

Health Plan Switching: A Case Study—Implications for Private- and Public-Health-Insurance Exchanges and Increased Health Plan Choice

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AT A GLANCE

This *Issue Brief* examines the experience of a particular large employer, and a subset of its employees, with respect to a recent increase in the number of health plans that employees could choose. In 2014, this employer offered employees a choice of four health plans— an HSA¹-eligible health plan, an EPO,² a PPO,³ and an HMO⁴—all with the same carrier. In 2015, it added six new health-plan choices—HSA-eligible plans, EPOs, and PPOs—from two additional carriers. As a result, employees saw their plan choices increase from four to 10.

This examination of the data produced the following findings:

- One-third of health plan participants enrolled in both 2014 and 2015 switched health plans between 2014 and 2015.
- Workers enrolled in the HSA-plan in 2014 were more likely to switch plans than other workers.
 - One-half of HSA plan enrollees switched plans, compared with 27 percent among EPO enrollees, 24 percent among PPO enrollees, and 13 percent among HMO enrollees.
- While HSA plan enrollees were more likely to switch plans, those who did switch were most likely to switch to the same plan type with a different carrier.
 - About 88 percent of HSA plan enrollees in 2014 who did switch plans for 2015 chose an HSA-plan with a different carrier.
 - Sixty-three percent of EPO enrollees in 2014 who did switch plans for 2015 switched to an EPO with a different carrier, and 72 percent of PPO enrollees switched to a PPO with a different carrier.
 - Because only one HMO was offered in 2014 and 2015, 100 percent of the HMO enrollees who switched chose a different plan type with a different carrier.
- Very few HSA-plan enrollees who switched plans switched to a different type of health plan.
 - Among workers switching health plans, 5 percent of the HSA plan enrollees in 2014 who switched plans for 2015 changed to a PPO, EPO or HMO with the original carriers, and 7 percent changed both their plan type and carrier.

- EPO and PPO enrollees in 2014 who switched health plan types were more likely than HSA plan enrollees to switch carriers.
 - Twenty-four percent of EPO enrollees and 21 percent of PPO enrollees in 2014 who switched plans for 2015 switched to a different type of health plan with a different carrier, while 13 percent of EPO enrollees and 7 percent of PPO enrollees switched to a different type of health plan with the same carrier.

In attempting to explain plan switching, certain demographics and prior use of health care services appear to be predictors of plan switching, but health status is not a strong predictor. For this employer, it appears that:

- Older workers were less likely to switch health plans than younger workers.
- Higher-income workers with employee-only coverage were more likely than lower-income workers to switch carriers. However, higher-income workers with family coverage were less likely than lower-income workers to switch carriers or switch plan type.
- The longer an employee was enrolled in his or her health plan, the less likely he or she was to switch plans.
- More actual use of office visits for both primary care physicians and specialists was linked to less plan switching.

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Health Plan Switching: A Case Study—Implications for Private- and Public-Health-Insurance Exchanges and Increased Health Plan Choice

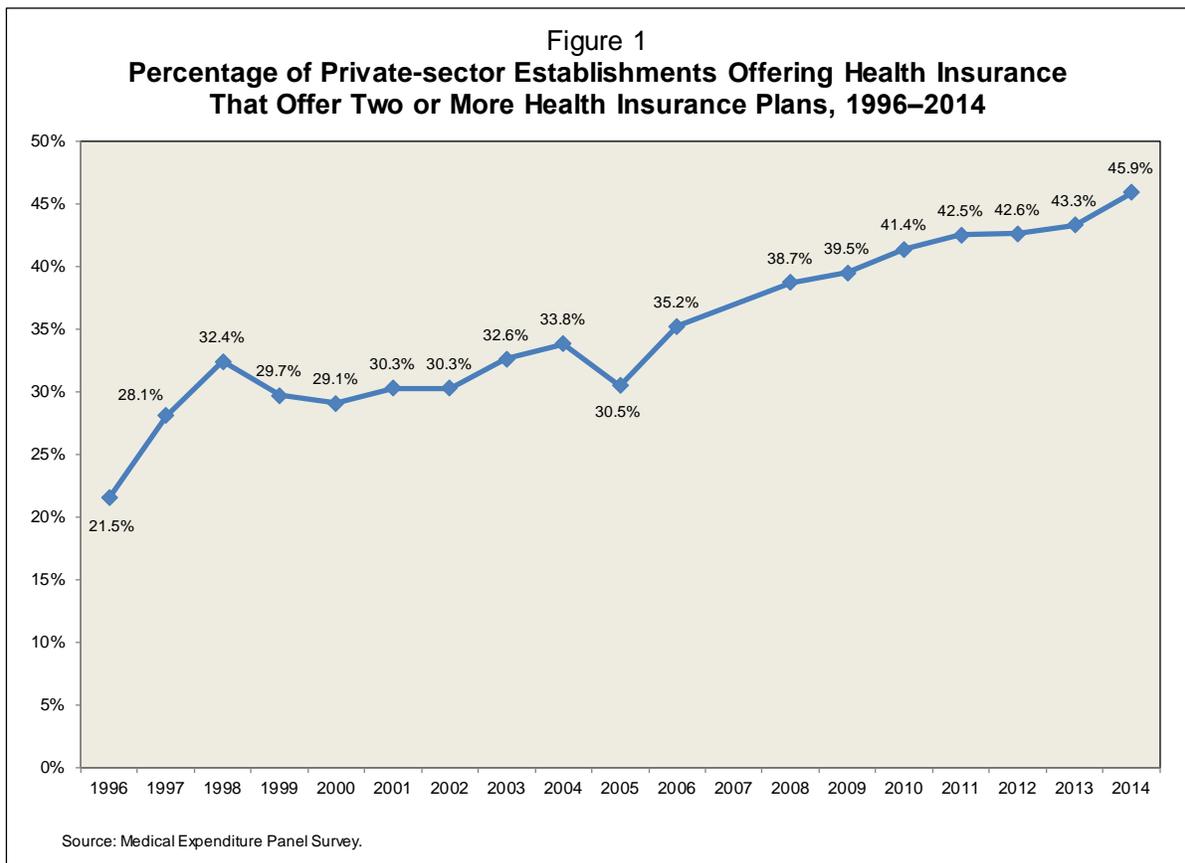
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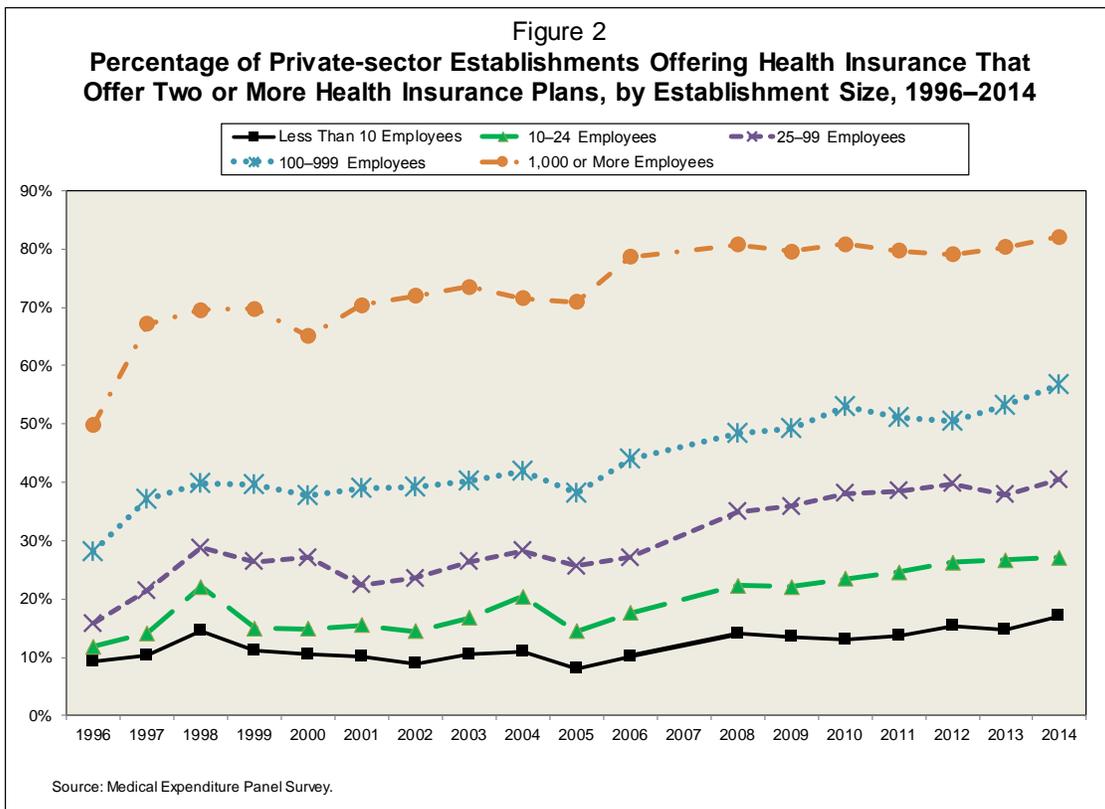
Introduction

