD OR INCREASE CO-PAYMENT	74.1%	10.1%	8.9%	3.1%	3.7%

Conclusion:

- Adding or increasing payroll deductions and deductibles were the activities implemented most often when increasing employee financial participation.

- Adding or increasing co-payments and reducing benefits were activities implemented least often.

- Less than 10% of the employers implemented activities increasing employee financial participation in any single category.

CHANGING HEALTH PLANS

Change to less expensive health care plan but retain the same benefits, deductibles and co-payments

Health care plan in this question means health insurance companies, health maintenance organizations, self insurance, health benefits trust and other groups of providers for which health services are paid for through a premium. This question refers to changing to a less expensive plan without changing coverage. It is simply buying the same plan at a cheaper price from a different source.

Limit employee choice of health plan(s) for the purpose of reducing cost

Many employers permit at least two choices of health plans. This question refers to limiting the employees' choice in health plans to those plans that cost less. This could mean adding a new plan that costs less, changing to a plan that costs less, or eliminating an existing plan because of its high cost.

Add a Preferred Provider Organization as a plan option

PPO - For the purposes of this question, a Preferred Provider Organization is an arrangement in which a group of providers have entered into a contractual agreement to provide services at a discounted rate. For the purposes of this survey any health plan option that includes contracted providers, regardless of sponsorship or incentives or requirements for employees to use contracted providers, is defined as a preferred provider organization plan option.

Self-insurance

Self-insurance means the employer assumes the risk of the costs incurred for the health care of all eligible employees. In a self-insurance arrangement, health care funds are retained by the employer or trust.

Joint Powers Agreement

A joint powers agreement is an arrangement between local government authorities who join together to perform a common function such as the purchasing of health benefits coverage. Joint powers authorities may also be self-insured and/or self-administered.

Health benefits trust fund

A health benefits trust fund is a formal agreement entered into by the employer and employee organization for the purpose of administering health care benefits for employees. A health benefits trust fund usually has representation from both the employer and the employee organization on the governing body although the fund may be administered by an employer, employee organization or the third party administrator. The governing body determines how benefits are to be provided and by whom.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
CHANGE TO LESS EXPENSIVE HEALTH CARE PLAN BUT RETAIN SAME BENEFITS, DEDUCTIBLES AND CO-PAYMENTS	44.6%	24.3%	11.0%	8.8%	11.3%
LIMIT EMPLOYEE CHOICE OF HEALTH PLANS FOR THE PURPOSE OF REDUCING COSTS	70.5%	9.1%	4.6%	5.8%	10.0%
ADD A PREFERRED PROVIDER ORGANIZATION AS A PLAN OPTION	38.9%	20.4%	8.3%	18.8%	13.6%
SELF-INSURE	36.4%	13.6%	12.2%	13.3%	24.6%
JOINT POWERS AGREEMENT	41.9	13.4%	11.9%	14.2%	18.6%
ESTABLISH A HEALTH BENEFITS TRUST FUND	77.3	6.0%	9.1%	3.7%	3.9%

Conclusion:

- Changing health plans was the most popular of the activities implemented to contain health care costs. Adding PPOs, self-insuring and joining JPAs were major activities that were implemented.

- The data indicated that many employers were taking advantage of the competitive nature of the health care marketplace and were changing to less costly plans, self-insuring and joining JPAs.

UTILIZATION REVIEW

Pre-admission review

The attending physician must request and receive prior approval for all elective hospitalization or request authorization within 24 hours of hospitalization for an urgent or emergency admission. When request is made, the reviewers will either authorize the admission and assign the number of approved days for stay or deny medical authorization and recommend outpatient services.

Concurrent review

While the patient is hospitalized, nurses or other designated persons under the supervision of doctors periodically evaluate the hospital records to assure that the appropriate level of medical services is being provided (e.g., intensive care room vs. semi-private room). They also determine the appropriate date of discharge and, during this review, the pre-authorized length of stay many be either shortened or lengthened depending on the patient's medical condition.

Ancillary services review

This review occurs at the same time as concurrent review and evaluates the appropriateness of the hospital services that the patient receives, such as laboratory tests, x-rays, physical therapy, etc.

Physician services review

During concurrent review, the reviewers can also evaluate the appropriateness and necessity for the services that the attending physician(s) provides to the patient during the hospital stay.

Outpatient services review

This is a review of the appropriateness of physician, other professional health services, and ancillary and therapeutic services performed in an outpatient setting, such as a doctor's office, etc.

