Vol. IX, No. 6
November 2006

STATE COVERAGE INITIATIVES

Changes in HEALTH CARE FINANCING & ORGANIZATION

issue brief

Major Changes in Benefit Design: A Plausible Way to Control Costs?

Since 1999, premiums for health insurance have increased by an average of more than 50 percent.[1] In response, many large employers have indicated that they are considering significant changes to their health insurance offerings.[2] Initially, employers opted to incrementally increase patients' cost sharing or focus on care management, rather than dramatically changing the benefit design.[3] These approaches did little to control overall health spending, so more significant changes are being implemented by some employers. As a result, employees have begun to see a decrease in benefits, including changes in cost sharing in recent years. For example:

- In 2000, 75 percent of employees had a copayment of $10 or less; in 2005, only 19 percent had a copayment of $10 or less;[4,5]
- From 2005 to 2006, the number of firms offering high-deductible health plans grew by 3 percent;[6]
- Ultimately, between 2003 and 2004, 15 percent of employees saw a reduction in the benefit package they were offered.[7]

Much attention has recently been given to high-deductible health plans. Designed to induce a larger decision-making role for consumers in the health care marketplace, these plans represent a major shift in responsibility from the employer to the employee. While these plans are gaining popularity due to lower premiums, little is known about their overall effect on health care spending, utilization, and outcomes. In addition, much criticism exists regarding significant increases in employee cost-sharing due to the lack of evidence to support equally significant cost-savings to the employer.[8] There is little evidence at this time proving that such changes will help curb health care spending, and could have considerable impact on patient access and utilization. This has led public and private employers, as well as many state initiatives, to look for other ways to enact change.

Changes in payment structure and benefit design through managed care were successful in maintaining health care spending levels for most employers through the 1980s and 1990s, yet the managed care backlash has restricted their utility as cost-containment methods.[9] Therefore, the question still remains: can benefit design changes adequately control health care costs? To explore the potential changes benefit design could have on controlling health care spending and the policies that accompany these changes, a small invitational meeting was conducted by the Robert Wood Johnson Foundation, through a joint effort of its Changes in Health Care Financing and Organization

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for HCFO, an initiative of The Robert Wood Johnson Foundation.

(HCFO) initiative and State Coverage Initiative (SCI) programs. The meeting brought together health care stakeholders from a variety of backgrounds and perspectives to engage in intellectual discourse on outcomes of previous changes, recently implemented changes, and promising policies for future changes that could help to control costs. In an informal, anonymous, and facilitated discussion, participants explored:

1) the current state of the field;
2) how best to predict patterns of insurance choices;
3) benefit design initiatives being considered or tested;
4) influencing benefit design; and
5) additional information or evidence needed to inform employer and policymaker decisions.

Current State of the Field

Employers, whether large or small, public or private, are motivated to provide health insurance to their employees in order to attract better talent to their firms. The ability to provide low-cost coverage with exceptional benefits enables an employer to attract the most qualified employees, often in exchange for lower wages. Large firms can provide lower cost coverage than smaller firms, because they have larger risk pools, and the option to self-insure, which allows them to bypass state mandates required of commercial insurance.

Public-sector employers, who are mostly unionized, tend to offer rich health care benefits relative to wages. The public-sector workforce is generally older and sicker than the private-sector workforce, and public-sector workers tend to have a higher prevalence of chronic diseases than their private-sector counterparts. The demographics of the public workforce, along with the tendency for public workers to have less turnover, have led to a trend of public employers increasingly offering disease management and self-assessment tools as a way to curb the costs associated with chronic diseases. Some states have also implemented innovative benefit designs for their employee coverage, such as basing premium and copayment tiers on salary, which help encourage even low-wage workers to purchase insurance.

Over the past five years, patient cost sharing for private-sector employees has both increased and changed forms.[10] As a part of this trend, employers are increasingly shifting their cost-sharing from copayment to either coinsurance only or a combination of copayment and coinsurance.* This change is most common in the small group market because small employers have felt more urgency to reduce premiums. In addition to shifting the cost burden, there is a trend toward tiered or targeted copayments, such as higher copayments for emergency room visits, mental health services, or prescription drugs. This trend is a result of health plan and employer attempts to motivate consumers to utilize lower cost services and treatments when possible.

