



# Traversing Tough Terrain: The Future of Employee-Sponsored Health Benefits

Health Care Horizons

Institute for the Future

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The Future of Employer-Sponsored  
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## Introduction

# TRAVERSING TOUGH TERRAIN

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Since 1990, employers have been a major driving force in changing health insurance and financing mechanisms for working Americans and their families. Employers transformed the most common form of health insurance from indemnity to managed care, and from retrospective to prospective coverage and payment policies. As a result, only 7% of workers are covered by indemnity insurance today, versus 27% in 1996,<sup>1</sup> with the balance in managed care (71%) and point-of-service (22%) plans. With this fundamental metamorphosis in American health insurance, employers were able to rein in health inflation—for a time.

Today, rapidly rising health insurance premiums threaten the employer-sponsored health system upon which two-thirds of Americans rely. In 2001, a survey of employers found premium growth to have reached 11%. This is not new territory. In 1988, premiums were rising at a rate of 12%. In the late 1980s, however, tightly managed care stood at the ready, and over the ensuing decade it combined with strong economic growth and low overall inflation to rein in the increase of premiums in particular and health care costs in general. At the beginning of the 21st century, however, much-publicized provider ire, consumer complaints, government regulation, and litigation have weakened the effectiveness of tightly managed care. As a result, employers must find alternative routes to controlling costs. Smaller employers are under the greatest threat, but large employers are feeling the pressure as well. The stakeholders with the most to lose, of course, are the employees pushed to shoulder more of the costs for health care or forced to lose health benefits altogether.



The great hope for controlling the costs of employment-based health benefits in the new century is creating a more direct market for health care products and services. Analysts believe that creating a market in which consumers actively choose and pay for the goods and services they use is the key to driving rational health care consumption. A softening economy, loosening labor markets, and the information-harnessing capabilities of the Internet offer employers new avenues for redesigning health coverage and incentives, and for shifting health care costs and decision-making responsibilities to employees. Many analysts hope that doing so will transform employees from passive health care *beneficiaries* into responsible health care *consumers*.

Given the current state of health insurance, we forecast that in the next ten years new information systems, health care financing mechanisms, and benefit designs will be put in place that attempt to move from employer-directed to consumer-driven, employer-subsidized health benefits. Five forces will drive this journey:

- The rising costs of health benefits, including premiums, hospitalization, pharmaceuticals, expensive new technologies, and administrative expenses.
- Federal and state regulations that mandate benefits, increase health plan liability, and complicate benefits administration.
- The retreat from restrictive managed care that fuels employees' pursuit of choice and access and limits employers' ability to control costs.
- An increasingly diverse workforce that confounds employers' attempts to find one solution that serves all employees well.
- The need to continue to maximize employee productivity by promoting good health.

Combined, these forces will ensure that employers continue to play an active role in providing benefits but will drive them to share more responsibility with employee-consumers and also continue to provide their employees with a range of choices as a quid pro quo for accepting an increasing share of costs.

These driving forces will not go unopposed, however. Competition for skilled labor will inhibit employers' ability to completely shift costs to employees and will keep any employer that can afford it in the business of offering some type of health benefit. The ultimate consumer-driven system would allow employers simply to subsidize insurance by giving their employees money to buy health insurance on their own. Yet employees are unaccustomed to being active health care consumers. Current tax law and the actuarial inequities of group and individual health insurance markets combined with the dearth of easy-to-use information about health care quality will inhibit such an approach. It is argued that while tax and actuarial problems could be addressed, the problems of incomplete provider information and passive consumers are more difficult to solve.

The truth is, providers are reluctant to be monitored, and the vast majority of employees with work-based health benefits have remained strikingly passive consumers of health care. Although employees have voiced discontent with restrictive forms of managed care and moved, in droves, to preferred provider organizations (PPOs), they have yet to seek high-quality clinical care at a good price. Instead, employees have favored wide-open access, choice, and convenience, and have all but ignored price and clinical quality. In their defense, there is precious little information available about the actual quality of care. What's more, studies have shown that employees prefer to have their health care purchased by their employers even though they want increased choice in providers.<sup>2</sup>

This report, *Traversing Tough Terrain: The Future of Employer-Sponsored Health Benefits*, is a ten-year forecast in which the Health Care Horizons arm of the Institute for the Future (ITF) explores the paths employers will travel as they navigate from employer-directed to consumer-directed health benefits. The report has five chapters:

- Chapter 1, "Lost in Familiar Territory," describes the history of health insurance in the United States.
- Chapter 2, "The Lay of the Land," sketches out the terrain of employment-based health benefits today.

## Introduction

- Chapter 3, “Drivers and Barriers in the Move Toward a Consumer Focus,” sets out the drivers for, and the barriers to, the transformation of the health care system from an indirect to a more direct market.
- Chapter 4, “The Forecast: The Employment-Based Landscape of 2012,” draws a picture of what the more direct market for health care may look like in ten years.
- Chapter 5, “The Four Paths to Consumer-Directed Benefits,” maps the ways that four different sets of employer-stakeholders will make their way through the landscape of health benefits in the next ten years.

We hope this report helps you navigate this familiar yet largely unmapped territory.

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**Endnotes**

- <sup>1</sup> Gabel, J., et al. Job-based health insurance in 2001: Inflation hits double digits, managed care retreats. *Health Affairs* (September/October) 2001; 20,5.
- <sup>2</sup> Watson Wyatt Worldwide. *Maximizing the return on health benefits*. Washington, DC: Watson Wyatt Worldwide, 2001.



## Chapter 1

# LOST IN FAMILIAR TERRITORY

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American health care finds itself on familiar ground. The growth of health insurance premiums has reached 11% annually, and employers, large and small—the primary purchasers of health insurance for those under age 65—are scrambling to contain costs. The terrain is similar to that of the 1980s, but different, too. In the 1980s, ahead of us was the great hope that managed care would rein in costs. Today, these hopes are but faint memories.

Indeed, apart from staff- and group-model health maintenance organizations (HMOs), managed care's standard tools for keeping down costs have by and large been removed from the toolbox. They've been neutralized by tighter regulations put in place to appease providers who feel their autonomy is under threat and to allay the fears of consumers who worry about choice and access. As a result, restrictive gate keeping, utilization review, and capitation are out; "any-willing-provider," external review, and "sue-your-health-plan" are in. Moreover, new developments are transforming the health care landscape even further. The Internet and emerging medical technologies are changing both consumers' options and their awareness of their options.

When it comes to controlling the costs of health benefits, employers are lost in familiar territory. How they navigate that territory not only affects who has health benefits in the United States and what benefits they receive, but also influences the quality and accessibility of health care in general.

How did we arrive in this familiar, yet poorly charted land? And where do we go from here? Sometimes it helps to look back before looking forward.

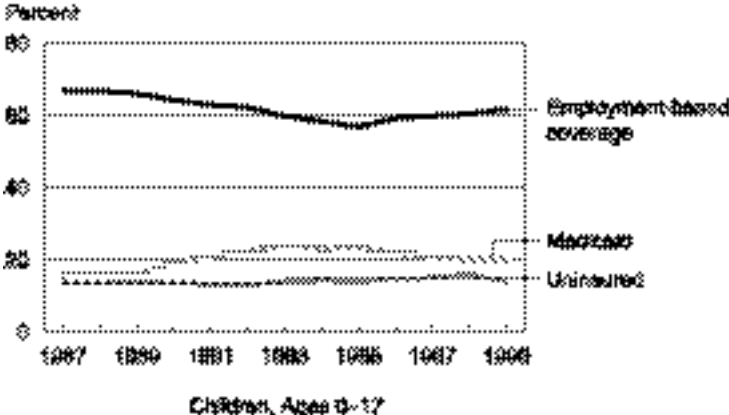
## By Default Rather Than by Design

The American health insurance system emerged by default rather than by design.<sup>1</sup> While other industrialized nations consciously created health care systems out of whole cloth, market forces determined the U.S. system. It evolved from the basic need for businesses to maximize productivity. Whether it means keeping construction workers strong enough to bore holes eight hours a day or ensuring that corporate Chief Executive Officers (CEOs) are in condition to lead their companies around the clock, employer-sponsored health benefits are designed to promote workforce productivity. In this way, the U.S. health insurance system has its origins in the pragmatism of employers rather than the cohesive efforts of public policymakers.

This business-sponsored system forms the infrastructure on which American health insurance is built. As a result, today more than 67% of adults (18 to 64 years old) and 61% of minors (0 to 17 years old) receive health insurance from employers.<sup>2</sup> Of those not covered by employer-sponsored health insurance, Medicaid covers 19 and 20% of non-elderly adults and youths, respectively. The rest are uninsured. Nearly 14% of youths and 6% of adults younger than 65 were among the 42 million Americans who were uninsured in 1999 (see Figures 1–1 and 1–2). More than 17% of adult workers were uninsured, nationally, in the same year.<sup>3</sup> As a result, many depend on a safety net that is being stretched increasingly thin.<sup>4</sup>

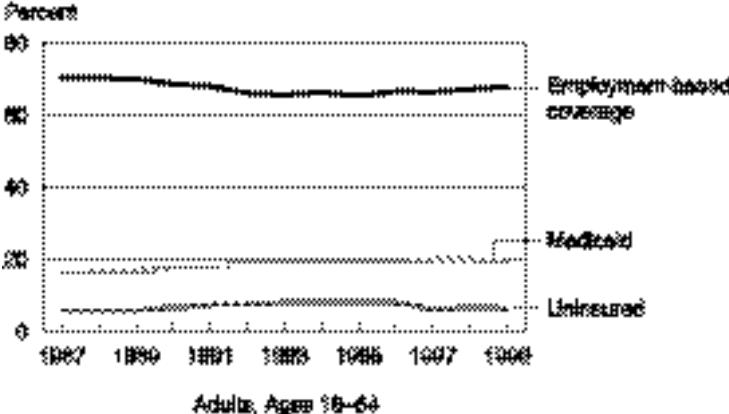
The fact that employers have been influential stakeholders in the American health insurance system has created a health care system in which the incentives are fundamentally misaligned. U.S. health care is a system in which the employer, rather than the employee, is the actual *customer*. The result is an indirect market in which the employer is the intermediary between the end consumers (the employees and their families) and the providers of health care goods and services. Many experts argue that this indirect market creates end customers who care little about cost and less about value. Rather, the users are beneficiaries who demand access, service, and convenience rather than cost-effectiveness. This makes health care costs hard to control, according to employers, who, in response, are trying to realign incentives and keep costs down.

**Figure 1-1**  
*Percent of American Children, Ages 0-17, with Employment-Based Health Benefits or Medicaid, and Without Health Insurance, 1987-1997*



Source: Fronstin, P. *Employment-Based Health Benefits: Trends and Outlook*. EBRI Issue Brief No. 293. Washington, DC: Employee Benefit Research Institute, May 2001.

**Figure 1-2**  
*Percent of American Adults, Ages 18-64, with Employment-Based Health Benefits or Medicaid, and Without Health Insurance, 1987-1997*



Source: Fronstin, P. *Employment-Based Health Benefits: Trends and Outlook*. EBRI Issue Brief No. 293. Washington, DC: Employee Benefit Research Institute, May 2001.



## A Brief History of Employer-Sponsored Health Insurance

The exigencies of the marketplace and government regulation combined to create today's health insurance system.

### *Keeping Workers on the Job*

One of the earliest examples of American employment-based health insurance was that of the mining, lumbering, and railroad industries in the late 1800s (see Table 1–1). Employers had an incentive to provide health services to workers, who often performed dangerous jobs in remote regions, where health care and replacement labor were hard to come by. Employers provided injured or ill workers with access to company doctors and occasionally offered general medical care for workers and their families.<sup>2</sup>

The Blue Shield concept grew out of the efforts in some of the lumber and mining camps of the Pacific Northwest at the turn of the century. Employers paid monthly fees to medical service bureaus. These pioneering programs led to the first Blue Shield Plan, which was founded in California in 1939.<sup>5</sup>

Meanwhile, in 1933, Dr. Sidney Garfield established a prepayment health plan for workers on a construction project in Southern California; Dr. Garfield and Edgar Kaiser, owner of the firm undertaking this project, later initiated the group-practice prepayment plan for Grand Coulee Dam construction workers and families that became known as Kaiser Permanente.

### *Regulation Lends a Hand*

Regulation bolstered employment-based health insurance in 1943, when the National War Labor Board ruled that employers' contributions to insurance did not count as wages. Confronted with World War II wage and price controls and a scarce labor supply, firms jumped on the ruling as an opportunity to offer nonwage benefits to attract workers. By the end of the war, the number of people covered by health insurance in the United States had tripled. Blue Cross/Blue Shield, for example, grew from 1.5 million members just before World War II to 60 million by 1951.<sup>1</sup>

**Table 1-1**  
**Seminal Events in the History of United States Health Benefits**

Year	Event
1847	First (short-lived) company to issue health insurance organized in Boston.
1849	New York passes first state law regulating insurance.
1870	Railroad, mining, and other industries begin to provide company doctors, funded by deductions from workers' wages.
1877	Granite Cutters Union establishes first national sick benefit program.
1906	American Association for Labor Legislation founded to promote workers' compensation and social insurance programs.
1912	National Convention of Insurance Commissioners (now National Association of Insurance Commissioners) develops the first model state law for regulating health insurance.
1913	International Ladies Garment Workers Union establishes first union medical services program.
1933	Group-practice, prepaid plan launched, which became Kaiser Permanente.
1935	Social Security Act passed without health insurance provisions.
1937	Blue Cross Commission established.
1938	Blue Shield Plan founded in California.
1943	National War Labor Board rules wage freeze does not apply to fringe benefits.
1947	Taft-Hartley Act requires collective bargaining on wages and conditions of employment for unionized workers in private industry.
1948	McCarran-Ferguson Act gives states broad power to regulate insurance.
1954	Revenue Act confirms that employer-paid health benefits are not taxable as employee income.
1965	Medicare and Medicaid legislation adopted (effective 1966).
1968	Firestone Tire and Rubber Co. becomes first to self-fund health benefits.
1973	HMO Act requires most employers to offer federally qualified HMOs in addition to indemnity insurance.
1974	Employee Retirement Income Security Act (ERISA) enacted to ensure uniformity in administration of multistate benefit programs.
1985	Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted to provide continued coverage after job termination.
1996	Health Insurance Portability and Accountability Act (HIPAA) enacted to enhance continuity of health insurance.

Sources:<sup>8</sup>

Another strong catalyst for the growth of the health insurance market in the postwar period was the exclusion of employer-provided health insurance premiums from taxable income. There was a catch, however—workers received this tax advantage only if health coverage was provided through an employer. In this way, early policy firmly established employers as the sponsor of choice for health insurance.

### Today, Regulation Draws The Boundaries

**T**oday, state and federal regulations establish a hierarchy of health insurance markets that favors large group purchasers over small, groups of any type over individuals, and employer-sponsored insurance over individually owned insurance. Regulation creates the incentives that perpetuate the employer-sponsored health insurance system by making the most favorable tax law, the most streamlined insurance regulation, and, as a result, the best prices and benefits packages accrue to large employers and insurance companies. This is true even though small employers (199 or fewer employees) account for one-third of workers and 73% of businesses in the United States

The current regulation of employee benefits plans and health insurance is a confusing patchwork of federal and state regulatory and enforcement relationships that draw the boundaries for employment-based health insurance. Agencies involved in health plan regulation include the Department of Health and Human Services, the Department of Labor, the Internal Revenue Service, and State Insurance Commissioners. In addition to tax law, the most important areas of regulation for health insurance are state insurance regulation and four federal initiatives—the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), and emerging federal Patients’ Bill of Rights legislation.

#### ***Federal Regulation Stacks the Deck***

The core legislation governing employee benefits in general and health benefits in particular is the Employee Retirement Income Security Act of 1974 (ERISA). Today, ERISA and its progeny (COBRA, HIPAA,

and the Patients' Bill of Rights) are the focal points of regulatory action in health care from patients' rights protection to privacy provisions and electronic data interchange.

*Employee Retirement Income Security Act of 1974*

The passage of ERISA did much to codify the inequities between large and small employers by creating a protective shield against a multitude of varied state regulations for the largest employers. ERISA provides the legal framework for ensuring uniformity in the administration of multistate benefits programs for the private, employer-based portion of the American health care system.