Employers and commentators point to several key reasons employers offer health benefits to workers, including to recruit and retain workers (those workers who value health plan coverage), increase worker productivity, provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury, and promote better health.

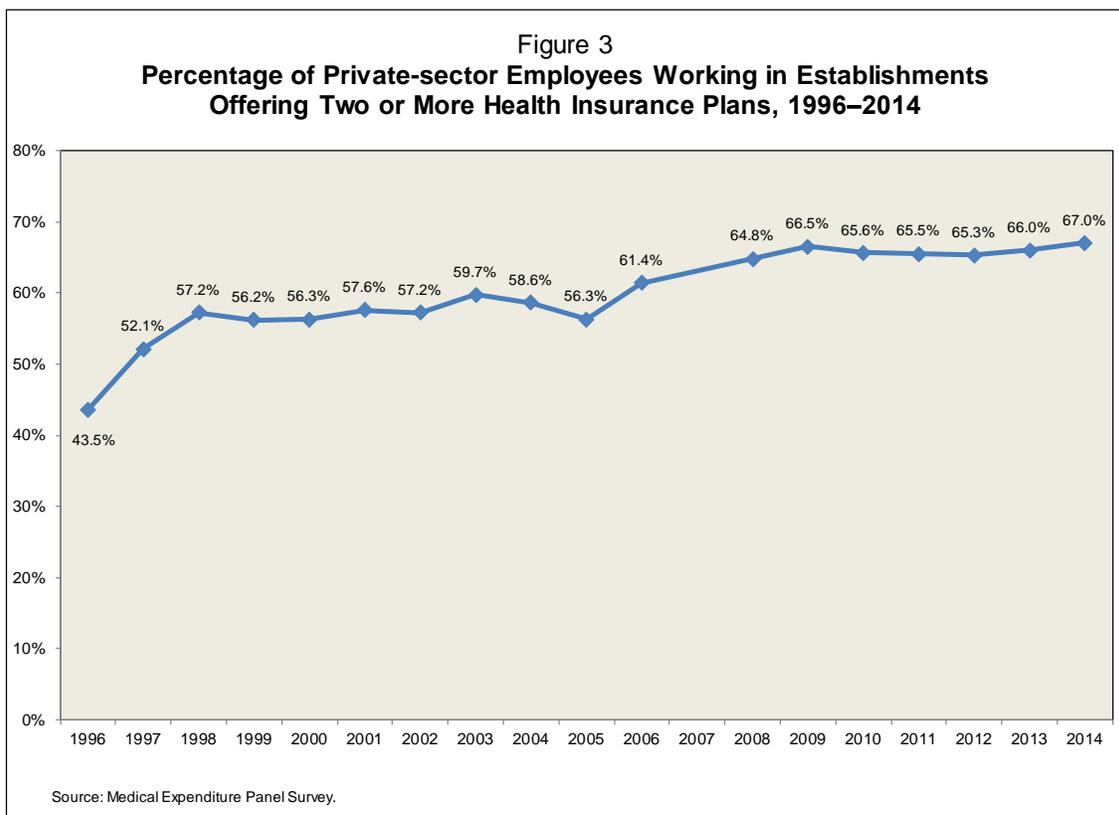
According to the 2015 EBRI/Greenwald and Associates Health and Voluntary Workplace Benefits Survey, workers overwhelmingly consider health insurance to be the most or second-most important workplace benefit (Fronstin and Helman 2015). Workers also place a high value on health plan choice: 80 percent of workers think that it is extremely or very important for employers to offer a choice of health plans (Fronstin and Helman 2016).

Not surprisingly, the trend has been toward more health plan choice. The percentage of employers offering health benefits that offer a choice of two or more health plans has increased from 21.5 percent in 1996, to 41.4 percent in 2010 (the year the Patient Protection and Affordable Care Act was enacted), and to 45.9 percent in 2014 (Figure 1). And the trend has held for all employer groups by size from 2005 to 2014; the lowest percentage increase was among the largest employers, which were already at a high percentage in 2005/6 (Figure 2).

