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Consumer Cost Sharing in Private Health Insurance: On the Threshold of Change

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OVERVIEW — *Employers are asking employees to pay more for health care through higher premium contributions, share of contribution, and out-of-pocket maximums, along with variations in deductibles, copays, and coinsurance based on choice of providers, networks, drugs, and other services. This issue brief examines consumer cost-sharing trends in private insurance, discusses the outlook for cost sharing in employment-based benefits, and considers public policies to support health care markets for consumers.*

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Consumer Cost Sharing in Private Health Insurance: On the Threshold of Change

Private employers are re-evaluating their health care cost-sharing and contribution strategies. Last year marked the seventh consecutive year of accelerated health care expenditure growth, with the last three years at double-digit rates. Though rate hikes are expected to moderate slightly in 2004, long-range analyses predict health care expenditures will continue to outpace economic growth.¹ Employers argue this trend is not sustainable.²

As a consequence, employers have begun asking employees to pay more for health care. Employee cost sharing has drifted upward through higher contributions and deductibles, lower subsidies for dependent coverage, and numerous benefit changes that increase spending at the point of care. At the same time, concerns about affordability have renewed employer interest in pay-related health care premium contributions to protect low-wage workers.

Even though employees are paying more for health care, their share of the cost has not kept pace with total spending. Consumer out-of-pocket spending accounted for 25 percent of total private health care expenditures in 2002, down from 33 percent in 1990.³ The drop in employee share of spending over those years is a result of managed care keeping cost trends low coupled with employers absorbing most of the annual increases.

Private employers have come under fire for raising employee health care costs, but state and federal governments face similar challenges. Typical health benefits do not encourage consumers to shop around for efficient, quality care. Leading employers argue that giving consumers a meaningful financial stake in health care decisions will help drive the system toward efficiency and medically appropriate utilization. Studies show that increased coinsurance, copays, and deductibles slow demand for routine and discretionary care in the short term. But it is not clear at what point cost sharing hampers treatment compliance and provision of necessary care. Some studies show that even moderate cost sharing creates financial hardship for low-income and chronically ill individuals.

Many consumers are ill-prepared to make the health care benefits choices and trade-offs ahead. Public policies supporting consumers, such as transparency of price and quality information and viable funding vehicles for retiree medical care, are sorely lacking.

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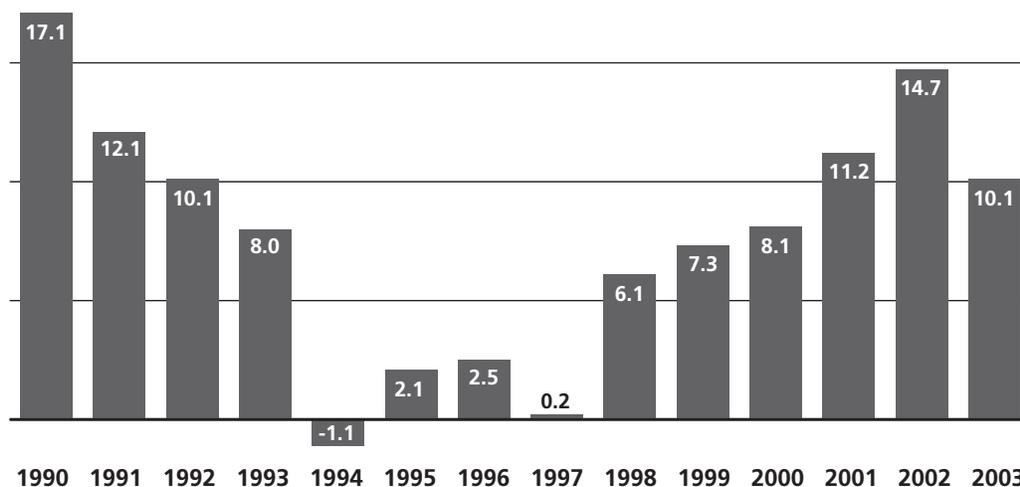
COST-SHARING TRENDS: EMPLOYEES PAY MORE FOR HEALTH CARE

Since 2002, employers have made a concerted effort to increase employee cost sharing relative to previous years.⁴ Employees are paying more for health care through higher premium contributions, percentage contributions, and out-of-pocket maximums, along with variations in deductibles, copays, and coinsurance based on their choice of providers, networks, drugs, and other services.

Premium Contributions

Employee premium contributions (and share of premium, according to some surveys) rose in each of the last two years. The annual Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) employer survey found average monthly employee premium contributions for preferred provider organizations (PPOs), the most popular plan, were \$42 for single coverage in 2003 (up 29 percent from 2001) and \$201 for family coverage (up 26 percent from 2001).⁵ Across all plan types, the Kaiser/HRET survey found the average employee share of premium was relatively steady for the past two years at 16 percent for single coverage and 27 percent for family coverage (Figure 1).

