Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes

Employers are finding ways to cut their health insurance costs, without passing premium increases on to their workers.

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ABSTRACT: Despite large premium increases, employers made only modest changes to health benefits in the past two years. By increasing copayments and deductibles and changing their pharmacy benefits, employers shifted costs to those who use services. Employers recognize these changes as short-term fixes, but most have not developed strategies for the future. Although interested in “defined-contribution” benefits, employers do not agree about what this entails and have no plans for moving to defined contributions in the near future. While dramatic changes in health benefits are unlikely in the short term, policymakers may want to watch for future erosions in health coverage.

With health care costs on the rise again, employers are struggling to hold premium increases to single digits. Premiums rose 8.3 percent in 2000 and 11.0 percent in 2001, a sharp reversal from the low rates of growth from 1994 to 1998. These increases are partly attributable to employers’ choosing looser managed care products in response to the managed care backlash, combined with rising corporate profits and a tightening labor market. At the same time, health spending has begun to rise, and health plans, to restore profitability, have abandoned premium-cutting strategies to gain market share. Employers now see a return of the double-digit premium increases of the late 1980s and early 1990s.

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This paper examines how employers have modified their health insurance benefits in response to rising premiums. Employers are questioning managed care’s ability to control costs, and some notable employers are beginning to question their roles as purchasers of health insurance. Defined-contribution approaches for health insurance have gained much attention by promising to reduce costs and administrative hassles by placing decision making in the hands of employees. Yet there is little agreement about the implications of this new trend, or about its future.

Here we explore whether employers are changing their contribution strategies or moving to defined-contribution approaches. We then examine employers’ responses and strategies for controlling costs, including shifting costs to workers and moving to three-tier pharmacy benefits. We also describe employers’ plans for the future and the potential implications for policymakers.

Data And Methods

This research is based on the Community Tracking Study (CTS) site visits to twelve communities between June 2000 and March 2001. In contrast to studies of best practices and innovative or cutting-edge markets, these twelve CTS communities were randomly selected to provide a representative perspective of national trends. This study used semistructured interviews with local representatives to capture changes implemented by large employers (500 or more workers) and small employers (fifty or fewer workers). Because of time constraints, we were unable to target midsize employers, but we expect that these employers’ responses to premium increases fall within the range of the largest and smallest employers.

To gain a reliable understanding of employers’ responses to premium increases, we sought to capture a broad perspective on employers’ strategies and the changes they are making. For a perspective on large employers, we interviewed benefit managers of large public and private employers, health benefit consultants, union representatives, leaders of local purchasing coalitions, and health plan marketing and pharmacy executives. To capture the perspective of small employers, we interviewed insurance brokers, representatives of chambers of commerce, and leaders of local small-business associations. All in all, we interviewed roughly 144 respondents (Exhibit 1). Because of the site visit design and the variety of respondents interviewed, we cannot estimate the prevalence of changes, as might be feasible with data from an employer survey. This design, however, provides a more reliable depiction than do interviews with the largest national companies, because it allowed us to corroborate views across a variety of respondent types.
For large public and private employers, we asked about current benefits and changes made over the past two years and about specific changes to health benefits such as changes to the contribution strategy, share of premium paid by employees, and the pharmacy benefit. We also explored changes employers plan to make to their benefit structure or purchasing processes. To provide a vantage perspective, health benefit consultants, brokers, and other respondents were asked similar questions about changes large and small employers are making. Findings reported here reflect consistency across the broad range of respondent types.

**No Change To Contribution Strategies**

From 1996 to 2000 the average percentage of premiums paid by employees with single coverage dropped from 21 percent to 14 percent. Given recent sizable premium increases, many have expected this downward trend to reverse as employers shift more of the premium to their workers. Based on our site visits, however, we found that very few large employers increased the share of premiums that workers pay or changed their contribution strategies. Across all twelve markets, consultants and health benefit managers felt that employers’ reluctance to greatly change benefits was a result of the stiff competition for talent within markets and nationwide.