Post-Service Audit

After the patient is discharged an audit of the billed charges is made to determine accuracy and appropriateness of both services and charges. Decisions to pay, question or deny payment are made by the payer during this review.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
INCREASE UTILIZATION REVIEW THROUGH:					
PRE-ADMISSION REVIEW	50.2%	16.8%	3.3%	16.2%	13.4%
CONCURRENT REVIEW	57.2%	15.8%	3.1%	14.0%	9.8%
ANCILLARY SERVICES REVIEW	72.6%	13.6%	1.5%	6.7%	5.7%
PHYSICIANS SERVICES REVIEW	64.2%	15.6%	1.8%	10.0%	8.3%
OUTPATIENT SERVICES REVIEW	68.9%	15.6%	1.2%	7.6%	6.7%
POST-SERVICES AUDIT	65.0%	15.1%	1.3%	10.4%	8.2%

Conclusion:

- Increasing utilization review was a major activity among employers, with pre-admission and concurrent review being implemented most often.
- 10% of all employers reported implementing physicians services review and post-services audit.

NEGOTIATING DISCOUNTED RATES

Negotiate discounts

Discounts on the cost of health services can be negotiated with providers through contractual agreements. Such negotiations can occur directly between the employer or group of employers through a trust fund or JPA, or by using a preferred provider organization as a health plan option.

Negotiating discounted rates with hospitals

This question refers to negotiating discounted rates for hospital services.

Negotiating discounted rates with physician

This question refers to negotiating discounted rates for physician services.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
NEGOTIATE DISCOUNTED RATES WITH:					
HOSPITALS	59.8%	13.1%	2.4%	14.3%	10.4%
PHYSICIANS	62.6%	13.1%	1.9%	11.6%	10.7%

Conclusion:

- Negotiating discounted rates with both hospitals and physicians were significant activities implemented. More employers reported negotiating rates with hospitals than with physicians.

SECOND OPINION FOR SURGERY

Second opinion for surgery

A second opinion for surgery occurs after surgery has been recommended by a physician. The second opinion is from another physician.

Mandatory second opinion for surgery

This means that the employee is required to obtain a second opinion.

Elective second opinion for surgery

This means that the employee is not required to obtain a second opinion for surgery, but may do so under the health plan.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
MANDATORY SECOND OPINION FOR SURGERY	54.4%	21.0%	4.9%	11.2%	8.5%
ELECTIVE SECOND OPINION FOR SURGERY	57.2%	17.7%	4.9%	8.9%	11.2%

Conclusion:

- Both mandatory and elective second opinion for surgery were significant activities implemented, with more plans requiring mandatory rather than elective second opinions.

ALTERNATIVE HEALTH SERVICES

Surgi-center services

Surgi-centers are free-standing (not hospital) facilities in which surgery is performed. The surgery does not require an overnight stay in the facility and the patient returns home the same day.

Hospice services

Hospice services are health care and support services that are usually provided in the home, to terminally ill patients and their families. Hospice is an alternative to hospitalization or other institutional care for the terminally ill.

Home care services

Home care services include services provided by a visiting nurse, physical or other therapist, etc. The services may be for the purpose of chronic disease management, rehabilitation, or for a protracted illness or injury.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
SURGI-CENTER SERVICES	70.3%	12.4%	1.5%	7.6%	8.2%
HOSPICE SERVICES	73.2%	12.8%	.9%	7.3%	5.8%
HOME CARE SERVICES	66.2%	12.2%	.6%	10.0%	11.0%

Conclusion:

- Implementation of home care services was the most significant alternative health service activity implemented. More than 7% of the plans implemented both surgi-center and hospice services.

PREVENTIVE HEALTH SERVICES

Alcoholism abuse programs

Alcohol abuse programs refer to coordinated employer/community medical care programs for the treatment of alcoholism or alcohol abuse. The question does not refer to simple hospital insurance coverage for alcohol detoxification but to comprehensive community programs involving the employer, employee organization, community services, and inpatient and outpatient medical care services.

Substance abuse programs (excluding alcohol and nicotine)

Substance abuse programs refer only to substances such as heroin, cocaine, marijuana, amphetamines, etc. They are the same kind of programs as for alcohol abuse.

Smoking cessation programs

Smoking cessation programs are designed to assist the employee to stop using tobacco in any form, including smoking. Such programs may be conducted at the work site or in the community.

Nutrition and weight control programs

Nutrition and weight control programs are for the purpose of developing healthful nutritional habits and losing weight to prevent or control illness relating to poor nutritional habits. Such programs may be performed at the work site or in the community.

Chronic disease management programs

Chronic disease management programs are for individuals who have chronic illness such as diabetes or hypertension. They are usually coordinated as an adjunct to continuing medical management. Such programs may be conducted at the work site, in the community, or through health care support organizations such as visiting nurses.

Stress reduction programs

Stress reduction programs are for the purpose of improving the capacity of an individual to cope with stressful situations. The programs may take many forms and may be conducted at the work site or in the community.

Physical fitness programs

Physical fitness programs are for the purpose of increasing cardiovascular capacity as well as physical fitness. Such programs may be conducted at the work site or in the community.