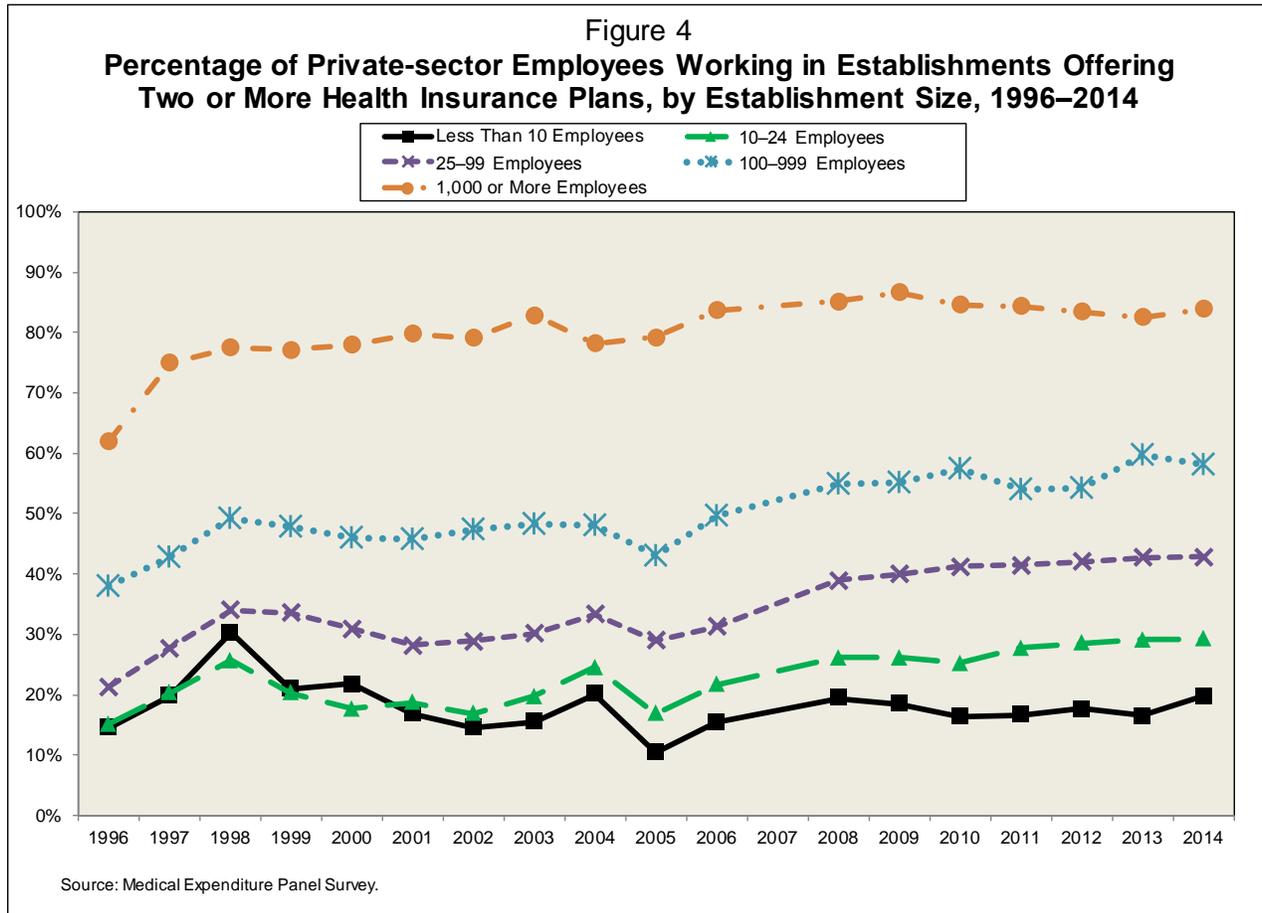




Also, larger employers are more likely than small employers to offer a choice of plans. In 2014, 82.1 percent of employers with 1,000 or more employees offered at least two health-plan choices, compared with 17 percent among employers with less than 10 employees (Figure 2). And because larger employers employ a larger percentage of the work force,⁵ about two-thirds of workers had a choice of two or more plans in 2014 (Figure 3).



From the worker (not the employer) perspective, the growth in the percentage of workers with a choice of at least two health plans occurred mainly before 1999 and between 2005 and 2008. Since 2008, the percentage of workers with a choice of at least two health plans has been relatively steady, both in aggregate and by employer size (Figure 4).⁶



While numerous studies have examined questions related to health-plan choice, very few have examined research questions related to an employer expanding the number of health-plan choices for employees and their dependents.⁷ There are several questions that research can address. For example, which workers switch plans when more choices are added? Does an increasing menu of plan options result in adverse selection? Are there ways to mitigate against adverse selection? Do workers choose the best plan for themselves in a choice environment? How is the best plan determined? Is there plan churn or enrollment “stickiness” over time? How many health plans are too many to choose from?

The case study examined in this *Issue Brief* addresses one set of questions: Which workers switch health plans when an employer introduces more choices? Does the introduction of more choices contribute to adverse selection?

Data and Methodology

The data for this study come from a large employer that recently increased employee choice of health plans. For the 2014 benefit year, this employer offered employees a choice between a preferred provider organization (PPO), an exclusive provider organization (EPO), a health maintenance organization (HMO) and an HSA-eligible health plan (HSA plan). The insurance carrier for the PPO, EPO and HSA plans was the same.

For 2015, the plan sponsor significantly expanded its health plan offerings. It added two new carriers, each of which offered a PPO, EPO, and HSA plan. Thus, for 2015, employees and their dependents had 10 health-plan options for 2015, up from four options for 2014.

The six new health-plan options for 2015 all used smaller networks of health care providers relative to the networks used by the plans available in both 2014 and 2015. In addition, the new options did not include any out-of-network benefits. As a result, the employer was concerned about adverse selection, also referred to as adverse retention (Strombom, Buchmueller and Feldstein 2002): that only healthy employees (and their healthy dependents) would enroll in the new plan options, leaving less-healthy enrollees in the original health plans. To mitigate against this, the employer provided financial incentives to nudge people with various health risks to enroll in the new plans. More specifically, the employer lowered employee premiums, increased HSA contributions, and eliminated cost sharing for primary care office visits and generic drugs.

Study Sample

To be included in the analytical sample, individuals had to be active, full-time, nonunion employees ages 18–64 (as of Jan. 1, 2015). Furthermore, employees had to have been continuously enrolled in a health plan in 2014 and enrolled in the health plan for at least January 2015. As described below, a set of household-level variables was created for employees with family coverage. Using those variables, this analysis excluded employees with spouses or dependents ages 65 and older, as it might not have received claims paid exclusively by Medicare. This study also dropped HMO enrollees from the statistical analysis, since there was only one HMO to choose from even after the six new health-plan choices were added. After applying these criteria, the analytical dataset contained 20,522 employees, which were separated into two cohorts: 6,948 with employee-only coverage, and 13,574 with family coverage.

Methods

The purpose of this study was to examine, for this particular employer, the variables associated with plan switching by employees under the expanded set of options, and to see whether additional plan options led to adverse selection. To accomplish this, the analysis first flagged those who switched plans between 2014 and 2015. Next, it further classified employees who switched plans according to the nature of their switch. Specifically, the study created three additional indicators for those who switched plans: also switched *carrier*, also switched *plan type*, and switched *both* carrier and plan type. Finally, since most plan switching that occurred was for carrier only (not plan type), the study also created three flags that segmented these employees by their baseline plan type. These dichotomous groups were then analyzed.

The explanatory variables believed to be associated with plan choice and switching were derived from 2014 eligibility and claims data. Demographic characteristics included age, gender, household size, income, and the number of years an employee was enrolled in his or her current plan. The latter was considered important, since inertia or stickiness has been reported in the context of health plan choice (Strombom, Buchmueller and Feldstein 2002) (Ericson 2012) (Handel 2013).

A course of health status measures was also examined. Using ICD-9CM diagnosis codes on medical claims, flags for six chronic conditions were created: high blood pressure, dyslipidemia (elevated cholesterol), diabetes, congestive heart failure (CHF), asthma/chronic obstructive pulmonary disease (COPD), and depression. Additionally, the Charlson Comorbidity Index was included as a general score of health status (Charlson, et al. 1987) (Deyo, Cherkin and Ciol 1992) (Quan, et al. 2005).