Some purchasers have added coverage for preventive services and prescription drugs with the hope that it will encourage better health care and ultimately reduce costs over time. In recent years, Medicare has started to expand these benefits. For example, the Medicare Modernization Act (MMA) of 2003 increased the preventive services covered under Medicare and added a prescription drug benefit. The Centers for Medicare and Medicaid Services (CMS) recently began advocating increased use of these services after an analysis showed that in 2001, Medicare paid more than $13 billion for potentially preventable hospitalizations.[11]

Predicting Patterns of Insurance

Research has shown that population characteristics may predict patterns of insurance choices.[12] Determinants other than health care needs often drive insurance choices. For example, the low-income population in the individual insurance market tends to choose products with higher premiums and lower copayments, as opposed to plans with high deductibles, because they need financial predictability and cannot afford to pay a large deductible all at once. Research has shown that gender also has an impact on health insurance choices. Because choices are tied closely to the needs of the population and the individuals, it is not surprising that women want coverage that includes pre-natal care and costs associated with delivery. Additional research has begun to focus on the growing Latino population. Early evidence shows that

* Note: Copayments are typically small amounts ($5-$25) paid to a provider at the time of service. Coinsurance is a beneficiary's contribution to the health insurance premium.

one of the reasons the Latino population favors HMO products is because they allow them to utilize health clinics, a delivery model with which they tend to be familiar. Further examination of underserved and special populations could offer the insights necessary to provide them with coverage that fits their needs and characteristics. It is important to note, however, that simply segmenting the population may create price volatility, which could decrease, rather than increase coverage, due to the small risk-pools created by such segmentation.

Benefit Design Initiatives Being Considered or Tested

Large Employers

Past experience has shown that large employers are often in the forefront of offering new options for employee benefits, including health insurance products. Recently, this has been demonstrated by large employers rapidly offering health plans with high-deductibles and savings features.[13] This phenomenon has been accompanied by large employers' interest in expanding consumer engagement in the health care marketplace. Although few tools currently exist to enable more informed consumer interaction with the health care market, large employers could drive the market to produce such tools. They have also begun to encourage increased use of primary and preventive care, realizing these services can help to control soaring health care costs over time. A growing number of large employers are also providing in-house medical clinics and pharmacies, making primary care more accessible. Several innovative firms are even attempting to help increase the amount of healthy foods their employees eat.[14] Others have taken steps to promote the use of preventive health services. For example, some employers have eliminated copayments for prescription drugs prescribed for chronic diseases.[15] Large employers tend to spend more on health benefits, but offer lower cost coverage, than their smaller counterparts, therefore they have the resources to support such innovation, and drive change within the market.

State Initiatives

In addition to playing a major role as regulators in the private insurance market, states are experimenting with benefit design in a variety of ways within their Medicaid and public programs. Some states are looking at changes to Medicaid benefit packages and cost-sharing as a result of new flexibility granted to them under the Deficit Reduction Act of 2005. A number of states are also focusing on offering non-Medicaid public products for individuals without access to Medicaid/SCHIP or employer-sponsored plans. For example, Massachusetts lawmakers recently approved legislation to expand access to private insurance in unison with a new law requiring all citizens to have health insurance coverage. The design of an affordable benefits package is critical for the success of the Massachusetts reform.

Examples of innovative public program benefit design in several states include:

1. The Health Care Group of Arizona† offers employees of local governments and small firms that do not offer health insurance a choice between three levels of unsubsidized benefits (active, secure, and classic) that are designed for varying health needs, incomes, and lifestyles. Dental and vision services are optional "add-on" benefits. The majority of enrollees have selected the richest benefit level, classic.
2. The Maine Dirigo Program combines and pools a small business and individual market product with a comprehensive benefit package and subsidies for individuals up to 300 percent of the federal poverty level ($60,000 for a family of four).[16] Within this initiative, rewards are offered for individuals who select a primary caregiver and for those who complete health risk assessments. The product is rich – it has no pre-exclusion, and includes mental health parity and 100 percent preventive services coverage.
3. West Virginia is establishing a pilot primary care, clinic-based plan for uninsured individuals to receive a defined set of primary care services for an affordable price ($1 per day at some clinics). The

† Health Care Group of Arizona provides lower-cost health insurance to small businesses in Arizona. It began using Medicaid dollars to purchase coverage, but is now completely self-funded.

goal of the initiative is to bring previously uninsured individuals, whose usual place of care is a clinic or an emergency room, into a system of care. Legislation proposed by the Governor was passed allowing limited benefit plans to be offered in the individual market. While this will allow companies the flexibility to develop different products for different demographics, all plans must include preventive services.