FIGURE 1
Annual Percent Change in Average Employer Total Health Benefit Cost, 1990–2003



Note: Results for 1990–1998 are based on cost for active and retired employees combined. The change in cost between 1998 and 2003 is based on cost for active employees only.

Source: Mercer Human Resource Consulting.

However, other surveys report higher employee premiums and contribution share. Mercer Human Resource Consulting reported employees contributed 27 percent of PPO premiums for single coverage and 58 percent for family coverage in 2003.⁶ Another survey by consulting firm Hewitt Associates found that the employee share of premium rose two percent last year.⁷ Methodological and reporting differences among surveys account for the range of calculations. The Mercer and Kaiser/HRET studies each surveyed about 3,000 randomly selected employers, ranging in size from small to very large. Results from both of these surveys can be projected nationally. Due to sampling and weighting methodologies, Mercer estimates the results represent about 600,000 employers and 90 million full-time and part-time employees.

By any survey, it is clear the amount of money deducted from employee paychecks for premium contributions is up, although employee share of cost as a percent of premium is generally down from the mid to late 1990s. The Kaiser/HRET survey assessed employee share of premium for single coverage at 16 percent, down from 21 percent in 1996. Mercer data show employee share of cost as a percent of premium fell between 1999 and 2002, although employers regained ground in 2003 (Figure 2).

Some employers have implemented or are considering higher cost sharing for dependent coverage. The Hewitt survey found these changes in 2003 and 2004: 34 percent have higher cost sharing for dependents than employees, 25 percent provide flexible credits for opting out of dependent coverage, 10 percent use surcharges for working spouses who do not elect coverage from their own employer, and nine percent require working spouses to elect coverage from their employer.

For example, Boeing Company charges employees \$100 per month if their working spouse elects the Boeing plan rather than their employer's plan, according to a 2003 report by *The Wall Street Journal*. They also reported Verizon Communications and its unions tentatively agreed to a \$40 per month fee for employees with working spouses who decline coverage from their own employer. Under the agreement, the surcharge does not apply to spouses who earn less than \$25,000 a year or who have to pay more than \$900 annually for their employer's health coverage.⁸

Eligibility structures for dependent coverage are also changing. Some employers have introduced four-tier structures: single, employee plus one, employee and children, and family. Some health benefits consultants believe we are moving toward assessing a surcharge for each individual covered by the plan in addition to the employee.

The Mercer survey detected a decrease in the percentage of employees electing family coverage at smaller companies (defined as fewer than 500 employees): 48% percent chose dependent coverage in 2003, down from 51 percent in 2002. Researchers surmised the drop was related to the \$389 average monthly premium contribution for PPO coverage at

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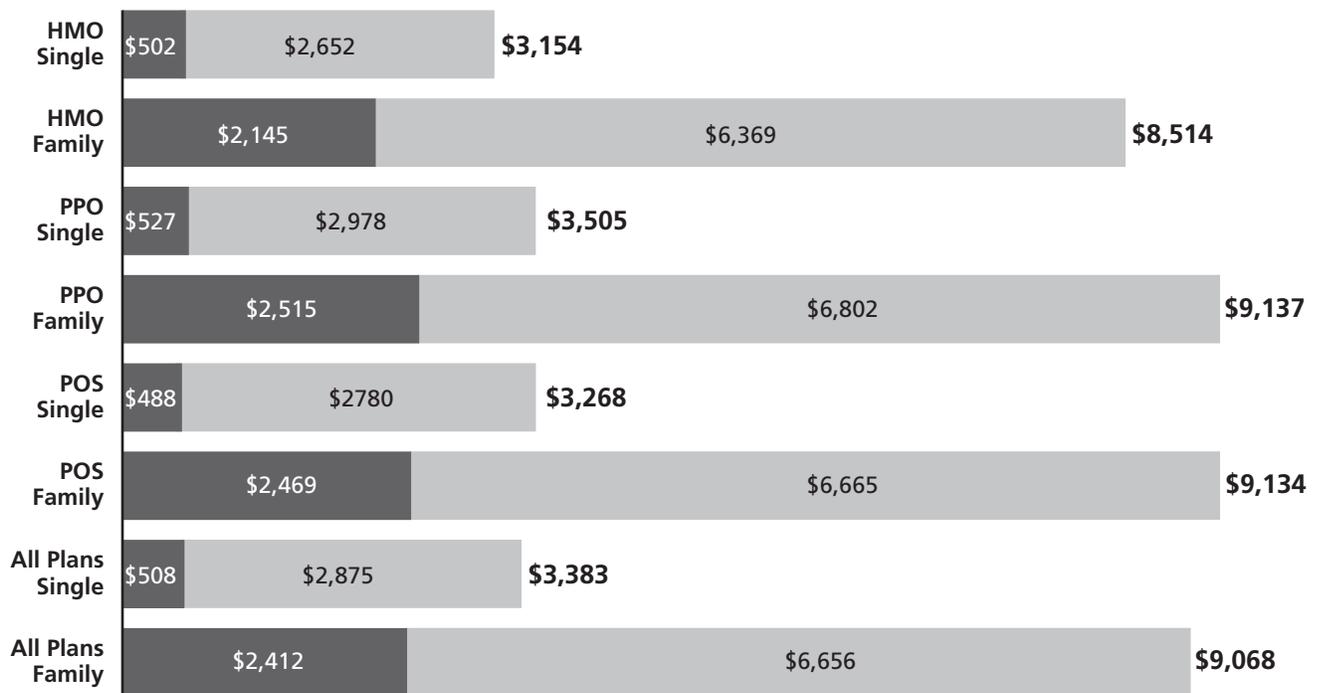
small companies. Dependent coverage election remained steady at large companies where average family contribution for PPO coverage was \$224 per month.

