

Health Policy Report

CHANGING HEALTH INSURANCE TRENDS

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WITH health care expenditures growing far more rapidly than the economy, employers and the health insurers whose plans employers purchase are implementing new ways to reconcile the strong demand for medical services with the means to pay for them. The changes fall short of a grand strategy, but they do underscore the emergence of a set of beliefs that will influence the shape of private insurance for the foreseeable future. Their centerpiece is a conviction that individual consumers of health care should assume greater financial responsibility for the decisions they make when selecting insurance benefits and seeking medical treatment. Central to this view is a belief among employers that if their employees manage their own insurance coverage and take greater responsibility for their health, they will become a more assertive force against excessive health care spending. Employers prefer this market-oriented approach to controlling costs over government intervention, which most companies distrust. In this report, I will discuss these developments and also the striking erosion of coverage for early retirees and persons over the age of 65 years who have relied on their former employers to supplement Medicare coverage, particularly for prescription drugs.

Whereas virtually all other industrialized nations make health care accessible to employees through policies enacted by government, the United States favors reliance on voluntary, employer-sponsored health insurance. Since World War II, though unintentionally at first, the federal government has encouraged this voluntary approach by exempting from taxation the income earned by workers that companies use to pay insurance premiums. This tax exemption — which favors people of means because the higher the tax bracket, the greater the break — cost the federal treasury about \$141 billion in 2000, making it the third largest federal health program on the basis of expenditures (after Medicare and Medicaid).¹

THE STATUS OF INSURANCE COVERAGE

Although a small but growing number of analysts and policymakers argue that the job-based insurance model is inequitable because of the tax advantage it

provides and that it is an inadequate basis on which to expand coverage, this approach remains the strong preference of most employers and employees, as a recent study showed.² In 2000, employer-based insurance covered some 171 million people, including 11 million retirees who have coverage that supplements Medicare,³ and about 16 million people purchased their own insurance. Medicare, Medicaid, and other public programs provided coverage for an additional 80 million people. Despite the robust economic growth that marked the years 1994 to 2000, by the end of this period, the number of people without health insurance remained unchanged — about 17 percent of the entire population. Although the number of people who were insured through their employers increased by 15.9 million, coverage through Medicaid and other public programs declined, almost entirely offsetting this trend.⁴

In contrast to the expansion of private coverage among active workers, many retirees (both those who chose early retirement and those who retired when they were 65 or older) whose former employers once offered them benefits that supplemented Medicare have seen their coverage diminish or disappear over the past decade.⁵⁻⁸ Lack of insurance is associated with an increased risk of a decline in overall health among adults nearing retirement.⁹ In 2001, coverage of early retirees (those under 65 years of age who were not yet eligible for Medicare) was offered by 29 percent of large employers, down from 46 percent in 1993, according to a recent survey of employers.¹⁰ Among those employers who did offer such benefits in 2001, 35 percent of them required early retirees to pay the full cost of their coverage. Only 8 percent of small companies (defined as those with 3 to 199 workers) offered any insurance coverage to their early retirees in 2001. Coverage of retired persons, excluding early retirees, that supplemented Medicare was offered by 23 percent of large employers last year, down from 40 percent in 1993. Many retirees who have retained some form of employer-sponsored coverage have had to pay more out of pocket, in the form of premium increases and higher copayments for prescription drugs.⁶ In addition, a growing number of these retirees are reaching caps on their coverage that their employers had imposed over the past decade.

Viewing this loss of coverage as a troubling trend that government should address, the Clinton administration proposed that persons nearing retirement be allowed to purchase Medicare coverage through a buy-in plan. However, the current Bush administration and many employers oppose this approach.^{11,12} The alternative proposed by the Bush administration — providing tax credits that would partially subsidize the cost of private insurance — has many detractors as well, because such coverage is expensive and the

scope of benefits is usually modest. The cost of individual insurance is based on the health status of the individual subscriber and other underwriting factors — which often places it out of the financial reach of many people, particularly those with a chronic or severe disease.¹³⁻¹⁵