Employers who have established a fixed-percentage contribution have a built-in mechanism for passing some of the premium increases on to their employees. In contrast, employers using a fixed-
dollar contribution must choose each year how much of the premium increase to pass along. Health benefit consultants in several markets mentioned that large employers were passing on less of the premium increases than they would like to because of the tight labor market. The Miami market was a notable exception, where consultants reported a shift in workers’ share of the premium, from roughly 20 percent to 25 percent.

A majority of large unionized and public employers offering full health insurance coverage reported that they were unable to introduce cost sharing because of union and political pressures. For example, the Massachusetts state legislature blocked efforts to move public employees from a fixed-percentage to a fixed-dollar contribution, even overturning the governor’s veto. In February 2000 engineers from Boeing went on strike to prevent the introduction of a 10 percent employee premium for Boeing’s Traditional Medical Plan. However, Boeing succeeded in adding a provision to the collective bargaining contract that allows cost sharing if premium increases exceed the national increase in the Consumer Price Index (CPI). As a result, Boeing employees enrolled in the traditional plan now pay $10–$30 per month for individual and dependent coverage.

**No Move To Defined- Contribution Approaches**

Despite the considerable buzz surrounding the concept of defined contributions for health benefits, large employers have not adopted this strategy. The most commonly touted defined-contribution approaches fall into three categories. The first and most controversial approach provides an employee with cash or a voucher to purchase insurance in the individual market. A second approach advertised as defined contributions involves an electronic benefit exchange in which an intermediary between the employer and the plans provides a choice of health plans for employees, administers enrollment, and risk-adjusts payments to health plans. This approach is typified by companies such as Sageo and eBenX. A third alternative, typified by Definity Health and Lumenos, includes a range of health plan options sometimes referred to as “self-directed” or “consumer-driven” health plans. As an example of one such option, an employee might receive $2,000 in a personal care account that is tapped first for any health care needs. Employees must then meet a $5,000 deductible before a catastrophic 80/20 insurance plan applies.

Health benefit consultants in the majority of markets reported that employers expressed great interest in defined-contribution approaches but had no employer clients that were actively pursuing these strategies. Survey findings illustrate that employers’ interest...
in defined-contribution approaches varies greatly depending on what is meant by the term. Similarly, what our respondents meant by defined contributions differed as well. The unionized and public employers we interviewed tended to refer to defined contributions as moving from full coverage to shifting some of the premium costs to employees. While these employers use competitive bidding and offer a choice of health plans, the only financial incentive their employees have for selecting a less expensive plan is being able to move any savings into flexible spending accounts. Therefore, unionized and public employer respondents expressed interest in defined contributions as a vehicle for increasing employees’ share of premium or using so-called flex plans to introduce cost awareness.

Benefit consultants, in contrast, were more apt to describe defined contributions as cashing out, electronic benefit exchanges, or self-directed health plans. How favorably they viewed defined contributions depended on which approach they referred to. That is, consultants with less favorable views toward defined-contribution approaches described them as cashing out employees, with employees forced to buy health insurance in the individual market. These consultants thought that employers would adopt this approach only if the economy took a major downturn or if patient protection legislation increased employers’ liability. Consultants with a more favorable viewpoint referred to the self-directed plans or the electronic benefit exchanges and mentioned specific vendors such as Health-Sync and Definity Health. These consultants thought that employers would eventually move to the new defined-contribution approaches, although they were advising them to wait a couple of years.

The common undercurrent throughout these discussions with large employers was the need to identify a way to reduce costs. Large employers interested in defined-contribution approaches were motivated by wanting employees to “have more skin in the game” and by a desire to reduce the amount of administration involved in health benefits. Some health benefit consultants were particularly pessimistic and saw no potential for defined contributions, regardless of the approach. One consultant thought that public and unionized employers would never be allowed to adopt defined-contribution approaches because of union pressures, while another characterized employers in his market (Syracuse) as too paternalistic.

Employers Target Copays And Drug Benefits

Copays. While employers were reluctant to make radical changes, most made modest changes to their benefit structure. Respondents reported that employers increased copayments for office visits, typically from either $5 to $10 per visit or from $10 to $15 per
visit. This corresponds to survey findings that the typical health maintenance organization (HMO) copay was $10 in 1999 but $15 in 2000. Some also added copays for emergency department and specialist visits and inpatient stays. These changes were a combined strategy by plans and employers to hold down premium increases. For example, the California Public Employees Retirement System (CalPERS) held 2002 premium increases to an average 6 percent through increased copays for office visits and prescription drugs. Respondents for large employers across all twelve markets reported that increased copays (including pharmacy) reduced premium increases from two to nine percentage points.