Point-of-Care Cost Sharing

The most notable change in employers’ cost-sharing strategy involves copays, coinsurance, and deductibles paid by employees when they use health care. Managed care was characterized by comprehensive benefits, low copays, no deductibles, restrictions on provider choice, and utilization controls. In this post-managed care era, cost-sharing arrangements recognize consumers’ desire for choice without the hassle of utilization management. Now, employee choice of provider, site, drug, or service often determines the degree of cost sharing, with less efficient options having higher cost.

Prescription drug plans typically use point-of-care cost sharing through tiered designs. For example, brand name prescription drugs are available,

FIGURE 2
Average Cost of Single and Family Health Insurance Coverage, by Plan Type, 2003



*Note: Family coverage is defined as health coverage for a family of four.
 Source: Kaiser Family Foundation/Health Research and Educational Trust.*

Contributions
 ■ Employee ■ Employer

but cost substantially more than their generic equivalents. Eighty-six percent of employees had a tiered prescription drug benefit last year. The average copays for generic, preferred, and nonpreferred drugs in three-tier plans were \$9, \$19, and \$29 respectively.⁹ Experts predict tiered prescription drug plans will become even more prevalent, with the third tier copay averaging \$50 within the next 3 to 5 years.¹⁰

In 2003, cost tiers were also applied to hospitals, physician networks, and services in certain high-cost specialty areas such as cardiology. Several major carriers offered tiered hospital plans beginning in 2002, including Humana, several BlueCross BlueShield plans, and PacifiCare. Nearly 80 percent of employers surveyed by Hewitt Associates said they were interested in a tiered hospital plan. Generally, the plans designate hospitals as preferred or standard based on relative cost. To counter criticism about cost-based tiers, most plans added quality and patient experience data to their tier structures by 2003.

PacifiCare's "Select Hospital" plan introduced in 2002 is one example. About half of the 230 hospitals with which PacifiCare maintains contracts in California were designated select hospitals. Under this plan, inpatient hospital copays are waived for members who use these preferred facilities, whereas members pay \$100, \$250, or \$400 daily copays for standard hospitals. Outpatient surgery copays are waived at select hospitals, whereas copays range from \$50 to \$200 in standard hospitals.

"Network Choice" is the BlueShield of California tiered hospital plan introduced in 2002. Hospitals are assigned a "choice" or "affiliated" designation, based originally on relative cost and now also on quality data and a calculation of patient mix. More than 80 percent of hospitals contracting with BlueShield of California are in the choice category. The program was applied to one million members enrolled in small employer and individual plans prior to 2004. Now, the product is offered to large employers too.

Network tiers are another new product. For example, PacifiCare's "Value HMO Network" has a preferred tier of medical groups and hospitals that were selected on quality and cost criteria. Introduced in 2003, the Value HMO Network produced premium savings for employers ranging from 4 to 15 percent. Although only 6 percent of employers currently use a tiered network, 55 percent are considering it for the future, according to the Hewitt survey.