Finally, several measures for use of health care services were also studied. These were all measured in 2014 to control for the impact of prior use of services on plan switching. They included 1) any hospitalizations, 2) any emergency department visits, 3) number of primary care physician visits, 4) number of specialist physician visits, 5) number of prescription drug fills (days' supply adjusted), 6) number of unique outpatient providers, and 7) any out-of-network health services utilization.

As previously noted, employees with individual coverage were analyzed separately from those with family coverage. Since policyholders must consider their entire family's insurance needs, the health-status and services-use variables were all constructed at the household level. Specifically, the chronic condition flags represent whether any member of the household had each disease; the Charlson Comorbidity Index is the maximum individual score yielded in the family

(i.e., the person in poorest health); the hospitalization and emergency department measures denoted whether or not any household member used either during the year; the health-services-utilization counts and the number of unique outpatient providers were calculated as the sum for all individuals on the policy; and the out-of-network flag pertained to whether or not anyone in the household received care from providers outside the plan's network. For individuals, all these household-level variables were the same as the employee-level measures.

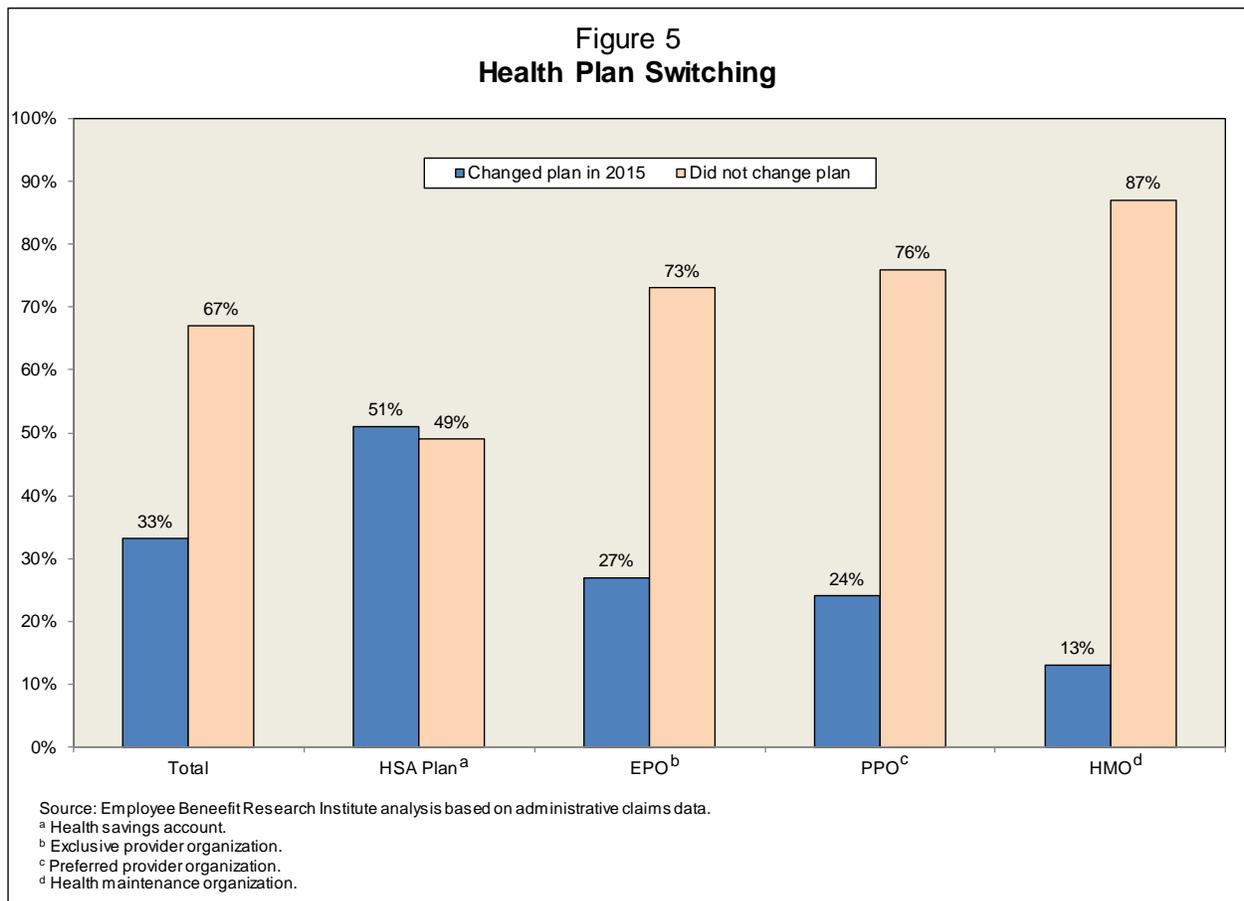
Statistical Analysis

In addition to sorting of members into health plans in 2014 and 2015 as described, as well as an examination of bivariate means, this study conducted multivariate analyses of plan switching as a function of the suspected determinants outlined above. For each dichotomous dependent variable of switching behavior, a probit model was estimated. Subsequently, marginal effects were calculated for all independent variables at their respective means for presentation in the results tables. Statistical significance based upon standard errors is denoted as follows: *** $p < 0.01$; ** $p < 0.05$; and * $p < 0.10$.