EMPLOYERS' CONCERNS ABOUT HEALTH CARE SPENDING

The rapid rate of growth of health insurance premiums, a key factor in the decision of many employers to reduce their coverage for retirees, has also spurred many companies to reconsider how they can best offer affordable coverage to their active workers. In the period from 1994 to 1997, as managed-care plans reduced spending, annual increases in premiums and overall health care expenditures were remarkably small — indeed, less than overall inflation, “a situation unprecedented in living memory.”¹⁶ But since then, a combination of related forces, all pulling in the direction of increasing costs, has led to another cost spiral. The backlash against the managed-care model led to the elimination of the most tightly managed insurance products in favor of less intrusive methods of cost control. At the same time, many hospital systems, exploiting the greater leverage they gained by virtue of the backlash, negotiated higher payment rates from health insurers.^{17,18} An analysis of trends in health care costs showed that expenditures for hospital care in 2000 accounted for 43 percent of the growth in overall spending, representing a substantial increase over the previous year's share and replacing pharmaceutical products as the key factor in rising expenditures.^{19,20} In a recent interview, the chairman of the Federal Trade Commission, Timothy J. Muris, said that because the agency was concerned about rising medical costs, it planned to step up scrutiny of previous hospital mergers to make certain that the organizations had not joined forces simply to fix prices.²¹ At the same time, the health insurance industry has also been consolidating.

Seeking to restore or sustain their own profit margins, insurers abandoned efforts to gain a greater share of the market by cutting premiums. This practice is part of what is called the “underwriting cycle,” and it recurs about every three years.²² In the other years, most insurers reduce premiums or hold them steady in an effort to attract new business. A recent national survey of 2014 randomly selected companies of all sizes showed that insurance premiums increased by an average of 12.7 percent in 2002, the highest rate of growth since 1990.²³ Figure 1 compares premium increases with overall inflation, workers' earnings, and medical-claims expenses between 1988 and 2002. Increases in premiums have varied little according to the type of plan. The average monthly cost of indi-

vidual coverage was \$255 (\$3,060 a year), and the cost of family coverage rose to \$663 (\$7,956 a year). These figures represent the sum of the employer's and the employee's contributions. In a recent analysis by Morgan Stanley, the investment banking firm offered its conclusion about what these premium increases would mean for health insurers: “Aggressive pricing action should enable these companies to experience margin expansion and increasing profitability in the large group segment of their operations through 2002.”²⁴

While the unemployment rate was low and their profits were growing, many employers were willing to absorb the cost of higher premiums (or granted smaller wage increases to their workers) as a price worth paying to retain skilled workers in a tight labor market.²⁵ Figure 2 documents the growth of average monthly contributions that workers and employers paid between 1988 and 2002 to cover the cost of insurance premiums. In an interview, Helen Darling, president of the Washington Business Group on Health, an organization composed mostly of Fortune 500 companies, said, “We have developed — even fostered — a culture that insulates employees from the true costs of health care and supports an expectation that all health care would be paid for by employers or the government. We have moved a long way from the concept of insurance. Things have to change.” Indeed, change has begun.

A recent announcement that put this development in the limelight was made by the California Public Employees' Retirement System, which negotiates benefits for 1.2 million state employees and retirees, making it one of the nation's largest purchasers of health insurance after the federal government. A trend setter among state agencies for wielding its purchasing power to hold down premiums in earlier years, the California program announced on April 17 that, effective in 2003, it would accept annual average premium increases of 25 percent for plans that enroll about three quarters of its covered workers.²⁶ In 2002 and 2001, the increases were 13 percent and 9 percent, respectively. The remaining employees are covered through other insurance offerings, the cost of which will also escalate sharply.

The cost of the premium increases in 2003 — \$2.4 billion — will be shared by the state and the employees and retirees who participate in the California program. The scope of benefits was left untouched. The program also dropped two of the health plans with which it had contracted and stated, “Implicit in our consolidation is the fact that we will seek to replace the current year-to-year pricing with longer term, performance-based compensation that is aimed at improving care management by plans and providers and into an era when our enrollees will be-