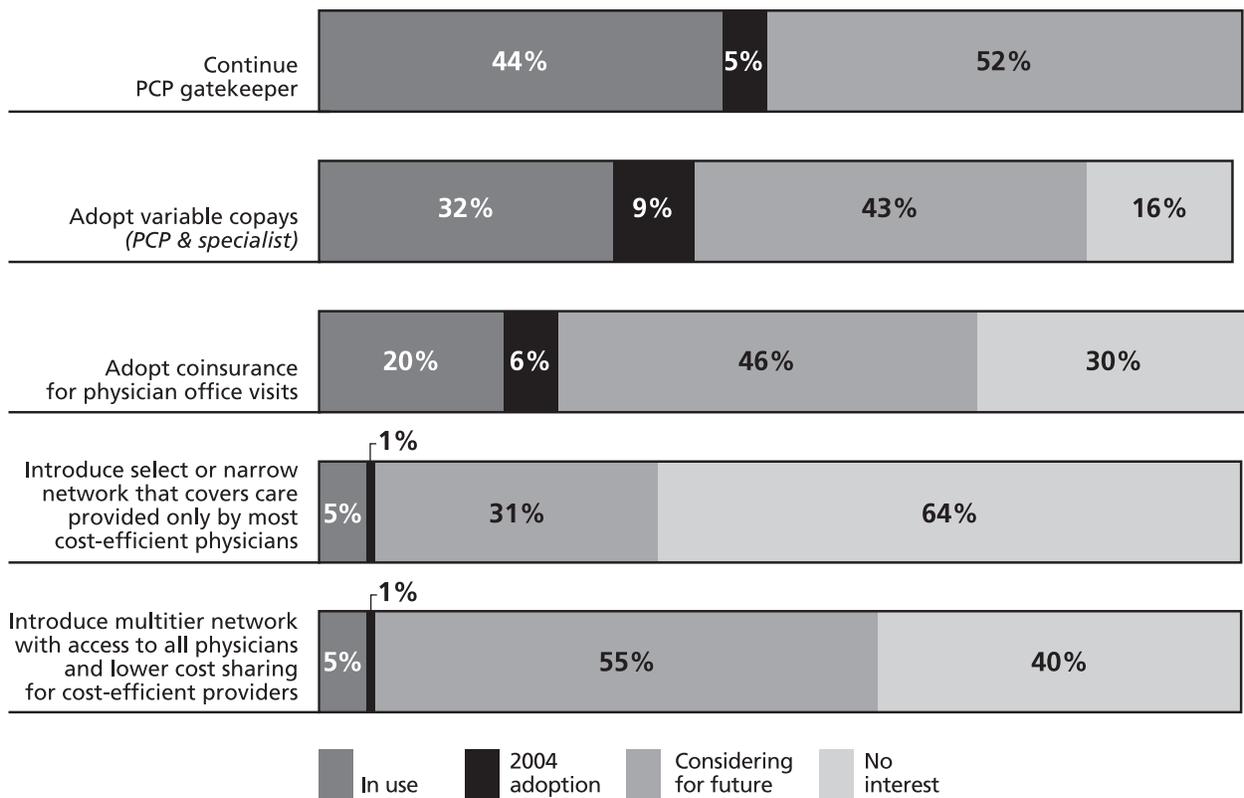
In another variation and a shift away from the large networks of recent years, a few major health plans are offering special networks of physicians for high-cost conditions. For example, Aetna's "Aexcel Network" has physicians in six specialty areas that account for about 30 percent of costs: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, and orthopedics. In those specialties, employees using out-of-network providers pay a higher copay or coinsurance. The product was introduced in January 2004 in three markets and will be expanded to other markets by mid 2004 (Figure 3).

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Employers with lower than average health care cost trends in 2003 used point-of-care cost sharing rather than relying solely on increases in premium contribution and share, according to a report by Watson Wyatt Worldwide and the Washington Business Group on Health.¹¹ The report concluded that employers believe point-of-care cost sharing helps sensitize employees to the actual costs of health care.

Another hallmark of recent cost sharing is a shift from copays to coinsurance. Again, the purpose is to sensitize consumers to the financial consequences of their choices. Coinsurance, the norm during the pre-managed care era, automatically indexes employee out-of-pocket cost to price of care. Returning first to prescription drug plans, coinsurance is becoming more common for physician office visits and hospital admissions, even in managed care networks.¹²

FIGURE 3
Percentage of Employers Interested in Each of Five Provider Selection Strategies



Note: Values in the figure are rounded to the nearest whole number.

Source: Hewitt Associates, 2004.

Employers have also increased deductibles, particularly for out-of-network providers. The average annual deductible for individual coverage outside the PPO network was \$561, a 20 percent increase from 2002, according to the Kaiser/HRET survey. The same survey found in-network deductibles rose nine percent. Thirty-four percent of employers had a PPO in-network deductible of \$1000 or more, up from 20 percent in 2002, according to Mercer Human Resource Consulting. They also found the median individual out-of-pocket maximum for in-network PPO coverage was \$2000, up from \$1500 in 2002.

More employers are adopting service-specific deductibles rather than a single deductible. In 2003, half of employers had a separate deductible for hospital admissions in their HMO plans, up from 15 percent the previous year.¹³ Service-specific copays are also more common. For example, major health plans such as Cigna HealthCare have separate copays for magnetic resonance imaging (MRI), computed axial tomography (CAT), and positron emission tomography (PET) scans to encourage appropriate use of the diagnostic tools.

In some policy circles, these incremental changes in employee cost sharing are being thought of with a stair step analogy. Copays are stepped up to coinsurance. Election of dependent coverage elicits an additional surcharge. A single deductible is replaced by separate deductibles for hospitalizations and prescription drugs. Physician visit copays are supplemented with service-specific copays, and so on. Each step gives consumers more financial responsibility for their elections and service use.

However, this scenario may prove too complicated for consumers, at least in the near term. A recent Institute of Medicine report on health literacy concluded almost half of adults have difficulty understanding and using health information.¹⁴ The report estimates that, among individuals, lack of ability to understand information necessary to make appropriate health and health care choices results in billions of dollars in avoidable costs. Expecting consumers to appropriately manage point-of-care cost-sharing decisions in the current environment may be unrealistic.

