

Managed Care in California: Cost Concerns Influence Product Design

Introduction

Health maintenance organizations (HMOs) have played a larger role in the California health insurance market over a longer time than they have in most other states. However, the role of the HMO in California is changing in response to increasing pressures from employers to control their health care spending by raising their employees' share of costs. Insurance carriers are marketing relatively new products and finding increased employer acceptance of products with higher deductibles and co-insurance rates. Competing in the current environment poses challenges for HMOs which, by regulation, must include relatively comprehensive benefits and comply with standards that do not apply to many other health insurance products. Insurance carriers have responded to this changing environment by modifying HMO benefit designs, developing new products built on or outside of HMO platforms, and packaging HMOs with other products in employer-based health benefits offerings.

The Center for Studying Health System Change's (HSC) recent site visits to six California regions found a blurring of longstanding distinctions among types of health insurance carriers and products, with almost all insurance carriers—including those that historically have focused almost exclusively on HMOs—now offering a broad array of products, some of which do not conform to traditional product designs. Given these developments, it may be time to examine the continuing relevance of the dual regulatory structure for health insurance in California, which was based

upon a perhaps now-outdated dichotomy between HMOs and other health insurance products.

Pressures for Change in the Health Insurance Market

In recent years, rising health insurance costs have caused employers to seek options from health insurance carriers that provide the possibility of greater employee cost-sharing. This change is now challenging the dominant position that HMOs have historically occupied in the California health insurance market. While HMO enrollment has declined significantly in many other states over the past decade, it has remained relatively strong in California, with over 60 percent of commercial insurance enrollees in HMOs or point-of-service (POS) products built around networks of HMO providers. The California-based Kaiser Foundation Health Plan is the nation's largest HMO, and Kaiser enrollees in California have a strong allegiance to their health plan: Kaiser's enrollment has remained relatively stable in recent years despite an overall decline in employer-based health insurance coverage in California.¹ All other major insurers in California offer HMO products, along with other benefit designs such as preferred provider organizations (PPOs).

Reflecting the historical dominance of HMOs in California, the health insurance market is overseen by a dual regulatory structure at the state level. The Department of Managed Health Care (DMHC) has responsibility for all HMO products and for many fully-insured PPO products sold by Anthem Blue Cross of California and Blue Shield of

HSC's Six-Community Market Study

In fall 2008, a team of researchers from the Center for Studying Health System Change (HSC) conducted site visits to six California communities to study those markets' local health care systems and to gain insights into regional characteristics in health care affordability, access, and quality. The six markets — Fresno, Los Angeles, San Francisco Bay Area, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions. Approximately 300 interviews were conducted between October and December 2008 in the six communities with representatives of hospitals, physician organizations, health plans, major employers, benefit consultants, insurance brokers, community health centers, state and local policymakers, and other stakeholder organizations.

The present issue brief is based primarily on interviews with insurers and health plans, employers, insurance brokers and benefit consultants. A two-person research team conducted each interview, and notes were transcribed and jointly reviewed for quality and validation purposes. The interview responses were coded and analyzed using ATLAS.ti, a qualitative data management software tool.

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California.² The California Department of Insurance (CDI) provides oversight for other PPO and insurance products. As in other states, self-insured employer plans are not subject to state regulation and are overseen by the federal Department of Labor. DMHC's regulatory scope is substantially broader than CDI's and includes dimensions such as quality of care. Also, products under DMHC jurisdiction are required to provide all "medically necessary basic health care services," such as maternity, whereas products under CDI jurisdiction have no equivalent requirement. In addition to these differences in regulatory scope, respondents in the present study also report that DMHC tends to interpret regulations more stringently than CDI does.

Health insurers are responding to cost-containment pressures from employers by offering some products that are new to California, and also by aggressively marketing existing products that facilitate greater employee cost-sharing

or restrict provider networks. As a consequence, the current health insurance market in California is quite fluid, with the traditional dominance of HMOs in question.

Consumer-Directed Health Plans

In the past few years, consumer-directed health plans (CDHPs) have gained traction among California employers by offering benefit designs featuring increased employee cost-sharing.³ However, their impact in the large employer health insurance market has been distinctly different than in the small employer market.