Small Group, Individual, and Niche Markets

Small businesses have more difficulty offering affordable health insurance to their employees because they have smaller risk pools.[17] Initiatives such as Association Health Plans (AHPs) attempt to create larger risk pools, and in some cases self-insure, to make health insurance coverage more affordable for small businesses and their employees.[18] For many reasons, these types of initiatives have not substantially increased the number of small businesses that are offering health insurance to their employees.[19] Further, AHPs have been charged with being a mechanism to skim healthier patients from the small group market and avoid state mandates.

Insurance companies are developing more products, which vary based on state regulatory laws, for the individual and niche markets, especially for healthy young people, who are an increasing share of the uninsured.[20] Alternative methods of coverage, such as direct funding of primary care by an employer or government with catastrophic coverage paid by the employee, could provide affordable coverage for those who do not currently have it. One problem with this type of coverage is defining primary care, because primary care needs differ based on a person's health status. Another concern is that there is a move towards a "user-fee" type of insurance, where individuals pay for the services they want to have covered. Critics worry that this type of insurance would eliminate consumer protections because lowered premiums would most likely eliminate coverage for high-cost or rare conditions, putting consumers at risk if they ever developed such conditions.[21]

What Should Influence Benefit Design?

When thinking about making changes in benefit design, it is important to remember the intention of health insurance: to ensure access to high quality health care, while ensuring financial security.[22] In today's market, improvements can be made that will allow more individuals financial access to high quality care.

Encouraging Engaged Consumerism

In most other markets, consumers research products and manufacturers before making a significant purchase, yet in health care, few individuals know how much the services they receive from doctors really cost, or whether one treatment is more effective than another. Health care is a complex industry, and consumers cannot be expected to know everything, but providing tools to increase knowledge and incentives to utilize the best services and providers could help to slow the growth of health spending and increase the quality of care provided. These tools will presumably not work under all circumstances. For example, most patients do not have the ability to choose which hospital they are rushed to in an emergency, nor would they take the time to find the best cardiac hospital in the area when they suspect they are having a heart attack.

Changes in benefits that are designed to increase consumer engagement are being tested by employers and insurance companies. Benefit changes that are being tested or proposed include:

- carving preventive services out of heavy cost sharing to encourage utilization of these services and help avoid an acute condition or emergency;
- including tiered copayments to encourage the use of efficient, high-quality providers;
- including incentives for treatment compliance, especially for chronic diseases; and
- providing easy-to-use tools to allow consumers to identify cost-effective and high quality services.

Making the Business Case

Businesses, much like individuals, still have much to learn regarding the appropriate use of health care and the rationale for providing appropriate tools and coverage to their workers. There has been little focus on the cost-effectiveness of quality health care among businesses, yet keeping people from becoming sick or facilitating faster recovery can save money.[23] Ensuring that workers have access to quality health care, in addition to health promotion in the workplace, can help to ensure that employees are performing their duties efficiently.[24]

Providing health insurance coverage to employees is a start, but businesses need to take responsibility for encouraging healthy living and workplace wellness, just as they have done for workplace safety. This includes understanding that much of their workforce may have chronic illnesses, allowing for breaks when necessary, and promoting healthy living, often through treatment compliance. An example of this is the rapidly expanding population of diabetics; in order to regulate their blood sugar and avoid complications, they need to periodically test their blood and eat accordingly. In many instances, employers do not allow for the required flexibility in an employee's schedule. This can cost them more health care dollars than the loss from an extra break or two during the work day.

Gaps in Current Research

Although much research has been done on specific populations and on the impact of certain kinds of cost sharing, more research is needed in order to fully understand the potential impact major changes in benefit design could have on controlling health care costs and encouraging the provision and consumption of quality care.

Research in the following areas could do much to advance understanding:

- Collect and analyze data on health insurance preferences and health care utilization by underserved markets, such as: the working poor, small business owners and employees, minority populations, and the young and healthy. Also on the implications of cost-shifting if the markets become further segmented by these niche markets.
- Collect data and analyze the effects of cost-sharing on access to care and utilization, specifically: copayments, coinsurance, high-deductibles, and preventive services. Also, evaluate the impacts of the different types of care, appropriate and inappropriate.
- Evaluate the effect of benefit design changes on: employer decision-making, employee take-up, and employee utilization.
- Complete comparison research on effective treatments and services for specific conditions. This research should include an evaluation of circumstances when no care may be the best treatment.
- Explore how to put desired health outcomes into insurance coverage terms. For example, convert Healthy People 2010 outcomes into clinical guidelines and coverage models.
- Clearly define problematic terminology, like primary care and preventive care. For example, someone with a chronic condition who needs specialty care has different primary needs than someone who is healthy. Also, should prescription drugs be considered preventive care?
- Evaluate the potential effects of benefit design on recruitment and retention of employees.
- Evaluate innovative product offerings and processes, including natural experiments.