Risk assessment programs

Risk assessment programs are for the purpose of determining health risks associated with employee behavior and physical/emotional status. The intent is to provide information, referral and follow-up services to correct problems. Most programs are conducted at the work site or by referral to community agencies.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
ALCOHOL ABUSE PROGRAM	55.4%	18.2%	1.6%	12.7%	12.1%
SUBSTANCE ABUSE PROGRAM (excluding alcohol and tobacco)	57.7%	18.2%	1.6%	11.6%	10.9%
SMOKING CESSATION PROGRAM	72.9%	16.4%	1.2%	5.4%	4.2%
NUTRITION AND WEIGHT CONTROL PROGRAM	69.9%	17.3%	1.3%	7.0%	4.5%
CHRONIC DISEASE MANAGEMENT PROGRAM	84.8%	11.5%	.4%	2.1%	1.2%
STRESS REDUCTION PROGRAM	61.1%	23.8%	.9%	8.8%	5.4%
PHYSICAL FITNESS PROGRAM	59.8%	24.7%	2.2%	8.5%	4.8%
RISK ASSESSMENT PROGRAM	69.9%	19.8%	.9%	6.0%	3.4%

Conclusion:

- Alcohol and substance abuse programs were the most frequent preventive health service programs implemented.
- Chronic disease management, risk assessment and smoking cessation were the least implemented programs.

CASH INCENTIVE FOR SPOUSAL INSURANCE COVERAGE

When both husband and wife are employed and both are covered by a family insurance policy, two employers pay for the same health coverage. This "double coverage" often results in one employee enrolling the family in one plan and other employee enrolling the family in another plan. The cash incentive program is one which pays a spouse a cash percentage of what a health plan would cost rather than paying for a health plan which represents "double coverage".

PARTICIPATE IN REGIONAL OR STATEWIDE HEALTH CARE COST CONTAINMENT ORGANIZATIONS

Participation in a county or statewide cost containment coalition that meets with other employers or employee organizations on a regular basis is an example of this activity.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
CASH INCENTIVE FOR SPOUSAL INSURANCE COVERAGE	88.4%	5.4%	2.2%	2.1%	1.9%
PARTICIPATE IN REGIONAL OR STATEWIDE HEALTH CARE COST CONTAINMENT ORGANIZATION	76.5%	12.5%	1.9%	4.8%	4.3%

Conclusion:

- Cash incentives for spousal insurance coverage and participation in health care cost containment organizations were not major activities implemented.

APPENDICES

APPENDIX 1

Public Sector Health Care Cost Containment
Data Base Survey
1985/1986

General Instructions

THIS SURVEY IS FOR THE PERIOD BEGINNING MAY 1, 1985, AND ENDING APRIL 30, 1986.

Please do not leave any blank spaces.

If the question does not apply to your organization, enter DNA (does not apply).

If a question is one in which you have no information and you are unable to obtain information enter IU (information unavailable).

1. Employer Name _____

2. Employer Address _____

   City _____ County _____ Zip _____

3. Name of person responsible for health benefits program _____

   Title _____

   Phone _____

4. Name of person completing survey _____

   Title _____

   Phone _____

5. Date _____

6. Average number of employees who received health care benefits between May 1, 1985 and April 30, 1986. 1985/1986 _____

   Employees includes all employees who receive health benefits from the employer but does not include retirees.

7. Total amount expended for health benefits for employees and their dependents (do not include retirees) by the employer between May 1, 1985 and April 30, 1986. 1985/1986 $_____

   This means total amount expended by the employer for health benefits, including contributions to premiums or total claims paid by self-insured organizations. It does not include dental or vision care or expenditures for retirees.

HEALTH PLAN TYPES

8. A health plan refers to any arrangement through which employees and dependents receive health care benefits.

   a. If you offer more than four health plans, please indicate.

      _____ yes _____ no

   b. Name all health plans available to employees (example: Blue Cross Prudent Buyer Plan, Kaiser Health Plan). If there are more than four plans available, list the four plans in which most employees are enrolled.

Plan #1	Plan #2	Plan #3	Plan #4
_____	_____	_____	_____

9. Type of health plan. Please indicate the type of plan by inserting the appropriate initials using those listed below.

Plan #1	Plan #2	Plan #3	Plan #4
_____	_____	_____	_____

HMO - A health maintenance organization (HMO) provides health benefits through a selected group of providers and is financially at risk for providing benefits.

An HMO may be a staff model HMO, such as Kaiser, or an independent practice association (IPA) in which providers have agreed to participate in the HMO.

PPO - A preferred provider organization is an arrangement in which a group of providers have entered into a contractual agreement to provide services to a sponsoring entity at a negotiated discounted rate. Employees who use PPO providers usually pay lower rates, or have no copayments or deductibles. Employees may use other providers but they usually have to pay copayments and/or deductibles. Insurers may offer PPO plans such as Blue Cross Prudent Buyer Plan and Blue Shield Preferred Plan.