Income Considerations

A small number of employers use pay-related contributions in an attempt to keep health care affordable for low-wage workers. One large company's benchmarking effort found that only nine percent of employers used this approach, whereas an informal poll of more than 40 of the nation's largest employers by a national employer membership organization found that 24 percent use contribution tiers based on salary. Kraft, GE, and Morgan Stanley are among the large employers using pay-related contributions.

As health care becomes more costly, more employers are at least considering pay-related contributions. The poll noted above found that almost one-third had recently discussed the option. However, administrative

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complexities, union contracts, and other issues are expected to limit the number of employers implementing this option.

Market-Oriented Approach Underlies Employer Strategy

Underlying employers' recent cost sharing strategy is a belief that market forces can do more than government interventions to manage costs and improve quality. That is not to say employers think cost sharing is the answer to our health system's ills. Employers know there is no silver bullet. But there are actions they can take as health care purchasers to promote quality and efficiency. Sharing the cost of health care with employees is one of those actions.

For many years, employers used supply-side tactics to rein in costs and encourage quality. Now, they are addressing the demand side in the hope that consumerism will lead to improvements. Writing in the *New England Journal of Medicine*, Galvin and Milstein summed up a prevailing employer view: "Employers believe that consumer pressure is a powerful, underused lever for improving quality and efficiency. They believe that higher quality and lower cost will result if consumers have more responsibility for their health care expenditures and if providers respond by improving their performance."¹⁵

Even among employers, however, there is growing pessimism that market forces can produce efficiency without government intervention. The Community Tracking Study, a longitudinal examination of 12 nationally representative health care markets sponsored by the Robert Wood Johnson Foundation, found even employers felt "some kind of intervention stronger than what has been tried before is thought to be necessary to force change."¹⁶

Although point-of-care cost sharing provides some relief to employers watching expenditures, it is primarily designed to change the way consumers interact with the health care system. In addition to raising employee costs, employers are sponsoring programs to help employees enhance their health, make wise health care decisions, and get more for their health care dollars.

Disease management programs are an example. They were offered by three-fourths of employers last year, according to the Hewitt survey. Many employers also added or redoubled efforts with existing programs such as health risk appraisals, nurse advice services, health coaches, online health information resources, and other personal health management tools.¹⁷ In addition, a number of plans used financial incentives to promote preventive care (such as low copays and coverage without having to satisfy a deductible) and to encourage a healthy lifestyle. For instance, IBM offers a \$150 rebate to nonsmoking employees and employees who successfully complete a smoking cessation program. Employees with a three-day-a-week fitness routine are also eligible for a rebate (Figure 4).¹⁸

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Despite these efforts, consumer readiness and ability to assume a more active role is likely a long-term proposition. Research on consumer involvement in their own health care finds that many consumers have difficulty using comparative information to inform their choices and that they often use high price as an indicator of high quality.¹⁹ Moreover, much of the information consumers want most, such as differences in cost and performance among physicians, is not yet readily available.²⁰

GREATER FINANCIAL STAKE MEANS NEW CONSIDERATIONS FOR EMPLOYEES

Employees are beginning to think more carefully about their health care choices regarding coverage, financing, and plan type, as well as the use of drugs and other services due to higher costs.²¹ In terms of coverage, experts advise employees to know which providers are in-network and what's covered under the plan. Knowing eligibility rules for dependent coverage can also make a significant difference in consumer spending. Even without incentives to opt out of dependent coverage, employees are beginning to review trade offs of coverage versus cost when both spouses work and are offered health care.

High-Deductible Plans

Most people with private insurance choose a high premium–low deductible plan to avoid out-of-pocket spending. But benefits experts warn that many of them may be over-insured and spending more in the long run. Experts recommend consumers do the math to determine whether a low-premium–high deductible plan will save them money while providing the protection they need.²² Many new catastrophic plans provide more coverage for preventive care than traditional catastrophic plans. It is also fair to say that many health policy experts are concerned the availability of less comprehensive coverage will create adverse selection against comprehensive plans.

Five percent of all employers and 17 percent of large employers (5000+ employees) offered a high-deductible plan (\$1000 deductible for single; \$2000 for family coverage) to at least some of their employees in 2003.²³

Consumer-directed health plans (CDHPs), high-deductible plans with an employer-funded health reimbursement account (HRA), are a new option for some employees. Annual employer contributions to the HRA range from \$300 for individual coverage to \$2000 for family coverage. Employees use the spending account and satisfy a deductible before PPO-style insurance kicks in. Employers design the

FIGURE 4
**Percent of Employers Considering
the Following Actions to Constrain
Health Care Costs**

15%	Factor quality information into plan selection
15%	Factor quality information into plan contracting
18%	Offer high deductible plan w/out HRA
19%	Implement tiered networks based on quality/cost criteria
23%	Provide employees information on provider quality
24%	Significantly increase point-of-care cost sharing
25%	Significantly increase premiums
42%	Provide employees information on specific health issues

Source: National Business Group on Health/Watson Wyatt Worldwide, 2004.