Conclusion

Many challenges still exist in controlling health care costs, and major changes in benefit design could offer promise toward this goal. It remains unclear to what extent any specific changes would impact health care costs, and whether these changes would make a lasting difference, or if they would require reevaluation shortly after implementation. Despite these unanswered questions, benefit design changes are taking place in every market. Evaluating the effects of these changes is the only way to truly understand their capabilities.

About the Author

Cyanne Demchak is a Research Assistant with the Changes in Health Care Financing and Organization (HCFO) initiative. She can be reached at 202.292.6700 or cyanne.demchak@academyhealth.org.

Endnotes

1 "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 1999-2005.

2 Tollen, L. and R. Crane, "A Temporary Fix? Implications of the Move Away From Comprehensive Health Benefits," Issue Brief, Employee Benefit Research Institute (EBRI), April 2002.

3 Ibid.

4 Due to inflation, goods or services that cost $10 in 2000 cost $11.34 in 2005. "Inflation Calculator." U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index Page. http://data.bls.gov/cgi-bin/cpicalc.pl. Accessed October 9, 2006.

5 Ibid.

6 In this data, a high-deductible plan is defined as $1,000 for single coverage or $2,000 for family coverage. The three percent increase in HDHP offerings was not considered statistically significant. "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 2006.

7 "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 2004.

8 Tollen, L. and R. Crane, "A Temporary Fix? Implications of the Move Away From Comprehensive Health Benefits," Issue Brief, Employee Benefit Research Institute (EBRI), April 2002.

9 Ibid.

10 "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 2005.

11 Alonso-Zaldivar, R., "Medicare Looks to Boost Seniors' Use of Preventive Care." *Los Angeles Times*. June 19, 2006.

12 Zillller, E, et al., "Patterns of Individual Health Insurance Coverage, 1996-2000," *Health Affairs*, Vol. 23, No. 6, November/December 2004, pp 210-221.

13 "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 2005.

14 Kritz, F.L., "Dilbert, Drop That Pastry." *Los Angeles Times*. June 19, 2006. http://www.latimes.com/features/health/la-he-officefood19jun19,1,5009784.story?coll=la-headlines-health. Accessed June 19, 2006.

15 Terlep, S. "Will free diabetes drugs cut health bills later?" *The Detroit News*. April 24, 2006. http://www.detnews.com/apps/pbcs.dll/article?AID=/20060424/LIFESTYLE03/604240341&SearchID=73242554830625. Accessed November 7, 2006.

16 "2006 Federal Povery Guidelines." U.S. Department of Health and Human Services. http://aspe.hhs.gov/poverty/06poverty.shtml. Accessed October 20, 2006.

17 Morrisey M., et al., "Small employers and the health insurance market." *Health Affairs*. Vol. 13, No. 5. Winter 1994. pp 149-61.

18 Hearne, J., "Association Sponsored Health Plans: Legislation in the 109th Congress." Congressional Research Service. March 29, 2006. http://www.all-health.org/briefingmaterials/CRSAHPLegislationin108thCongress-94.pdf. Accessed November 7, 2006.

19 "Survey of Employer-Sponsored Health Benefits." Kaiser/HRET. 2005.

20 Collins, S., et al., "Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help." The Commonwealth Fund, Updated May 24, 2006.

21 "What Would Association Health Plans Mean for California?" California Health Care Foundation. January 2004. http://www.chcf.org/documents/insurance/AHPIssueBrief.pdf. Accessed November 7, 2006.

22 "About AHIP." America's Health Insurance Plans. http://www.ahip.org/content/default.aspx?bc=31. Accessed November 7, 2006.

23 Reinhardt, U., "Is There Hope for the Uninsured?" *Health Affairs*. Web Exclusive, August 27, 2003.

24 Warner, K., "Wellness at the Worksite." *Health Affairs*. Vol. 9, No. 2. Summer 1990. pp 63-79.