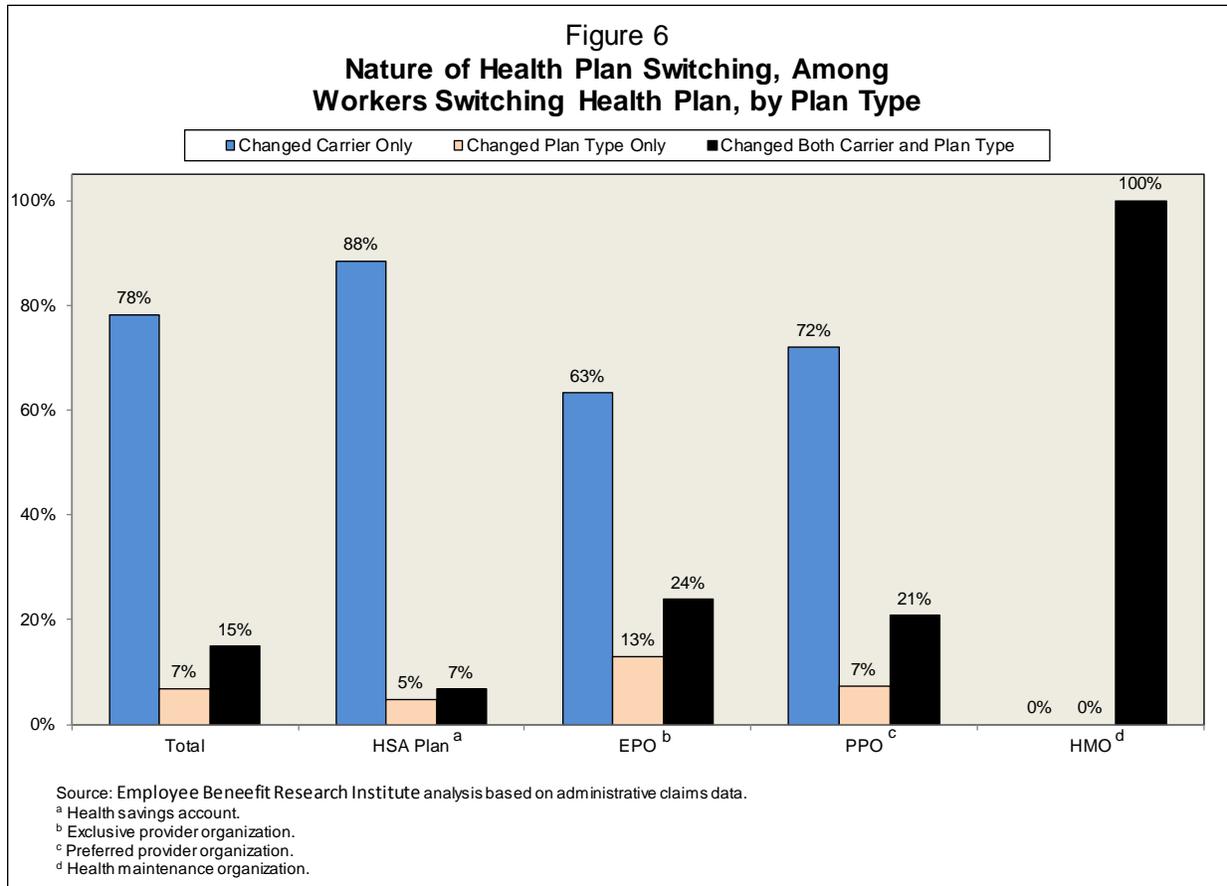
Findings

Descriptive Statistics

What 2014 enrollees did for 2015: Overall, one-third of 2014 plan enrollees switched health plans in 2015 (Figure 5). Workers enrolled in the HSA plan were more likely to switch plans than other workers. One-half of HSA-plan enrollees switched plans, compared with 27 percent of EPO enrollees, 24 percent of PPO enrollees, and 13 percent of HMO enrollees.



However, while HSA-plan enrollees were more likely to switch plans, they also were the most likely to switch to the same type of plan with a different carrier. Nine in 10 (88 percent) of HSA-plan enrollees in 2014 who switched plans remained in an HSA plan with a different carrier (Figure 6). In contrast, 63 percent of EPO enrollees switched to an EPO with a different carrier, and 72 percent of PPO enrollees switched to a PPO with a different carrier. Because only one HMO was offered, enrollees who switched from the HMO had to choose a new carrier and new plan type.



Very few of the HSA-plan enrollees who switched plans also switched to a different type of health plan. Five percent switched to the PPO, EPO or HMO with the same carrier, while 7 percent switched to a different health plan type with one of the new carriers. By comparison, EPO and PPO enrollees who switched were much more likely to switch their type of health plan. Thirteen percent of EPO enrollees and 7 percent of PPO enrollees switched to a different type of health plan with the original carrier, while 24 percent of EPO and 21 percent of PPO enrollees switched the type of health plan and moved to a new carrier.

Relationship of Variables With Switching/Non-Switching

Sample means are shown in Figure 7 for individuals with employee-only coverage. Separate statistics are presented by whether an individual switched health plans, and if they did, the nature of the health plan switching in terms of changing of the type of health plan, the carrier, or both. When it came to overall plan switching, there was no difference by gender, but the study did find that individuals who switched plans were younger than individuals who did not switch plans. The average age was 42.2 years among those who switched plans and 46.5 years among those who did not switch. Also, plan switchers had been in the plan for less time (2.7 years) than non-switchers (3.6 years). In addition, plan switchers earned more (\$95,697) than non-switchers (\$92,083).

Concerning health status, plan switchers were generally healthier than non-switchers. Among plan switchers, the comorbidity index for plan switchers was 0.18, while for non-switchers it was 0.23. Also, plan switchers were less likely to have been treated for high blood pressure and dyslipidemia than non-switchers, and they were about as likely to have been treated for diabetes, congestive heart failure, asthma/COPD, and depression.

Figure 7
Variable Means by Health Plan Switching, Individuals With Employee-Only Coverage

	Health Plan Switching		Nature of Health Plan Switching		
	Changed Plan in 2015 (n=2,524)	Did Not Change Plan in 2015 (n=9,160)	Changed Carrier Only (n=3,555)	Changed Plan Type Only (n=181)	Changed Both Carrier and Plan Type (n=402)
Demographics	Full Sample (n=6,948)				
Male	45%	45%	46%	35%	45%
Age	45.0	46.5	42.3	43.1	41.2
Household size (individuals)	1.0	1.0	1.0	1.0	1.0
Annual earnings	\$94,384	\$92,083	\$92,374	\$89,575	\$91,807
Years in plan	3.3	3.6	2.7	2.7	3.0
Health Status					
Charlson comorbidity index	0.21	0.23	0.18	0.19	0.17
Hypertension	14%	16%	12%	13%	8%
Dyslipidemia	20%	22%	15%	25%	13%
Diabetes	6%	6%	5%	4%	6%
Congestive heart failure	0.3%	0.2%	0.3%	1%	0%
Asthma/chronic obstructive pulmonary disease	4%	4%	4%	4%	3%
Depression	9%	9%	9%	9%	8%
Use of Health Care Services					
Any hospitalizations	1%	1%	0.4%	1%	1%
Inpatient hospital stays (per 1,000 individuals)	6.2	7.2	3.6	5.5	7.5
Inpatient hospital days (per 1,000 individuals)	21.7	28.0	10.3	5.5	14.9
Any emergency department visits	9%	9%	8%	12%	6%
Emergency department visits (per 1,000 individuals)	108.2	116.0	94.8	138.1	74.6
Primary care physician visits	2.3	2.4	2.1	2.8	2.0
Specialist physician visits	1.9	2.1	1.6	2.5	1.5
Prescription drug fills	17.2	18.6	14.7	16.9	14.2
Number of outpatient providers	3.9	4.1	3.5	4.8	3.3
Any out-of-network services utilization	10%	10%	11%	11%	7%

Source: EBRI analysis based on administrative claims data.

With respect to prior use of health care services, plan switchers were less likely than non-switchers to have used health care services. Specifically, they were less likely to have been admitted to a hospital, they had fewer days in the hospital, fewer emergency department visits, fewer primary care and specialist office visits, fewer prescription drug fills, and they used a fewer number of unique outpatient providers.

Findings are presented in Figure 8 for employees with family coverage. There were a number of differences between the group with employee-only coverage and the group with family coverage. Those with family coverage were more likely to be male, older, and to have higher income. Family health status was measured by the maximum individual Charlson index score yielded in the family (i.e., the person in poorest health). The prevalence of high blood pressure, dyslipidemia, diabetes, CHF, asthma, COPD, and depression was much higher in families than among individual workers, mostly because of the presence of spouses. As such, total use of health care services was much higher at the family level than at the individual level.

When it came to plan switching among workers with family coverage, the findings were comparable to those for workers with employee-only coverage. Compared with family-plan non-switchers, plan switchers earned more; were younger, healthier, and less likely to have had someone in the family treated for the various health conditions; and used fewer health care services.