**Tiered pharmacy benefits.** In all twelve markets respondents reported that the three-tier pharmacy benefit design has made major inroads. Under this design, consumers pay increasingly higher copays for generic prescription drugs, drugs on a preferred list or formulary, and brand-name drugs. This structure is designed to provide financial incentives that encourage use of lower-cost substitutes, such as generic instead of brand-name drugs. Some respondents noted that higher copays also are expected to encourage substitution, reduce overuse, and lower premium increases. About 42 percent of retail prescription drug spending from 1999 to 2000 has been attributed to increased volume, while 36 percent has been attributed to a shift from lower-price to higher-price drugs. Typically, the tiers were $5–$10 for generic, $15–$20 for formulary, and $25–$45 for brand-name drugs. One consultant observed that the effectiveness of the tiers depends on their spread and believed that at least a $10 differential was needed to affect behavior.

Respondents also reported that some health plans and employers also used preauthorization for expensive drugs and dropped coverage for Viagra, Claritin, and oral contraceptives to control costs. Many employers also reported modifying their mail-order pharmacy benefit to provide a 90-day, instead of a 100-day, supply of prescription drugs. Some employers also initiated education programs to encourage generic substitution when possible.

How rapidly the three-tier design is being adopted by employers depends on the health plans in each market. For example, HMOs in Boston can make changes to their pharmacy design midyear, and both Tufts and Harvard Pilgrim mandated midyear changes for many of their subscribers. Only a few health plans and employers have avoided the three-tier pharmacy design. Two staff- and group-model HMOs (Group Health Cooperative of Puget Sound in Seattle and Kaiser Permanente in Orange County), in particular, resisted the three-tier design even when it was specifically requested by employers. These health plans had implemented programs to reduce
pharmacy costs through physician education and management of physicians’ prescribing. These plans reported that they wanted physicians to make the cost-effectiveness trade-off for their patients. Physicians in group- and staff-model plans need only to learn the ins and outs of one formulary, making this approach more feasible, in contrast with physicians who contract with several health plans.

According to respondents, employees generally accepted the three-tier pharmacy design, and most complaints focused on the formulary. Employees found it difficult to know whether or not a particular drug was included in a plan’s formulary. The size of formularies also differs. One employer noted that when it switched health plans, the size of the formulary doubled, unwittingly resolving its primary human resources problem. But complaints can arise when employees switch plans and find that their prescription drugs are not included in their new plan’s formulary. Preauthorization for prescription drugs also sparked complaints by employees because of the delays involved in obtaining approval. A Seattle union noted that an employer had expanded coverage to include Viagra and Claritin but at the same time implemented an aggressive management strategy that made these drugs harder to get. Although the structure and coverage of benefits was open to collective bargaining, the union had not anticipated changes in utilization management.

Respondents universally identified direct-to-consumer (DTC) advertising as responsible for driving the increase in pharmacy costs. Since the Food and Drug Administration (FDA) relaxed restrictions on prescription drug advertising in 1997, the number of drug ads on television and in magazines has risen sharply. Respondents felt that increased advertising was only for the most expensive drugs and led employees to request and expect these drugs without knowing about less costly alternatives.

Other Cost-Reduction Strategies

Employers can also reduce costs by changing who is eligible for benefits and how they administer them. We asked respondents about other changes employers may have made, but we identified no other consistent findings across respondent types. A few large employers have introduced a “spousal access fee,” where an employee must pay an extra $50–$100 per month if a spouse is covered through the employer’s plan because the spouse has rejected coverage through his or her own employer. Conversely, some employers are paying an employee to opt out of the employer’s coverage to be covered by the spouse’s coverage instead.

Respondents identified retirees as being hit hardest by recent benefit changes. Employers have increased retirees’ premium contri-
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Contributions and deductibles and raised out-of-pocket maximums. In addition, health plans’ pullout from the Medicare+Choice program has also raised the costs to both employers and retirees.

