EBRI ISSUE BRIEF

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October 1983 #23

CONTROLLING THE COST OF HEALTH CARE: RECENT TRENDS IN EMPLOYEE HEALTH PLAN DESIGN*

ABSTRACT

Ways to control health care costs are of great interest to Congress. Employers have been aggressive in pursuing strategies to control the cost of their health plans. Although no national surveys of employers adequately track recent changes, various industry surveys indicate that many employers are changing their plan design to: (1) encourage economical use of health care by employees; (2) restrict the use of some benefits where their appropriateness is questioned; (3) restructure service delivery by entering contractual relations with individual or group providers of health care; and (4) accommodate flexible benefit packages to hold down health care costs. Preliminary evidence indicates that these changes have been at least moderately successful in stabilizing employer costs and in raising employee awareness of the cost of health care. By inference, strategies that reduce employers' costs of health insurance serve the broader public policy goal of curbing the growth of national health care costs. What is particularly noteworthy about these employer efforts is that they have come about in a relatively undramatic, incremental fashion, and without legislation requiring or encouraging change. Any proposed legislation to restrain health care costs should take into consideration its impact on efforts already underway in the private sector.

Various measures taken by employers to contain the cost of providing health insurance benefits to employees and their dependents have been widely publicized over the last few years. While these measures are designed to serve the narrower goal of controlling employer costs, they also promise to serve the broader goal of controlling aggregate health care costs. Neither the prevalence nor the effectiveness of alternative strategies adopted by employers to control the cost of their health insurance programs, however, has been adequately documented. No nationally representative data have yet been compiled that would track recent changes in the design of employer group plans.

* Portions of this issue brief were drawn from a forthcoming EBRI study, Employer-Provided Health Benefits: Coverage, Provisions and Policy Issues.

Nevertheless, private industry surveys indicate that plan design changes to control costs are increasingly frequent. Furthermore, these changes may be at least moderately successful in stabilizing employer costs and in raising employee awareness of the cost of their health care. Many experts believe that consumer awareness of health care costs is a critical step toward containing aggregate health care cost inflation.

The variety of plan design changes that have been adopted by employers can be grouped into three categories: (1) changes that increase employee incentives to use health care more economically; (2) changes that specifically restrict the use of some services; and (3) changes that restructure the delivery of health care services to persons covered by the plan.

Changes in the first group--those that redirect employee incentives--include imposing higher deductibles and copayments for all or some services covered by the plan, and expanding the scope of covered services to include substitutes for more costly inpatient hospital care.

Changes in the second group--those that restrict the use of services covered by the plan--include requiring compliance with formal review of hospital utilization as well as second-opinion and same-day surgery requirements.

Changes in the last group--those that restructure service delivery to persons covered by the plan--include the establishment of "preferred providers" for services covered by the plan.

In addition to these changes within the framework of existing employer health insurance plans, some employers have initiated a much more sweeping reorganization of their health insurance benefits. In some cases, this reorganization involves simply the offering of more than one health insurance plan option to employees with the same employer contribution to each option. Other employers have more fundamentally reorganized their health insurance plans within the framework of flexible benefits or "cafeteria" plans.

Limited experience suggests that the employee incentives to reduce health insurance coverage in favor of greater cost sharing are effective in flexible benefits plans. Most employers who have adopted flexible benefits have done so to induce employees to share more of their health insurance costs and to take greater responsibility for controlling those costs.

This issue brief describes the changes in employer plan design that have occurred over the past three years. In addition, it describes, in a summary fashion, the operation of flexible benefits plans, and the legal and regulatory impediments to their development. Finally, the issue brief concludes with an examination of existing evidence on the success of alternative measures adopted by employers to control the cost of their own health insurance plans and, at the same time, the national cost of health care.

Improving Incentives to Economically Use Health Care

Plan design changes that encourage employees to use health care services more economically include: (1) raising the level of cost sharing required by the plan, and (2) changes in the scope of covered services. Increased cost sharing under employer group plans may be achieved by raising deductibles and

copayments for all or some services covered by the plan, as well as by raising employee contributions for their own coverage or for dependents' coverage under the plan. Because these changes reduce real compensation levels by raising employees' out-of-pocket health care costs, they have been generally resisted by employees, particularly by those with collectively bargained health insurance plans.