Self-insuring organizations that are single entities, joint powers agreements or trusts, may also negotiate discounts with some or all of the providers that provide health benefits for their employees. They may directly negotiate the discounts or a third party may negotiate the discounts on their behalf, or a provider, or group of providers, may offer the discounts.

For the purposes of this question, if any providers have negotiated discounted rates through an insuror, directly, through a third party, or through an offering of local providers, then the health plan type is a PPO.

BC/I or BS/I - Blue Cross and Blue Shield offer a diverse array of health plans and services. BC/I or BS/I refers only to those health plans where Blue Cross or Blue Shield assumes the actuarial risk of paying for health benefits of employees and pays the community rate for physician services and actual charges for hospital care.

Blue Cross also offers the Prudent Buyer Plan and Blue Shield offers the Preferred Plan which are preferred provider organization plans (PPOs). For the purpose of this question, DO NOT USE the BC/I or BS/I designation if your plan is the Blue Cross Prudent Buyer plan or the Blue Shield Preferred Plan.

Blue Cross and Blue Shield also administer the health benefits programs of organizations that are self-insured through contractual agreement with the organization. The employee usually retains the Blue Cross or Blue Shield card, but the self-insuring organization assumes the actuarial risk for health benefits for employees. DO NOT USE the BC/I or BS/I designation if Blue Cross or Blue Shield is only administering your self-insured plan through an administrative services only, ASO contract.

I - An indemnity insurance plan is a plan in which the insurer assumes the risk of paying health benefits for employees and dependents. The employer pays the insurer a premium for this function and the insurer pays providers on a fee-for-service/cost reimbursement basis.

SI/I - For the purposes of this question, a self-insured indemnity plan is a plan in which your organization assumes the actuarial risk of paying for employee health benefits, but continues to use an insurer for administrative services. If a self-insured indemnity has negotiated rates it should be recorded as a PPO.

10. What was the average number of employees (do not include retirees) enrolled in each plan between May 1, 1985 and April 30,1986?

Plan #1	Plan #2	Plan #3	Plan #4
_____	_____	_____	_____

11. What was the total amount the employer contributed to each plan for employees between May 1, 1985 and April 30, 1986 (do not include retirees)?

Plan #1	Plan #2	Plan #3	Plan #4
_____	_____	_____	_____

EMPLOYEE FINANCIAL PARTICIPATION

12. a) Payroll Deduction for Premium Contribution - Check yes or no under which plan requires an employee contribution to the premium.

Plan #1	Plan #2	Plan #3	Plan #4
yes___ no___	yes___ no___	yes___ no___	yes___ no___

b) Coinsurance - For purposes of this survey, coinsurance refers to an arrangement in which the employee is responsible for a stated percent of billed charges of the provider with the insurer paying the balance. For example, the insurer may pay 80% of the hospital bill and the employee is responsible for the remaining 20%. Check yes or no if there is a provision for coinsurance.

Plan #1	Plan #2	Plan #3	Plan #4
yes___ no___	yes___ no___	yes___ no___	yes___ no___

c) Deductible - Check yes or no under which plan requires a deductible for medical and/or hospital care. If there is no deductible for the employee but there is a deductible for dependents, place (D) after the check.

Plan #1	Plan #2	Plan #3	Plan #4
yes___ no___	yes___ no___	yes___ no___	yes___ no___

A deductible is the amount an employee must pay before the health plan will pay. For example: a $200 deductible means the plan would require the employee to pay $200 out-of-pocket before the plan would begin to pay.

d) Co-payment - Check yes or no under which plan requires a co-payment for specific service such as a $5 co-payment for an office visit. If there is no co-payment for the employee but there is a co-payment for dependents, place (D) after the check.

Plan #1	Plan #2	Plan #3	Plan #4
yes___ no___	yes___ no___	yes___ no___	yes___ no___

TYPE OF SPONSORING ENTITY

13. Please indicate which type of sponsoring entity provides health benefits to your employees.

PERS___ Single Entity___ Joint Powers Agreement___ Health Benefits Trust ___

a) PERS

If the majority of your health benefits are administered through the Public Employees Retirement System (PERS), please indicate and DO NOT answer question 14.

b) Joint Powers Agreement (JPA)

A joint powers agreement is an arrangement between local government authorities who join together to perform a common function such as the purchasing of health benefits coverage.

If your health benefits are administered through a JPA, please indicate above and complete the following:

Name of JPA _____

c) Health Benefits Trust

A health benefits trust fund is a formal agreement entered into by the employer and employee organization for the purpose of administering health care benefits for employees. A health benefits trust fund usually has representation from both the employer and the employee organization on the governing body although the fund may be administered by an employer, employee organization or the third party. The governing body determines how benefits are to be provided and by whom.