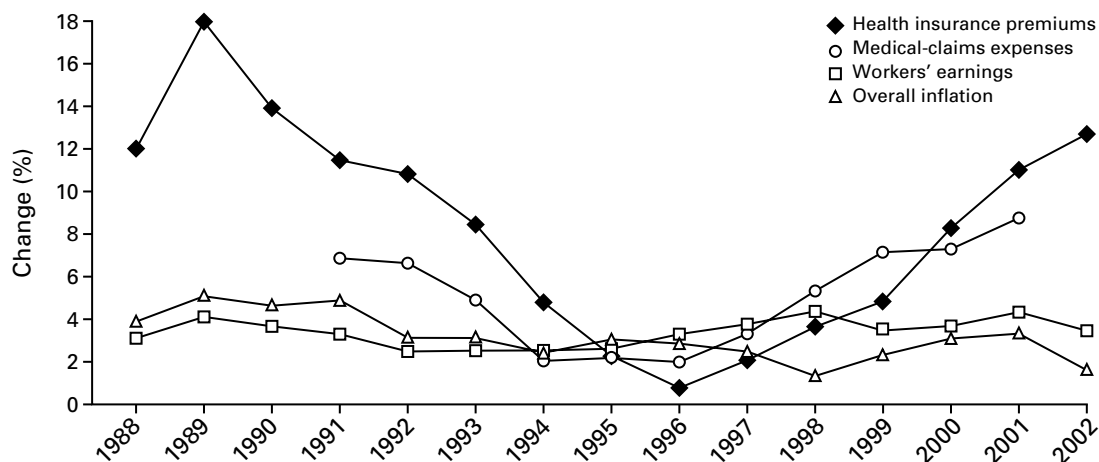


Figure 1. Changes in Health Insurance Premiums, as Compared with Overall Inflation, Workers' Earnings, and Medical-Claims Expenses, 1988 through 2002.

Data are from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, the KPMG Survey of Employer-Sponsored Health Benefits, and the Bureau of Labor Statistics. The change from the previous year is statistically significant for 1997–1998, 1998–1999, 1999–2000, 2000–2001, and 2001–2002. Significance tests were not performed for the years before 1997 or for workers' earnings or overall inflation. The sample included firms with 200 or more workers only.

come more engaged.”²⁶ Active and retired federal workers covered through the Federal Employees Health Benefits Program are also expecting double-digit increases in their 2003 premiums; the exact increases will be announced soon.²⁷

THE RETURN OF COST SHARING

Although premium increases affect all employees with health insurance coverage, insurers (at the behest of employers) are also redesigning their benefit packages in ways that will have the greatest effect on workers who seek medical care.²⁸ These packages generally feature fewer benefits, larger cost-sharing requirements at the point of service, or both, but also smaller premium increases than would have otherwise been the case. Structuring benefits in ways that subject patients to larger out-of-pocket expenditures is a reversal of a pattern that had been in place for decades, according to the Centers for Medicare and Medicaid Services. The agency estimates that approximately 15 percent of personal health expenditures were borne by consumers in the form of out-of-pocket costs in 2000, down from 20 percent in 1990 and 48 percent in 1960.²⁰ Figure 3 depicts trends in out-of-pocket costs as a percentage of total health expenditures between 1970 and 2000.

Reflecting the changes in benefit packages, the recent employer survey showed that 17 percent of employees worked for a firm that reduced the level of benefits in 2002, as compared with only 7 percent in

2000 and 10 percent in 2001.²³ In addition, among small firms, the percentage of employees receiving free individual coverage (i.e., without a payroll deduction) fell from 57 percent in 2001 to 44 percent in 2002. There is virtually no free family coverage offered by small firms. Among large companies, the percentage of employees with free family coverage fell from 13 percent to 5 percent.

Cost sharing by patients comes in a variety of forms: an annual deductible (an amount that a patient pays up front, before using health care services), a specific deductible for hospital admission, a copayment (an amount that a patient pays per unit of service, such as an office visit or a hospital stay), and various cost-sharing features for generic and brand-name drugs, all of which can be “mixed and matched to achieve whichever premium price point is desired by the purchaser.”²⁸ A recent study suggested that employers could realize the greatest reductions in their insurance premiums through increased cost sharing by patients rather than the elimination of specific benefits.²⁹

TIERED BENEFITS

One of the newest cost-containment methods being used by insurers differentiates prescription drugs, hospitals, and, in California, medical groups and physicians on the basis of cost. This approach was first used with prescription drugs, the costs of which grew more rapidly in the 1990s (from \$40 billion to