Large private-sector employers in California typically have offered employees the choice of a PPO and one or more HMO products, often with Kaiser as one of the HMO options. Now, some large employers also offer a CDHP product, though generally not as the sole plan option. So far, CDHPs have drawn relatively few enrollees away from

HMOs and PPOs. California does not offer the same favorable tax treatment for health savings account (HSA) contributions as the federal government and many other states do; some respondents in the present study suggested that this has contributed to the low number of employees in large firms who have chosen the CDHP option.⁴

Despite this experience, insurance carriers generally believe that CDHPs will gradually increase the number of enrollees they draw from large, mostly self-insured, private firms in California. Consequently, most health insurance companies are now aggressively marketing these benefit designs as complements to their existing HMO and PPO products. To keep up with the changing market, Kaiser has secured a license to offer products to self-insured employers and has developed a high-deductible plan option that is eligible for an HSA. Kaiser believes that such a product will help it “get in the door” with these employers, even though the employers ultimately may choose not to offer the high-deductible plan. Other health plans also have introduced deductibles to some versions of their HMO products, to the extent allowable under existing regulations, which is a significant departure from the first-dollar coverage that has been nearly universal in HMO products in the past.

In contrast to the relatively limited impact of CDHPs in the large employer health insurance market, insurance brokers report that small employers with primarily low wage employees are increasingly replacing their existing plans with CDHPs. Some brokers are encouraging this strategy, observing that small employers see CDHPs as their best—and possibly last—hope to maintain employee health benefits. It is not uncommon for small employers facing financial difficulties to offer CDHPs without making any contribution to the HSA, an approach that reportedly costs employers significantly less than PPO or HMO alternatives. Similarly, so-called “limited-network” CDHPs, which only cover enrollee use of providers who are in the core network of an insurer’s HMO product, are attractive to some small

employers because they can be offered at a lower premium level than full-network products.

Another strategy insurance carriers use to make insurance products less expensive for small employers, and for individual health insurance consumers, is to offer lower-premium products with relatively limited benefits that they hope will attract young, healthy people who may not be willing to pay for the comprehensive benefits characteristic of HMOs. These products, overseen by CDI and sometimes described as “PPO lite” by respondents, might exclude benefits such as maternity coverage, brand-name prescription drug coverage, or any prescription drug coverage. Typically, limited-benefit products cannot be offered within an HMO structure because, as noted above, HMOs in California are subject to a mandate to provide all “medically necessary services.”

Limited-Network Products

Two ways in which California health insurance carriers have tried to address employer demands that they demonstrate “value” for health benefit dollars and more aggressively control costs are the development of “high-performance network” and “narrow-network” products.

HIGH-PERFORMANCE NETWORK PPOs

National carriers, including Anthem, Aetna and CIGNA, have introduced high-performance-network PPOs throughout California, as they have in other markets nationally. In these tiered-network products, a group of providers designated as “high performance”—based on a set of cost and quality measures—forms the first tier of providers.⁵ The second tier consists of the remaining in-network providers; the third tier is out-of-network providers. How plans implement these products varies widely. Aetna and CIGNA, for example, have made only certain physician specialties eligible for high-performance designation, while Anthem evaluates all network physicians, including primary care physicians. The methods used to measure physician

performance, particularly the quality metrics, also differ across plans.⁶

Although many large California employers have expressed support for high-performance networks, benefits consultants noted that these same employers are often hesitant to introduce financial incentives to steer enrollees to providers in the “high-performance” tier. Benefits consultants also suggested that relatively few employers are offering these products, and few employees choose them when offered. For example, an Anthem executive noted that its Blue Precision tiered-network PPO—a Blue Cross Blue Shield product aimed at national accounts—“has not sold well... [and] is being overhauled.”

NARROW-NETWORK PRODUCTS

In some California communities, health insurance carriers have responded to employer pressures to contain costs by developing narrow-network products, which restrict access to a subset of the carriers’ full networks. While narrow-network products have been introduced as variants of both HMO and PPO products, the HMO variants reportedly have met with more success. One benefits consultant suggested that this stemmed from California’s longstanding familiarity and “high-comfort level” with the Kaiser model; another remarked that narrow-network PPOs are “a tough sell” because network breadth is a key aspect of PPOs’ appeal.

One notable implementation of narrow-network products has taken place in the San Diego market. There, in recent years, medical groups belonging to the Scripps Health System converted their commercial HMO contracts from capitation—fixed per-member, per-month payments—to fee-for-service, reportedly resulting in substantially higher costs for payers. Most major health plans reacted to the Scripps conversion by introducing new HMO products that exclude Scripps medical groups from their provider networks. According to some respondents, premiums for these products are typically 5 to 20 percent lower than premiums

for broader-network HMO products that include Scripps providers.