Employers are continuing to drop, or want to drop, retiree coverage for newly hired workers. When asked about future plans, health benefit consultants, benefit managers for large employers, and union representatives reported that dropping retiree coverage altogether topped large employers’ wish list. Several employers mentioned ending their retiree benefits in response to the Financial Accounting Standards Board’s (FASB’s) implementation of FAS 106 in 1993.16 This required employers to report their liability for current and future retirees’ health benefits, which reduces shareholder equity. Unions have resisted employers’ elimination or reduction of retiree benefits in markets where unions have a strong presence, such as Boston and Seattle.

Future Direction Of Employer-Based Insurance

Anticipating the future direction of employer-based insurance may prove difficult given employers’ preference for incremental changes and a wait-and-see attitude. When asked about their future plans for restructuring health benefits or controlling costs, respondents did not identify explicit long-term strategies. For all but the largest employers, planning tends to be pragmatic with decisions made year to year or contract to contract. Benefit managers who had recently released a request for proposals (RFP) described what they were looking for in that next contract but had no plans beyond that RFP. As a result, the RFP process serves as a tool that encourages health plans to identify cost containment strategies, such as three-tier pharmacy benefits. Understanding the direction of health plan innovations, such as the new self-directed health plans, may help policymakers to anticipate future trends. Yet, as in the past, new products continuously evolve, and employers pick and choose among them.

In addition, employers’ changes may reflect not a general trend but, rather, specific circumstances in the context of the local market. For example, one benefit consultant described how one of his clients learned from a satisfaction survey that cost was the number-one employee concern, while choice of physician and hospital ranked in sixth place. Because having a particular hospital in the network would increase premiums 5 percent, the employer chose a restricted
network instead of increased cost sharing. In other markets, such as Miami, some employers are willing to pay more for broader networks or direct access to specialists.

The most recent increases in copays and deductibles suggest a slight movement toward increasing out-of-pocket costs for workers who use services. New defined-contribution products may further shift costs to those who use and need services. On the other hand, several respondents mentioned that managed care had introduced first-dollar coverage and expanded coverage of prescription drugs and preventive services. These respondents blamed managed care for creating employees' unrealistic expectations and would move away from first-dollar coverage if given the chance.

As described earlier, if premiums continue to rise, policymakers may expect the average percentage of premiums paid by workers to increase. Some public and unionized employers did speculate that an economic downturn might allow the introduction of some premium cost sharing, bringing cost-sharing arrangements in line with those of other private companies. Although this change would reduce the average percentage of premiums paid by employees, policymakers may be less concerned about such a shift. On the other hand, a large increase in the employee share for low-wage workers or for those who already pay a large share may be of greater concern, as these workers would be more likely to decline their employer's offer of coverage.

Respondents were especially concerned about the limited range of options available to small employers. Small employers have experienced larger premium increases than have large employers, yet they share the same tight labor market. Furthermore, health plans are more apt to have specific requirements for small employers such as contributions of at least 50 percent of the total cost of premiums. Despite this, we found no general trend of small employers dropping insurance coverage altogether over the past two years. In Miami and smaller markets like Greenville, South Carolina, respondents did report that because of the high cost of premiums, some workers dropped health insurance coverage for their children. Respondents in these markets predicted that if premiums continue to rise, some small employers might be forced to drop health benefits altogether. In markets with a high proportion of small employers, such as Miami, Phoenix, and Little Rock, the consequences might be felt across the community.

Given the incremental nature of employers' responses to premium increases and the lack of future strategies, policymakers also may have to adopt a wait-and-see attitude. Based on the perspectives of a broad range of employers, in contrast to those of innova-
tors, dramatic changes in the short term are unlikely. In the meantime, an important issue for policymakers is likely to be the potential erosion of coverage, especially for low-wage workers, or redistribution of out-of-pocket costs to older workers or the seriously or chronically ill.

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NOTES


9. HealthSync was based in the Cleveland market but has since gone out of business. For more about this company, see S. Trude, Defined Contributions: The Search for a New Vision, Issue Brief no. 37 (Washington: HSC, April 2001).