Relationship of Demographics, Health Status and Use of Health Care with Plan Switching

Figure 9 presents the estimated relationships of demographics, health status, and prior use of health care services with plan switching for workers with employee-only coverage. Results are presented for any plan switch, as well as by the type of plan switch, which includes instances where 1) enrollees switched the insurance carrier but not the type of health plan, 2) enrollees switched the type of health plan, but not the carrier, and 3) enrollees switched both the type of health plan and the carrier. The findings indicate that demographics and prior use of health care services are predictors of plan switching, but health status is not a strong predictor.

Overall, gender had very little relationship to plan switching. This study observed that men were less likely than women to switch their type of health plan, but overall there was no statistical correlation. In contrast, regardless of the type of health plan switch, older workers were less likely to switch health plans than younger workers. Higher-income workers were more likely than lower-income workers to switch carriers. And the longer an employee was enrolled in his or her health plan, the less likely they were to switch plans. Overall, for every year that a person was enrolled in a health plan, they were 5 percentage points less likely to switch plans.

Despite the findings in the bivariate analysis, health status had a negligible relationship to plan switching. Overall, the Charlson Comorbidity Index was not related to plan switching. Employees with high blood pressure were less likely than those without it to switch the type of health plan or both the health plan type and carrier. And employees with dyslipidemia were less likely to switch carriers than those without it. Employees with diabetes were more likely to switch carriers than those without it. While all these relationships were statistically significant, none was significant at the $p < 0.01$ level. The presence of congestive heart failure, asthma/COPD, or depression was not related to plan switching.

In contrast to the presence of specific diseases and/or health conditions, the higher use of office visits for both primary care physicians and specialists was related to less plan switching. But other types of health-service usage—use of inpatient services and emergency departments, number of prescription drug fills, number of different outpatient providers used, and the use of out-of-network services—were not related to plan switching.

Figure 10 presents the estimated effects of demographics, health status, and prior use of health care services on plan switching for workers with family coverage. The health-status variables measure whether anyone in the family has the disease or health condition. Similarly, the use of health-care-services variables measure whether anyone in the family used the health care service, and the total number of services used, where applicable. Similar to the findings for individuals with employee-only coverage, health status was not related to plan switching, but prior use of health care services was related. In fact, this relationship was stronger among employees with family coverage than they were for

Figure 8
Variable Means by Health Plan Switching, Individuals With Family Coverage

	Health Plan Switching		Nature of Health Plan Switching			
	Full Sample (n=13,574)	Changed Plan in 2015 (n=2,524)	Did Not Change Plan in 2015 (n=9,160)	Changed Carrier Only (n=3,555)	Changed Plan Type Only (n=312)	Changed Both Carrier and Plan Type (n=547)
Demographics						
Male	72%	69%	73%	70%	66%	70%
Age	49.0	47.2	49.8	47.1	47.4	47.3
Household size (individuals)	3.3	3.3	3.2	3.3	3.2	3.3
Annual earnings	\$111,932	\$113,824	\$108,005	\$108,647	\$106,210	\$104,860
Years in plan	3.4	2.9	3.6	2.8	2.7	3.2
Health Status						
Charlson comorbidity index	0.19	0.16	0.21	0.16	0.19	0.14
Hypertension	26%	22%	28%	22%	25%	23%
Dyslipidemia	35%	31%	37%	31%	33%	30%
Diabetes	11%	10%	12%	10%	11%	10%
Congestive heart failure	1%	0.3%	1%	0.3%	1%	0.4%
Asthma/chronic obstructive pulmonary disease	12%	11%	12%	11%	10%	10%
Depression	19%	18%	20%	18%	21%	20%
Use of Health Care Services						
Any hospitalizations	5%	4%	5%	4%	5%	4%
Inpatient hospital stays (per 1,000 individuals)	64.7	59.6	67.1	58.2	73.7	60.3
Inpatient hospital days (per 1,000 individuals)	385.4	313.3	420.2	303.5	464.7	290.7
Any emergency department visits	29%	26%	31%	25%	33%	28%
Emergency department visits (per 1,000 individuals)	466.9	389.4	504.3	371.6	496.8	444.2
Primary care physician visits	7.2	6.8	7.3	6.8	6.9	7.1
Specialist physician visits	4.8	4.1	5.2	4.1	4.8	3.9
Prescription drug fills	38.0	32.4	40.7	32.1	34.1	33.2
Number of outpatient providers	8.0	7.2	8.4	7.1	8.5	7.3
Any out-of-network services utilization	22%	20%	23%	19%	24%	20%

Source: EBRI analysis based on administrative claims data.

those with employee-only coverage. More office visits for both primary care physicians and specialists, more emergency department usage, and more visits to outpatient providers were all related to less plan switching.

Figure 9
Impact of Demographics, Health Status, and Use of Health Care Services on Plan Switching, Among Enrollees With Employee-only Coverage, by Type of Plan Switch

	Any Switch	Switch Carrier	Switch Plan Type	Switch Both
Demographics				
Male	-0.01	-0.01	-0.01*	-0.005
Age	-0.005***	-0.004***	-0.002***	-0.001***
Household size (individuals)				
Annual earnings	0.01***	0.01***	0.001	0.001
Years in plan	-0.05***	-0.04***	-0.01***	-0.001
Health Status				
Charlson comorbidity index	0.001	0.01	-0.003	0.001
Hypertension	-0.02	-0.02	-0.02**	-0.02**
Dyslipidemia	-0.01	-0.03*	0.01	-0.01
Diabetes	0.05	0.06*	0.02	0.02
Congestive heart failure	0.12	0.03	0.04	
Asthma/chronic obstructive pulmonary disease	-0.01	-0.01	-0.01	-0.02
Depression	0.02	0.02	-0.004	0.001
Use of Health Care Services				
Any hospitalizations	-0.003	0.01	0.033	0.048
Any emergency department visits	-0.01	-0.02	-0.003	-0.005
Primary care physician visits	-0.01**	-0.01**	0.001	-0.0001
Specialist physician visits	-0.01***	-0.01***	-0.0004	-0.001
Prescription drug fills	0.0000	0.0002	-0.0001	0.0001
Number of outpatient providers	0.001	-0.001	0.001	-0.001
Any out-of-network services utilization	0.02	0.03	-0.018	-0.013

Source: Employee Benefit Research Institute analysis based on administrative claims data.
Notes: Statistical significance denoted as follows: *** p<0.01; ** p<0.05; * p<0.10.

Figure 10
Impact of Demographics, Health Status, and Use of Health Care Services on Plan Switching, Among Enrollees With Family Coverage, by Type of Plan Switch

	Any Switch	Switch Carrier	Switch Plan Type	Switch Both
Demographics				
Male	-0.01	-0.01	-0.002	0.001
Age	-0.004***	-0.004***	-0.001**	-0.0004*
Household size (individuals)	0.02***	0.02***	-0.0001	-0.0002
Annual earnings	-0.003***	-0.003**	-0.002***	-0.002***
Years in plan	-0.04***	-0.04***	-0.004***	-0.001
Health Status				
Charlson comorbidity index	-0.01	-0.01	-0.004	-0.01
Hypertension	-0.003	-0.005	0.002	0.0001
Dyslipidemia	0.001	0.0004	-0.003	-0.003
Diabetes	0.03**	0.03**	0.00	0.01
Congestive heart failure	-0.02	-0.02	0.01	0.004
Asthma/chronic obstructive pulmonary disease	-0.01	-0.001	-0.01	-0.004
Depression	0.02*	0.02	0.01	0.01
Use of Health Care Services				
Any hospitalizations	-0.01	-0.01	-0.01	-0.01
Any emergency department visits	-0.02**	-0.03***	0.005	0.001
Primary care physician visits	-0.002**	-0.002*	-0.0003	0.0003
Specialist physician visits	-0.003***	-0.002***	-0.001**	-0.001**
Prescription drug fills	-0.0002	-0.0002	-0.0001	0.0000
Number of outpatient providers	-0.004***	-0.01***	0.0004	-0.0003
Any out-of-network services utilization	0.01	0.003	0.004	0.002

Source: Employee Benefit Research Institute analysis based on administrative claims data.
Notes: Statistical significance denoted as follows: *** p<0.01; ** p<0.05; * p<0.10.