Views vary widely regarding the popularity of these limited narrow-network products in the San Diego market. One benefits consultant reported enthusiastic adoption by some mid-size and large employers and estimated that, in some employer groups, when the narrow-network HMO is offered alongside a Kaiser HMO, a full-network HMO that includes Scripps, and a PPO, it can command a majority of the non-Kaiser share. However, another benefits consultant observed: “We show [narrow-network products] to clients, but because... Scripps is not in the network, it’s not regularly adopted by employers.” Health plans in San Diego are attempting to create even narrower networks—excluding other large providers, such as University of California San Diego Medical Center physicians and Sharp Rees-Stealy Medical Group, as well as Scripps physicians—but these products have not met with success. A benefits consultant noted that, with Scripps already excluded from the network, the additional exclusion of Sharp Rees-Stealy, for example, makes provider access too restrictive to be acceptable to most employers and employees, even at a substantial premium discount.

Another narrow-network product recently introduced in California, the Blue Shield NetValue HMO, was developed specifically for the California Public Employees’ Retirement System (CalPERS), the largest purchaser of health benefits in the state. According to a CalPERS respondent and several benefits consultants, development of the NetValue product was driven largely by CalPERS’s concerns about the costs of the dominant Sutter Health system in northern California. The NetValue HMO excludes medical groups affiliated with Sutter Health, as well as other medical groups, based on their performance on a combination of cost and quality criteria. NetValue is offered to most CalPERS members alongside a full-network HMO product (the Blue Shield Access+ HMO), a Kaiser HMO, and three self-funded PPO products administered by Anthem. Data provided to the

authors of this brief suggest that NetValue premiums are about 5 percent lower than Kaiser premiums and 12 percent lower than Access+ premiums. NetValue currently accounts for approximately 17 percent of CalPERS HMO enrollment and 13 percent of total CalPERS enrollment among active workers.⁷ In northern California, NetValue is available only to CalPERS members, while in southern California it is also marketed to other employers as the SaveNet HMO.

While narrow-network products have made some inroads in San Diego and statewide with CalPERS, they have yet to gain broad traction. Employers have expressed strong interest in benefit designs that encourage use of efficient, high-quality providers, but plan executives and benefits consultants observed that it has been very challenging to find the right combination of benefit designs, provider networks, and price points to achieve widespread employer adoption and significant employee take-up.

Packaging Health Benefits Products

Over the past several years, health insurance carriers have pursued several approaches to “packaging” their products in a way that preserves HMO options for employees, while at the same time offering benefit designs with the potential for greater employee cost-sharing. For example, Blue Shield offers Core Flex products to employer groups of over 50 in which employers must fund the full monthly costs for either the Basic HMO or the PPO product. Employees can “buy up” to any of the three more comprehensive HMO options in Core Flex HMO, or to four PPO options in Core Flex PPO (all offered by Blue Shield), without increasing their employers’ costs. However, employers are limited to offering one (non-Blue Shield) HMO alternative if they offer the Core Flex PPO, and are similarly restricted to one PPO alternative if they offer the Core Flex HMO. Similar options are available for groups with 50 or fewer employees. For example, through Aetna Pick-A-Plan and Anthem Blue Cross Employee Elect offerings, employees have access to a range of benefit design options. Most employers fund a middle-of-

the-road benefit design, giving employees the ability to buy up to more comprehensive benefits or buy down to more limited-benefits and apply the “saved” employer contribution to dependent coverage. Respondents throughout California suggested that these types of packaged benefit approaches are becoming increasingly popular options for employers as cost pressures intensify.

Packaged benefit approaches also offer health insurance carriers a way to “leverage their portfolio,” replacing other carriers in situations where insurers may have split a pool of enrollees in the past. Another approach health insurance carriers have taken in order to leverage their portfolios is to collaborate with other carriers to offer a fuller range of insurance options than each could provide alone. For example, Kaiser and United recently collaborated to offer Suite Spot, a portfolio of products from the two plans. The joint effort is a way for Kaiser to preserve a market presence for its HMO products, especially among medium-size multi-state employers. For United, the collaboration is a way to gain a foothold among California employers, particularly groups that would otherwise, because of size and selection concerns, struggle to offer multiple choices to employees.