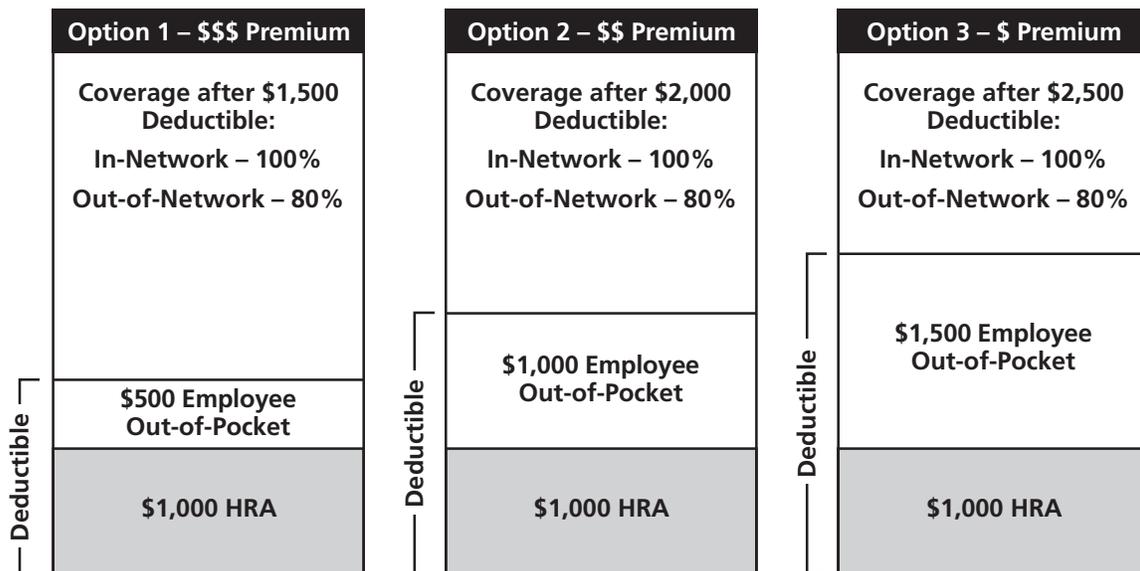
CDHP, determining HRA contribution, eligible expenses, maximum out-of-pocket payments, carry-over limits, and what happens to unused funds when an employee leaves. Many employers provide two or three options, allowing employees to pay a higher contribution for a lower deductible. More than half of employers offering a CDHP cover eligible preventive services at 100 percent through the insured part of the plan (Figure 5).

Almost one half-million people will be enrolled in CDHPs this year, according to a recent study by Watson Wyatt Worldwide and the National Business Group on Health.²⁴ Mercer Human Resource Consulting found 1 percent of all employers offered a CDHP in 2003, whereas 9 percent of the largest employers (20,000+ employees) offered them, up from 7 percent in 2002.²⁵ The June 2002 Internal Revenue Service (IRS) decision to not tax HRAs, to allow carry-over of unused funds, and to permit concurrent use with employee-funded flexible spending accounts (FSAs) accelerated interest in CDHPs.

HSAs and Other Funding Options

There are more health benefits financing options than ever before. Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created a new tax-favored Health Savings Account (HSA) beginning January 2004 for use with a qualified high-deductible plan.²⁶ Unlike HRAs and FSAs, HSAs can combine employer and employee

FIGURE 5
Sample Consumer-Directed Health Plan Design



dollars with employee pre-tax salary deductions, employer contributions, and flex credits. Maximum allowable contribution to the account is 100 percent of the annual deductible or \$2600 for individual coverage in 2004 and \$5150 for family coverage in 2004, whichever is less. The accounts are portable (from job to job), and unused balances may be carried forward (from year to year). They may also be used to save for retiree medical coverage.

The Department of Treasury and the IRS are in the midst of issuing HSA guidance with the final round of regulations, due out this summer. Among the implementation issues under consideration are coordination of HSAs with HRAs and FSAs, qualified high-deductible plan design, nondiscrimination rules, and employer contributions. Analysts predict HSAs will increase interest in CDHPs and other high-deductible plans. At the same time, many policy experts are concerned about their ultimate effect. Paul Ginsburg, president of the Center for Studying Health System Change, warns that HSAs will “transfer resources from the sick to the healthy.”²⁷

While HRAs and HSAs are new to the health care funding alphabet soup, FSAs are not. In 2003, 83 percent of large employers offered an FSA, although only 14 percent of small employers (3 to 199 employees) did so. FSAs, funded by employee pre-tax salary deductions, are only used by about 20 percent of employees nationwide. Inability to carry over unused FSA funds from year to year is primarily to blame for low participation. More than half of employees responding to a 2003 survey by Fidelity Investments said they did not participate in their company's FSA because they were afraid of losing unspent money. A third said the reimbursement process required too much effort.²⁸

However, participation in FSAs increased 15 percent in 2003 and annual contributions grew by 7 percent, according to Fidelity Investments. They attribute the growth to employees reaching a tipping point on health care spending, such that any amount saved through pre-tax contributions mitigated risk and inconvenience. Another factor may be greater availability of health benefit debit cards. Debit cards simplify administration by eliminating paperwork and helping employees keep track of their account spending. Also used to administer HRAs, these debit cards can double as health plan identification cards. Often, users have private Web access to account information where they can check claims, payments, and balances; view lists of eligible/ineligible expenses; and calculate potential tax savings.

