

Health Care Trends for 2002

The start of a new year brings projections and predictions for what is to come. In this month's piece we review and highlight some of the dominant themes and trends in health care and managed care for the year 2002. The fight against terrorism and the sagging U.S. economy will be primary factors responsible for shaping and altering the health care landscape in 2002.

Health Care Spending

Escalating health care costs will remain a major concern. National health care spending is projected to reach more than \$1.5 trillion in 2002 or \$5,805 per capita, an increase of 8% from the previous year. The health care industry accounted for one in every seven dollars spent in the United States in 2000—13.1% of the Gross Domestic Product (GDP)—and the percentage is expected to grow to 15.9% by 2010. Increases in overall medical costs are projected to be greater in 2002 than 2001 for active employees (14% increase in 2002 vs. 12% in 2001) and Medicare retirees (15% increase in 2002 vs. 13% in 2001) (Watson Wyatt WorldWide and Towers Perrin). National pharmaceutical costs are expected to increase but stabilize, a 19% increase in 2001 vs. a 17% increase in 2002; changes in benefit plans requiring higher patient copayments are expected to slightly dampen demand (Center for Medicare and Medicaid Services). Hospital costs, particularly for outpatient services, are expected to be a principal cost driver of health care inflation in 2002.

Rising health care costs within a larger economy experiencing a downturn have compounded the fiscal pressures for payers,

insurers, providers, and consumers. Cost-containment strategies have become paramount for all the parties in the health care system, but efforts in this area must take into account the growing concerns over quality and accessibility. The emphasis on consumer demand and the loosening of utilization controls by managed care organizations will make implementation of cost-containment strategies difficult.

In 2002, employers will continue to absorb a large percentage of health care cost increases. In response, employers are choosing to pass cost increases along to employees, rather than reducing benefits (an exception being pharmacy benefits). Employers are increasing office visit copayments and deductibles for physician visits and hospital admissions. Employers and health plans are introducing multiple-tiered pharmacy benefits and tiered provider networks, in which members pay more higher out-of-pocket costs for certain benefits. Despite attention to defined contribution plans, employers generally have been reluctant to release control of health care decisions to their employees (for more on defined contribution, see TMCI's January 2001 topic-of-the-month).

Managed Care

In 2002, escalating medical costs, increased provider clout, and pressure from consumers and employers for more choice and flexibility will challenge how managed care organizations (MCOs) operate. MCOs are offering less restrictive plans and revamping existing plans to relax restrictive features. They are relaxing preauthorization requirements for certain services, streamlining

or abolishing the referral process, and offering HMO plans that do not require a gatekeeper.

Preferred provider organizations (PPOs) continue to be the most popular form of managed care for consumers and employers alike. In 2001, enrollment in PPOs stood at 46% of all covered employees, compared to just 33% in health maintenance organizations (HMOs) (William H. Mercer, Inc.). While HMOs typically remain the least expensive plan available, the cost increases of HMO plans were nearly identical to PPOs in 2001.

According to Interstudy, HMO enrollment continued to slide to 79.5 million members, from its peak of 81 million in 1999. The consolidation trend also continued as there were 541 operating plans as of Jan. 2001, down from 568 plans one year earlier. HMOs have retooled their business strategies by trying to repair provider relations, offering more attractive plans to employers and customers, withdrawing from unprofitable markets, increasing the number of self-funding plans, and passing along premium increases to employers.

The Delivery System

In 2002, providers will again face a turbulent year of trying to balance quality and cost concerns. Vertically-integrated delivery systems continue to split apart as promised cost savings and efficiencies have not been realized. Provider networks have responded by refocusing operations on delivery of patient care and leveraging their strong marketplace position to restructure contracts with insurers and health plans to secure higher payments.

Quality issues remain at the forefront of care concerns for providers. Upgrading clinical information systems, implementing clinical

practice guidelines, and initiating disease management programs are some of the most prevalent approaches that providers are counting on to achieve cost-effective, high-quality outcomes. Still, providers face a myriad of issues in 2002 including: bioterrorism preparedness, the rising cost of prescription drugs, raising capital for expansion and continued improvement, continued nursing shortages, HIPAA compliance, and declining Medicare payments.

Consumers and Patients

The marketplace is changing from the past decade. In the 1990s, patients demanded access to the latest innovations in health care, while employers absorbed most of the cost increases. As the economy entered a recession late last year and medical costs continue to climb, employers have begun passing along costs more directly to their employees and limiting health plan options. Increasingly, patients will have to choose the level of care they desire based upon their ability to pay.

Access to health information through the Internet and patient education has enabled patients to participate more actively in their treatment decisions. Still, a lack of quality information, especially in regards to the cost and quality of provider services, severely hampers the ability of patients to be well-informed consumers. Advocacy groups are calling for the release of more provider information, and some health plans and private groups are indeed making more information available over the Internet. Still, it remains to be seen how much will change in the short term during 2002.

Legislative Action

Emphasis on the September 11 terrorist attacks, mid-term congressional elections, and

narrow majorities in both the House of Representatives and the Senate make major health care policy changes in 2002 unlikely. Issues such as the Patients' Bill of Rights, a prescription drug benefit for Medicare recipients, provider relief on Medicare payments, and rising numbers of uninsured are carried over from 2001.

President Bush's proposed budget outlined his health care priorities for FY 2003: a massive increase for bioterrorism preparedness, expansion of tax credits for individuals to buy private insurance, increased Medicaid funding for the State Children's Health Insurance Program (SCHIP) program, and targeted improvements to the Medicare program including some form of a subsidized prescription drug benefit.

President Bush's priorities and the projected budget deficit make it unlikely in 2002 that legislation addressing a large expansion of coverage for the uninsured, the Patients' Bills of Rights, large-scale provider relief on Medicare payments, and a full-scale Medicare prescription benefit will be enacted. Instead, lawmakers are likely to amend current Medicare payment growth caps to enact slight relief for providers, and address the rising number of uninsured through piecemeal means including expansion of coverage under Medicaid programs and COBRA and tax credits.

Resources

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