More than 120 million Americans participate in ERISA-covered group health and retirement plans, all of which are voluntarily sponsored by employers, or employers and labor unions jointly. Many employers have employees in numerous states, so ERISA overrides (preempts) the patchwork of state laws that might otherwise subject these plans to inconsistent regulations. The act preserves the traditional role of the states in regulating the business of insurance, while preempting noninsurance laws that relate to employee benefits plans.

There are two major types of employer-sponsored insurance plans. Fully insured plans are arrangements in which an employer purchases a policy from an insurer or a health plan. In *self-funded* plans, an employer sets aside some of its revenues to pay health claims for its workers, assuming the risk for loss should extraordinary claims be filed. Strictly speaking, size does not determine which companies can self-fund and which can't; however, larger companies are more likely than smaller companies to meet the fiscal requirements to self-fund.

Under ERISA, states may not regulate the content of self-insured plans; states may regulate the content of the fully insured plans by regulating the insurer itself. Thus, fully insured plans are generally subject to greater regulation than self-insured plans, and they are generally more expensive to maintain, in part because they are subject to state mandated benefits laws and state premium taxes. As a result, small employers, which are more likely to be fully insured than large

employers, face more stringent regulation and more expensive plans. Ultimately, ERISA amplifies inequities between large and small employers and between those that self-insure and those that buy fully insured health plans.

Congress has repeatedly revisited ERISA to expand the regulation of health plans, namely by adding COBRA and HIPAA.

*The Consolidated Omnibus Budget Reconciliation Act of 1985*

COBRA requires covered employers that offer health benefits to more than 20 employees to provide continued coverage to most former employees, their dependents, and certain others for 18 to 36 months or until coverage under another plan begins. The employee pays for the coverage at group rather than individual market rates at substantial savings. The employer, however, maintains the administrative burden for the employee's benefit during the bridge period, a requirement that has proven onerous to small employers.

*Health Insurance Portability and Accountability Act of 1996*

President Bill Clinton signed HIPAA (otherwise known as the Kennedy-Kassebaum bill, after its Senate sponsors) into law in 1996. HIPAA was designed to enhance the portability and continuity of health insurance coverage in both group and individual markets and to benefit employees of small firms and people who purchase insurance policies on the individual market. Specifically, HIPAA requires plans to guarantee the issue of all products in the small group market that are offered in the large group market, setting premiums according to group experience, not based on individual health status. HIPAA also requires states to ease the transition from group to individual plans in order to ensure that individuals have access to coverage.<sup>6</sup>

HIPAA provisions included other small group and individual market reforms that are designed to make health insurance accessible for more Americans: long-term care insurance tax incentives, a medical savings account (MSA) demonstration project, and a mandate for the adoption of standards for electronic transactions and transmission of information.

### *The Federal Patients' Bill of Rights*

The two Patients' Bill of Rights proposals now pending before Congress attempt to provide those enrolled in self-insured plans the same protections as those in fully insured plans. Each proposal would amend ERISA in the following ways: by requiring new patient protection provisions (e.g., emergency room coverage, specialty care, and others), new claims procedures (internal and external review), and remedies to patients for denial of medically necessary services. Among the most controversial provisions of each bill is the patient's right to sue health plans.<sup>7</sup> Employers are concerned that the Patients' Bill of Rights will increase health care costs and expose them to increased liability.

All of the aforementioned federal regulations, enacted or proposed, either coexist with or preempt state laws. In some cases, federal protections established by ERISA exceed those afforded by state law; in other cases, they do not. As state regulation grows more active in the area of patient protection, there is mounting conflict between state and federal governments. This results in strict regulations for the employers that buy fully insured health plans—often the smallest employers, and the least able to shoulder the burden.

### **State Regulations Today**

Every state has passed some type of patient protection similar to that being considered at the national level. Since Texas enacted the first law allowing suits by enrollees of health plans in 1997, eight additional states have adopted similar legislation: Arizona, California, Georgia, Maine, New Jersey, Oklahoma, Washington, and West Virginia.

Forty states have enacted protections relating to access to emergency services. Thirty-six states have enacted laws providing direct access to OB-GYN providers for women. Forty states have enacted some external review program, allowing individuals to seek independent review of their benefit disputes with their health plan. Texas and nine other states have enacted laws holding HMOs accountable for injuries caused by negligence. These regulations represent a formidable gauntlet for national employers and insurers. In each case, employers and insurers must assess whether state law applies or is preempted by ERISA and comply. Since both state laws and ERISA are in flux, compliance often is confusing and costly.

Ironically, the discrepancies between state and federal protections are also impelling efforts to fortify ERISA patient protections to match more aggressive state measures, and this may prove detrimental to employers subject to ERISA protections. Mandates such as the federal Newborns' and Mothers' Health Protection Act of 1996 and the Mental Health Parity Act of 1996 chipped into ERISA's protective shield against state laws because they are federal rather than state regulations and neither employers nor insurers are exempt from them. In the end, it is becoming increasingly difficult to control costs by limiting benefits.

### Conclusion: Market Dynamics Determine Employer-Sponsored Benefits

**A**lthough regulation does much to shape the employer-sponsored health care system, the availability and nature of employment-based benefits are inextricably linked to the economy. As the economy worsens, so does the ability of employers to offer health benefits. What's more, the size of the employer plays a large role in determining how well it can maintain its health benefits in the face of market forces. We discuss the interaction of the economy and health benefits in more detail in the next chapter.

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### Endnotes

- <sup>1</sup> Gabel, J. Job-based health insurance, 1977–1998: The accidental system under scrutiny. *Health Affairs* (November/December) 1999; 18,6:62–74.
- <sup>2</sup> Fronstin, P. *Employment-based health benefits: Trends and outlook*. EBRI Issue Brief No. 233. Washington, DC: Employee Benefit Research Institute, May 2001.
- <sup>3</sup> U.S. Census Bureau. "Table B: People without health insurance for the entire year by selected characteristics: 1998–1999." *Health insurance coverage: 1999*. Washington, DC: U.S. Census Bureau, 2000.
- <sup>4</sup> Medicare is the dominant program for people 65 and older though the elderly are among the ranks of the uninsured. Here we present statistics for those who constitute the bulk of working Americans. Analysis of the mix of sources of health insurance for workers 65 and older is beyond the scope of this report.
- <sup>5</sup> Institute of Medicine. *Employment and health benefits*. Washington, DC: National Academy Press, 1993, p. 68.
- <sup>6</sup> For discussion of market reforms, see Blumberg, L.J., and Nichols, L.M. *Health insurance market reforms: What they can and cannot do*. Washington, DC: The Urban Institute, 1998.
- <sup>7</sup> Lewis, S. "A guide to the federal Patients' Bill of Rights debate." Prepared for Kaiser Family Foundation, Menlo Park, CA, August 2001.
- <sup>8</sup> Somers, H.M., and Somers, A.R. *Doctors, Patients, and Health Insurance*. Washington, DC: The Brookings Institution, 1961; Muntz, R. *Bargaining for Health: Labor Unions, Health Insurance and Medical Care*. Madison, WI: University of Wisconsin Press, 1967; Anderson, O. *The Uneasy Equilibrium: Private and Public Financing of Health Services in the United States, 1875–1965*. New Haven, CT: College and University Press, 1968; Wilson, F., and Neuhauser, D. *Health Services in the United States*. Cambridge, MA: Ballinger Publishing Co., 1974; Brandes, S. *American Welfare Capitalism: 1880–1940*. Chicago, IL: University of Chicago Press, 1976; Starr, P. *The Social Transformation of American Medicine*. New York, NY: Basic Books, 1982; Stevens, R. *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. New York, NY: Basic Books, 1989; Health Insurance Association of America. *Health Care Financing for All Americans: Private Market Reform and Public Responsibility*. Washington, DC: HIAA, 1991.





## Chapter 2

# THE LAY OF THE LAND

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Accidents of history, tax law, and regulation have created the basic elements of today's U.S. employment-based health insurance system, but they are not independent of the macroeconomic forces that drive the fortunes of American business. The variability of health insurance markets has led us to a large but inequitable system that leaves the most vulnerable workers and employers on shifting ground, while the largest employers with the best-paid employees are able to acquire and offer benefits under the most favorable terms. In recent years, macroeconomic trends have led employer-sponsored coverage to expand, but as the impact of the recession of 2001 is fully realized, the terrain may grow more unforgiving.

How employers respond to the interaction between the economy and the health markets depends on their size, resources, and the competition they face for labor. While large employers can attempt to limit demand for benefits by changing employee incentives and to exert downward pressure on the supply side by using aggressive benefits management strategies, small employers have fewer tools at their disposal. Many small employers can only cut back on benefits or pull out of the game altogether.

What does the employment-based health benefits landscape look like today and what does it presage for the future?

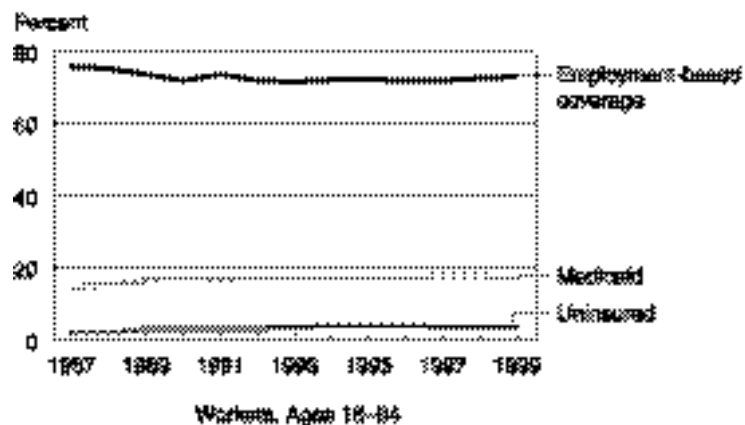
## Employment-Based Coverage Works— For Those Who Have It

For better or for worse, Americans depend on employment-based health insurance. The Employee Benefit Research Institute (EBRI) estimates that 73.3% of workers, ages 18 to 64, had employment-based health insurance in 1999, compared to 71.8% in 1993. The majority, 55.6%, received benefits from their own employer, while 17.7% got them through a family member's employer. This marks a slight gain in employer-sponsored benefits in recent years, after six years of decline between 1987 and 1993 (see Figure 2-1).<sup>1</sup>

### *Employment-Based Health Benefits Are Comprehensive*

Although the move to managed care has suffered a lashing in the media, it has ushered in more comprehensive health benefits for people with health insurance. Health benefits are, in fact, more generous today than they were 20 years ago, when most insured workers had conventional indemnity coverage. Most plans today go well beyond clinical care for

**Figure 2-1**  
Workers Ages 18-64 with Employment-Based Health Benefits or Medicaid, and Without Health Insurance, 1987-1999



Source: Ferenchik, P. *Employment-Based Health Benefits: Trends and Outlook*. EBRI Issue Brief No. 238. Washington, DC: Employee Benefit Research Institute, May 2001.

acute illness to include prescription drugs, prenatal care, preventive care, reproductive health, and mental health services. As might be expected, larger firms offer richer benefits than smaller firms.

Employers are also trying to improve worker productivity by investing in health promotion and wellness programs. To this end, they offer a range of programs, including health education, financial incentives for participating in health screenings, disincentives for poor health behaviors, health risk appraisals, screening tests (e.g., for cholesterol and hypertension), and special programs like disease management and flu shots. Hewitt Associates reports that 92% of U.S. companies offered such health promotion programs to employees in 2000, up from 88% in 1995.<sup>2</sup>

***Employment Helped Decrease the  
Number of Uninsured***

While the number of uninsured rose during the 1980s and most of the 1990s, by 1999 the booming economy helped decrease the ranks of the uninsured to 17.5% of non-elderly Americans, and the actual number of uninsured fell from 44 million in 1998 to 42 million.<sup>3</sup>

Employment-based insurance accounted for most of the health insurance coverage gains realized in recent years. Employer-sponsored insurance covered more minors (0 to 17) in 1999 than in 1994 (61.5% versus 58.1%), as more parents worked and more parents worked for larger firms. Adults benefited, too. The percentage of adults with employer-sponsored health insurance reached its nadir in 1993 when just over 65% of adult workers were covered; in 1999 that percentage was 67.6.

These increases occurred even though employers' premiums had increased for three consecutive years. Employers' concerns about rising costs were tempered, however, by their voracious demand for labor. By 1999, unemployment had fallen to 4.2%. Even as premium growth reached nearly 8% for all firms and 10% for firms with 199 or fewer employees, firms offered employees health insurance without passing along the cost of premium growth.<sup>4</sup>

***But Even in Good Times, Employer Benefits  
Don't Reach Everyone***

Although a great majority of people in the United States are covered by some form of health insurance, a significant minority are not. And the uninsured are not necessarily those you might expect—the poor and the unemployed. Indeed, in 1999, 35.4 million of the 42 million uninsured Americans were members of families in which the head of household worked.<sup>5</sup> More than 24 million working adults—employees and self-employed—were uninsured in 1999.

Workers most likely to be uninsured are young white men without a college diploma, who work full-time in the retail or wholesale trades for wages of less than \$20,000 a year. Although white men form the majority of uninsured workers, Hispanic men are disproportionately likely to be among the working uninsured.

One in four self-employed workers is also likely to be uninsured, but the self-employed uninsured are a different matter. In contrast to typical uninsured workers, self-employed workers, who number about 8.5 million, are more likely to have college and graduate school education, their income is likely to be higher, they are likely to be slightly older, and they are more likely to be skilled. As the uninsured self-employed battle for coverage, they will become vocal constituents in health insurance policy, which we discuss in more detail in Chapter 5.

**Size Matters in Offering Benefits,  
Income in Accepting Them**

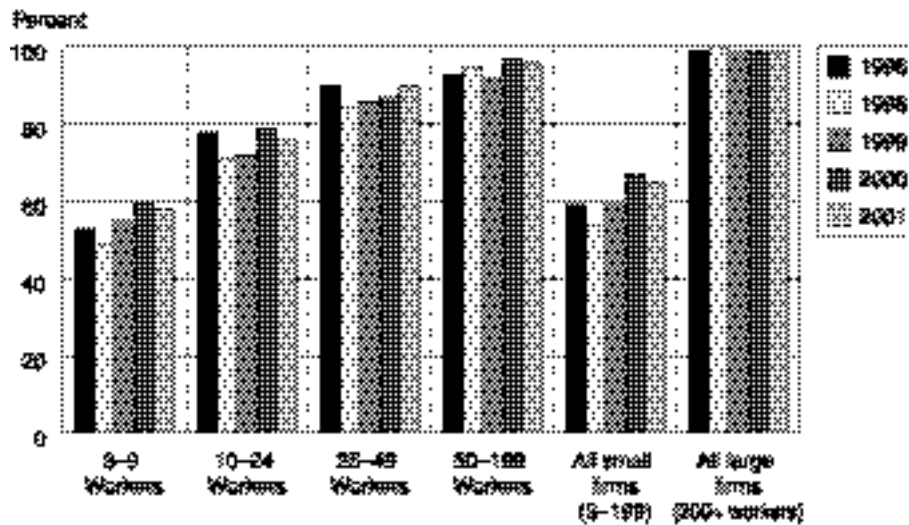
**I**n good times, size is a major factor in whether companies offer benefits and in how much they pay for them. In hard times, size may determine whether employers can keep health benefits. Which employees accept health benefits depends on income.

***Big Employers Offer More***

Small employers (three to 199 employees) are less likely to offer benefits than their larger counterparts (200 or more employees) (see sidebar, “How Big Is Small?” on page 24). In 2001, 99% of large firms and 65% of small firms offered employees health benefits. Among small employers, the percentage of firms that offer benefits drops, stepwise,

descending from 96% of firms with 50 to 199 employees to 58% of firms with three to nine employees (see Figure 2-2).<sup>6</sup>

**Figure 2-2**  
**Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2001**



Source: Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.

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## How Big is Small?

Reputable sources cut the employer pie in different ways, and some even refuse altogether to categorize employers as large or small. For this report, we primarily use the categories of the annual Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey (see Table 2-1). For convenience, we collapse the categories and call firms of 199 employees or fewer small and those with 200 or more large. This division between large and small is certainly inadequate by itself, since firms of 24 people are different from those of 150, and firms of 200 are vastly different from those of 50,000. Because of the way some of the most recent data are reported, however, we believe this division proves useful in understanding the many differences among health markets in which large and small employers operate.