Delivery System Options

Yet another choice for many employees is the type of plan delivering their care. Eighty percent of large employers and 31 percent of small employers offer more than one plan.²⁹ The most commonly selected plan type in 2003, but also the most expensive, was the PPO.³⁰

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Though such numbers could be interpreted as a ringing endorsement of PPOs, surveys show many employees are uncertain about their benefit choices. For example, the Fidelity survey found 42 percent of employees do not understand the differences among PPOs, HMOs, and indemnity plans; 34 percent do not understand the differences in services covered by the plans; and 32 percent do not understand differences in copays, deductibles, and coinsurance used by the different plans.³¹ In another survey by Cigna HealthCare, 65 percent of employees did not know whether their plan offered a wellness program, 57 percent did not know whether their plan had disease management programs, and 53 percent did not know whether they were offered a nurse advice line.³²

OUTLOOK: DIRECTION IS CLEAR; ULTIMATE BALANCE, CONSEQUENCES ARE NOT

With resources lagging behind demand, it is clear consumers will pay more for health care. It is also clear employers are in the midst of redesigning their role. Answers to other questions are less obvious. How will cost sharing be designed and for what level of benefit? Will consumers bear most of the cost for routine and discretionary care and be well covered for catastrophic events? Or will consumers pay much higher premiums for lower out-of-pocket costs and comprehensive coverage? Can point-of-care cost sharing help consumers be more cost conscious without discriminating against the chronically ill? How will providers react if utilization is significantly reduced or if consumers ask for guidance in making cost-effective decisions? What types of education and decision-support tools are needed to encourage consumers to take on these roles?

Although there are numerous studies on the effects of cost sharing on health care utilization, few assess its effects on health.³³ The most well-known research on cost sharing and utilization was the RAND Health Insurance Experiment, which ran from 1974 to 1982. Laura Tollen, with the Kaiser Permanente Institute for Health Policy, summarized major findings of the experiment in a 2001 Health Benefits Policy Roundtable sponsored by the Kaiser Permanente Institute and *Health Affairs*: "Significant cost sharing does substantially impact utilization of all types of services, and the impact on a range of care, from preventive to traumatic, is fairly consistent. The utilization impact on the poor is greater than the impact on the non-poor."³⁴ She went on to note the RAND Experiment found no clear impact of cost sharing on health status.

Much of the recent research on point-of-care cost sharing and utilization focuses on prescription drug plans. For example, in one study, RAND Corporation researchers found that when prescription drug copays increased from \$5 to \$10 per prescription, employees reduced drug spending by 22 percent. They attributed the reduction to shifting to generics, cutting back on medication use, and switching to over-the-counter medications.³⁵

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Another study by researchers at Harvard Medical School, Brigham and Women's Hospital, and Medco Health Solutions (a pharmacy benefit manager) found between 16 and 32 percent of patients enrolled in one large company's prescription drug plan stopped using needed medication in the six months following a switch from a single copay to a three-tier copay. The research team suggested that a more incremental change along with better communications might have supported better treatment compliance.³⁶ Other studies of tiered prescription drug benefits found adding a third higher cost tier did not result in negative health outcomes, such as increased emergency room visits or inpatient hospitalizations.³⁷

Employers Redefine Their Role

Employer health care expenditures are expected to rise another 12 to 14 percent in 2004. Although health benefits are a prime tool for attracting and retaining employees, uncontrollable costs and a soft job market mean employers will likely continue to share health care cost increases with their employees.

Speaking at a recent Center for Health System Change meeting on consumer cost sharing, Arnold Milstein, with Mercer Human Resource Consulting, predicted "more will be paid by service users, those with dependents, the more affluent, and those making certain types of selections which increase spending." He went on to say employers' best option is to vary employee cost sharing by "choice of provider, participation in disease management and wellness programs, and choice of where and what care they receive."³⁸ James C. Robinson, writing in *Health Affairs*, characterized employers' latest cost sharing strategy as "moving away from a one-size-fits-all approach toward more limited subsidies to support a broader variety of options."³⁹

However, leading employers are quick to add that their efforts are concerned with more than sharing costs. Speaking at a recent conference, Helen Darling, president of the National Business Group on Health,⁴⁰ said our health care system's continuing quality problems are another reason employees need to start paying attention to their health care choices. She reminded participants that experience shows employees take quality for granted, and without cost sharing they are less likely to note either options or costs.⁴¹ Employers and their health system partners will continue to refine point-of-care cost sharing arrangements by factoring more quality criteria into their rating and payment systems.