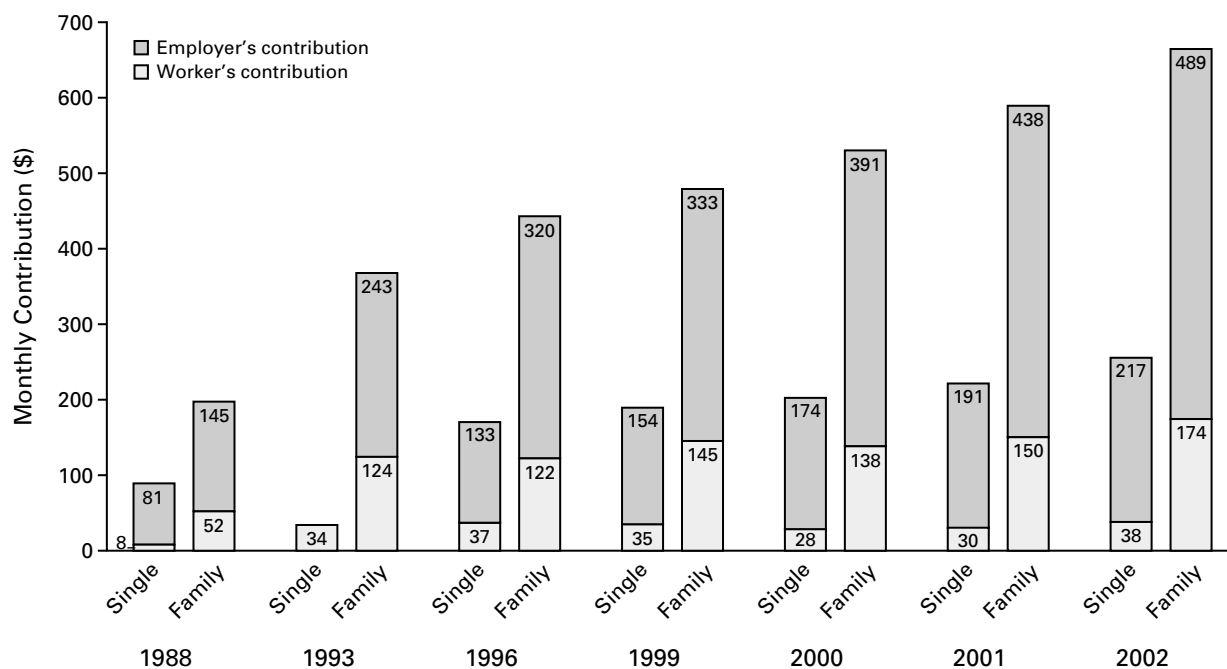


Figure 2. Average Monthly Contributions of Workers and Employers for Single and Family Coverage, 1988 through 2002.

Data are from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits and the KPMG Survey of Employer-Sponsored Health Benefits. Data are not available for the employer's contribution to single coverage in 1993.

\$122 billion a year) than did the costs of any other major component of personal health care.²⁰ According to the recent survey of employers, 57 percent of workers with drug coverage have benefits that are based on a three-tier cost-sharing formula, as compared with 36 percent in 2001 and 28 percent in 2000.²³ Under such coverage, the lowest copayment is required if a generic drug is prescribed, a higher copayment is required for a brand-name drug when no generic equivalent is available, and the highest copayment is required for a brand-name drug when a generic drug is available.

The most recent form of tiered benefits — different levels of copayments for hospital care that are based on costs — is being offered by some of the nation's largest insurers on either a trial or a permanent basis. The employer survey reported that 5 percent of covered workers have insurance plans that require a lower copayment for admission to a lower-cost hospital and a higher copayment for admission to a higher-cost hospital.²³ Among insurers offering benefit packages with this feature are Blue Shield of California, Humana, PacifiCare Health Systems, and United Health Group. The Tufts Health Plan sells insurance that includes tiered benefits for hospital care, but only a few companies have purchased these products so far.

Partners Healthcare System of Boston reported that tiered copayments for hospital care have had no effect on the number of patients admitted to its major teaching institutions (Brigham and Women's Hospital and Massachusetts General Hospital) (Zane E, Partners Healthcare System: personal communication). CIGNA and HealthNet have announced plans to market benefit packages with tiered copayments for hospital care next year. PacifiCare and Blue Shield of California are exploring ways to provide tiered benefits for physicians' services based on the fees they charge and possibly on selected indicators of the quality of care they provide³⁰ (and Joyner D, Blue Shield of California: personal communication).

In general, patients admitted to lower-cost ("preferred") hospitals face copayments that range from \$0 to \$250 for an inpatient stay, depending on the insurer. Patients admitted to "nonpreferred" hospitals face out-of-pocket copayments in the range of \$400. In virtually all these plans, the quality of care delivered at any particular hospital does not figure into the equation, which is designed to save employers money. All these benefit packages place an annual maximum on a patient's out-of-pocket expenditures, but the amount varies widely, depending on the extent of coverage.