Ultimately, we do discuss a middle ground of employers with between 50 and 499 employees. These employers are too large to take advantage of some important small group market programs and may not be large enough to gain the full advantages enjoyed by firms of 500-plus employees.

The distribution of workers between large and small businesses is important because firms of different sizes behave differently in providing health benefits. Small firms account for the vast majority of employers (73%), but for only about one-third of the 136 million workers employed as of June 2001. While jumbo and large employers account for less than 1% of firms, they employ nearly two-thirds of the workers in this country. Indeed, large employers are the dominant players providing employer-sponsored health benefits.

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**Table 2-1**  
**Firm Size Categories**

<i>Firm Size</i>	<i>Firm Size</i>
Small (3-9)	Midsized (200-999)
Small (10-24)	Large (1,000-4,999)
Small (25-49)	Jumbo (5,000 or more)
Small (50-199)	
All small (3-199 employees)	All large (200 or more employees)

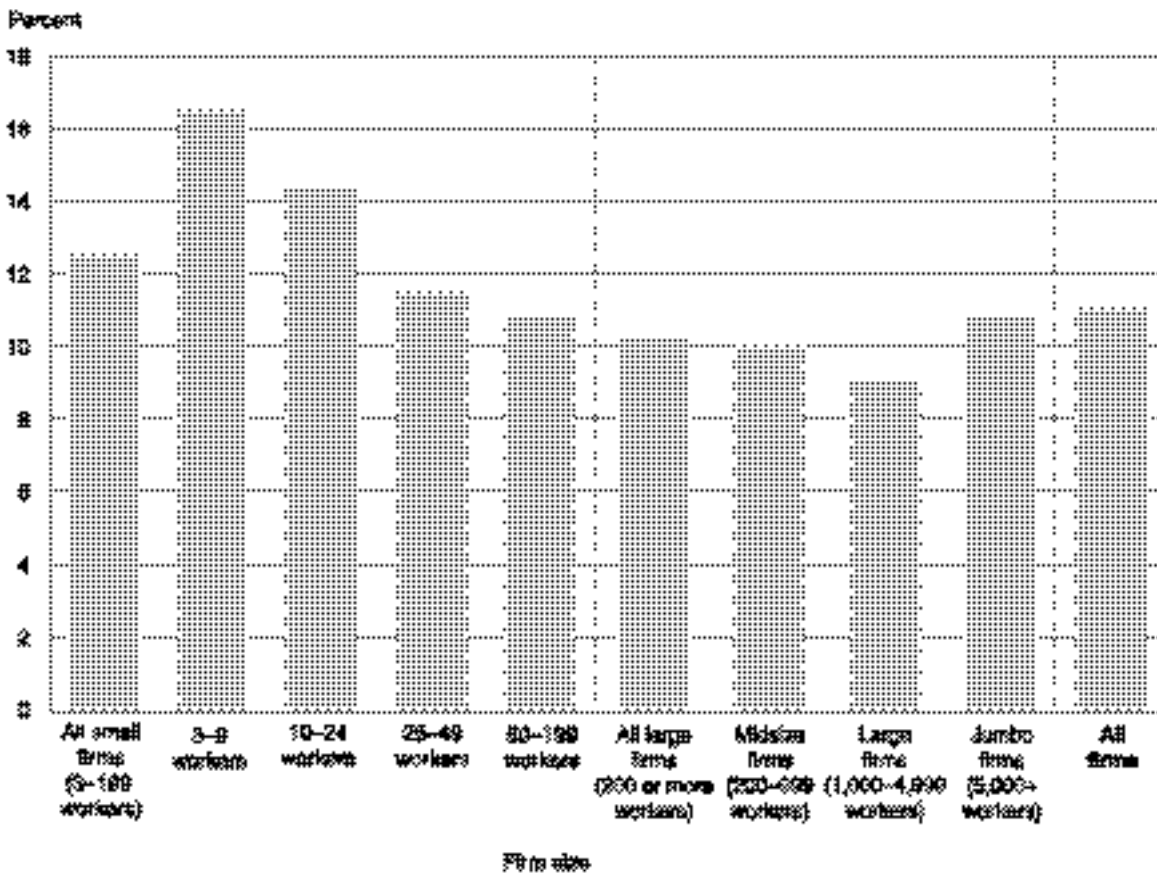
Source: Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.

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**Small Firms Pay More**

Larger firms enjoy significant cost advantages compared to small employers. In addition to being able to self-insure, larger firms can also pool the health risk of a larger group of people and, as a result, secure more favorable premiums or premium equivalents than small firms. The fact that large firms may also cover a substantial share of the workforce in a particular market has historically given them bargaining clout when setting prices with plans or providers.

Figures 2-3  
Percent Change in Premiums by Firm Size, 2001



Source: Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.



In contrast to large firms, small firms pay more for single coverage and, for the past five years, have seen premiums grow faster than those of larger employers (see Figure 2–3 on page 25). Less than one-quarter of smaller firms are self-insured. They are much more likely to purchase fully insured products, which cost more in the long run. Thus, small firms were more directly affected by the sharp upturn in the insurance premiums. On average, firms that self-insure saw their premium equivalents<sup>7</sup> grow more slowly than did fully insured employers: 9.4% in 2001 rather than 12.3%.

Not only do small firms pay more for benefits, but also how much they pay may determine whether or not they offer benefits. Sixty-four percent of all small employers rate price as a very important reason for not offering insurance.<sup>6</sup>

#### ***Low-Wage Workers Get Fewer Benefits***

Low-income workers—those with incomes of \$20,000 or less—are less likely to be offered health benefits by their employers and less likely to take them if offered.<sup>8</sup> Employers with fewer low-income workers have a higher proportion of eligible employees than do those with more low-wage workers. These firms also have a higher percentage of their workers participate in health benefits programs. By corollary, firms in which low-income workers make up at least 35% of the workforce have a significantly lower proportion of workers participate in their health plans (see Table 2–2). Benefit take-up rates are as much as 12% lower in low-wage firms than in higher-wage firms.

Overall, 65% of employers offered health benefits to their employees in 2001. Although 78% of all workers are eligible for health insurance, only 66% of workers are enrolled. The explanation for this discrepancy lies in who offers health insurance and how much it costs.

Low-wage workers who are eligible for health benefits are more price-sensitive than their higher-income coworkers. The Commonwealth Fund found that 39% of workers with annual incomes of \$20,000 or less and 29% of those with incomes of between \$20,000 and \$34,999 who declined health benefits did so because they were too expensive (see Table 2–3 on page 28). For employees with incomes of \$35,000 to \$59,000 and \$60,000 and above, the percentages were significantly different: 14 and 10%, respectively.<sup>9</sup> Though these data show that higher-

wage workers decline benefits as frequently as do low-wage workers, they do so primarily because they get health insurance from another family member, not because the benefits are too expensive.

## Employers Are Poised to Raise the Employee Ante

The nine-year economic expansion of the 1990s produced a decrease in the share of premiums paid by workers for their health benefits as well as an increase in health insurance coverage for the population at large. In the past four years, annual gross domestic product growth hovered at about 4% and unemployment dropped to 3.9%, the lowest level since 1970. Strong growth and low unemployment meant that employers competed fiercely for workers. In fact, when health insurance premiums began to rise precipitously, employers were only too willing to

**Table 2-2**  
*Eligibility, Take-Up, and Coverage Rates, by Firm Size and Earnings Group*

	Workers Eligible for Coverage	Take-Up Rates*	Workers Enrolled in Company Health Plan
<b>Firm Size:</b>			
Small (3-199 workers)	80%	83%	66%
Midsize (200-999 workers)	75%	89%**	66%
Large (1,000-4,999 workers)	76%	81%	63%
Jumbo (5,000 or more workers)	80%	84%	68%
<b>Workers (percent earning \$20K or less per year):</b>			
10% or less of workers	83%**	87%**	73%**
11-34% of workers	72%	86%	62%
35% of workers or more	75%	75%***	55%
<b>All Firms</b>	<b>78%</b>	<b>84%</b>	<b>66%</b>
*Rates at which eligible employees accept benefits.			
**Estimate is significantly different from all firms at the .05 level.			
***Estimate is significantly different from all firms at the .01 level.			

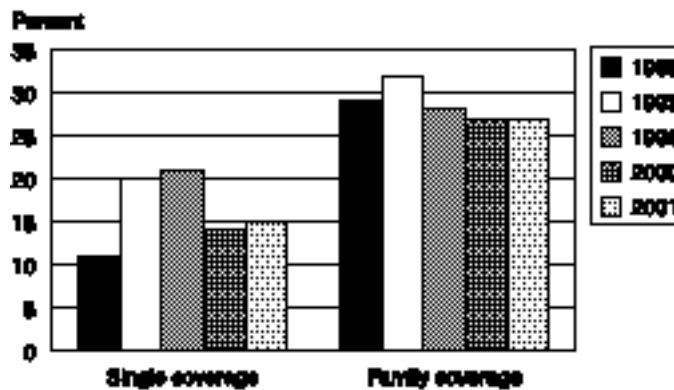
Source: Institute for the Future, based on data from Gabel, J., et al. *Embraceable You: How Employers Influence Health Plan Enrollment*. *Health Affairs* (July/August) 2001; 20,4.

**Table 2-3**  
**Availability of Health Insurance from Own Employer, Employed Adults Ages 18-64**

Offers and Eligibility	Total	ANNUAL INCOME			
		Less than \$20,000	\$20,000-\$34,999	\$35,000-\$59,999	\$60,000 or More
No plan offered or not eligible	19	42	19	14	9
Employer does not offer	11	25	13	7	3
Offered, but adult not eligible	8	17	7	7	6
Adult eligible to participate	79	54	80	84	91
Eligible but declined	14	15	11	15	15
Reason declined:					
Too expensive	19	39	29	14	10
Benefits not good enough	7	9	9	4	3
Had other family plan	39	18	19	52	54
Other	22	26	31	19	16

Source: Institute for the Future, based on data from Gabel, J., et al. *Embraceable You: How Employers Influence Health Plan Enrollment*. Health Affairs (July/August) 2001; 20,4

**Figure 2-4**  
**Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2001**



Source: Kaiser Family Foundation-Health Research and Educational Trust, *Employer Benefits Survey, 2001*.

cover the bulk of the increases in order to retain their best employees, and both actual dollar contribution and share paid by workers for single coverage were lower in 2001 than in 1996 (see Figure 2–4). The result of this economic boom was that the percentage of workers covered rose to just over 73% in 1999, and the number of uninsured declined overall.

The year 2000 brought an end to economic expansion, however, and recession took hold.<sup>10</sup> Employer-sponsored health insurance is particularly vulnerable to recession. As business profits and stock market valuations fall, companies come under severe pressure to improve cash flow. Lowering the cost of health benefits is the primary way to fight rising costs because health benefits are not only the biggest chunk of indirect costs but are also rising the fastest. Although long-term collective bargaining contracts and the need to retain skilled labor are likely to prevent employers from dropping health benefits altogether, employers certainly will restructure them to cut expenses.

In 2002, employers are likely to begin to shift the cost of health benefits to employees. In fact, in 2001, there were slight but statistically insignificant increases in employee contributions to premiums for single and family coverage; however, this came after four years of decline. The recent gains in health insurance coverage of the population may have halted as well. Data from the 2001 Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey showed no gains in coverage in 2001; although the difference between 2000 and 2001 data are not statistically significant, they indicate a notable stall.

Meanwhile, 42% of small firms and 75% of large firms reported that employee costs for coverage are either very or somewhat likely to increase in 2002. William M. Mercer reported that 40% of the employers it surveyed intend to push cost increases through to employees.<sup>11</sup> What's more, interviews conducted by IFTF found that employers expect to institute incentive structures that would help control employers' costs and allow employees to control how much of the additional costs they assume (e.g., employees would pay more of the cost for a comprehensive plan if they wanted it, but little more for a basic plan).

In the opening rounds of current cost controls, employers are acting on a number of measures on the demand side to help them begin to constrain cost growth and shed liability by sharing both with their employees.

***Employee Contributions to Deductibles and Copayments Are on the Rise***

While employee contributions to premiums seemed to have only just reached a plateau after several years of decline, deductibles have been on a four-year climb, and copayments are growing as well. Deductibles for all forms of insurance except conventional coverage continue to grow for both single and family coverage. In addition, although the vast majority of HMOs require \$10 copays for doctor visits, the distribution of copays is shifting toward the upper end of the scale. In 2001, more HMOs required \$15 copays and fewer accepted \$5 copays than in 2000. Here, size matters again. The largest employers have been more effective at protecting employees from increases in deductibles and copays.<sup>6</sup>

***Employers Are Cutting Back Employees' Health Plan Choice***

While only 20% of employers offer a choice of health plans, 60% of employees have a choice of two or more plans, and 45% have a choice of three or more. It appears that plan choice may start to decline, however. While the percentage of workers with two plan options remained the same in 2001 as it was in 2000, the percentage with three or more options fell 5% and those with one grew. In fact, most employers are reporting that they expect to decrease plan choice. Ninety-five percent of Fortune 100 and 93% of Fortune 500 firms reported having decreased the number of carriers they offered employees between 1994 and 1999.<sup>12</sup> In 2001, Watson Wyatt Worldwide found employers to be cautious about adding health plans in response to employees' demands for choice, for fear it would reduce employer clout when negotiating premiums with plans and increase administrative burden.

***Employers Are Deliberating on Defined Contribution***

Some experts argue that the most important way of encouraging consumers to assume more of the costs and responsibility for health benefits is switching to a system of defined contribution rather than defined benefit. There is much talk of health benefits moving toward employee-

directed investment vehicles that allow employers to predict and limit their financial commitment, and enable employees to take their investments with them should they switch employers. Although the comparison with 401(k) and 403(b) plans is strained at best, this comparison picks up on employers' impulse to (1) find some means of controlling costs and (2) get out of the health benefits services (and liability) business.

There is some movement in this direction. Twenty-seven percent of employers that offered employees a choice in health plans contributed a fixed dollar amount in 2000, as compared to 13% in 1994.<sup>13</sup> This falls short of providing a portable, 401(k)-like health account that many defined-contribution theorists envision. Rather, it is an annual cap on employer dollar contribution that does not put funds in the hands of employees.

The data on employers' likelihood of shifting to defined contribution are decidedly mixed. While some reports say that 50 to 60% of firms are considering a shift to defined contribution,<sup>14</sup> others say that only 24% of all firms and 13% of large firms are very or somewhat likely to shift in the next five years (see Figure 2–5 on page 32).

Experts note that employers are reluctant to kick employees onto the individual market, where both tax treatment of individual premiums and the problems of risk pooling jeopardize employees' ability to purchase insurance at an affordable price. This would be particularly true for older or sicker employees whose medical risks and costs are so high that they may be virtually uninsurable. At the same time, experts note that many employers are limiting the amount they contribute to health care by using incentive structures that increase employee out-of-pocket payments for services employers find cost-inefficient.

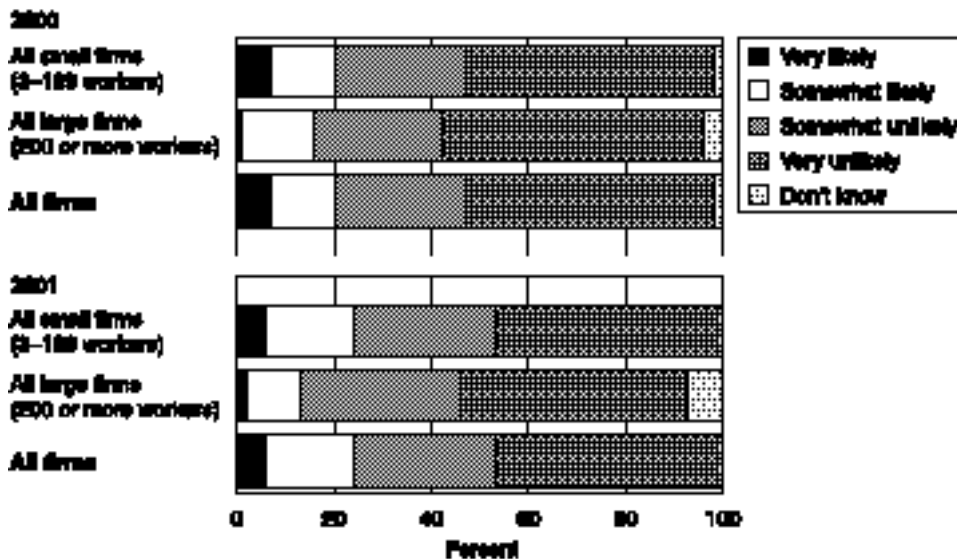
The flip side of the debate is about what employees want, and the data are equally mixed. KPMG found that 44% of the employees it surveyed were either extremely or very interested in defined contribution as defined in its survey.<sup>15</sup> One 2001 survey found that 39% of employees would like their employers to make a fixed contribution to health benefits even if they had to find a plan on their own.<sup>16</sup> However, the same survey found that the majority of employees want employers to continue to provide a wide variety of services that employees themselves would have to perform under the pure subsidy form of defined contribution. In short, it is difficult for employees to evaluate "defined

contribution” because for many it is both hypothetical and poorly defined. Employees don’t necessarily understand the trade-offs between cash and service, responsibility and entitlement.

