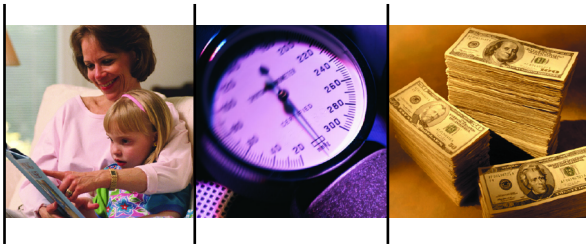
Issue Brief
Findings from HSC



EMPLOYERS SHIFT RISING HEALTH CARE COSTS TO WORKERS: NO LONG-TERM SOLUTION IN SIGHT

by Lydia Regopoulos and Sally Trude

Despite concerns that an economic downturn would prompt employers to rein in rapidly rising health insurance premiums by radically reducing benefits, few have made dramatic benefit changes, according to findings from the Center for Studying Health System Change's (HSC) 2002-03 site visits to 12 nationally representative communities. Key employer changes focused on increasing patient cost sharing and revising family coverage policies. Few employers adopted innovative health benefit strategies or major design changes. Given employers' lack of confidence in alternative strategies and their unwillingness to restrict workers' choice of providers, employers will likely continue incremental cost-sharing increases in the face of ongoing premium increases.

Employers Incrementally Raise Cost Sharing

Employers faced rapidly rising health insurance premiums in recent years, with three consecutive years of double-digit increases, culminating in 2003 with a 13.9 percent increase—the largest annual increase since 1990.[1] Noting the slowing economy, many observers predicted that employers would dramatically increase employees' share of health care costs or even abandon health benefits altogether. But employers responded to rapidly rising premiums with incremental changes, according to findings from HSC's 2002-03 site visits to 12 nationally representative communities (see Data Source).

The major employer strategy was to increase employee cost sharing moderately, either by passing on a larger share of premiums to workers or by increasing copayments, deductibles and coinsurance—where patients pay a percentage of the total cost of care. The specific changes adopted depended in large part on employers' existing benefit design:

- Employers who were still paying the full premium—typically large, public employers and those with a unionized workforce—began requiring employees for the first time to contribute toward their health insurance. For example, instead of the employer paying the full premium, an employee might be required to contribute 10 percent of the premium. In contrast, the typical employer already required workers to contribute 20 to 40 percent toward their health insurance premiums, and these employers did not change the contribution percentage.
- Employers with modest patient copayments increased them. For example, employers that had offered options with $5 office visit copayments doubled them to $10. Employers with office visit copayments of $10 doubled them to $20 and introduced new copayments for particular services such as specialist care, urgent care and outpatient surgery. Copayments for emergency

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Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. In 2002-03, HSC researchers interviewed health benefit managers of large companies of 500 or more workers, health benefit consultants and brokers about changes to employers' health benefits due to rising health insurance premiums and a slow economy.

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department visits also were doubled, for example, increasing from $25 to $50 or from $80 to $150. Per-day copayments for inpatient hospital stays often replaced per-admission copayments.

- A few employers that already had high copayments replaced them with coinsurance.

Increases in employees' copayments, deductibles and coinsurance essentially reduced the level of benefits in exchange for lower premiums. Nationally, employers are estimated to have reduced health benefits to "buy down" their insurance premiums by 2 percent to 3 percent in 2002 and by roughly an additional 3 percent in 2003.[2]

Choice at a Price

Employers noted that two of employees' biggest concerns were the cost of health care and having access to their choice of physicians and hospitals. Although broad provider networks are costly, employers were unwilling to risk employee discontent by returning to tightly managed care, calling the possibility of limiting networks a "nonstarter" and explaining that giving employees less than full choice would be a "bitter pill." As a result, health benefit managers maintained workers' access to broad networks but required workers to pay more.