If your have employees who receive health benefits through a Health Benefits Trust, please indicate above and complete the following:

Indicate the number of Trusts in which your employees participate,

_____ Number

Average number of employees covered in Health Benefits Trust(s) between May 1, 1985 and April 30, 1986.

_____ All _____ Actual Number $_____ Total employer contribution to Trust(s) between May 1, 1985 and April 30, 1986

Name of Trust _____

d) Single Entity

For the purpose of this question, if you administer the health benefits program for your employees, and have not entered into an agreement with a JPA or a trust, you are a single entity.

SELF-INSURANCE

14. Self-insured means that you have assumed the risk of paying health benefits and retain control of premium dollars. For the purpose of this question, if you belong to a JPA or a Trust that is self-insured then your organization is self-insured. If you are self-insured, please indicate and complete the following:

    Self-Insured - yes_____ no_____

    a) If you are self-insured, which of the following arrangements do you or your JPA or Health Benefits Trust use:

        1) Direct self-administration means that you pay claims to providers directly from your health benefits fund for health services provided to your employees or dependents in your health benefits plan.

            Direct self-administration

            yes_____ no_____

        2) An administrative services only (ASO) contract with an insurer is a contract in which the insurer pays health care providers for health services received by employees and dependents in your health benefit plan. The insurer may also perform actuarial and other functions. If you have an administrative services only (ASO) contract, please indicate.

            Administrative services only (ASO) contract with an insurer

            yes_____ no_____

        3) A third party administrator is an organization that pays claims to health care providers for health services received by employees and dependents in your health benefit plan. In this definition, a third party administrator is not an insurance company performing the claims processing function. If you have a third party administrator, please indicate.

            Third party administrator

            yes_____ no_____

        4) Other administrative arrangement

            yes_____ no_____

            Please describe _____

            _____

            _____

COST CONTAINMENT ACTIVITIES

15. The purpose of this part of the survey is to determine the extent to which public employers and employee organizations are involved in health care cost containment activities and what specific activities have been addressed since May 1, 1985.

    It should be emphasized that this survey is intended to measure changes occurring since May 1, 1985, as well as current considerations.

    IF A COST CONTAINMENT ACTIVITY WAS IMPLEMENTED PRIOR TO APRIL 30, 1985, CHECK PREVIOUSLY IMPLEMENTED.

    IF A COST CONTAINMENT ACTIVITY WAS IMPLEMENTED BETWEEN MAY 1, 1985 and APRIL 30, 1986, CHECK IMPLEMENTED.

IF YOU DO NOT UNDERSTAND AN ACTIVITY LISTED, REFER TO PAGES 12-18, FOR AN EXPLANATION.

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
REDUCE BENEFITS					
ADD OR INCREASE EMPLOYEE CONTRIBUTION TO HEALTH PLAN PREMIUMS (Payroll Deduction)					
CO-INSURANCE					
ADD OR INCREASE DEDUCTIBLES					
ADD OR INCREASE CO-PAYMENT					
CHANGE TO LESS EXPENSIVE HEALTH CARE PLAN BUT RETAIN SAME BENEFITS, DEDUCTIBLES AND CO-PAYMENTS					
LIMIT EMPLOYEE CHOICE OF HEALTH PLANS FOR THE PURPOSE OF REDUCING COSTS					
ADD A PREFERRED PROVIDER ORGANIZATION AS A PLAN OPTION					
SELF-INSURE					
JOINT POWERS AGREEMENT					
ESTABLISH A HEALTH BENEFITS TRUST FUND					
INCREASE UTILIZATION REVIEW THROUGH:					
PRE-ADMISSION REVIEW					
CONCURRENT REVIEW					

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
ANCILLARY SERVICES REVIEW					
PHYSICIANS SERVICES REVIEW					
OUTPATIENT SERVICES REVIEW					
POST-SERVICE AUDIT					
NEGOTIATE DISCOUNTED RATES WITH:					
HOSPITALS					
DIRECTLY ___YES ___ NO					
THROUGH PPO ___ YES ___ NO					
PHYSICIANS					
DIRECTLY ___YES ___ NO					
THROUGH PPO ___ YES ___ NO					
MANDATORY SECOND OPINION FOR SURGERY					
ELECTIVE SECOND OPINION FOR SURGERY					
SURGI-CENTER SERVICES					
HOSPICE SERVICES					
HOME CARE SERVICES					
ALCOHOL ABUSE PROGRAM					
SUBSTANCE ABUSE PROGRAM (excluding alcohol and tobacco)					
SMOKING CESSATION PROGRAM					

	HAVE NOT CONSIDERED	CONSIDERING	REJECTED AFTER CONSIDERING	IMPLE-MENTED	PREVIOUSLY IMPLEMENTED
NUTRITION AND WEIGHT CONTROL PROGRAM					
CHRONIC DISEASE MANAGEMENT PROGRAM					
STRESS REDUCTION PROGRAM					
PHYSICAL FITNESS PROGRAM					
RISK ASSESSMENT PROGRAM					
CASH INCENTIVE FOR SPOUSAL INSURANCE COVERAGE					
PARTICIPATE IN REGIONAL OR STATEWIDE HEALTH CARE COST CONTAINMENT ORGANIZATION					
OTHER (specify)					

_____

_____

_____

Definition of Cost Containment Activities Listed on pages 9, 10 and 11 of this survey.