Employers know paying more for health care is a bitter pill for employees to swallow. Consequently, many have developed comprehensive employee health care communications plans. Cognizant that they helped develop the environment in which employees are insulated from the true costs of health care, employers have begun communicating difficult messages and complex information about health care's cost and value, as well as changes to company plans.

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Along with communications, employers are investing in decision-support tools for employees. Tools helping employees choose a health plan at open enrollment, such as calculators, comparison charts, and report cards, have been around for more than a decade. Newer tools and services help consumers make decisions at the point of care. They include health coaches, nurse advice lines, automated health risk appraisals, self-study modules, medical consultations, and online information. Many employers are optimistic that helping consumers evaluate treatment options and manage their health conditions will improve quality and cost efficiency.⁴²

Consumer Policies Needed

Large employers are well positioned to provide employees information and tools to help them make informed health care decisions, but employer efforts can go only so far. Assuming that consumer responsibility for health care costs continues to increase, governments have a role in creating health care markets for consumers through public policies and investments across several areas. Although seemingly straightforward, each of these areas requires an unprecedented level of cooperation among health care stakeholders. They include:

Transparency—The Institute of Medicine report *Crossing the Quality Chasm* calls for transparency, saying the health care system should make information available that allows consumers to make informed decisions when selecting a health plan or choosing among alternative treatments.⁴³ Last year, for example, Kaiser Permanente and consumer groups came to an agreement that Kaiser Permanente would publish clinical guidelines developed by its physicians and provide information on its physician compensation structure. Consumer advocates hoped it would have a ripple effect throughout the industry, but there is little incentive and no requirement for such public disclosures. Seventy percent of employers surveyed by Hewitt Associates said the government should require providers to disclose prices publicly, whereas 85 percent said the government should mandate quality reporting by hospitals and physicians.⁴⁴

Uniform provider data and reporting requirements—The MMA of 2003 encourages hospitals to submit standardized quality of care data. Beginning in 2005, hospitals that do not report will not receive increased payments that year.⁴⁵ However, hospital report cards designed for consumers are relatively new, even though accrediting and regulatory organizations have collected hospital data for years. The National Quality Forum (NQF) began developing a standard set of evidence-based hospital performance measures for public reporting in 1999. To date, there are about 40 measures. Adoption of the standards is important because several studies suggest that negative attitudes and distrust by hospitals participating in public reporting could be lessened if there were a national set of standards offered by a credible group.⁴⁶

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Public education and decision-support tools—Education about health care quality and cost variability are needed. Government could take a lead role in providing that education and in making easily accessible decision-support tools for plan choice as well as point-of-care treatments. Also needed are comparative performance information and guidance on how to interpret it, information on how to interpret technology assessments, and assistance on how to use calculators and other tools to help individuals determine what type of coverage is best for them.

Tax treatment of health benefits—Tax policy favors employer sponsorship of health benefits. Speaking at a February 12, 2004 briefing sponsored by the National Center for Health Policy Analysis, Rep. Bill Thomas (R-CA), chairman of the House Ways and Means Committee said that the employment-based health insurance system is fundamentally flawed and that HSAs “have given the individual market some of the same government-sponsored subsidies that employers receive when they make health care coverage available to employees.”⁴⁷ He did, however, go on to say the government needs to be careful not to distort the market by creating financial incentives for particular products, such as the HSA. Stuart Butler, with the Heritage Foundation, also points to tax policy as the linchpin for the creation of health care markets geared toward consumers. As a first step, he recommends expanding “tax credits and other tax relief for non-employer-sponsored coverage, and for consumers’ direct expenditures, preferably in combination with a phased-in ceiling on the tax exclusion.”⁴⁸

CONCLUSION

Private employers have increased employee cost sharing for health benefits through increased contributions and out-of-pocket costs. The degree of cost sharing at the point of care is often based on the cost efficiency of the choice. Long range analyses showing health care expenditures will continue to outpace economic growth make it likely that these cost sharing trends will continue. In addition, the rejection of managed care by consumers and the growing complexity of medical care make the one-size-fits-all approach of the past difficult to maintain.

Underlying the employers’ cost sharing strategy, particularly at the point of care, is a belief that market forces can do more than government interventions to manage costs and improve quality. Generally, leading employers believe cost-conscious demand can improve health care quality and efficiency.

There is growing recognition, however, that consumers are unprepared to make informed decisions at each step in the process and that government interventions will be needed to create health care markets supportive of informed consumer choice. Areas for public policy change and investment include transparency, uniform provider data and reporting requirements, public education and decision-support tools, and tax treatment of health benefits.

Tax policy favors employer sponsorship of health benefits.

ENDNOTES

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