Despite health benefit managers' embrace of increased cost sharing, few considered this approach the ultimate solution to rising health care costs. Some were beginning to question whether the complexity of the benefit changes and the educational campaigns warranted the few percentage point reductions in premiums. Others were reluctant to burden employees with increases to cost sharing for health care at the same time they were withholding pay increases.

While almost all employers increased workers' share of total costs, the proportion borne by employees varied substantially across communities and employers. In contrast to Seattle and Boston, markets with historically rich health benefits, Greenville and Little Rock employees already shouldered relatively large shares of their health benefit costs. For example, one Greenville employer covered 60 percent of workers' health care costs and planned to reduce this amount to 50 percent. In addition, workers in small firms typically pay a greater share of their health care costs compared with public employees and workers in large national companies.

Grappling with Family Coverage

Family coverage was an area of focus for many employers in 2002-03. Some employers promoted public insurance as an alternate source of coverage for children of their low-income employees (see box on page 3). Many reported modifying family coverage or planning to do so, using one of two strategies: (1) changing relative premium subsidies between single and family coverage and (2) encouraging workers' spouses to obtain coverage through their own employers when possible.

Rising premiums led some employers to change how they structured and paid for family coverage. For example, one company that had contributed 92 percent toward both single and family coverage now pays 90 percent of the premium for single coverage and 70 percent of the premium for family coverage. Alternatively, employers added a new category under family coverage to differentiate families that include the worker, spouse and dependents from those that consist of just the worker and dependents. Such policies typically helped lower premium costs for single parents, while helping employers reduce total payments for health insurance. In contrast, one employer that previously had provided no subsidy for dependent coverage added one to help make coverage more affordable for employees with children.

In addition, employers adopted a variety of approaches to encourage employees' spouses to accept coverage through their own employers. Employers with rich benefit packages, in particular, complained that they carried an "excessive load" of dependents or were "subsidizing" other employers. Strategies to limit spousal coverage included:

- Refusing to cover spouses unless the employee showed proof that the spouse could not enroll elsewhere;
- Imposing financial penalties for spouses who have access to their own employer-sponsored insurance;

Employers Steer Employees to SCHIP

One employer response to rising premiums identified in HSC's 2002-03 site visits was the promotion of the State Children's Health Insurance Program (SCHIP) as an alternate source of coverage for low-income workers' children. Employers in three of the 12 markets—Miami, Cleveland and Phoenix—had adopted this approach.

The strategy was most widely reported in Miami, where the Chamber of Commerce publicized Florida's program, KidCare, in a letter to 6,000 small employers and the county Department of Health promoted the program to small businesses. Moreover, the Miami-Dade School District, which faced a drastic 85 percent premium increase in just one year, provided information about KidCare to help employees who would have difficulty paying their share of the family premium. The school district also created a short-term special exception to its benefit policy to allow employees to re-enroll a child after the open enrollment deadline in case the child was deemed ineligible for KidCare.

By design, SCHIP has sought to discourage enrollment of children with access to employer-based coverage. Some states require the child to be uninsured for three to six months before becoming eligible for SCHIP, particularly if the child's parent voluntarily dropped employer-based coverage. But other states only require the child to be uninsured at the time of enrollment. The communities where employers promoted SCHIP enrollment were in states with more lenient enrollment requirements. In fact, Florida recently tightened KidCare eligibility requirements to exclude anyone with access to employer-sponsored coverage unless it would cost more than 5 percent of family income.

- Requiring a significantly higher premium contribution for a spouse; and
- Offering employees a spending account for out-of-pocket expenses if the spouse selected coverage through his or her employer.

One employer began requiring employees' spouses to sign up with their own employer's health plan if the annual cost was less than $600. This employer's rich benefits and zero premium sharing reportedly had prompted extensive spousal coverage, but after the policy was instituted, half of the employees with family coverage dropped their spouses from the plan. Another approach was to encourage workers to obtain coverage through their spouses, offering extra pay for employees who enrolled elsewhere.