The list of cost containment alternatives is a compilation of alternatives being undertaken or proposed by a variety of employers, employee organizations, health care providers, health economists and consultants, and others. It is recognized that there is considerable disagreement about the appropriateness or effectiveness of the alternatives among interested parties. However, the intent of this survey is to objectively determine what alternatives are currently being considered without regard to appropriateness or effectiveness, therefore, the following is intended to clearly explain the questions presented rather than present information regarding appropriateness or effectiveness.

Reduce benefits.

A benefit may be for a health service that is provided in a health care plan such as coverage for hospital care, physician care, hearing and vision screening, etc. A benefit may also be a product other than a service such as medical appliances, prescription drugs, hearing aids, dentures, glasses, etc. This question refers to reducing or eliminating a health care service or product. Reducing benefits in this question does not include requiring additional employee contributions to the plan, increasing deductibles or co-payments, or reducing the employer's contribution to the plan.

Add or increase employee contributions to health plan premiums (Payroll Deduction).

Payroll deduction is a deduction from the employee's check to pay for part of the health plan premium. Health plans refer to insurers such as Travelers, Cal-Western, Blue Cross/Shield, etc.; or health maintenance organizations such as Kaiser Health Plan or other group of providers for which services are paid for through a premium. Premium means the amount paid on a periodic, usually monthly, basis for coverage of specified health benefits. Adding or increasing the employee contribution means that the employee would pay a greater percentage toward the premium than is now paid.

Co-Insurance.

For purposes of this survey, coinsurance refers to an arrangement in which the employee is responsible for a stated percent of billed charges of the provider with the insurer paying the balance. For example, the insurer may pay 80% of the hospital bill and the employee is responsible for the remaining 20%. Check yes or no if there is a provision for coinsurance.

Add or increase deductibles.

A deductible is the amount paid by the employee before the health care coverage of the plan begins to pay. For example, some plans have a $200 deductible for non-hospital, i.e., ambulatory care. This means that the employee must pay $200 during the year for non-hospital benefits, such as doctor office visits, before the plan will begin to pay for non-hospital benefits. Adding or increasing deductibles would mean that the employee would pay a greater amount for health services before the plan would begin to pay.

Add or increase co-payment.

A co-payment is an amount paid by the employee as partial payment for a service. For example, if a doctor's office visit is $25 and the employee is required to make a $5 co-payment toward the office visit, then the health plan will pay the other $20. Adding or increasing a co-payment would mean that the employee would have to pay a greater fee for each service.

Change to less expensive health care plan but retain the same benefits, deductibles, and co-payments.

Health care plan in this question means health insurance companies, health maintenance organizations, self insurance, health benefits trust and other groups of providers for which health services are paid for through a premium. This question refers to changing to a less expensive plan without changing coverage. It is simply buying the same plan at a cheaper price from a different source.

Limit employee choice of health plan(s) for the purpose of reducing cost.

Many employers permit at least two choices of health plans. This question refers to limiting the employees' choice in health plans to those plans that cost less. This could mean adding a new plan that costs less, changing to a plan that costs less, or eliminating an existing plan because of its high cost.

Add a preferred provider organization as a plan option.

PPO - For the purposes of this question, a preferred provider organization is an arrangement in which a group of providers have entered into a contractual agreement to provide services at a discounted rate. For the purposes of this survey any health plan option that includes contracted providers regardless of sponsorship or incentives or requirements for employees to use contracted providers is defined as a preferred provider organization plan option.

Self-insurance.

Self-insurance means the employer assumes the risk of the costs incurred for the health care of all eligible employees. In a self-insurance arrangement, health care funds are retained by the employer or trust.

Joint Powers Agreement.

A joint powers agreement is an arrangement between local government authorities who join together to perform a common function such as the purchasing of health benefits coverage. Joint powers authorities may also be self-insured and/or self-administered.

Health benefits trust fund.

A health benefits trust fund is a formal agreement entered into by the employer and employee organization for the purpose of administering health care benefits for employees. A health benefits trust fund usually has representation from both the employer and the employee organization on the governing body although the fund may be administered by an employer, employee organization or the third party administrator. The governing body determines how benefits are to be provided and by whom.

Increase health care provider surveillance through:

Questions relating to provider surveillance do not apply to health maintenance organizations.