Despite employee resistance to greater cost sharing, many employers report having raised the deductible or copayment provisions of their group health plans since 1980. One survey of 1,420 employers throughout the United States indicated that approximately one-third (34 percent) had increased the copayment required for coverage of inpatient hospital care.1/

Another survey of 308 large employers, conducted by the National Association of Employers for Health Care Alternatives (NAEHCA), indicated that 53 percent had increased their plan's deductible; 25 percent had increased the copayments required by the plan. In addition, nearly one-third (31 percent) had raised the employee contribution for either their own coverage or dependents coverage under the plan.2/

A corollary of increased deductibles and copayment provisions for hospital care has been the reduction of "first-dollar" coverage for inpatient hospital expenses. First-dollar coverage pays initial expenses for hospital care, with no deductible or copayment on the "first dollar" of care delivered. An annual Health Insurance Association of America (HIAA) survey of new comprehensive major medical plans underwritten by thirty-three major insurers in the United States indicated a sharp reduction in the proportion of new plans that cover initial expenses for inpatient hospital or surgical care.3/ The annual proportion of new plans providing first-dollar hospital/surgical coverage since 1980 is presented in table 1. In 1982, only 7 percent of all new plans (weighted by plan size) provided first-dollar hospital/surgical coverage. This rate represents an 81 percent drop since 1980 in the (weighted) number of new plans that provide first-dollar coverage for inpatient hospital or surgical care.

Changes in the scope of services covered by the plan may be intended to redirect patient use of health services toward less expensive substitutes for inpatient hospital care. Consistent with this goal, employers have expanded the scope of group health plans to include coverage of home health care services, hospice services and outpatient hospital care. Outpatient care covered by employer group plans may include preadmission testing, outpatient surgery or surgery performed in free-standing surgical centers. Coverage of these services is often intended to discourage the use of inpatient hospital care or to discourage protracted hospital stays by equalizing insurance incentives between inpatient and outpatient care.

The HIAA survey of new comprehensive major medical plans indicates emerging coverage of services that substitute for inpatient hospital care. In 1982, 89 percent of all new major medical plans (weighted by plan size) covered preadmission testing; 81 percent covered home health care services. Coverage of paramedical testing and hospice care was somewhat less common (44 percent and 13 percent, respectively). Evidence from other surveys of employers (in

TABLE 1

Distribution of Employees In New Comprehensive Major Medical Plans, First-Dollar Coverage of Hosptial/Surgical Expenses, 1980-1982 1/

Level of Coverage	1980 (percent)	1981 (percent)	1982 (percent)	Percentage Change, 1980-1982
All Employees	100.0	100.0	100.0	--
First-dollar coverage 2/	36.4	24.4	6.6	-81.0
Deductible or first-dollar copayment	63.6	75.6	93.4	46.9

Source: Health Insurance Institute, New Group Health Insurance Policies Issued in 1980 (Complete Tables), Mimeo, table 45; Health Insurance Association of America, New Group Health Insurance Policies Issued in 1981 (Complete Tables), Mimeo, table 49; and Health Insurance Association of America, New Group Health Insurance Policies Issued in 1982 (Complete Tables), Mimeo, table 50.

1/ Includes new comprehensive major medical plans with hospital room and board coverage only, ancillary hospital service coverage only, all hospital service coverage only, surgical coverage only or all hospital plus surgical coverage. Surgical coverage may include coverage of schedule or actual charges.

2/ Plans that provide first-dollar hospital/surgical coverage require no deductible for coverage of hospital or surgical care and no copayment on initial expenses for these services.

particular, the 1980 and 1982 surveys conducted by NAEHCA) confirms that all of these coverages have become much more common features of employer group plans since 1979.

Restricting Use of Benefits

Restrictions on benefits for the purpose of controlling health plans costs usually apply to the use of inpatient hospital care by plan participants. Restrictions on benefits covered by the plan may include: (1) compliance with hospital utilization review, (2) requirement of a second or third physician opinion before undergoing elective surgery, or (3) same-day surgery provisions. Although many employers have adopted these benefit restrictions, cost sharing as a method of controlling plan costs appears to be more common.