Few Innovations or Major Changes in Benefit Design

During the previous round of site visits in 2000-01, employers predicted they would have to drastically change health benefit offerings if premiums continued to rise. Despite this warning, most employers ultimately favored a more conservative approach and did not make changes of the scope predicted. In fact, only one employer reported significantly restructuring its health benefit design in response to rising premiums. That employer revised its benefit offering to increase employees' share of health care costs by 40 percent and offered its employees a choice between a preferred provider organization (PPO) and a consumer-driven health plan with comparable out-of-pocket costs. For the PPO, deductibles increased from $50 to $300 for single coverage and from $150 to $900 for families.

A few large employers focused on improving the quality of care as a long-term strategy to control costs. For example, one particularly innovative employer was creating an array of decision-support tools for employees, including providing access to nurse coaches to help high service users navigate the care delivery system and making available treatment protocols for certain conditions. This employer's health benefit manager explained that "consumer engagement is not a panacea, but it is a necessary condition for appropriate cost control in the long run."

A handful of other large employers were tailoring disease management, health risk

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appraisals and wellness programs to their workforces as their primary long-term strategy to control costs. These efforts focused on disease prevention by promoting healthy lifestyles and cost containment by carefully managing chronic care. By analyzing their own claims data, employers identified which services and diagnoses led to their highest costs and then tailored disease management and cost sharing designs accordingly. Some employers were opting to self insure to gain access to their claims data to develop such programs, although their ability to generate cost savings remains to be seen.[3]

Some employers focused attention on administrative cost savings. Abandoning the model of trying to contain costs by offering products from different carriers that compete on price and quality, these employers opted to develop a long-term relationship with a single carrier. They believed this gave them more leverage in premium negotiations, facilitated customer service and lowered administrative costs.

Implications

Despite cost pressures comparable to the early 1990s, most employers did not drastically reduce health benefits, opting instead to incrementally increase patient cost sharing under existing benefit designs. Although health benefit managers generally concur that greater cost sharing will increase employee sensitivity to health care costs and, thereby, help slow premium trends to some degree, few view this approach as a long-term solution to underlying cost growth.

Yet, most employers see no viable alternatives on the horizon. Unlike in the early 1990s, when employers embraced managed care's promise of cost control and quality improvement, most employers today see no innovative idea or model that inspires enough confidence to motivate reform. Moreover, expectations that labor markets will remain relatively tight in the near future make employers even more cautious about adopting changes that will spark employee discontent. Under the continued pressure of rising premiums, employers will likely further increase workers' share of health care costs, even as the economy recovers.

Although employers' benefit changes are incremental, the combination of large increases in premiums and modest increases in patient cost sharing is leading to financial hardship for some workers and has likely caused some to drop coverage or delay seeking needed care. Furthermore, research has shown that increased cost sharing leads to reductions in both needed and discretionary care, making it a blunt tool to achieve cost savings.[4] For the future, some health plans and employers are refining cost-sharing approaches to encourage patients to seek efficient providers, choose effective treatment options and obtain care in the most cost-effective setting.[5] But how soon these refinements will be developed, how widely they will be accepted and how effective they will be at controlling health care costs remain to be seen. ●

Notes

1. Gabel, Jon, et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing," *Health Affairs*, Vol. 22, No. 5 (September/October 2003).
2. Strunk, Bradley and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Stabilize But Remain High in 2002," *Health Affairs*, Web Exclusive (June 11, 2003).
3. Short, Ashley, Glen Mays and Jessica Mittler, *Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care*, Issue Brief No. 69, Center for Studying Health System Change, Washington, D.C. (October 2003).
4. Newhouse, Joseph P., *Free for All? Lessons from the RAND Health Insurance Experiment*, Harvard University Press, Cambridge, Mass. (1993).
5. Trude, Sally and Joy M. Grossman, *Patient Cost-Sharing Innovations: Promises and Pitfalls*, Issue Brief No. 75, Center for Studying Health System Change, Washington, D.C. (January 2004).