### Employers Use Benefits Management Strategies to Control Costs

In addition to changing employees’ contribution, employers are looking to other management strategies to control costs on the supply side: self-insuring, direct contracting, joining pooled purchasing arrangements, and contracting with digital health companies. Taken together, these strategies seek to control costs by taking away the middleman (the health plan), creating more purchasing clout, or increasing the efficiency of benefits management.

**Figure 3-5**  
*Likelihood of Employers Switching to Defined Contribution for Health Benefits in the Next Five Years, 2000 and 2001*



Source: Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.

### **Self-Insurance**

Overall, 47% of workers are covered by self-insured plans. Employers that can afford to do so prefer to self-insure because it has significant price advantages. While many firms have both fully insured and self-insured plans, the likelihood that workers will be covered under self-insured plans increases with firm size (see Table 2–4).

### **Direct Contracting**

Self-insured employers purchase health care services either directly from providers (direct contracting) or through health plans. The most notable example of direct contracting is the Buyers Health Care Action Group in Minnesota, which has pioneered direct contracting based on quality and cost. The Buyers Health Care Action Group was able to hold premium increases to an average of 7.5% between 1997 and 2000.

Nationally, direct contracting has been viewed both as a viable option for controlling costs and improving quality and as an idiosyncrasy of Minnesota, but the scope of direct contracting may have been underestimated. A 1997 study suggests that as many as 5% of employers contract directly with providers, accounting for 19% of employees.

**Table 2–4**  
Percentage of Covered Workers Under Different Funding Arrangements, by Firm Size, 2001

	Coverage Underwritten by Insurer	Self-insured (Employment bears all or any of the financial risk)	Don't Know
Small (3–9 workers)	97	1	2
Small (10–24 workers)	93	4	2
Small (25–49 workers)	95	31	–
Small (50–199 workers)	64	35	1
<b>All Small (3–199 workers)</b>	<b>78</b>	<b>21</b>	<b>1</b>
Midsize (200–999 workers)	45	51	5
Large (1,000–4,999 workers)	33	67	0
Jumbo (5,000+ workers)	40	60	0
<b>All Firms</b>	<b>52</b>	<b>47</b>	<b>1</b>

Source: Institute for the Future, based on data from Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.



They also found that 15% of health plan enrollees are covered through direct contracting.<sup>17</sup> Direct contracting may be a growing option for large, self-insured employers.

#### ***Employer Coalitions***

Over the years, most employer coalitions on health care addressed price and choice with varying success. In the large group market in the 1990s, employer coalitions were able to either negotiate savings in premiums or slow the rate of growth, but they seem to have lost steam by 2000. Frankly, the sheer size of the companies that join these coalitions has meant that they are needed less for actual purchasing than for standardizing contracts and exerting pressure on plan and provider performance. In the small group market, employer coalitions have been less successful at bargaining for good prices and more successful at giving small employers access to choice in plans. Employer coalitions have amassed unique expertise in purchasing and contract negotiation, and raised the profile of health care quality and value purchasing, but their influence on improvements in health care delivery has resulted in painfully slow change.<sup>18</sup>

Today, employer coalitions are in a state of self-evaluation. The growth of Internet-based companies that provide administrative and employee services options to employers, the return of unrestrained cost increases, and the incremental improvements in health care quality are driving these coalitions to define their niches carefully. Some, like the Leapfrog Group and Washington Business Group on Health, focus on market reforms and education. Pacific Business Group on Health, the National Business Coalition on Health, and the Buyers Health Care Action Group maintain parallel programs in market reform, education, and purchasing, and are leading voices in market reform.

#### ***Digital Health Companies***

Assuming that more consumer control over health care dollars and decisions is imminent, a cadre of companies has emerged that uses the Internet to capitalize on the much-anticipated move to consumer-directed health benefits (see Appendix, “New Tools in Employer-Sponsored Health Benefits,” on page 81). These digital health companies<sup>19</sup> offer health insurance and administrative services. Some zero in on employer fatigue with the burden of benefits administration, and they target market weaknesses (e.g., small group health insurance markets).

The digital health companies are both optimistic and pragmatic. The most likely to succeed sell their wares to large employers, offering them services that will have to be performed whether there is a move to defined contribution or not. Hewitt Associates' Sageo is a case in point. Sageo is a health and welfare benefits outsourcing firm that provides enrollment administration and HIPAA and COBRA compliance support.

Taken as a group, these digital health companies provide marketplaces through which insurance and health care services can be purchased; they may assume risk either directly or through third-party underwriters; they may serve as financial intermediaries by offering and managing personal health savings accounts (otherwise known as medical savings accounts, or MSAs); and they may act as navigators of the health insurance and care markets for health care consumers. These companies offer employers potential savings and decreased administrative burden while they offer employees manageable choice and control. Their most important contribution, however, may be on the demand side—offering a means for employees to take on more responsibility for their health care benefits.

### Point of Departure

Employers large and small are trying to navigate through a complex health benefits market in which costs are rising and familiar tools for controlling them are no longer working as well as they once did. They face the challenge with vastly different resources in buying clout and options for influencing employees' choices.

Employers and employees are at a crossroads. Overall, employers are seeking to decrease their costs and to reduce their involvement in directing employee health benefits by cutting out the middlemen, increasing their purchasing clout, and reducing their administrative burden. Their hypothesis is that creating a more direct, consumer-driven health benefits market is the key to holding down health care costs.

Employees want choice and control over their health care, but not the administrative burden—and most certainly don't want to pay for that choice and control. The challenge for employers—and the system at large—is, then, to prepare employees to accept more responsibility for the costs and administration of their health benefits in return for choice and control.

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### Endnotes

- <sup>1</sup> Fronstin, P. *Employment-based health benefits: Trends and outlook*. EBRI Issue Brief No. 233. Washington, DC: Employee Benefit Research Institute, May 2001.
  - <sup>2</sup> Hewitt Associates. *Health promotion/managed health provided by major U.S. employers in 2000*. Lincolnshire, IL: Hewitt Associates, 2001.
  - <sup>3</sup> See National Center for Policy Analysis. Fewer uninsured than previously estimated. *Daily Policy Digest*, Health Issues (August 9) 2001. The U.S. Census Bureau recently announced a recalculation of the number of uninsured for 1999, revising its estimate from 42.1 million to 39.3 million. However, the published, peer-reviewed analyses of insurance trends rely upon the estimate of 42.1 million uninsured, and we will base the discussion on that number for the sake of consistency.
  - <sup>4</sup> Gabel, J., et al. Job-based health insurance in 2000: Premiums rise sharply while coverage grows. *Health Affairs* 2000; 19,5.
  - <sup>5</sup> Fronstin, P. *Sources of health insurance and characteristics of the uninsured*. EBRI Issue Brief No. 228. Washington, DC: Employee Benefit Research Institute, December 2000.
  - <sup>6</sup> Kaiser Family Foundation/Health Research Educational Trust, Employer Benefits Survey, 2001.
  - <sup>7</sup> Employers that self-insure (self-fund) do not pay premiums because they are not buying insurance. Instead they pay claims and the premium equivalent is the estimate average annual cost of claims per covered life.
  - <sup>8</sup> Gabel, J., et al. Embraceable you: How employers influence health plan enrollment. *Health Affairs* (July/August) 2001; 20,4.
  - <sup>9</sup> Duchon, L., et al. *Listening to workers: Challenges for employer-sponsored coverage in the 21st century*. Commonwealth Fund Publication No. 361. New York City: The Commonwealth Fund, January 2000.
  - <sup>10</sup> Ranking, K. Recession defined. *The Dismal Scientist* (May 3) 2001. [www.dismal.com](http://www.dismal.com)
  - <sup>11</sup> William M. Mercer, 15th Annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2000.
  - <sup>12</sup> Maxwell, J., et al. *Corporate health care purchasing among the Fortune 500*. Washington, DC: National Health Care Purchasing Institute, May 2001.
  - <sup>13</sup> Fronstin, P. *Defined contribution health benefits*. EBRI Issue Brief No. 231. Washington, DC: Employee Benefit Research Institute, March 2001.
  - <sup>14</sup> Booz Allen & Hamilton. *When consumers rule: The next revolution in U.S. health care*. 2000.
  - <sup>15</sup> Scandlen, G. *Defined contribution health insurance*. Idea House Policy Backgrounder No. 154. Washington, DC: National Center for Policy Analysis, October 26, 2000. Employees were asked the following question: "What if you were able to select from any health plan being offered in your area, at the cost you choose, using both your employer contributions and the personal contributions you make, instead of having your employer select plan options for you? How interested would you be in this concept as a replacement for your current health care selection options from your employer?"
  - <sup>16</sup> Watson Wyatt Worldwide. *Maximizing the return on health benefits*. Washington, DC: Watson Wyatt Worldwide, 2001.
  - <sup>17</sup> Marquis, M., and Long, S. Prevalence of selected employer health insurance purchasing strategies in 1997. *Health Affairs* (July/August) 2001; 20,4.
  - <sup>18</sup> Rauber, C. Coalitions: Losing patience. *Healthcare Business* (July) 2000.
  - <sup>19</sup> McGoldrick, C., O'Dell, S., and Ziegler, S. *The digital health company: Threat or opportunity? Implications for the health plan market*. First Reports series. Long Beach, CA: First Consulting Group, February 2001.
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## Chapter 3

# DRIVERS AND BARRIERS IN THE MOVE TOWARD A CONSUMER FOCUS

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Employers may want to control the costs of providing health benefits to their employees, but most do not anticipate getting out of the benefits business altogether. They expect to continue to provide benefits for the same good reasons they did so in the first place: to maintain employee productivity and to give themselves tools for attracting good workers, especially in tight labor markets.

Although most employers won't do away with health care benefits, they do plan to share more responsibility and risk with employees. Employers hope to make employees less pure beneficiaries and more front-line consumers who are interested in the value they receive for their health care dollar in the health benefits marketplace. The cultural change required to move in this direction will be driven by potent market forces and inhibited by formidable barriers.

## Drivers

**F**ive forces are driving employers to continue to offer benefits to employees while handing over more responsibility for decisions and costs:

- The rising costs of health benefits, including premiums, pharmaceuticals, expensive new technologies, and administrative expenses.
- Federal and state regulations that mandate benefits, increase health plan liability, and complicate benefits administration.
- The retreat from restrictive managed care that fuels employees' pursuit of choice and access, and limits employers' ability to control costs.
- An increasingly diverse workforce that confounds employers' attempts to find one solution that serves all employees well.
- The need to continue to maximize employee productivity by promoting good health.

### ***Rising Costs Drive Employers to Control Expenses***

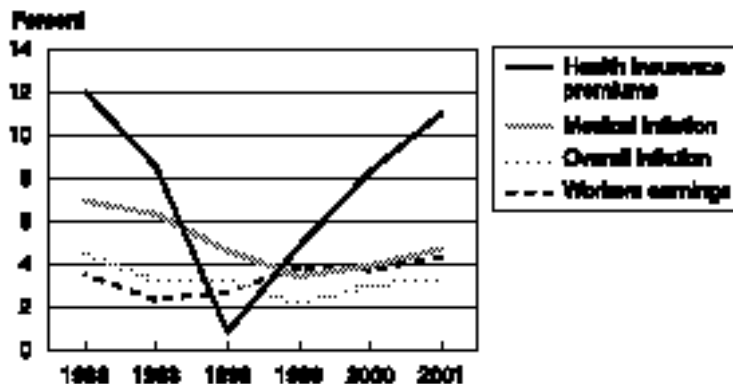
Although employers intend to continue to provide benefits to their workers, they need to keep the costs of such benefits down. Indeed, health benefits costs—the combination of direct and administrative costs—are rising much faster than inflation, and are unlikely to slow down in the near term. The aging of the population, rising pharmaceutical costs, and advances in medical technology exert inflationary pressure on overall medical costs. At the same time, litigation, regulation, and consumer and provider resistance have disarmed managed care's traditional cost-constraining tools.

For employers, dramatic growth in health insurance premiums is the most tangible and pressing symptom of a system out of control. U.S. employers have witnessed five consecutive years of disproportionate premium inflation. In 2001, premiums grew 11%, a rate greater than three times the rate of overall inflation, two-and-a-half times the rate of workers' earnings, and two times the rate of medical inflation (see Figure 3-1). In fact, premium growth rates are back up near 12%—the rate that prompted employers to embrace managed care in the late 1980's.

Though not as high as the premiums themselves, the 9.4% growth in premium equivalents for self-insured plans suggests that the rising costs are real, not just an anomaly of the health insurance industry. In 2000, hospital spending for both inpatient and ambulatory care and pharmaceuticals were potent cost drivers, estimated to have accounted for 47 and 27% of the growth in health expenditures, respectively.<sup>1</sup> Medical technology may also be driving significant cost increases. Experts note that, although medical technologies such as minimally invasive surgical techniques, sensors, and new drug delivery mechanisms may offer better diagnosis and treatment of illness, they are costly in and of themselves and also increase utilization (and thus costs) in the long run. Ultimately, advances in medical technology are both good for patients and inflationary.

Given these numbers, it is not at all surprising that Deloitte & Touche reported that controlling health care costs was the number one priority for employers in 2001, for the second year in a row.<sup>2</sup> The second- and third-place priorities, expanding the use of Internet/intranet applications and expanding the use of employee self-service technology for benefits communication and administration, are related to health care costs as well. Their aim is to reduce the burden of benefits management and to put more control in the hands of employees.

**Figure 3-1**  
**Increases in Health Insurance Premiums Compared to Other Indicators**



Source: Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.

The Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, estimated that national health expenditures grew at an annual rate of 8.3% in 2000 and projected them to grow by 8.6% in 2001. However, it anticipates that a slowing in the growth of the economy and adjustments in the health care market, including employer attempts to control costs in response to rising insurance premiums, will result in an average annual growth rate of about 7.1% through 2010. This is an adjustment to the administration's previous projection of 6.5% per year, reflecting both the tension between higher than expected growth and employers' responses to it.<sup>3</sup>

Rising costs, particularly in the context of an increasingly tough economy, are driving employers to control health benefits spending. In the short run, employers can attempt to control costs by altering the configuration of benefits by increasing employees' contributions to premiums, increasing copays for goods and services, cutting back on benefits, attempting to buy more cost-efficient care or insurance, or capping their contribution to health benefits. To control administrative expenses, employers can also implement more self-service benefits management and outsource human resource functions. In the long run, rising costs are driving employers to look for fundamental structural changes that will control costs. We discuss these in greater detail in Chapters 4 and 5.

***Regulation Drives Employers to Limit Their Exposure to  
Rising Costs and Liability***

Inherent in the much-publicized dissatisfaction with managed care is the belief that it has prevented enrollees from getting timely, medically necessary services and treatments. As a result, there has been a slew of regulatory and legal responses to ensure that managed care patients get the services they need to protect their health. These include the federal Patients' Bill of Rights, state regulations granting health plan enrollees the right to sue, mandated coverage for specific conditions, external review processes to assess plan decisions, and legislation requiring plans to accept any willing provider. Furthermore, such regulations seek to provide remedies to patients when health plan decisions prevent them from getting services experts deem necessary. Proposed federal Patients' Bill of Rights legislation, as described in Chapter 1, is emblematic of the direction of such regulation.