Carrier Switching by Type of Health Plan

Figure 11 shows the relationship between several variables—demographics, health status, and use of health care services—and plan switching by the type of health plan the employee was enrolled in for 2014 among employees with employee-only coverage. Because most enrollees who switched plans switched to the same type of health plan with one of the new carriers, this study examined only these types of plan switches. Findings are presented separately for PPO, EPO and HSA plan enrollees. Individuals enrolled in HMOs before the introduction of the new plan options were not examined because the new carriers did not offer an HMO option to switch to.

There are some noteworthy findings. First, very few variables were related to why an individual enrolled in an EPO would switch to a new EPO. Men were less likely than women to make this switch. And individuals with high blood pressure were more likely than those without it to switch. Because individuals with health conditions would be expected to be less likely than those without conditions to switch plans, this finding may indicate that individuals with high blood pressure were not satisfied with the quality of care they received in an EPO and therefore were willing to try a different EPO.

Figure 11
Impact of Demographics, Health Status, and Use of Health Care Services on Carrier Switching, Among Enrollees With Employee-only Coverage, by Type of Health Plan

	PPO ^a	EPO ^b	HSA-Eligible Health Plan ^c
Demographics			
Male	-0.03**	-0.05*	0.02
Age	-0.003***	-0.001	-0.003***
Household size (individuals)			
Annual earnings	-0.002	-0.0001	0.005
Years in plan	-0.01***	-0.001	0.06***
Health Status			
Charlson comorbidity index	0.02*	-0.03	0.03
Hypertension	-0.06**	0.06*	0.06
Dyslipidemia	-0.02	-0.02	-0.02
Diabetes	0.05	0.03	-0.08
Congestive heart failure	0.01		0.32
Asthma/chronic obstructive pulmonary disease	-0.01	0.07	-0.11
Depression	0.002	0.03	0.05
Use of Health Care Services			
Any hospitalizations	-0.02		0.18
Any emergency department visits	-0.01	0.02	-0.04
Primary care physician visits	-0.002	0.003	-0.02**
Specialist physician visits	-0.01**	-0.003	-0.01**
Prescription drug fills	0.001*	0.001	0.0002
Number of outpatient providers	0.0004	-0.003	0.003
Any out-of-network services utilization	-0.0001	0.03	0.09**

Source: Employee Benefit Research Institute analysis based on administrative claims data.
Notes: Statistical significance denoted as follows: *** p<0.01; ** p<0.05; * p<0.10.
^a Preferred provider organization.
^b Exclusive provider organization.
^c Health savings account.

In contrast to the EPO findings, enrollees in the PPO with high blood pressure were less likely to switch to another PPO than enrollees without high blood pressure, which is consistent with expectations. Otherwise, no other health status indicators were related to plan switching among PPO and EPO enrollees, and no health status indicators were related to plan switching among HSA plan enrollees.

When examining plan switching among individuals with family coverage, it was again found that health status had an impact on plan switching among EPO enrollees (Figure 12). In this case, individuals who were in families where someone in the family had either diabetes or asthma/COPD were more likely to switch to another EPO than individuals in families where no one had either of these conditions.

Implications for Plan Sponsors and Public Policy

This case study raises an important question relevant to all stakeholders including employers offering health coverage options through employment-based health plans, insurers and policy makers, Medicare, public exchanges under the ACA, and private exchanges regarding the advantages and disadvantages of offering a wide array of health-plan choices to individuals. Is it possible to create a marketplace where individuals are offered a choice of health plans that does not lead to adverse selection?

Figure 12
Impact of Demographics, Health Status, and Use of Health Care Services on Carrier Switching, Among Enrollees With Family Coverage, by Type of Health Plan

	PPO ^a	EPO ^b	HSA-Eligible Health Plan ^c
Demographics			
Male	0.01	-0.03	-0.04**
Age	-0.003***	-0.004***	-0.01***
Household size (individuals)	0.007	0.02**	0.005
Annual earnings	-0.01***	-0.0001	-0.01**
Years in plan	-0.003	-0.005	0.06***
Health Status			
Charlson comorbidity index	0.001	-0.02	0.02
Hypertension	0.02	0.001	-0.03
Dyslipidemia	-0.004	0.02	-0.003
Diabetes	0.01	0.04*	0.05
Congestive heart failure	-0.06	0.06	-0.06
Asthma/chronic obstructive pulmonary disease	-0.02	0.06**	-0.02
Depression	0.005	0.03	0.02
Use of Health Care Services			
Any hospitalizations	-0.002	-0.03	0.01
Any emergency department visits	-0.02	0.01	-0.03*
Primary care physician visits	-0.001	-0.003*	-0.0003
Specialist physician visits	-0.003*	-0.002	-0.002
Prescription drug fills	0.0002	0.0000	0.0001
Number of outpatient providers	-0.003**	-0.002	-0.01***
Any out-of-network services utilization	0.01	-0.03	-0.01

Source: Employee Benefit Research Institute analysis based on administrative claims data.
Notes: Statistical significance denoted as follows: *** p<0.01; ** p<0.05; * p<0.10.
^a Preferred provider organization.
^b Exclusive provider organization.
^c Health savings account.

Health-plan choice has existed for many years. For example, the federal government as an employer has been offering a wide range of health-plan choices to employees and retirees since the 1960s through the Federal Employees Health Benefits Program (FEHBP). At present, participants have an average of about 20 health plans to choose from in any given year.

Also, Medicare Advantage has been in existence in some form since the 1980s—Medicare Advantage is itself an option to “traditional” Medicare coverage—and additional options around choice for supplemental insurance and prescription drugs accelerated with the passage of the Medicare Modernization Act (MMA) in 2003.

Also since the 1980s, more private-sector employers have been introducing health-plan choice to their employees, via cafeteria plans and flexible spending arrangements, as part of the shift from more paternalistic benefit approaches to programs making employees more accountable via cost sharing (with defined, flat-dollar employer contributions) and choice. Interest by employers in providing workers with more plan choices continued to be evident leading up to the ACA debate and its 2010 enactment.⁸ And most recently, some employers have shifted the health plan options they offer their employees into private exchanges or have added private exchanges as a way to offer more options (Fronstin 2012).

In the individual and small group markets, health-plan choice expanded in 2014 with the introduction of the ACA public exchanges (and the related insurance market reforms and subsidies).