Hospital utilization review involves assessing the appropriateness of hospital admission, inpatient hospital services and hospital discharge. Individual employers or insurers may contract with professional service review organizations (PSROs) or with peer review organizations (PROs) to evaluate hospital use. Hospital utilization review may be conducted prospectively (before hospital admission), concurrently (during the patient's hospital stay) or retrospectively (after hospital discharge). Prospective and concurrent review are highly labor-intensive and costly to conduct; review organizations often subcontract prospective and concurrent review to the admitting hospital. Critics of the utilization review process, however, have charged that the practice of delegating review to the hospitals compromises its effectiveness. As a result, employers who use utilization review most often use retrospective review. Although retrospective review itself does not limit benefits covered by the plan, it may enable the plan to enforce other restrictions on coverage prior to payment. Retrospective review probably also exerts a sentinel effect on plan participants, physicians and hospitals, particularly when the employer or insurer is large and well known to local health care providers. The 1982 NAEHCA survey indicated that 35 percent of the surveyed employers used utilization review; this rate was 10 percent greater than the 1979 rate reported in NAEHCA's earlier survey.

Plan provisions that require a second or third medical opinion before elective surgery are often enforced either by refusing payment for failure by plan participants to comply, or by imposing a separate deductible or higher copayment for expenses related to the surgery. Same-day surgery provisions are intended to eliminate unnecessarily early hospital admissions and the subsequent higher cost of hospital room and board. This provision may uniformly exclude coverage of hospital room and board charges for weekend admissions unless surgery is scheduled for the following morning. To date, no survey information has tracked the emergence of same-day surgery provisions in employer group health plans. Second- or third-opinion surgery provisions, however, have become quite common. The 1982 HIAA survey of new comprehensive major medical plans underwritten by major insurers indicated that 84 percent of new plans (weighted by plan size) included a second-opinion surgery provision.

Restructuring Service Delivery

The emergence of contractual arrangements between individual providers or provider groups and some employers or insurers is an important development in the effort to control health care costs. These arrangements have come to be known generically as "preferred provider organizations" (PPOs). A PPO is a contractual arrangement between providers and buyers of health care services. Under the arrangement, providers may agree to discount charges in return for guaranteed prompt payment. In addition, providers may cooperate with utilization review that would monitor and contain the growth of health service use and plan costs. As an incentive for plan participants to use the services of the PPO, plan coverage is often greater than for services delivered by other providers. Greater coverage might be achieved by waiving the deductibles, copayments or limits on coverage for services delivered by the PPO.

The legal status of preferred provider organizations has impeded their development. Several forms of PPOs have been found in violation of antitrust laws as horizontal price-fixing (Arizona v. Maricopa County Medical Society,

1982) or as potentially in restraint of trade (Group Life and Health Insurance Company v. Royal Drug Company, 1979). In general, a PPO is open to legal review; nevertheless, PPOs have been aggressively developed by some employers and insurers in an effort to control the cost of their group health insurance plans.

Adopting Flexible Benefit Plans

A flexible benefits or "cafeteria" plan is an employee benefits plan which gives employees some choice among types of benefits or relative amounts of different benefits provided by the employer. Plans established under Internal Revenue Service (IRS) Code Section 125 may not contain a pension plan or other deferred compensation plan other than an employee profit sharing plan. To the extent that a "typical" flexible benefits plan exists, these plans usually include two or more health insurance plans. They may also include dental insurance, group life and disability insurance, dependent care benefits, group legal services, vacation and sick leave, and a cash account--sometimes called a "reimbursement account." Employees may reimburse themselves from this account for out-of-pocket health care expenditures. IRS Code Section 125 was legislated in 1978; implementing regulations, however, have not been issued by the Department of the Treasury. Despite regulatory uncertainty, the popularity of flexible benefits programs among both employers and employees has generated growth of these plans during the last five years.

Employer goals in implementing a flexible benefits program are complex. Often they include:

(1) containing the cost of group health insurance benefits by inducing employees to share more of the health care costs covered by the plan;

(2) offering employees new, specialized benefits tailored to the needs of a demographically changing work force, without substantially raising total benefits costs;

(3) encouraging employees to elect higher levels of saving, anticipating the need for greater reliance on personal savings for retirement income.

The inclusion of a cash reimbursement account in these plans may be critical to the success of a flexible benefits plan in reducing health care costs. Employers anticipate that employees would resist "trading down" to a less generous health insurance plan option in the absence of the ability to, in effect, self-insure against out-of-pocket expenses. Usually the employee can designate year-end residual balances in the reimbursement account to pretax savings (possibly to a 401(k) plan), or cash the account out as taxable earnings.