What concerns employers about the Patients' Bill of Rights is this: if passed, it has the potential to increase both health care costs and plan liability. Cost increases would come primarily from the requirement to pay for more medical services (e.g., access to out-of-network providers), for external review processes, and for litigation. The Congressional Budget Office estimates that the House of Representatives version of the Patients' Bill of Rights, the more restrained of the two, would increase premiums by 2.6% over five years. The Congressional Budget Office assumes that 60% of this cost would be offset by adjustments to benefits structures (i.e., reduced benefits) and that 40% would be passed on to employees either in direct costs or reduced wages.<sup>4</sup>

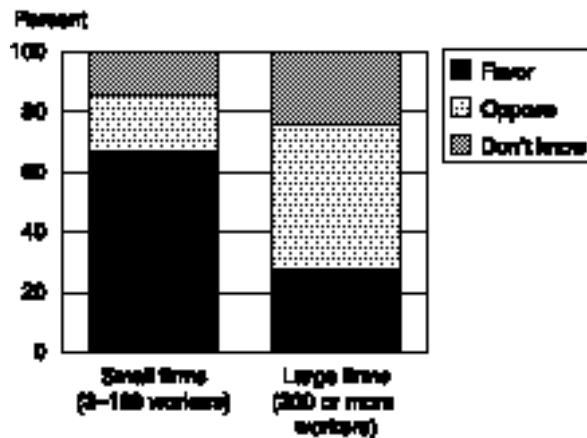
Employers' opinions of Patients' Bill of Rights provisions vary by the number of employees they have. This difference is most pronounced on the most controversial provision of the proposals, the patient's right to sue a health plan. Those employers with fewer than 200 employees are more likely to support a patient's right to sue a health plan than are those with more than 200 employees, 67 versus 28%, respectively (see Figure 3-2 on page 42). This may be due to the fact that more large employers sponsor self-funded health plans and fear direct liability.

For both large and small businesses, however, there is significant price sensitivity in employer support of the patient's right to sue, suggesting that both fear potential cost increases. If the right to sue costs employers \$5 more a month, 12% of the small employers and 11% of the larger employers that originally favored the right to sue would oppose it<sup>5</sup> (see Figure 3-3 on page 42).

The effect of these regulatory trends is to compel employers to limit their role in making health care decisions in an effort to reduce potential liability. One means of doing so is to ensure that decisions about plan choice and care are put in the hands of employees. This regulation also reinforces employers' efforts to limit their responsibility for covering rising costs by shifting costs to employees.

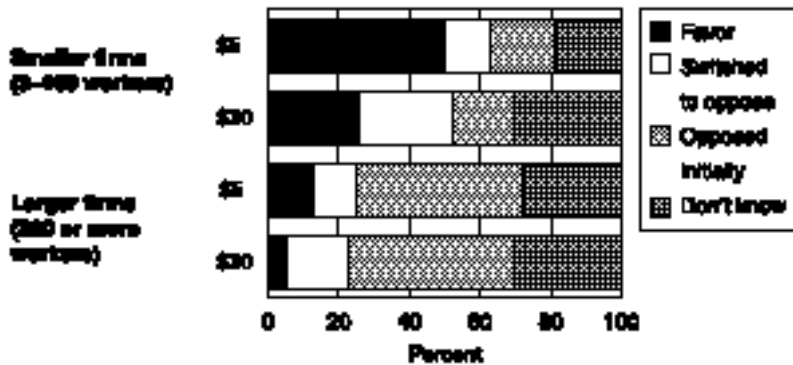


**Figure 3-2**  
**"Would Your Company Favor or Oppose a Law Requiring Health Plans to Allow Patients to Sue?"**



Source: Selected data from Kaiser Family Foundation-Health Research and Educational Trust, Employer Benefits Survey, 2001, and Kaiser Family Foundation, National Survey on Small Business, 2001.

**Figure 3-3**  
**"Would Your Company Still Favor a Law Allowing Patients to Sue Their Health Plans if it Costs ...?"**



Source: Selected data from Kaiser Family Foundation-Health Research and Educational Trust, Employer Benefits Survey, 2001, and Kaiser Family Foundation, National Survey on Small Business, 2001.

***The Managed Care Backlash Pushes  
Employers to Retreat***

Employers are backing away from the most restrictive and the most effective managed care cost-control tools in response to consumer and provider dissatisfaction. Consumers seek choice and access to specialists and treatments as proxies for quality health care, and providers want better reimbursement and greater autonomy in making treatment decisions. As a result, the hallmarks of tightly managed care—restrictive provider networks, utilization review, gate keeping, and capitation—grow increasingly unavailable.<sup>6</sup>

As employees fled restrictive managed care, they migrated to PPOs in large numbers. Today, the number of workers enrolled in PPOs is more than double the number enrolled in HMOs (see Figure 3–4 on page 44). The problem is that this less restrictive form of managed care affords few mechanisms to control costs and little health care quality information, leaving employers with more satisfied employees but with fewer checks on costs or other measures of value.

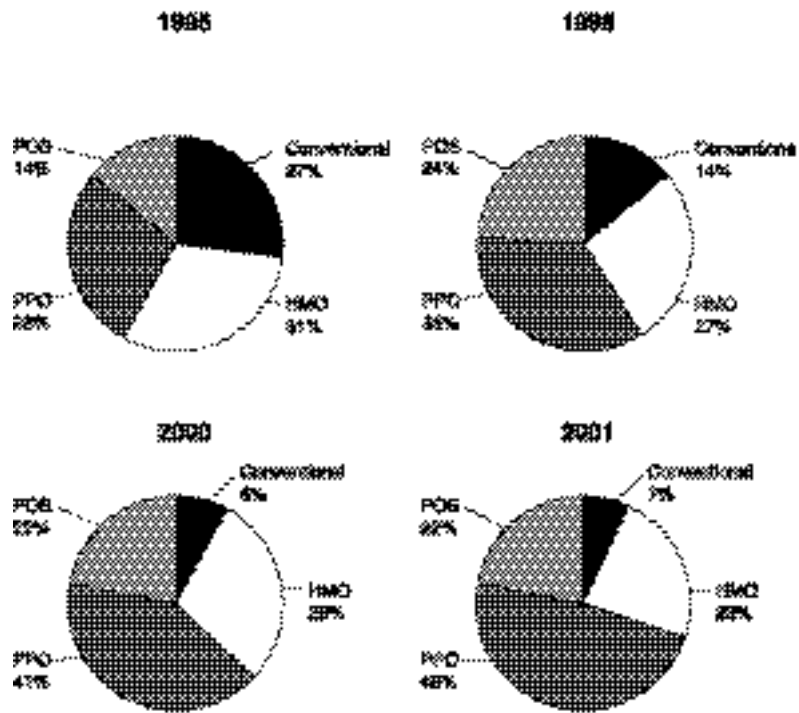
Meanwhile, providers have consolidated in order to gain market clout to negotiate favorable terms with managed care plans. They have also begun to repulse low reimbursement rates, hampering employers' attempts to contain costs on the supply side. Experts have noted that, in certain markets, providers and delivery systems have chosen not to contract with managed care plans that offer poor terms. The threat of limited access to providers makes it hard for plans and purchasers to negotiate on price in highly consolidated markets.

With supply-side fixes limited by the increasing ineffectiveness of managed care, employers are looking to create demand-side fixes. This is where many employers will encourage their employees to move from being entitled beneficiaries to value-conscious consumers. The employers' hypothesis is that better-informed employees with financial responsibility and the ability to make more decisions will become conscientious users of health care. In this way, they believe that engaged consumers, not employers, are the key to controlling health care costs.<sup>7</sup>

**Growing Workforce Diversity Prompts  
Customized Health Benefits**

The Bureau of Labor Statistics projects that between 1998 and 2008 the U.S. labor force will increase by 12%, reaching 155 million by 2008. What's more, the composition of the workforce will be different from that of the 1988–1998 period. The workforce will be older—the median age will be 40.7 years in 2008 versus 35.9 years in 1988. It will also have a greater proportion of women and Hispanics. These developments are only part of the story, however. With these changes comes a different mix of

**Figure 3-4**  
**Health Plan Enrollment for Covered Workers, Selected Years 1995–2001**

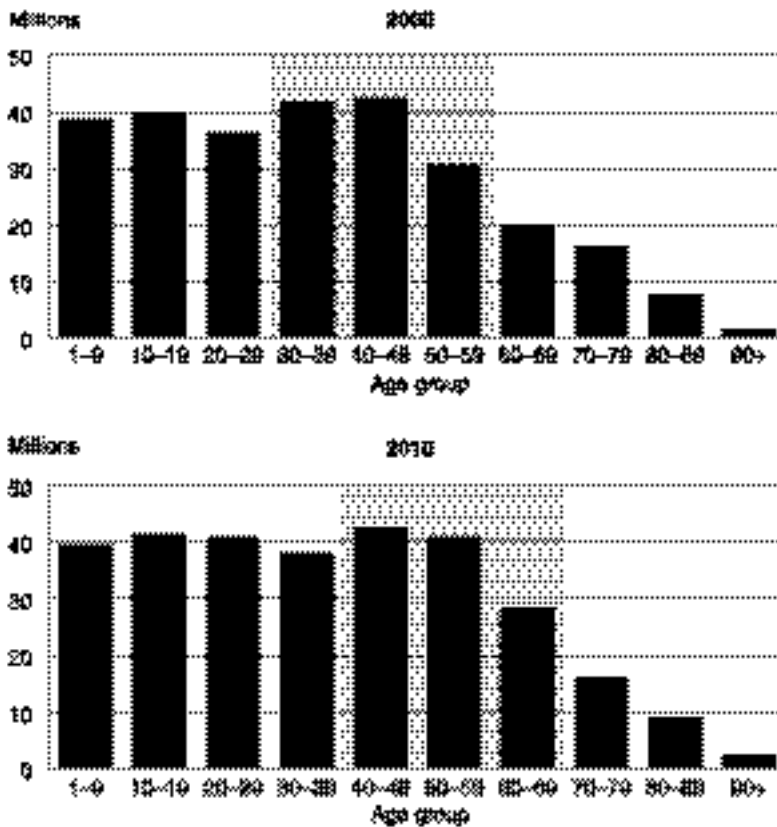


Source: Geisel, J., et al. *Job-based Health Insurance in 2001: Inflation Hits Equity Digits, Manager Goes Retrosive*. *Health Affairs* (September/October) 2001; 20(9):180–188.

education, skills, and experience, as older workers retire or shift to part-time status and are replaced by a more diverse group of echo boomers, the children of the baby boomers (see Figure 3-5 and Table 3-1 on page 46).

Not only is the population from which the workforce is drawn becoming more diverse, but it is also growing more educated and computer savvy. While predominantly white, *new consumers* (those with some college education, access to computers, and discretionary income) are becoming more diverse. People of color made up 15% of new con-

**Figure 3-5**  
**Changing Age Structure of the Population**  
 (Number of people per age group, in millions)



Source: Institute for the Future, based on data from U.S. Census Bureau.

sumers in 1999, but are expected to reach 20% by 2010. This growth will be driven largely by increases in education, income, and computer and Internet access for African Americans and Hispanics.

Although there have been real gains in education and income in general, disparities among the U.S. population have also increased. Educational attainment is rising for the entire U.S. population, but the numbers vary by ethnicity, with Hispanics lagging in high school graduation and African Americans lagging in college enrollment and graduation. Though real wages grew for all income groups during the recent economic expansion, those of the highest wage earners grew faster than those of the middle- and lower-income workers. Differences in skill predict wage differences even among those with the same education. High-skill workers' wages increased in the 1990s while those of low-skill workers declined.<sup>8</sup>

The changes in the workforce mean that employers face great variation in education, income, age, and computer literacy among their employees. These differences confound employers' ability to use one-size-fits-all approaches to health benefits. Employers and the health care sector alike will have to respond to both the new consumer, who is ready and able to gather and process complex information, and the traditional consumer, who is less prepared to do so. The need to segment and customize health benefits while containing costs will drive employers to find approaches that help them respond to the needs of such diverse employees, while at the same time placing more responsibility in their hands.

**Table 3-1**  
*America Is Becoming Increasingly Diverse*

	1980	1990	2000	2010
White	83	76	72	67
African American	12	12	12	13
Hispanic (any race)	6	9	12	15
Asian/Pacific Islander	1	3	4	5
Native American	<1	<1	<1	<1

Source: Institute for the Future, based on data from U.S. Census Bureau.

### ***Productivity Is at the Core***

All these drivers function in the context of an employer-based health insurance system that was erected on a foundation of enlightened self-interest: a healthier worker is a more productive worker. In the past 60 years, the definition of health has expanded beyond the simple absence of acute illness to include the management of chronic disease, mental health, substance abuse treatment, stress reduction, and even general physical fitness. The scope of health benefits has grown, in turn, from catastrophic coverage for hospitalization by means of indemnity plans to coverage for preventive services by managed care.

The need to keep employees physically and mentally on the job is an important factor driving employers to continue to offer health benefits.

## **Barriers**

**A**lthough many drivers are pushing employers to continue to offer benefits to their employees while at the same time sharing more of the costs and responsibilities with them, equally formidable barriers are working to prevent their doing so. These include:

- Tight labor markets.
- The advantages of group health insurance.
- Tax law.
- Lack of information about providers.
- Low employee engagement in health care decision making.

### ***Competition for Labor Limits Employer Options***

A tight labor market makes shifting costs to employees difficult even if employers are able to shift some of the decision making. If the recession of 2001 is prolonged, it may loosen labor markets in the short run, but markets for skilled labor will stay competitive as economic growth resumes. At the same time, competition for employees is not exclusively a macroeconomic phenomenon, but can be specific to markets, industries, or even certain occupations. Those employers that experience tight labor markets may be unable to shift costs and decision making to employees if those employees view the shifts as undesirable.

***Employees Want Group Insurance***

The group health insurance market is more attractive to individuals than the individual market. Rather than calculate actuarial risk and set the price of insurance on an individual's health status, the group health market pools the risk of a group of people, some healthy and some ill, calculates the actuarial risk of the group, and sets premiums accordingly. Thus, group insurance moderates the insurer's risk by giving it access to a mix of healthy and ill enrollees and protects the sick by offering them access to insurance to which they may not have access if they sought it individually.

While it is arguable that the cost of insuring young, healthy employees is higher than necessary in group plans, the manageable surcharge has been seen as a reasonable trade-off for covering older or ill group members. The advantages of group health insurance markets prevent some employers from forcing their employees into the individual market, where they would be unlikely to find benefits packages comparable to those available through employers at a reasonable price. The same group market advantages also induce individuals to seek group coverage when they have the opportunity.

***Tax Law Inhibits Cash-Based Defined Contribution***

Tax law currently favors employment-based health insurance because premiums that employers pay are not taxable income for employees and premiums that individuals pay are not tax deductible. Current tax law means that, if an employer gives an employee cash for health benefits, the employee would pay taxes on the amount of the premium, would most likely have to acquire health insurance at a higher individual rate, and would still be unable to deduct the premium paid from income tax. The problems of tax treatment pose a formidable barrier to implementing cash- or voucher-based defined contribution.

***Scarce Provider Information Inhibits  
the Consumer Market***

A dearth of provider information means that individuals have limited data with which to make health care decisions. While provider and plan cost data may be easy to provide, data on provider quality is another story.

Technical issues such as assessing the clinical outcomes of medical interventions that are performed infrequently or identifying measurable clinical practices that are definitively linked to clinical outcomes do

inhibit good provider quality measurement. The real obstacle, however, is provider opposition. Provider resistance to performance review and reporting limits access to precisely the information that people want most—data that tell them how well their doctors or medical groups treat their conditions. Recent studies of health care consumers have shown that, given adequate information and the proper incentives, employees will change plan and provider choices based on quality and cost. Until they get this type of information, however, they have no ability to choose cost-effective plans and providers.

#### ***Employees Are Passive Health Care Consumers***

Currently, employees' engagement in deciding what type of health benefits they get is very low. Today the most frequent decisions employees make are about providers and treatments. During open enrollment for benefits, for example, most employees need to do nothing to continue their current coverage. In this climate, the vast majority of employees with work-based health benefits have remained strikingly passive consumers of health care.

Given this tendency, employees may be reluctant to take charge of acquiring coverage or of footing more of the bill. Some studies show that employees prefer to have their health care purchased by their employers, even though they also want increased choice in providers. Creating a more direct market may prompt decisions about insurance products and financial arrangements that some employees are unprepared or unwilling to make.

### **Driving Toward Active Consumers**

**D**riven by employers' needs to cut costs, employees' role in employer-sponsored health benefits is evolving from that of being the beneficiaries of employer-directed entitlements toward becoming informed and value-conscious consumers. This increased employee engagement in making health care decisions will be accompanied by greater employee responsibility for the resulting expenses. In this way, employers hope to create more of a direct market for health care. The interplay of the drivers and barriers will determine the pace at which the market progresses toward this goal.