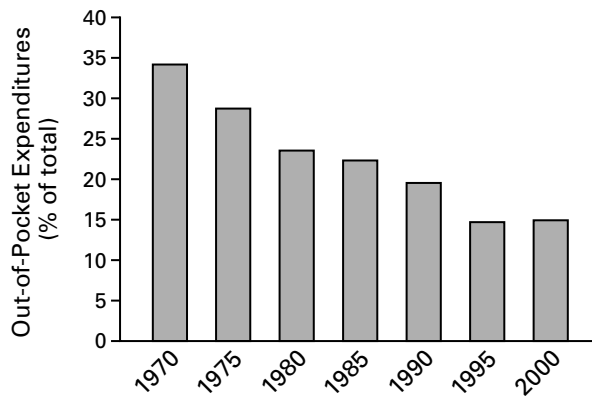


Figure 3. Out-of-Pocket Expenditures by Consumers as a Proportion of National Health Expenditures, 1970 through 2000. Data are from the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Out-of-pocket expenditures include insurance copayments, deductibles, and payments for services not covered by insurance.

Tiered copayments for hospital care that are based on the costs of such care took root in California, a state with a heavy concentration of managed-care plans and a highly competitive market. Not surprisingly, the higher-cost hospitals oppose this approach. In the face of “vigorous opposition from hospitals,” Blue Cross of California, the state’s largest insurer, announced recently that it would not offer tiered copayments for hospital care in its benefit packages.³¹ Blue Shield of California, a separate enterprise that competes vigorously with Blue Cross of California, announced on June 25 that in the future, it will evaluate hospitals not only on the basis of their costs but also on the basis of data on patient satisfaction and the quality of care, compiled by two independent organizations.^{32,33} The quality of care will be determined by, among other things, whether a hospital has a computerized order-entry system for medications and whether the intensive care unit is adequately staffed. These two measures are also being used by large companies that belong to the Leapfrog Group.³⁴ Under the Blue Shield plan, about 1 million covered California residents would typically pay either \$150 to \$200, in addition to the amount already required by the insurance contract, or 10 percent of the cost each time they are admitted to a hospital that is not on Blue Shield’s preferred list.

On the basis of costs, Blue Shield placed some of California’s teaching hospitals (e.g., Stanford University, the University of California at San Francisco, and the University of California at Los Angeles) on its preferred list. But other teaching hospitals, including the University of California at Davis and Cedars–Sinai Medical Center in Los Angeles, failed to make the list. The chief executive officer of Cedars–

Sinai, Tom Priselac, is also chairman of the Council of Teaching Hospitals, an affiliate of the Association of American Medical Colleges. The council has been monitoring the evolution of tiered copayments for hospital care (Dickler R, Association of American Medical Colleges: personal communication). In a telephone interview, Priselac said that he opposed the concept of tiered copayments because they would place at a disadvantage those patients most in need of tertiary care. But he also emphasized that tiered copayments “ignore the economic reality” that teaching hospitals face:

They must admit a substantial volume of patients requiring only routine care to help cover the costs of their social missions [teaching, research, and care for the uninsured]. Unless patients have remarkable insight into the nature of teaching hospitals and their value to society, why would they elect to spend more out of pocket for a routine service for which they could get like results in a less expensive setting? In the absence of a public policy that requires all third parties to share in financing the cost of these social missions, the dire consequences of tiering for teaching hospitals becomes abundantly clear.

IN SEARCH OF A NEW BALANCE BETWEEN EMPLOYERS AND EMPLOYEES

These new insurance products represent only the first wave of profound changes that lie ahead as employers redefine and seek to limit their obligation to pay for the fringe benefits they offer to their employees and retirees.³⁵⁻⁴⁷ In essence, the basic change that many employers are considering, but that only a handful have thus far implemented, is to abandon the traditional approach of offering employees a defined set of insurance benefits and instead offer them a fixed amount of money to pay for coverage. Under this approach, the employee would pay for any costs that exceeded the employer’s contribution, up to a maximal amount, beyond which insurance would cover the cost of a serious or catastrophic illness. The concept of a “defined contribution,” as it is commonly known, was first introduced in the context of pension benefits for retirees. Most large employers have shifted from a traditional pension plan, which guarantees a level of payment on retirement, to a defined-contribution plan, which guarantees only the amount of the contribution to the plan over time. This approach places greater responsibility on employees to manage their retirement accounts.⁴⁸

The defined-contribution model of insurance coverage — or, as insurers and employers are increasingly referring to it, “consumer-driven health care” — features a continuum of products, most of which have been introduced in only the past year or so by start-up insurance companies and some of the traditional carriers. The purest of these approaches is one in which the employer is essentially removed from

the insurance transaction by virtue of having provided employees with cash or a voucher that can be used to purchase coverage. No large, medium, or small company is offering this option to its employees (Darling H: personal communication).