Employers anticipate reducing their health insurance benefits costs, and reducing total employee health care expenses, by fixing their contribution to health insurance benefits. Employer contributions can be fixed either absolutely or as a percentage of the cost of the lowest-cost health insurance

plan. Employees have an incentive to use fewer health care services, even with a cash reimbursement account. Employees may take money from the reimbursement account to pay the higher initial costs of health care under the less generous plan. These withdrawals reduce their ability to: (1) purchase other benefit options, (2) contribute to pretax savings, or (3) receive additional cash income.

The repricing of alternative health insurance plan options in a flexible benefits program consistent with their cost experience is important to the program's potential success in containing health insurance costs and aggregate health care costs. Employers who provide more than one health insurance plan option anticipate "adverse selection" by employees. That is, employees who expect to have lower health care expenditures over the year are most likely to elect a low-cost, less generous health insurance plan. Conversely, employees who expect to have higher health care expenditures over the year are most likely to elect a high-cost health insurance plan that provides fuller coverage. Subsequently, the average cost of the most generous plan option is likely to rise much faster than the average cost of the least generous plan option. Repricing plan options according to experience, therefore, will result in the prices of the plans diverging over time.

Employers are concerned that the tax code that now governs flexible benefits plans will ultimately limit the repricing of health insurance options according to experience. That is, the nondiscrimination rules that govern flexible benefits under the IRS Code (Section 125(g)(2)) require employers to contribute not less than 75 percent of the cost of the most expensive health plan to the health plans of all employees. The purpose of this restriction is to prevent employers from offering "luxury" plans to highly compensated employees that are not accessable to lower-paid employees. Employers who seek to reduce their health plan costs through a flexible benefits program, however, are concerned that this section of the tax code restricts their ability to induce employees away from generous health insurance coverage by repricing plans according to experience. Nevertheless, employers generally agree that the intent of the Code with respect to nondiscriminatory benefits is worthy, and might be served by a modified nondiscrimination rule.

The Effectiveness of Plan Redesign

Evidence of the effectiveness of alternative plan design changes is scarce. Most research that has been conducted has examined the effect of greater cost sharing on health service utilization and, subsequently, on hospital costs. This research has uniformly concluded that higher cost sharing by insured consumers reduces the use of health care services, including the use of inpatient hospital care. It appears that lower use of hospital care and lower hospital costs result from significantly lower rates of hospital admission among persons with insurance that requires greater cost sharing for hospital expenses.4/ Whether increased cost sharing is more effective in containing health plan costs than alternative plan design strategies, however, has received little attention.

The data collected in the 1982 NAEHCA survey of employers allow a preliminary assessment of the relative effectiveness of alternative changes in plan design

intended to control health care costs. By inference, strategies that are effective in reducing employers' costs of providing health insurance benefits are probably also effective in reducing aggregate health care utilization and cost. The magnitude of the saving, however, cannot be measured with available survey data.

The information provided by the NAEHCA survey must be considered with caution. These data provide the only published assessment of the relative effectiveness of the various cost-control strategies that have been adopted by employers. Nevertheless, the published distributions provide no information about the combinations of strategies used by employers. The good cost experience associated with any particular strategy, therefore, may reflect interactive effects of more than one strategy. Conversely, poor cost experience may reflect the isolated use of a particular strategy, unreinforced by other measures to control employer health care costs.

Despite this problem, the results reported in the NAEHCA survey are reasonable. Table 2 isolates factors that contribute most to health care cost control. The cost experience of employers who have implemented specific plan

TABLE 2

Proportion of Respondents Who Experienced Cost Increases Below the Survey Median Increase in 1981 by Whether They Implemented a Specific Plan Feature

Plan Feature	Have Implemented (percent)	Have Not Implemented (percent)	Difference
Added or Increased Amount of Coinsurance	70.0	32.1	37.9
Covered Hospice Benefits	60.0	54.4	5.6
Used Outpatient Review	58.3	46.2	12.1
Covered Outpatient Surgery or Surgical Centers	52.5	27.3	25.2
Covered Home Health Care	52.2	38.5	13.7
Used Inpatient Review	50.8	45.5	5.3
Implemented a Health Promotion Program	50.7	47.3	3.4
Required a Second Surgical Opinion	50.4	47.2	3.2
Covered Preadmission Testing	48.3	42.1	6.2
Covered Extended Care Facilities	47.7	39.3	8.4
Increased Deductibles	40.1	44.9	-4.8
Increased Amount Employee Pays of Premium	26.1	49.0	-22.0
Added an Optional Low Benefit Plan	12.5	48.4	-35.9