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**Endnotes**

- <sup>1</sup> Bradley, C., et al. Tracking health care costs, hospital care surpasses drugs as the key cost driver. *Health Affairs* Web Exclusive (September 26) 2001:W39–W50.
- <sup>2</sup> *The top five benefits priorities for 2001*. Deloitte & Touche, 2001.
- <sup>3</sup> Health Care Financing Administration. *National health care expenditures projections: 2000–2010*. Washington, DC: HCFA, 2001.
- <sup>4</sup> Congressional Budget Office. *Cost estimate of HR 2315 Patients’ Bill of Rights Act of 2001*. Washington, DC: CBO, July 20, 2001.
- <sup>5</sup> Kaiser Family Foundation. “Selected results from the annual survey on employer health benefits 2001 and the national survey on small businesses 2001.” *Kaiser Family Foundation Chart Pack*. Menlo Park, CA: Kaiser Family Foundation, 2001.
- <sup>6</sup> Institute for the Future. *The future of managed care: Experiments in reinvention*. Menlo Park, CA: IFTF, Health Care Horizons, 2001.
- <sup>7</sup> Towers Perrin, *Facing Health Care Challenges in an Era of Change Survey*, 2000.
- <sup>8</sup> U.S. Department of Labor. *Futurework: Trends and challenges of work in the 21st century*. Washington, DC: DOL, 1999.

Chapter 4

THE FORECAST:  
THE EMPLOYMENT-BASED LANDSCAPE OF 2012

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Analysts argue that the problems of American health care have arisen because the purchasers and the users of health care are not the same, because the interests of the buyer and the beneficiary differ, and because physicians serve patients but are paid by third parties.<sup>1</sup> In short, health care woes are the inevitable result of a market that shelters consumers from the true cost and quality of the products and services they use.

This cannot stand. Driven by a waning economy and accelerating health care costs, policymakers, e-health companies, and health care purchasers of all types, but particularly employers, will strive to remedy the system's intrinsic problems by creating more direct markets for health care in the next ten years.

How long is such a transformation likely to take? And what will it look like when we get there?

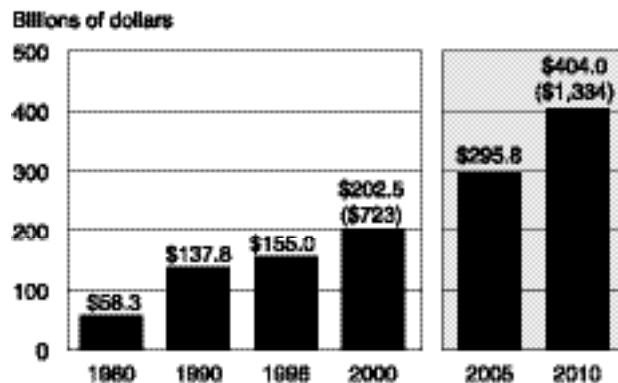
## Employees Will Pay More and Do More

If one thing is certain about health benefits in the near term, it is that employees will become more informed and active consumers, making more decisions and paying more money out of pocket for their health care. While few will have total control over their health benefits, they will have a growing array of self-service benefits management tools available, and many will use the flexible spending account provisions of Internal Revenue Service Code Section 125 more extensively.

Thus, fixed (defined) contribution coupled with flexible spending accounts of some type will become common by 2012. By 2010, the Centers for Medicare and Medicaid Services anticipates that consumer out-of-pocket costs for health care goods and services will reach \$404 billion (See Figure 4-1).<sup>2</sup> Although this is a significant sum, nearly twice as much as projected for 2001, it will not be a greater share of national health expenditures (NHE), since the employers' share of NHE is likely to hold steady and the government share is likely to grow.

As a result, employees will choose from a larger array of tiered benefits, and will have choice of treatments, benefits packages, and providers. But they will have to pay more to exercise the higher cost choices. To this end, providers will be organized into a more refined

**Figure 4-1**  
**Consumers Will Pay More**  
*(Out-of-pocket expenses minus premiums)*



Source: Health Care Financing Administration, Office of the Actuary, 2001.

hierarchy based on cost and quality of clinical performance, where possible. Employees will be able to choose the providers they want, but they will pay more out of pocket for less cost-efficient choices.

By the end of the forecast period, employees who work for large employers will understand that all providers do not deliver the same quality of services. In the most sophisticated workplaces, benefits incentive structures will support higher-quality care, and employees will choose providers and plans accordingly.

All will not be peaceful among consumers, however. Forceful moves to benefits management techniques that curtail the administration services employees value will be met with solid resistance. Survey after survey shows that employees believe that employers are better able to select health plans than they are—that they appreciate the employer’s role in screening and negotiating with plans and advocating for employees. Employees seem to want a menu with lots of variety and choice, but they want it to remain a menu, not become a cookbook. Employers do recognize this about their workers, and a good amount of their work in the next decade will be to engage their employees in health care purchasing decisions a little at a time.

But it won’t be easy. Differences in educational status and occupation, combined with the influence of employees who have been unengaged in health benefits decisions, will slow progress. Although 50% of health care consumers will be active new consumers by 2005, the other 50% will remain as traditional, more passive consumers.<sup>3</sup> It is possible that traditional consumers and those without the analytical resources for operating in an information-driven environment will lose out. Yet, phone-based support systems, quarterly personal health benefits statements like those used for retirement accounts, and educational programs offered through membership organizations like Consumers Union, American Association of Retired Persons, or labor unions may help traditional consumers navigate an increasingly complex information stream.

### Coverage Options Will Expand

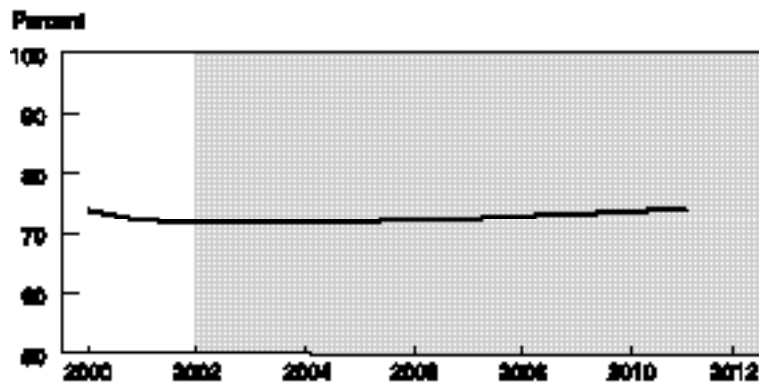
As consumers take on more responsibility for their health care decision making, those among the *active* workforce in the largest firms will have even more coverage options. But they will pay for the choices they make.

Indeed, accepting more costs will be the trade-off for greater choice. As employers seek to shift or contain costs, they will offer employees more choice in providers and services, though plan choice is likely to decrease. Employees will make more decisions, but the choices will be guided by increasingly refined incentives put in place by employers. Ultimately, individual employees will not necessarily pay a greater share of the cost. What they pay will depend on the choices they make.

The percentage of employees covered by their employers will fluctuate in the short term in reaction to the economy but will grow as labor markets tighten with economic recovery. We forecast that, after reaching a low of 71.8%, roughly 74% of employees will have employer-sponsored health benefits by the end of the forecast period (see Figure 4-2). Although the percentage changes appear small, it is important to note that the 0.5% increase in employment-based coverage in 1999 resulted in 3.6 million more people being insured.<sup>4</sup> Thus, a gain of 2.2% would insure nearly 8 million more people, nearly one-fifth of the number uninsured in 1999.

Experts posit that four trends will drive the slow, steady growth of employment-based insurance. One, immigration that in the past has brought in a steady influx of workers that often provided lower-wage

**Figure 4-2**  
**Employment-Based Coverage 74 Percent**  
**(Percent of workers insured)**



Source: Institute for the Future

labor will level off and tighten demand for workers. Two, the growth of the self-employed has also leveled off, and as more workers become employees of larger companies, the probability of having employment-based coverage will grow. Three, the ranks of managerial and professional workers are growing, and it is these workers who are most likely to have insurance coverage. Four, the imminent retirement of the baby boomers threatens to siphon off skilled and highly experienced workers. Employers will seek to keep these workers in the workforce as long as they are productive, even if they maintain reduced schedules. The baby boomers will force employers to accommodate them to keep them, and health benefits will be a key part of their compensation.

But something's got to give, and in this case, it's retirees who will lose out. The trend toward reducing or dropping retiree benefits for new hires will grow. This may create either a market opportunity for the individual insurance market as affluent and relatively healthy baby boomers age and seek coverage to supplement limited retirement benefits and Medicare, or it could spark a major outcry that produces government response as increasing numbers of the voting public find themselves unable to access health insurance in retirement.

Advances in medical technology and the associated cost increases will challenge employer (and plan) frameworks for deciding what to cover. The culprits in the first half of the forecast period will be minimally invasive surgery, advances in drug delivery, and sensors. Near the end of the forecast period, genetic screening and therapies may push the envelope even further. Employers may find the costs of the newest technologies so prohibitive that they offer them only with high employee contributions. The biggest employers will lobby hard to prohibit mandated coverage of such big-ticket items at the federal level.

## Mass Customization Will Thrive in Health Insurance Markets

The insurance marketplace will continue to prototype a wide variety of products to streamline benefits management and to support consumer-directed benefits. These products and services will run the gamut from rich defined-benefits programs and flexible benefits plans to catastrophic insurance with buy-up options and some form of

defined contribution. At any given time in the forecast period, employers will use any of these mechanisms for offering health benefits. In general, large companies will change more slowly than small ones.

Employers will use a mix of in-house and contracted methods to administer benefits based on the size of their workforce, the delivery system marketplace, and workforce health status. Examples are Lumenos's insurance administration system for self-insured employers and Sageo's health and welfare benefits management tool that supports open enrollment and COBRA and HIPAA compliance for large employers. Ultimately, such services will be available to small and large businesses. The services will educate employees, facilitate plan and provider choice, process claims, and help individuals manage MSAs.

Customized, consumer-directed benefits programs such as these will be delivered to employees via the Internet with the support of flexible spending accounts. First-generation examples are Vivius, which allows members to create personalized provider networks with the support of Internet-enabled decision-making and benefits account management tools, and MyHealthBank, which offers similar tools for use with defined contribution-based benefits (see Appendix on page 81). The result will be that employee-consumers will be required to actively configure and manage their health benefits portfolio, spending their own and their employer's money.

### Providers and Plans Will Differentiate Themselves in the Marketplace

**P**lans and providers have begun to articulate compelling product advantages to consumers. Their traditional target audience has been employers, primarily. In the next era of employment-based health insurance, plans and providers will have to speak to consumers directly. Those that can articulate a compelling value proposition to consumers and deliver on it will gain market share.

Providers—physician groups and hospitals—will have to find meaningful data on quality of care, and they will have to figure out how to talk about their prices. Both the quality of clinical care and the pricing structure of health care are arcane subjects. The challenge in a consumer-focused era is to make them as commonplace as automobile price

and performance information. There is a long way to go to accomplish this. It will require quality measures that consumers find meaningful and useful (and that are presented in a palatable way) and that providers believe are fair and credible. It may require an overhaul of health care pricing. Most of all, it will require a sea change in the attitude of providers that will enable them to open themselves up to scrutiny and comparison, an approach that until now they've been loath to adopt.

An efficient consumer market—one that has the potential to control costs and improve quality—can only evolve if consumers have the information to make rational choices. Providers will rise to the occasion if the incentives are in place to reward them. This means that better compensation and greater market share must accrue to those who deliver good value for the dollar. Efforts are arising to support such incentives. If the elite employers currently focused on value purchasing and quality of health care can maintain that focus without getting derailed by rising costs or the challenges of the economy, the next five years will yield models of value purchasing that may build credible incentives for providers to offer more cost-effective care. If the focus on quality and value wanes, providers still will differentiate themselves, but it may be solely on price and customer service.

### Forecast Wild Cards

A wild card is an event or a trend that has less than a 10% chance of occurring, but if it does occur, has tremendous impact. As the IFTF Health Care Horizons team prepared this forecast, the United States declared war on terrorism in response to the September 11, 2001, attacks on the World Trade Center and the Pentagon. This constitutes a wild card beyond our imagining. It changes the nation's priorities, placing this war squarely before domestic policies that are not central to the purpose of national security. Though we opened the millennium on the brink of great change in health insurance financing and organization, the pace of change certainly will be influenced by the challenges that domestic policies will face in capturing congressional and public attention in a time of national crisis.

The events of September 11 may accelerate some of the trends that existed before and may well slow others. Perhaps they sped the economy's slump into true recession, for example, as the effects on the airline



and travel industries rippled outward. These developments may force the pace at which employers move to cut their health care costs by cutting back benefits or shifting costs and responsibilities to employees. However, they may well inhibit changes in tax and insurance laws and other regulations that would help to restructure health insurance financing, specifically to increase the ability of individuals to deduct premium payments and increase the viability of MSAs as consumer-managed health care financing tools.

We stand in the wake of the wild card of national disaster, but we face three other potential wild cards as well. Taken together, they portend the demise of the employer-sponsored health insurance system as we know it.

#### ***Employer Liability Becomes Untenable***

As a result of passage of the Senate version of the Patients' Bill of Rights, litigation ensues that makes employers' liability for harm done by the plans or providers they sponsor untenable. The financial risk is so high that employers get out of the business of sponsoring health coverage altogether: no negotiating with plans, no direct purchasing of services, no provision of educational materials to employees. Given the need to attract and retain employees, employers that compete for skilled labor simply subsidize workers' health care through a variety of flexible spending accounts, likely through a third-party administrator. Other firms drop health insurance to limit risk. The health care market loses one of its most effective advocates for cost control and quality improvement, and, unless the government takes up the slack, such efforts languish.

#### ***Economic Depression Spurs a Single-Payer System***

Sustained and deep economic depression, coupled with continued double-digit premium inflation, drives employers to negotiate a government-sponsored, single-payer system. Employers agree to pay a health tax and be done with the whole business of health benefits management. All the old models of single-payer health insurance come off the shelves and a massive effort ensues to establish an efficient system of coverage that allows Americans a modicum of the independence and self-determination they require. All in all, more people receive health care coverage under the single-payer system.

***Tax Law Reform Paves the Way for  
Cash-Based Defined Contribution***

Startling tax reform makes cash payments to workers for health care tax deductible. As a result, cash-based defined-contribution programs take off. Employers are finally out of the role of middleman and simply subsidize employee health care. Health benefits consultants lose work. Brokers and financial managers are very busy. Individuals without the wherewithal to manage health accounts and to maintain coverage slip in and out of the ranks of the uninsured or find themselves underinsured in times of need. Sophisticated consumers have a new asset to add to their portfolio.

**Miles to Go Before We Rest**

**W**ild cards aside, the shift to a more employee-centered system of health benefits is inevitable given the current drivers, but it won't happen overnight. Indeed, the journey to that goal will not be completed in the next ten years—the period of our forecast. But the paths will be mapped out in that time, as described in the next chapter, and the migration will be well under way.

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**Endnotes**

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## Chapter 5

# THE FOUR PATHS TO CONSUMER-DIRECTED HEALTH BENEFITS

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Most health care analysts and stakeholders agree that there is an undeniable move toward consumer-directed health benefits. Yet they caution that there is no single path ahead, but many, and that most options for advancement rely upon transforming the role of health care consumers.

In fact, the key to creating a more direct market for health care benefits is the consumer. Consumers capable of making informed decisions about insurance and care are able to put their money where their minds are. If consumers become responsible for more of the costs of the services they receive, many experts believe that they will be more likely to make cost-effective choices. Experts hypothesize that this type of responsible consumption will reduce the overuse of medical services, increase quality, and constrain the growth of health care costs overall. Consumers must have options if their decisions are to change health care, for it is in exercising choice that they register their preferences. As one benefits consultant we interviewed stated: “The biggest market force that could improve the health care system is the consumer, but we have not given them the information to exercise that force in a directed way.”