One of the earliest proposals on health-plan choice was the concept of “managed competition.” Alain Enthoven developed the concept in the late 1970s as an alternative to the markets for health insurance *and* health care services.⁹ In managed competition, a health-plan-purchasing cooperative would offer individuals a menu of health-plan choices including all key information about each plan in the marketplace. The information would include plan coverage and benefits, price, cost sharing, consumer satisfaction, provider networks, specialized programs, geographic coverage, and measures of quality. An individual would choose the plan with attributes most suited to his or her preferences.

Adverse selection is a key concern associated with health plan choice. This occurs when too many healthy individuals are concentrated in the less expensive and less comprehensive health plans, and too many less-healthy individuals are in the more expensive and more comprehensive health plans. This can result in a so-called “death spiral”—in which the risks and costs associated with the more expensive and more comprehensive plans rapidly rise, so that the employer or insurer needs to continue to increase the premiums, thus exacerbating the trends toward the concentration of the more healthy individuals in the less expensive plans and the less healthy individuals in the more expensive, more comprehensive plans and thus toward continually increasing premiums for the more expensive plans. At some point, the employer or insurer ultimately decides it cannot spread the costs and risks associated with these plans over a sufficiently broad population that includes enough healthy people to make the health plan’s cost (and premiums) reasonable on a per-covered-individual basis, so it’s forced to terminate or modify the health plan or alter the bases on which individuals choose among the health plan options (Fronstin & Ross, 2009).

For example, an employer that is offering a wide choice of health plans may find that offering one or more comprehensive (higher premium) plans alongside less comprehensive (and lower premium) plans is not feasible if only less healthy employees enroll in the more comprehensive plans.

There is evidence that adverse selection does exist and can impact the availability of health plans in the employment-based group market. For example, Buchmueller and Feldstein (1997) and Buchmueller (1998) looked at the effect of moving to a fixed contribution at the University of California (UC). Prior to 1994, UC set its contribution equal to the cost of the health plan with the largest membership, but in 1994 UC reduced the employer premium contribution to the amount charged by the least costly plan available statewide. This policy led to a high degree of plan switching by UC employees, and the switching contributed to significant adverse selection, driving one plan out of the UC internal market and leading the high-option plan to raise premiums 49 percent in 1996.

Similarly, Cutler and Reber (1998) examined changes that took place at Harvard University. In 1995, Harvard moved to a fixed contribution for health benefits. Contributions were set at 85 percent of the least-costly policy for employees earning below \$45,000 a year, 80 percent for employees earning between \$45,000 and \$70,000 a year, and 75 percent for employees earning more than \$70,000 a year. Non-union employees experienced the change in 1995, while union employees were not affected until 1996, which allowed the researchers to look at a treatment group (the 1995 non-union workers) and a control group (the 1996 union workers).

The study found evidence of adverse selection: Younger employees were more likely to switch to less-costly plans than older employees. This resulted in a 16 percent premium increase in the high-cost plan in 1996. Non-random disenrollment continued. Within three years, the high-cost plan was no longer offered because of adverse selection.

The same dynamic could occur in the public marketplace—or in any other health plan choice situation—where the more-healthy people either drop coverage or migrate toward less-expensive and less-comprehensive plans, leaving more and more of the less healthy in the more comprehensive plans with higher premiums.

This study examined data from an employer that increased from four to 10 the number of health plan options available to employees. To mitigate against excessive concentrations of the less healthy individuals in the older plan options, the employer provided financial incentives in the form of lower employee premiums, higher HSA contributions, and no cost sharing for primary care office visits and generic drugs, hoping to encourage less healthy individuals to switch to the new plans, as the new plan options all used smaller networks for health care providers and did not provide out-of-network benefits, which some might view as less comprehensive coverage.

Despite the incentives, this study found that in this particular employer's situation, older workers and individuals who used higher amounts of health care services were *less likely* to switch health plans. The incentives may have been insufficient to get less healthy individuals to switch to a plan with a smaller network. Alternatively, it simply may be that inertia is a stronger influence (at least in the short term) than financial incentives, and that over time more migration of less healthy individuals into the new plan choices may be seen.

While employers have a number of tools they can use to try to mitigate against adverse selection, and this study examined only one employer, it is possible that adverse selection will exist despite best efforts to eliminate it. This is something that private-sector employers may have concluded, as the adoption of increased plan choice has slowed. Similarly, the slower-than-expected adoption of private-health-insurance exchanges and the plateauing of choice since 2008 (as discussed above and shown in Figure 4) may reflect employers' reluctance to increase health-plan choices because of an inability to avoid adverse selection.

Conclusion

This analysis used data from an employer that increased from four to 10 the number of health plan options available to employees to show whether certain demographics and prior use of health care services are related to plan switching. The six new health plan options all used smaller networks of health care providers relative to the original plan options and did not provide out-of-network benefits.

As a result, the employer had a concern about adverse selection. To mitigate against this, the employer provided financial incentives to nudge people with various health risks to enroll in the new plans. The new plans had lower employee premiums, higher HSA contributions, and no cost sharing for primary care office visits and generic drugs.

Despite the incentives to enroll in the new plan options, older workers were less likely to switch health plans than younger workers, and the higher use of office visits for both primary care physicians and specialists, higher use of emergency departments, and a higher number of outpatient providers were all correlated with less plan switching.

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Endnotes

¹ Health savings account.

² Exclusive provider organization.

³ Preferred provider organization.

⁴ Health maintenance organization.

⁵ According to unpublished estimates from the Employee Benefit Research Institute based on data from the March 2016 Current Population Survey, about 60 percent of workers were employed by firms with 100 or more employees in 2015.

⁶ On average, the percentage of employers offering a choice of plans more than doubled between 1996 and 2014, but the percentage of workers offered a choice of plans has increased by only 54 percent.

⁷ Bhargava, Loewenstein and Sydnor (2015) examined plan choices among employees working for an employer that increased plan choices from nine to 48. They found that the majority of employees made objectively worse choices than they could have, with the average employee opting into a plan costing them \$373 more per year compared with choosing an otherwise equivalent plan with a higher deductible. This is equivalent to 2 percent of mean annual income and 42 percent of the average employee portion of the premium.

⁸ In June 2007, the ERISA Industry Committee (ERIC), a membership organization representing the employee benefit plans of the largest corporations in the United States, released its position paper, entitled "A New Benefit Platform for Life Security." In it, ERIC outlines a proposed structure that employers could use as an alternative to the current way in which they provide both health and retirement benefits. The proposal used an exchange ("benefit administrator") combined with a fixed contribution from participating employers. Furthermore, in October 2007, the Committee for Economic Development (CED), an organization of business leaders and educators, released its recommendations for replacing employment-based health benefits with a system of independent regional exchanges from which individuals, who would be given a fixed contribution, could purchase health insurance from among competing private health plans. See http://www.eric.org/forms/uploadFiles/b86a00000009.filename.ERIC_New_Benefit_Platform_FL06060.pdf and <https://www.ced.org/pdf/Quality-Affordable-Health-Care-for-All.pdf>

⁹ See Enthoven (1978a), Enthoven (1978b), Enthoven (1988), Enthoven and Kronick (1989a), and Enthoven and Kronick (1989b).

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