The purpose of provider surveillance is to determine if the care provided is appropriate from the viewpoint of cost and quality.

Note

The six most common methods of reviewing health care provider performance are listed in the next six questions.

If you do not know if your insurance company or health plan performs the following review functions, please contact the company or health plan and ask the next six questions.

Pre-admission review - The attending physician must request and receive prior approval for all elective hospitalization or request authorization within 24 hours of hospitalization for an urgent or emergency admission. When request is made, the reviewers will either authorize the admission and assign the number of approved days for stay or deny medical authorization and recommend outpatient services.

Concurrent review - While the patient is hospitalized, nurses or other designated persons, under the supervision of doctors periodically evaluate the hospital records to insure that the appropriate level of medical services are being provided (e.g., intensive care room vs. semi-private room). They also determine the appropriate date of discharge, and during this review, the pre-authorized length of stay may be either shortened or lengthened depending on the patient's medical condition.

Ancillary services review - This review occurs at the same time as concurrent review and evaluates the appropriateness of the hospital services that the patient receives such as laboratory tests, x-rays, physical therapy, etc.

Physician services review - During concurrent review, the reviewers can also evaluate the appropriateness and necessity for the services that the attending physician(s) provides to the patient during the hospital stay.

Outpatient services review - This is a review of the appropriateness of physician and other professional health services and ancillary and therapeutic services performed in an outpatient setting such as a doctor's office, etc.

Post Service Audit.

After the patient is discharged an audit of the billed charges is made to determine accuracy and appropriateness of both services and charges. Decisions to pay, question or deny payment are made by the payor during this review.

Negotiate discounts.

Discounts on the cost of health services can be negotiated with providers through contractual agreements. Such negotiations can occur directly between the employer or group of employers through a trust fund, or by using a preferred provider organization as a health plan option.

Negotiate discounted rates with hospitals.

This question refers to negotiating discounted rates for hospital services.

Directly - Refers to direct negotiations with hospital for discounts by an employer, group of employers or through a trust fund. Negotiations may be accomplished by the staff of the organization or through a third party contracted to perform the negotiating function.

Through a preferred provider organization - Means that discounted hospital rates are negotiated by a preferred provider organization.

Negotiate discounted rates with physician.

This question refers to negotiating discounted rates for physician services.

Directly - Refers to direct negotiations with physicians by an employer, group of employers or through a trust fund. Negotiations may be accomplished by the staff of the organization or through a third party contracted to perform the negotiating function.

Through a preferred provider organization - Means that discounted physician rates are negotiated by a preferred provider organization.

Second opinion for surgery.

A second opinion for surgery occurs after surgery has been recommended by a physician. The second opinion is from another physician.

Mandatory second opinion for surgery.

This means that the employee is required to obtain a second opinion.

Elective second opinion for surgery.

This means that the employee is not required to obtain a second opinion for surgery, but may do so under the health plan.

Surgi-center services.

Surgi-centers are free-standing (not hospital) facilities in which surgery is performed. The surgery does not require an overnight stay in the facility and the patient returns home the same day.

Hospice services.

Hospice services are health care and support services that are provided usually in the home, to terminally ill patients and their families. Hospice is an alternative to hospitalization or other institutional care for the terminally ill.

Home care services.

Home care services include services provided by a visiting nurse, physical or other therapist, etc. The services may be for the purpose of chronic disease management, rehabilitation, or for a protracted illness or injury.

Alcoholism abuse program.

Alcohol abuse programs refer to coordinated employer/community, medical care programs for the treatment of alcoholism or alcohol abuse. The question does not refer to simple hospital insurance coverage for alcohol detoxification but to comprehensive community programs involving the employer, employee organization, community services, and inpatient and outpatient medical care services.

Substance abuse programs (excluding alcohol and nicotine).

Substance abuse programs refer to the same kind of programs for alcohol abuse, only the substances are heroin, cocaine, marijuana, amphetamines, etc.

Smoking cessation programs.

Smoking cessation programs are designed to assist the employee to stop using tobacco in any form including smoking. Such programs may be conducted at the work site or in the community.

Nutrition and weight control programs.

Nutrition and weight control programs are for the purpose of developing healthful nutritional habits and losing weight to prevent or control illness relating to poor nutritional habits. Such programs may be performed at the work site or in the community.

Chronic disease management programs.

Chronic disease management programs are for individuals who have chronic illness such as diabetes or hypertension. They are usually coordinated as an adjunct to continuing medical management. Such programs may be conducted at the work site, in the community, or through health care support organizations such as visiting nurses.

Stress reduction programs.

Stress reduction programs are for the purpose of improving the capacity of an individual to cope with stressful situations. The programs may take many forms and may be conducted at the work site or in the community.

Physical fitness programs.