Although the overarching direction of change is toward employer-subsidized, consumer-driven markets, we forecast that employers—the primary purchasers of health insurance for the non-elderly in the United States—will traverse four intertwined but different paths to get there, and they will take their employees with them:

- Large employers will lead the long march toward consumer-directed benefits by consciously training employees to take on more of the costs and responsibilities of their own health care benefits.
- Companies that are too large for small group market initiatives, but too small to have market clout on their own will seek joint purchasing pools to offer their employees the choice and savings needed to foster value-conscious health care decisions.
- As costs increase, the smallest companies with the most vulnerable employees will take the shortest route by opting out of health benefits altogether.
- Simultaneously, the self-employed, some small purchasing coalitions, and financial services firms will pursue individual market fixes that will facilitate an employer-subsidized, employee-paid system.

These journeys will be perilous and full of detours and delays. There will be fruitful new partnerships and innovations—as well as unsuccessful ones. There will be winners and losers. But there will be no shortcuts.

### Path 1: Large Employers Will Coach Capable Consumers

**T**he retreat from the controls of restrictive managed care can be seen as the retrenchment of supply-side interventions in the 1990s, by which health care payers (plans and purchasers) tried to control costs by discounting provider reimbursement and moderating utilization. Having lost hope in these supply-side controls, large employers are turning to demand-side interventions. The leaders among them will endeavor to make employees more accountable for health decisions, behaviors, and the resulting costs. Their hope is that, once harnessed, consumer clout will prompt the health care market reforms the third-party-payer system failed to achieve on its own.

### ***Demand-Side Interventions***

The campaign to jump-start the consumer's role in controlling costs is propelling employers to reinvigorate old strategies for changing employee behavior and to develop new ones as they go. To this end, large employers will take some or all of the following measures:

- Offer employees more information with which to make decisions as well as self-service tools to use the information.
- Refine and increase incentives for employees to make sound choices among plans and providers.
- Shift more costs for premiums and services to employees.
- Turn to defined contribution to keep their costs and liabilities down.
- Seek to influence employees' health behaviors, rewarding those who participate in health promotion programs that target the most costly conditions.

### ***Building the Information Infrastructure***

The cost and the quality of American health care remained opaque to its users for most of the 20th century. For a long time, prepaid health care shielded its users from knowing the full cost of care. End consumers paid their copays and never saw a final bill. There are hints now that a change is under way. One HMO prints the real cost of prescription drugs on its receipts along with the \$5 copay. But even with these changes consumers see only pieces at a time. Employers will accelerate efforts to make health care costs (and quality) apparent to employees.

Some important tools for making cost and quality transparent are self-service kiosks or Web pages on an Internet or intranet site. In fact, Web sites that allow employees to manage their own health benefits are already on the rise among large employers. It is estimated that 38% of employers are using the Internet to administer benefits today. Eighty-six percent expect to do so by 2005.<sup>1</sup> These Internet sites, whether outsourced or created in-house, will strive to make the costs and benefits of employees' decisions clear. They will evolve from enrollment-only sites to health account management tools through which employees can not only choose plans and providers but also maintain personal health records, track claims, and get relevant health information. The goal is to make health care costs, quality, and trade-offs explicit to users, and available to them at their convenience.

## What Information Will Employers Provide?

In order to facilitate sound decision making, employers will offer:

- Data that compare cost and clinical quality of plans and providers.
- Training on what the quality data mean.
- Rationales for why employees are asked to contribute more for some providers and plans.
- Access to sources of information on specific treatments and diseases.
- Plan and coverage reference materials so employees can check what is covered.
- Claims tracking information.
- Account management tools for flexible spending accounts.

There is a problem with this approach, however. A lot of employees in the biggest companies don't sit at desks. Many workers in manufacturing companies, for example, work on an assembly line or in a warehouse. It's true they could be provided PDAs to surf the company intranet, but that's unlikely to work. As one expert noted, "We have 40 years of reinforced passive behavior among employees, and we cannot move to a level of getting consumers involved rapidly, no matter how much we put on the Internet." As a result, the reach of Internet-based approaches to engaging employees in benefits decisions is limited. Employers that want to make costs and quality apparent to employees will have to use multiple media to engage the workforce.

To some extent, all of the information that employers will provide is available now on paper and online (see sidebar, "What Information Will Employers Provide?" on page 64). In the next ten years, these materials will become more sophisticated, customized to individual employees, and more widely available. The challenge to employers, particularly those with large and diverse workforces, will be to find the most effective ways to get the information to employees.

#### *Structuring Powerful Incentives*

Information about products and services and the money to buy them are the essential tools of active consumers. The largest employers (5,000-plus employees) will lead the pack in making sure that employees have a choice in health care goods and services, and have the information and tools they need to exercise that choice. They will also use powerful incentives to ensure that employees pay for the decisions they make.

This is a variation on a familiar theme for large employers. Today, an employer may require different contributions from employees based on whether they select an HMO, PPO, point-of-service, or conventional coverage. However, these different contributions are often based solely on the cost of whatever is deemed reasonable coverage, without consideration of quality. Thus, the employee distinguishes among options without full information on value.<sup>2</sup>

In the early years of the forecast period, the most sophisticated employers will refine these incentives, requiring employees to pay according to the price and quality of the service or product they choose. Employees would contribute more, for example, if they have coronary



artery bypass graft surgery at a hospital that performs less than 500 such procedures a year, because the data show that outcomes are better at hospitals that perform more than 500 a year. What's more, as the data on provider group performance get better, employers will require employees to pay more if they select less cost-efficient provider groups, for example.

Large employers will also use incentives to address the challenges of advances in expensive medical technology. First, they will look for evidence that a new and initially more expensive treatment is not only effective in and of itself, but also more effective than the less expensive alternatives. They will also look at how use of a new treatment is likely to affect employee productivity and overall costs. Although new technologies, such as minimally invasive surgery, may cost less and require less recovery time than traditional surgery, they may also increase demand. In response, employers will create open access to these new technologies but offer low subsidies. The most obvious example is in the choice of older generic versus newer prescription drugs. If a newer, more expensive drug doesn't offer a distinct benefit, consumers will certainly have access to it, but they will pay more for it.

Many experts agree that while large employers may leave more basic decisions regarding care and coverage to employees, they will continue to more actively drive consumer choices in managing chronic conditions or addressing health-threatening behaviors (such as smoking). Although issues of privacy and discrimination will prevent mandatory individual health risk profiling, employers will find ways to encourage and reward employee participation. For example, employers will reward employees with premium discounts for volunteering to participate in health risk assessments and allowing the information to be used to contact them about relevant health programs. On the flip side, employees will pay more for failure to attend to behaviors and conditions that drive health care costs up and productivity down, like smoking and poorly managed diabetes.

The interesting thing about more refined incentive structures is that whether they result in more employee out-of-pocket costs depends on the choices the consumers make themselves. An individual employee may or may not pay more for his or her care because the cost ultimate-

ly depends on personal choices and utilization. The move of the workforce into HMOs demonstrated that employees are quite price-sensitive. Among large employers, modest out-of-pocket cost differences between HMOs and traditional indemnity insurance made employees choose HMOs.

The bottom line is this—within the next three years, employers will refine incentives based on better data about cost and clinical performance of treatments, plans, and providers. This marks an expansion and deepening of the existing incentive structures. Incentives will go beyond tiered drug formularies to drive employees to cost-efficient providers and treatments. Not only will employers use these value-based incentives, but they also will make them completely transparent to employees so that at every step of the way the employees can make fully informed, cost-effective decisions.

#### *Shifting Costs to Employees*

As part of this campaign to increase employees' knowledge of and responsibility for their own health care, large employers will shift premium costs to employees and continue to increase copays and deductibles. In a recent survey, 75% of large firms (200 employees or more) reported that they were either very likely (44%) or somewhat likely (31%) to increase the amount that employees pay for insurance.<sup>3</sup> We forecast that, in contrast to what employers did in 1999 and 2000, they will now do what they say. The advent of recession and rising unemployment has given employers the window of opportunity they lacked at the end of the 1990s.

The purpose of shifting costs to employees is twofold: (1) it saves the employer money, and (2) it makes employees aware of the true costs of the insurance they have and the care they use. The second reason is the most germane to transforming beneficiaries into consumers. If the cost of health care is too high, employee-consumers will decrease their use of discretionary care, because historically they have already done so. They will think about whether to take the generic instead of the prescription drug. They will begin to question the necessity of getting an MRI for lower back pain. Utilization will go down when services are not mandatory, and employee-consumers will begin to distinguish between what is necessary and what is not.

### *Moving to Defined Contribution*

A very significant way for employers to keep down costs is transforming the health care insurance system from defined benefit to defined contribution. This notion has been a long time coming, and for many the question is not *if* the system will move to defined contribution but *when*.

Defined contribution, in which an employer designates a specific financial commitment to benefits rather than chooses the general benefits it will cover, is merely a means to an end: shifting the role of the employer in providing health benefits. It is one mechanism for fostering more direct markets in health care. In the next ten years, inroads will be made on this front as more large companies introduce defined-contribution options into their health benefits mix. Some experts posit that it will not take a large number of companies to create a sea change; rather, it will take only a few employers at the top to lead the way.

While experts agree that there will not be a mass migration from defined-benefit health insurance financing in the next ten years, they are just as sure that we are moving down the road toward defined contribution. Employers' desire to create direct markets and to retire from the role of middleman between patients and providers is compelling this move. Indeed, the ranks of employers that offer fixed contributions for health benefits more than doubled between 1994 and 2000. As cost pressures rise and attempts to shift responsibility and costs to employees grow, more employers will fix (define) their contribution to health benefits. In the first generation of defined contribution, employers will continue to generate the plan and provider choices, inform employees of their choices, and establish mechanisms for employees to pay for additional services from pretax dollars with flexible spending accounts.

Most experts agree that no regulatory changes are needed to accomplish this. It is happening now. Coupled with the provisions of Section 125 of the Internal Revenue Service Code that facilitate flexible spending accounts, employers can fix their benefits contributions and offer employees the ability to pay for additional benefits on a pretax basis.

The next generation of defined contribution is likely to be more like the third-party administered accounts used for retirement now, 401(k)s and 403(b)s. Accounts will be established that allow both employees and employers to contribute, and funds will be permitted to roll over

from year to year. Employers would limit their responsibility to engaging qualified third-party administrators or aggregators to generate plan and provider options and to administer accounts. Under this structure, however, tax law would have to change to allow for Section 125 accounts to accumulate and roll over from year to year rather than be spent or lost each year. Alternatively, MSAs, now restricted to businesses with 50 or fewer employees, would have to become more widely available. While such amendments to the law are possible, no group of influential stakeholders appears to be pushing for the necessary changes, and thus such changes are not probable in the near term.

As a result, it is unlikely that employers will simply give cash to employees and send them out on their own to buy health insurance in the near future. Most analysts interpret tax law to mean that money given directly to employees is taxable. Thus, in the absence of substantial changes to income tax law, cash-based defined contribution is not viable at this time. Such changes would have to allow individuals to deduct employer cash contributions to health care from their income taxes even if individuals purchase the care directly.

*Employers Will Tailor Benefits Coverage to Population Health*

Very large employers will attempt to tailor their benefits programs to meet the health needs of their workforces. This means taking an epidemiologist's view of the workforce and managing benefits accordingly. With automation of administrative processes, employers will use data mining to assess health care cost drivers, to correlate them with diseases, and to seek vendors and coverage that best manage the most costly conditions. Experts note that a handful of disease states can drive the majority of health care costs for a large employer. Getting a handle on these is crucial to controlling costs.

In some cases, population health management will lead to forced marriages between provider groups and disease management vendors. Employers will demand the most cost-effective care for their populations rather than simply find the most comprehensive plans. Such a strategy could mean, for example, that an employer would require a provider group to work with the disease management companies that showed evidence of excellent clinical quality and outcomes for the three most costly diseases in an employer's workforce. To succeed in

securing contracts and actually delivering cost-effective care, providers will have to learn to work in new partnerships that many would not have chosen on their own.

#### ***Winners and Losers***

The era of the active health care consumer will be one in which those who can master information and act on it will win and those who cannot will lose. This will be true for employees, employers, insurance companies, and providers alike.

Employees who are adept at acquiring and analyzing information and have the resources to act on it will be able to maximize the benefits they get from more self-directed health insurance. Employees without the capacity to maneuver through an information-driven system may be left behind unless employers create favorable default conditions for them. As cost shifting increases and costs rise, employees who are unable to keep up with rising contributions to premiums and copays may either migrate toward catastrophic coverage or drop insurance altogether. This will be a particular hardship to the old and the sick, since their health care costs are generally higher than the norm. Underinsurance and lack of insurance could certainly put an increasing burden on the already fragile health care safety net.

Employers that invest in the information-driven approaches to benefits management will be most likely to save money and limit their administrative burden. Experts agree that the first savings will arise from the effective automation of benefits functions. As employers push self-service systems for employees, the benefits administration workload should moderate. In addition, some experts believe that matching the right portfolio of benefits with the right employee will reduce overinsurance at the same time cost shifting discourages overuse of health care services. To succeed in a consumer-driven, self-service environment, both plans and providers will have to differentiate themselves and their products in ways that are meaningful to consumers. This means insurance companies, physician groups, hospitals, and even providers offering specific treatments will have to communicate their advantages to consumers. Those that track their costs and report their quality will have an advantage over those that do not or do it poorly. If

employers advocate for quality health care and support it with financial incentives, providers that don't differentiate themselves on value will begin to lose market share.

## Path 2: Employers in the Middle Join Larger Groups

Two categories of firms are caught in the middle: the larger, small firms of from 50 to 199 employees and the smaller, midsize firms of from 200 to 499 employees. Special rules carve out markets for employers with fewer than 50 employees and sheer size creates market advantages for firms of 499 employees or more, but those in the middle have few options to pursue in controlling costs and encouraging responsible consumer behavior.

As a result, we forecast that firms in the middle will hang on to health benefits and attempt to gain advantages enjoyed by large firms by joining larger groups. They will pursue two options for group purchasing: employer coalitions and aggregators.

Employer coalitions are an old and well-established means of pooling expertise and numbers to gain bargaining clout for employers. Employer coalitions that actually purchase health care and insurance are most effective at controlling price when their members are geographically concentrated. Employers with 50 to 499 employees often fit this description. Purchasing coalitions will offer these employers bargaining clout, information, and tools to help them support employees who are savvy health care consumers.

Aggregators are third-party trusts that select plans and providers, collect money, pay premiums and claims, provide information to their members – in essence they are purchasing agents. We forecast that, enhanced by the agility of the Internet, aggregators will expand in the next ten years and offer great advantages to small and midsize companies. Although aggregators like the California Public Employees Retirement System existed before the Internet, their operations will gain efficiency and specificity by using the Internet. Aggregators use the Internet to reach members, to deliver information, and to go beyond regional boundaries to create larger groups. They also offer purchasing and insurance product packaging expertise that many smaller firms

don't have. Thus, the aggregator can provide the easy-to-use consumer interface needed to help employees manage their own benefits and handle benefits administration for employers.

The Internet has given rise to a new breed of aggregators that we expect will find successful business models after bumpy times at the beginning of the forecast period. Among the first generation of aggregators are HealthMarket and Vivius (see Appendix on page 81). They offer distinct advantages to companies that don't have the benefits administration expertise to secure the best benefits at the best costs. Thus, they are a viable option for addressing the needs of small and midsize employers.

#### ***Winners and Losers***

The big winners will be aggregators that can find a viable business model and employer coalitions that deliver cost savings. They will pave the way for providing choice and cost control and delivering tools to employees in firms of 50 to 499 for use in directing their own health benefits.

Aggregators may pose stiff competition to insurers, health plans, brokers, and benefits consultants, or they may prove to be indispensable partners. They will rise or fall based on their ability to gain market share and to negotiate relationships with employers, insurers, and providers.

On this path, just as on the first, employees must master self-service health benefits management to thrive—maybe even to survive.

### **Path 3: The Exit Route**

**I**n the current climate of a tightening economy and rising health insurance premiums, many small employers are stranded with few options for controlling health benefits costs and administrative burdens. Small employers do not come together in large enough purchasing pools to wield much market clout, and as a result they must struggle with the vicissitudes of the small group insurance market. They also have few options for using consumer engagement to control health care costs. More than 90% of them don't offer employees choices among plans, and few have the administrative capacity to take on employee education on cost and quality. Moreover, small businesses already require employees to pay higher copays and to make greater contributions to premiums than do larger firms (34% versus 27%) and may have already exhausted the potential for shifting costs to employees.

This may be the reason small firms are less likely to report that they plan to shift costs to employees to control health benefits expenditures.<sup>4</sup> In fact, many of our experts say that the primary option for small firms is to drop coverage altogether, and we expect many small firms to do just that.