Conclusion

The economic downturn in California, more intense than in many other regions of the United States, has increased the already significant pressures on employers to control their health care costs. In response, health insurance companies are offering products that include greater employee cost-sharing. Historically, HMO products in California have featured comprehensive benefits, with relatively little enrollee cost-sharing, both because carriers have traditionally marketed HMOs as an alternative that provides comprehensive coverage and, for their fully insured products, because of the need to comply with regulatory requirements. Now, carriers are searching for ways to keep these products viable in the changing market environment. In a few instances, they have narrowed HMO provider networks in order to offer a lower-

priced option for employers, and designed HMO variants that feature higher deductibles. Insurance carriers also are packaging their HMO products in new ways with other products that have greater potential for cost-sharing.

From a consumer perspective, the insurance market is becoming broader with respect to both the number and variety of products available. Health insurance carriers, however, are becoming more alike in the mix of products they offer. One question that arises from this increasing homogeneity among carriers is whether maintaining the present dual regulatory structure in California—with one set of rules governing HMOs (and some PPOs) and another governing other insurance products—remains in the best interests of the state and its consumers. This structure was put in place at a time when HMOs were perceived as quite distinct from other health insurance products, and there was concern about overly-aggressive care management and inadequate networks within HMOs. Given the increasing similarity among health insurance carriers and their respective products, it can be argued that a more integrated regulatory approach may now be warranted.

Looking to the future, it is uncertain whether national health reform legislation will be enacted and, if it is, precisely what new insurance requirements it would impose. It appears likely that individuals would be required to have some form of minimum benefit coverage, either purchased on their own or through their employers. If federal health reform legislation is enacted, state regulatory agencies might be called upon to play more extensive roles in monitoring benefits and consumer cost-sharing, and in facilitating disclosure to consumers. Meeting these new demands on the state's agencies may require a re-examination of California's health insurance regulatory structure with an eye toward more streamlined and efficient oversight.

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California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to www.chcf.org/topics/almanac.

ENDNOTES

1. Fronstin, Paul. *Snapshot: California's Uninsured*. California HealthCare Foundation. Oakland, CA, 2008.
2. There is some historical context to today's regulatory oversight of Blue Shield of California (which originated as a nonprofit prepaid plan closely linked to the California Medical Society) and Blue Cross of California (historically, a nonprofit provider of hospital coverage). Decisions by California policymakers and regulators in the 1970s, 1980s, and early 1990s aimed to bring as much as was feasible of Blue Shield's and Blue Cross's business under the Knox-Keene regulatory umbrella; however, the two organizations were permitted to continue to offer products regulated by CDI as well. As a consequence, most PPO products offered by Anthem Blue Cross and Blue Shield of California are under DMHC regulatory control. In contrast, PPO products offered by other health insurance carriers are regulated by the CDI. See Roth, Debra L., and Deborah Reidy Kelch. *Making Sense of Managed Care Regulation in California*. California HealthCare Foundation, Oakland, CA, November 2001.
3. Consumer-directed health plans are high-deductible plans with (or eligible for) a health savings account (HSA) or health reimbursement arrangement (HRA). HSAs are tax-favored accounts that must be linked to health plans with minimum deductibles of \$1,150 for self-only coverage and \$2,300 for family coverage (2009). HRAs are accounts funded and owned by the employer; no companion health plan is required. HRA contributions are not subject to business income tax, and unused funds revert to the employer when the employee retires or leaves the company.
4. OptumHealth Financial Services Web site, Individuals & Families page. *HSA Tax Resource Center: State Tax Information*. Accessed November 16, 2009 (www.optumhealthfinancial.com).
5. Hospitals are not targeted directly by high-performance networks, but since hospital costs are included in physician efficiency assessments, physicians treating patients at relatively high-cost hospitals will have more difficulty meeting cost/efficiency standards.
6. For more information about high-performance network products, see Draper, Debra A., Allison Liebhaber, and Paul B. Ginsburg. *High-Performance Health Plan Networks: Early Experiences*. Issue Brief No. 111, Center for Studying Health System Change, Washington, D.C., May 2007.
7. Authors' analysis of "CalPERS 2009 Health Premiums — State" and "CalPERS Health Program Enrollment Report, July 1, 2009."