Source: W. Pollock and R. H. Stack, 1982 Survey of National Corporations on Health Care Cost Containment, (Minneapolis: National Association of Employers on Health Care Alternatives, 1983), pp. 29-31.

features is compared with that of employers who have not implemented these features. Column 3 presents, by plan feature, the difference between the share of employers in each group who experienced cost increases less than the survey median increase. Where the difference is positive and large, that plan feature is more likely to have been effective in reducing the total cost of the plan. Among respondents that had added or increased the coinsurance required by the plan, 70 percent had experienced cost increases that were less than the median cost increase reported by all respondents. By comparison, only 32 percent of respondents who did not add or increase coinsurance amounts experienced relatively small plan cost increases. Similarly, coverage of hospice benefits was associated with good cost experience. The relatively narrow margin between the cost experience of employers whose health insurance plans covered hospice care and those whose plan did not probably reflects the low frequency of terminal illness and hospice use even among plans that continue health insurance coverage to retirees.

Raising deductibles or increasing the level of employee contributions to the plan have apparently been less successful strategies for controlling health plan costs. The reason may be that these increases have been less than either the increase in health plan costs or the general inflation rate. Alternatively, employers who have raised deductibles or employee contributions may have done so in order to avoid implementing other plan changes that would reduce health service utilization or redirect patient care to less expensive forms or sources of care. The poor cost experience of employers who adopted optional low-benefit plans may reflect adverse selection and a rapid increase in the cost of the more generous plan. The data do not indicate whether the multiple plans were offered in the context of a flexible benefits program, whether other incentives were provided for employees to elect less generous health insurance coverage, or what proportion of employees actually choose the low-option health plan.

Conclusion

Changes initiated in employer group health plan design over the last few years have received considerable media attention. No nationally representative data have been collected, however, to document the extent of those changes or their impact. Nevertheless, private industry survey evidence suggests that some employer initiatives may be effective in controlling both plan costs and the aggregate cost of health care.

The changes initiated by employers are notable for two reasons. First, they have occurred in a relatively undramatic, incremental fashion--and without legislation that would either encourage or require change. In fact, employers have implemented both PPOs and flexible benefits programs in spite of potential conflicts with existing law.

Second, these changes reflect the real options available to employers who compete for labor and to competing private insurers. Other potential strategies to control health care costs--such as the implementation of prospective pricing for services delivered to plan participants--may be unfeasible in a competitive environment. Neither employers nor insurers are

able to require providers to accept prospective payment as payment in full, as do both Medicare and Medicaid. Prospective pricing by a single small plan, therefore, might lower the value of health insurance coverage to plan participants and restrict their access to health care. The options open to employers are constrained by the competitive environment in which employee health benefits and health insurance contracts are bargained.

The strategies that have been used by employers to control the cost of their health insurance plans often rely on making employees more aware of their own health care costs. Many who would reform the health care delivery system in the United States see the lack of consumer awareness of health care costs as a critical source of health care cost inflation. Survey evidence suggests that health care cost inflation itself has forced employers to consider major changes in their health insurance benefits. These changes may be the single most promising avenue for controlling the rising cost of health care for all payers.

Notes

1/ The 1982 survey of health care cost containment efforts conducted by William M. Mercer, Inc. was an industry survey, and was not designed to be nationally representative. More than 55 percent of the respondents were employee groups of more than 1,000 workers.

2/ The Survey of National Corporations on Health Care Cost Containment was conducted by the National Association of Employers for Health Care Alternatives (NAEHCA) in 1982. This survey, like the Mercer survey, was a specialized survey of large firms and was not designed to be nationally representative. The average firm size that responded to NAEHCA's survey was about 30,000 employees; the smallest respondent employed 100 workers. The 1979 information from NAEHCA was obtained from their 1979 Survey of National Corporations on Health Care Costs and Health Maintenance Organizations. The 1979 survey included 251 large employers.

3/ Health Insurance Association of America (HIAA), New Group Health Insurance Policies Issued in 1982 (Complete Tables), Mimeo (1983).

4/ See, for example, the results reported by J.P. Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," The New England Journal of Medicine, 1981, 305, no. 25, pp. 1501-1507.

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