Physical fitness programs are for the purpose of increasing cardiovascular capacity as well as physical fitness. Such programs may be conducted at the work site or in the community.

Risk assessment program.

Risk assessment programs are for the purpose of determining health risks associated with employee behavior and physical/emotional status. The intent is to provide information and referral and follow-up services to correct problems. Most programs are conducted at the work site or by referral to community agencies.

Cash incentive for spousal insurance coverage.

When both husband and wife are employed and both are covered by a family insurance policy, two employers pay for the same health coverage. This "double coverage" often results in one employee enrolling the family in one plan and the other employee enrolling the family in another plan. The cash incentive program is one which pays a spouse a cash percentage of what a health plan would cost rather than paying for a health plan.

Participate in regional or statewide health care cost containment organizations.

Participation in a county or statewide cost containment coalition that meets with other employers or employee organizations on a regular basis is an example of this activity.

Other

If you have made or are considering other activities, programs, etc., for the purpose of containing health care costs, please indicate.

APPENDIX 2

Distribution of School Employees by Size of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	158	5,932	38	32
101-200	55	8,006	146	141
201-500	72	23,252	323	318
501-1,000	44	30,916	703	624
1,001-10,000	36	73,989	2,055	1,583
10,001 +	1	50,115	--	--
TOTAL	366	192,210		

Distribution of City Employees by Size of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	97	4,439	46	43
101-200	34	5,044	148	150
201-500	43	13,707	319	310
501-1,000	15	9,301	620	550
1,001 + 10,000	6	12,371	2,062	1,500
10,001 +	1	28,032	--	--
TOTAL	196	72,894		

Distribution of County Employees by Size of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	0	--	--	--
101-200	0	--	--	--
201-500	7	2,554	365	351
501-1,000	5	3,513	703	616
1,001-10,000	18	80,737	4,485	2,926
10,001 +	3	88,706	29,569	13,627
TOTAL	33	175,510		

Distribution of Special District Employees by Size of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	68	1,719	25	19
101-200	4	510	128	131
201-500	2	561	--	--
501-1,000	1	520	--	--
1,001 +	1	1,350	--	--
10,000+	--	--	--	--
TOTAL	76	4,660		

APPENDIX 3

Employer Contributions for School Employees by Size of Employer

Number of Employees	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	$2,264	$2,306
101-200	$2,254	$2,297
201-500	$2,316	$2,339
501-1,000	$2,202	$2,157
1,001-10,000	$2,077	$2,177
10,001 +	$2,227	--

Employer Contributions for City Employees by Size of Employer

Number of Employees	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	$2,287	$2,209
101-200	$1,920	$1,836
201-500	$2,186	$2,129
501-1,000	$2,015	$2,005
1,001-10,000	$2,291	$2,029
10,001 +	$2,305	--

Employer Contributions for County Employees
by Size of Employer

Number of Employees	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	--	--
101-200	--	--
201-500	$1,792	$1,921
501-1,000	$1,785	$1,833
1,001-10,000	$1,504	$1,452
10,001 +	$1,871	$1,839

Employer Contributions for Special District Employees
by Size of Employer

Number of Employees	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	$1,993	$1,964
101-200	$1,975	$2,067
201-500	$2,174	--
501-1,000	$2,235	--
1,001-10,000	$2,561	--
10,001 +	--	--

APPENDIX 4

TOTAL

Distribution of Employees
by Type of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
CITY	196	72,894	372	104
COUNTY	33	175,510	5,318	1,844
SCHOOL DIST	366	192,210	525	139
SPECIAL DIST	76	4,660	61	20
TOTAL	671	445,274	664	112

TOTAL

Distribution of Employees
by Size of Employer

	Total Number Of Employers	Total Number Of Employees	Average Number Of Employees Per Employer	Median Number Of Employees Per Employer
1-100	323	12,090	37	32
101-200	93	13,560	146	141
201-500	124	40,074	323	310
501-1,000	65	44,250	681	602
1,001-10,000	61	168,447	2,761	1,686
10,001 +	5	166,853	33,371	28,032
TOTAL	671	445,274	664	112

APPENDIX 5

TOTAL

Employer Contributions for Employees
by Type of Employer

Type of Employer	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
CITY	$2,216	$2,108
COUNTY	$1,699	$1,776
SCHOOL DIST	$2,178	$2,265
SPECIAL DIST	$2,204	$2,005
ALL EMPLOYERS	$1,996	$2,164

TOTAL

Employer Contributions for Employees
by Size of Employer

Number of Employees	Average Annual Contribution Per Employee	Median Annual Contribution Per Employee
1-100	$2,234	$2,209
101-200	$2,119	$2,164
201-500	$2,236	$2,204
501-1,000	$2,130	$2,120
1,001-10,000	$1,822	$1,979
10,001 +	$2,051	$2,133
ALL EMPLOYERS	$1,996	$2,164

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