Most employers are interested in offering their employees a less radical version of the model with several key features. One feature is that a portion of the employer's contribution to health insurance is placed in a personal health account from which the employee can draw to purchase health care services with tax-exempt dollars. A second feature is the provision of a major medical policy, also purchased with a portion of the employer's contribution, that covers the costs of catastrophic illnesses. Under this arrangement, employees pay out of pocket for any health care expenses they incur that exceed the balance in their personal health account but that fall short of the threshold set by the major medical policy. The assumption is that people will be more prudent in purchasing health care services if they recognize that they are spending their own money. Generally, these insurance plans give covered employees access to a preferred network of physicians, who are compensated on a discounted fee-for-service basis, and hospitals. Workers can visit physicians who are not in the preferred network, but it will cost them more out of pocket to do so.

These insurance plans would require that employers educate their employees about this new world of coverage, as well as provide information and counsel in the initial phases of implementation. Because the insurers offering these plans all rely on the Internet to provide information about providers and treatment options and as a tool to administer the plans, consumers must become familiar with this technology. In addition, medical groups and physicians in solo practice will have to assemble the computer systems required to maintain connection with a wide variety of insurers, many of which use different systems. The defined-contribution model has attracted considerable attention through media coverage, conferences, interest on the part of employers, and marketing efforts by the start-up companies that are promoting it. Large organizations that are offering their workers the option of enrolling in a defined-contribution plan include Aon, CIBA Vision, Medtronic, Novartis, Pharmacia, Raytheon, Textron, Louisiana State University, and the University of Minnesota.

Most companies have been slow to embrace this model, for several reasons. A major concern of self-insured employers is that the defined-contribution approach could become more, rather than less, expensive for companies if employees, particularly those with the best health, drew heavily on their personal accounts for discretionary services. Another concern

is the harsh criticism voiced by some analysts in late 1999, when an executive of Xerox stated at a health policy conference in Washington, D.C., that the company was planning to give its employees, regardless of their health status, a fixed contribution to purchase health insurance in the open market.⁴⁹ The critics said the scheme would jeopardize the pooling function of health insurance, a view recently expressed by Fuchs.⁴² But that is precisely what many advocates of the defined-contribution model favor, since they believe that employees must be made to assume greater financial responsibility for their health care decisions. Greg Scandlen, a senior fellow at the National Center for Policy Analysis (an organization best known for developing the concept of medical savings accounts), argues that the defined-contribution model would create "a rational health care system that can meet the needs of each family. It is not a one-tiered, or two-tiered or even five- or six-tiered health care system. It is a 270-million-tiered health care system that delivers exactly those services each individual demands. Now, that is a market-based system."⁵⁰

On June 26, the Internal Revenue Service resolved another issue of concern to employers by announcing that in the future it would allow employees to roll over from one year to the next any amount left over in an eligible personal health account. In a press release on the ruling, Treasury Secretary Paul O'Neill said, "With this new guidance, we clear the way for employers to adopt health plans with patient-directed features so that employees have more choice and greater control over their health care coverage."

CONCLUSIONS

Almost all Americans with health insurance contribute to the premiums that finance their coverage and have varying levels of out-of-pocket costs when they visit a physician, are hospitalized, or seek other health care services. With increases in insurance premiums returning to double-digit levels, many employers believe that their employees should be sensitized to the high cost of care by paying more out of pocket. Although implementation of the many variants of defined-contribution plans poses major challenges, Galvin and Milstein assert that "large employers see no better path to improve the value of their health care purchases."⁵¹ In the process, having been burned by the backlash against managed care, employers and insurers want to refrain from intruding in the physician-patient relationship and instead place the consumer in charge, armed with a wealth of information and financial incentives for using health care resources more prudently.

The RAND Health Insurance Experiment, now 25 years old but still viewed as relevant, demonstrated that, on average, insured persons seek medical at-

attention less often when they have to pay a portion of the cost out of pocket.⁵² But the research also suggested that cost sharing is a rather crude instrument for matching health care services with individual health care needs. Whether that remains the case will soon be put to the test, and physicians, who are increasingly being asked to weigh society's demands for cost containment against the individual needs of their patients, will be central players in this unfolding saga. In the meantime, with Democrats and Republicans sharply divided over the relative roles of government and the private sector in addressing the issue of rising health care expenditures, Congress has failed to move beyond the rhetoric that has dominated its deliberations in recent years.⁵³

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