We forecast that as premiums rise, regulation grows more burdensome, and the economy bogs down even further, the percentage of small businesses that offer insurance will continue to fall from the 2000 high of 60% to a rate somewhere between 50 and 55%. This is significant because these firms form the majority of employers in the United States (73%) and employ slightly more than one-third of all workers. Attrition from the ranks of small businesses that provide health benefits could increase the number of uninsured, limiting access to optimal health care and stretching the health care safety net even further.

#### ***Winners and Losers***

There is no doubt that the losers will be the employees who lose access to health insurance. Access to health insurance makes a difference. The uninsured are less likely to receive preventive health care, such as physicals, or to have regular doctors who may be instrumental in providing continuity in care. This is troublesome because the uninsured are also more likely to engage in behaviors that put their health at risk, like smoking, not exercising regularly, and eating poorly.<sup>4</sup>

The safety net may also be a loser. Already troubled by the shift in public resources from public clinics and hospitals to private providers through Medicaid Managed Care, the time-honored formulas for subsidizing uncompensated care have ceased to function. Yet they may become the providers of choice for some of the poor working uninsured.

The winners may include complementary and alternative medicine providers and the individual insurance market. Complementary and alternative medicine providers offer access to a wide range of remedies, from sound to dangerous, on a fee-for-service basis.

The individual insurance market gives uninsured workers with sufficient means the opportunity to purchase coverage. Insurers that can configure bare-bones plans that individuals can afford and that can market them well stand to gain. If local area health plans and county health plans are ever able to compete for non-Medicaid patients, they could capitalize on the lower-income market, too.



#### Path 4: Pursuit of Small Group and Non-Group Market Reforms

There's another option for small employers, however, and that is to change the system so that they can survive with some form of health benefits intact. To this end, a diverse cadre of activist small employers and the self-employed will seek small group and individual market reforms through small-business coalitions and advocacy groups. These are the small employers fighting to provide benefits for themselves and their employees. They are also the small employers that must offer benefits because they employ highly skilled workers and compete with large employers for employees. These firms include unionized bakeries and dry cleaners, accountants and real estate agents, dentists and opticians, software firms and biotech companies. Some may have been forced down Path 3 to drop insurance altogether; others that employ highly skilled workers may always have to offer a full array of health benefits at mounting costs.

Access to affordable health benefits is an issue high on the agenda of many small businesses, the self-employed, and their associations. These associations include state health insurance purchasing coalitions serving employers with 50 or fewer employees and national advocacy groups such as the National Federation of Independent Businesses. Over the next ten years, small businesses and their advocates will continue to work for access to affordable health insurance, including reforms of the small and individual insurance markets.

Several of the reforms these businesses will pursue seek to expand options in the small group market. Small-business advocates have supported and will continue to push for the creation of association health plans (AHPs) that would allow small businesses to band together across state lines to purchase health care. Such associations would create market clout and offer ERISA preemptions from state insurance regulations to businesses of 50 or fewer employees. The House of Representatives already has passed legislation authorizing AHPs.

Some analysts posit that small businesses will push for legislation to support an open market for MSAs. Established as a pilot program under HIPAA in 1996, MSAs are true savings accounts in which funds contributed by employees or employers may accumulate for use on medical

expenses. The drawback is that MSAs must be used with health insurance plans with high deductibles: \$1,500 to \$2,500 for individuals and \$3,000 to \$4,500 for families. Contributions may be up to 65% of the deductible for individuals and 75% of the deductible for families. HIPAA provides for 750,000 accounts per year for businesses of 50 or fewer employees and the self-employed.<sup>5</sup>

As of 1999, the Internal Revenue Service had on record 43,000 taxpayers who had MSAs. Industry analysts put the number closer to 100,000, but in either case it is a far cry from the limit of three-quarters of a million established in the pilot program.<sup>6</sup> The barriers to growth of MSAs may be that high-deductible insurance is unattractive to many people, that MSAs are limited to employers with 50 or fewer employees, that the caps on contributions don't allow the users to buy much, and that in any given year only the employee or the employer may contribute to the plan. Small employers and others seeking to expand the use of MSAs will work to make the federal MSA provisions more liberal.

Efforts are under way to reform tax law to make it easier for the self-employed and individuals to purchase their own insurance. Internal Revenue Service Code Section 162 is set to allow self-employed individuals to deduct 70% of their health insurance premium payments in 2002, and 100% in 2003. Section 162 helps to level the tax-law playing field for the self-employed, treating their premium payments the same way other employer premium payments are treated. No such provision is scheduled to take effect for employed or unemployed individuals who purchase their own insurance, however.

Many see individual tax credits or deductions as a means of expanding the number of Americans with health insurance, and others see it as an essential step toward cash-based defined contribution in health benefits. Both constituencies are working for preferential tax treatment for premiums paid by individuals. Should they succeed, this change in tax law would clear the way for employers to give their employees cash to buy health insurance. The result would be to lessen employers' role in acquiring health insurance and managing health benefits.

Small-business advocates will also lobby to lessen the burden of federal regulations that fall disproportionately on small businesses. According to the National Federation of Independent Businesses, the regulatory cost per employee in small firms is approximately 50% more

than the cost to large firms. Experts confirm that the administrative burden of COBRA expansion and HIPAA regulations is difficult for small businesses to bear. They simply do not have the staff. And state mandated benefits and patients' rights regulations drive health care costs up. Since many small businesses buy fully insured rather than self-insured health plans, they do not enjoy ERISA protections from these state laws. Small-business advocates will work to implement administrative paperwork reforms for relief from COBRA and HIPAA regulations. They will also work to constrain medical malpractice laws by capping punitive and noneconomic damages in state and federal patients' rights legislation.

#### ***Winners and Losers***

Clearly, small employers that are well connected to fellow purchasers are more likely to benefit from small-group market reforms. Employers have to build relationships with associations of employer groups to participate in AHPs or purchasing coalitions. Small employers working with unsophisticated brokers will miss out.

AHPs may hold great promise for small employers and the self-employed, but they may cannibalize health insurance purchaser coalitions (HIPCs), compete with brokers, and be biased toward the young and healthy. If AHPs simply compete with HIPCs, both HIPCs and AHPs may fail to gain the critical mass necessary to increase choice or to attempt to bargain for better prices. Instead, they may simply fragment the small group market. Consumer advocates fear that they will cherry-pick young and healthy members. If they do, they may make it even harder for the old or the sick to find affordable coverage by reducing the number of low-risk enrollees in other group purchasing pools.

Insurance companies may benefit by small-group market reforms that in effect transform the small group to a large group market. They may find more stable enrollment and easier account management. The same cannot necessarily be said of reforms that facilitate increased dependence on the individual market. While it is true that expanded use of MSAs could bring more secure dollars into the individual market if employers maintained contributions to employee MSAs, it could also transfer employees from group to individual insurance markets and increase the risk that the sick would be overrepresented among those with insurance.

Financial services firms are waiting in the wings to capitalize on individually controlled health care accounts. The way they see it, \$1.3 trillion is spent on health care each year. If a significant portion of that is moved to individually controlled accounts – like 401(k) accounts – then there is an opportunity to make money managing those accounts. Financial services firms may become the beneficiaries of a shift to consumer-directed health benefits if these benefits are supported by individual health care accounts.

### Toward Consumer-Directed Health Benefits

**A**lthough employers of different sizes will move toward a consumer-directed benefits system in different ways, it is clear that employers, large and small, must share costs and responsibilities with their employees if the employment-based health insurance system is to continue to function. As we have discussed throughout this report, many employers and analysts see health care consumers—their employees—as the key to transforming today’s indirect health care market into a more direct one. While a more direct employer-subsidized health care market will not emerge fully formed in the next ten years, such a market will certainly begin to reveal pathways to success for purchasers, plans, providers, and consumers by 2012.

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**Endnotes**

- <sup>1</sup> Bearegard, T.R. Driving a more effective health care market by putting consumers behind the wheel. *Managed Care Quarterly* 2001; 9,1:1-4.
- <sup>2</sup> PricewaterhouseCoopers. Choice: The salsa of e-benefits. *HealthCast 2010 e-Health Quarterly* (February) 2001.
- <sup>3</sup> Meyer, J.A., and Tillman, I.A. *Building quality improvements into defined contribution strategies*. Washington, DC: National Health Care Purchasing Institute, September 2001.
- <sup>4</sup> Kaiser Family Foundation/Health Research and Educational Trust, Employer Benefits Survey, 2001.
- <sup>5</sup> Employee Benefit Research Institute. *EBRI research highlights: Retirement and health data*. EBRI Issue Brief No. 229 and EBRI Special Report SR36. Washington, DC: EBRI, January 2001.
- <sup>6</sup> Council for Affordable Health Insurance. Snapshot: What are medical savings accounts? *CAHI Policy Brief* (July 1) 1998; 2,7.
- <sup>7</sup> Associated Press Online. August 25, 2001. [www.ap.org](http://www.ap.org).

## Conclusion

# FROM HEALTH CARE BENEFICIARY TO ENGAGED CONSUMER

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The past 20 years produced a transformation in how Americans finance and access health insurance. The health care system was converted from indemnity to managed care, from retrospective to prospective coverage and payment decisions, and from employee-acquired to employer-acquired coverage. The next 20 years may well deliver a change of equal magnitude.

Indeed, by the end of the next decade, the paths to a new, consumer-directed system will be cut. Consumers will be prepared for the transition, regulation amended, and providers readied for a more direct health care market in which consumers make health insurance and health care decisions and control more of the health care dollars available to them.

In this new era, those with money, education, and choice will prevail. Large employers and their employees, the well educated and well paid, will continue to have access to the best coverage at the best price. Under this system, there is a potential to remake health care for the better—by cutting waste and improving quality. There is also the great risk of further disenfranchising the poor, the uneducated, the unsophisticated, and the timid, and cost shifting low income employees into the ranks of the uninsured.

Thus, the road to direct health care markets is perilous even as it may be promising. Success will depend not only on creating responsible consumers but also on establishing transparent markets that allow consumers of many types to meet their needs.



## Appendix

# NEW TOOLS IN EMPLOYER-SPONSORED HEALTH BENEFITS

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What are the new tools, the new technologies, and the new approaches that might one day transform the delivery of health insurance? And what are the larger trends in employer-based health insurance driving these innovations?

The current focus of health insurance innovators is the consumer. As a result, multiple consumer-driven health care models have appeared in the last few years. Several of these tools, and the companies that produce them, are discussed on the next page. So, what are the consumer-driven models? How are they differentiated and in what ways do they empower consumers in their health care choices? Many, if not all, of these companies rely on decision-support tools: helping consumers make informed decisions by providing benefits, quality, and cost data. These informed decisions can happen at the time of enrollment (e.g., Lumenos) or at the time of service (e.g., HealthMarket); the decision can be among several different preapproved health plans (e.g., MyHealthBank) or among a smorgasbord of options (e.g., Sageo). Whether acting in concert with a health plan or an employer, these innovators are all finding methods to involve the consumer in the responsibility of the health care decision-making process.



Company	What is the product?	What is the market?
Bevco Health	Insurance consisting of three parts: a personal care account (or MSA), catastrophic coverage, and case management/health education tools. Risk is based on the employer group.	Employees
Geacny Health	Full insurance product. It consists of three parts: a personal care account (or MSA), catastrophic coverage, and case management/health education tools. The insurance includes incentives for members to follow preventive care guidelines. Following guidelines leads to better insurance coverage and lower out-of-pocket expenses. The risk pool is defined by the employer group.	Employer groups and smaller employers. The company plans to move into the self-insured and individual markets in the future. Currently located in Florida, with 1,000 covered lives.
HealthPlus	Offers member discounts on complementary or alternative medicine and out-of-pocket expenditures through partnerships with provider networks. Acts as a purchaser of services. The company has a discounted out-of-pocket plan for traditional health care expenses that is targeted at pre-illness care and essential/part-time workers (i.e., the individual insurance market).	Discounted complementary or alternative medicine services used by employees/owners to supplement benefit packages. Discounted out-of-pocket plan used by employees and individuals.
HealthMarket	Insurance product. Self-insured health plans that include an MSA and catastrophic coverage. HealthMarket has a provider network offering discounted negotiated rates, as well as some quality data. Also offers additional fringe and administrative services to help individuals track and monitor their personal health expenses. Risk is based on employer groups.	Employers, brokers and advisors, and individuals.
Lumipro	Insurance administration for self-insured employers. The Lumipro product consists of a health savings account (or MSA), catastrophic coverage, and Web and telephone tools to monitor health expenses, seek advice, and so on. The company assumes no risk.	Self-insured employers. Large firms that are national and global. Future market focus will remain centered on the self-insured market. Currently, the company has 6,000 small group members through a subsidiary. Open enrollment for several large employers will begin in January 2002.

Company	What is the product?	What is the market?
MyHealthlink	Enrollment and management administration for health plans. 401(k)-type tool structure for health plan members to see defined contribution funds from an employer to select type of coverage. Includes decision-support/choice technology for plans and providers, member education, finance management, and co-branding with health plans.	Health plans. Pilot program begins in Oregon in October 2000. Available across the state, through Oregon Blue Cross/Blue Shield in the first quarter of 2001. Available through Washington Blue Shield in August 2001. Through health plans. Included on small and midsize employer marketplace.
Patient Choice Healthcare	Insurance product. The Bayarea Health Cost Action Group model applied to outside environments. This is a defined benefit insurance plan that allows for the selection of provider groups directly by cost and quality. Providers are organized into groups, and members can choose what group to use. This choice immediately and directly affects the premium and copay rates. Quality data are available on these provider choices. Risk is based on the employer group.	Employees.
Signa	Health and welfare benefits administering tool. Provides eligibility, open enrollment (plan and provider selection), COBRA and HIPAA, and so on, for large and self-insured employers.	Large and self-insured employers. Also focused on middle-market employers (200 to 500 employees). Currently working with 24 employers (210,000 employees and 490,000 total participants).
Vivus	Administration of an insurance product. The member selects a personalized provider panel, including physician, hospital, and laboratory choices. The choices have a direct and immediate impact on both the premium and the copay rates. Includes decision support and provider selection tools.	Clients: health plans, HMOs, insurers.

Company	Where is the support?	What is the innovation?	What are they banking on?
Quality Health	First round venture capital produced \$33 million in support in April 2005.	MBA and defined contribution with wellness and preventive care coverage.	Shift to defined contribution. Employers seeking to manage and reduce costs.
Quality Health	Quality is a wholly owned subsidiary of Discovery Health, a large insurer with more than 1 million covered lives, based in South Africa.	Consolidation of the consumer-oriented health care and cost containment into an MBA-type product with incentives and engagement services to ensure the appropriate use of preventive and wellness services.	The economic downturn and the increasing employer cost-consciousness will continue. Straight-forward MBAs will not provide appropriate care for their members.
HealthAllies	Second-round venture capital financing secured \$32 million in June 2005.	The consolidation of purchasing power allows consumers to make rate decisions at time of need, using personal prior-to-visit comparisons.	Complementary or alternative medicine will grow in popularity and the new consumer will demand that their health coverage encompass it.
HealthFactual	Individuals and employers.	Using MBAs to lower health costs. Technology for empowered consumers to control their health expenses.	Defined contribution is the wave of the future. MBAs will really work.
Lumencore	Second-round venture capital funds of \$47 million, secured between 2000 and 2001.	A consumer-driven health care model with capacity for co-branding and a high level of benefit and style flexibility.	Consumer-driven health care is the future. Administration of these services will be outsourced.

Company	Where is the support?	What is the innovation?	What are they banking on?
MyHealthBank	Funding provided through venture capital and health plans.	Administration of insurance between employees with shifted contributions from their employer and the health plan providing different benefit packages.	Defined contribution will continue to grow. Consumers will insist on tools to make health coverage decisions.
Patient Choice Healthcare	Funding through employers.	Allows for more transparency in the health benefits provision market.	Consumers want to choose the providers of their health care.
Sigmap	Part of the Health Association, a large health resources consulting firm.	Integrated series of tools to support the outsourcing of all aspects of health benefits administration in fast and effective manner.	Employers will seek to outsource more and more of the health benefits administration.
Vivid	Venture capital funding.	Technology allows for one-by-one costing of different benefits so consumers pay for what they choose.	Consumers want to choose their providers, without having to take on the full burden of an exclusively out-of-pocket health expense.