

Large Employer Views of Consumer-Driven Health Care: Current Interest, Barriers, and Potential Solutions

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The words of Syrus, “It is a good thing to learn caution by the misfortunes of others,” aptly describe most employers’ current reaction to the concept of shifting from the prevailing employer-sponsored health care benefit system to a more efficient consumer-driven approach.

The Current Employer Circumstance

Today, employers are faced with rising costs, the threat of malpractice liability legislation, increasing compliance burdens (such as the government privacy rules), significant plan administration challenges, and the backlash of employees who view the current system as an inadequate entitlement. They are visibly attached to an industry that produces negative consumer and press reactions, and they are not generally credited for their attempts to improve the industry or for the huge financial subsidy that they provide. (See Appendix for the history that led to the current situation).

Given these circumstances, the vision of a consumer-driven system is very appealing. Most employers would like to move to a system where they could provide a tax-effective subsidy to individual employees (as a more visible form of compensation) and allow free choice within local health care markets.

Although individual employer perspectives will differ, the following are the general large employer objectives under a consumer-driven model:

Objectives for Employees:

- **Provide individual employees with more options** within the individual health plan market. While large employers typically offer a choice of plans their fairly standardized and comprehensive designs do not effectively meet the needs of the wide demographic range represented in today's workforce.
- **Provide individual employees with improved financial flexibility.**
Individuals who purchase a lower cost/lower coverage design that meets their expected health care needs and risk tolerance will be able to direct excess subsidy dollars to other benefit areas (e.g., dependent care, life insurance, or retirement savings) or take the excess as income.
- **Create a system that allows portable health care coverage.** In today's turbulent labor market, the concept of ongoing and consistent coverage between employers is critical. The group insurance coverage void that COBRA (Consumer Omnibus Budget Reconciliation Act of 1985) that HIPAA (the Health Insurance Portability and Accountability Act of 1996) attempted to fill is inadequate and creates an undue administrative burden on employers).
- **Gain more visible credit for the significant employer investment in health care** through a system that clearly defines the per employee subsidy as a form of direct compensation.
- **Control financial commitment.** Eliminate the current connection between the employer subsidy and the health plan rate of increase.

- **Minimize future health care malpractice liability risks.** Allows employees to make more coverage, provider, and treatment decisions.
- **Eliminate the current time-intensive focus on compliance,** plan administration, and customized employee communications and allow a greater focus on human resource issues that impact business results (e.g., recruiting, training, and retention initiatives).

Objectives for the Health Care System:

- **Stimulate managed care product innovation,** including customized coverage options and long-term individual contracts in exchange for premium discounts and direct product links to other relevant products, e.g., long-term care.
- **Drive fair physician and hospital cost controls through competition,** including the elimination of redundant resources within markets.
- **Create added incentive for health plans to invest in customer service infrastructure and plan design** innovation by presenting them with a more informed and empowered group of *individual* consumers armed with better data and more product options than in the past.

While these outcomes could ultimately benefit employers and current health care consumers, they will also achieve broader health care industry and social consequences. A consumer-driven health care system would reduce the cost of health care in the United States as buyers with direct financial incentives would gravitate to the most cost-efficient delivery systems by market. This demand for high quality, low cost service would ultimately reduce administrative inefficiencies and redundant resources, such as 60 percent hospital occupancy

rates and an over-supply of select specialist services relative to primary care services from the provider system. A lower health care cost base would provide opportunities within the public and private sector to stem and, possibly, reverse the rising tide of uninsured Americans.

Despite these compelling objectives, significant emotional and structural barriers must be addressed before this system can be effectively implemented.

Market Barriers and Potential Solutions

A consumer-driven health care system is achievable today. The significant barriers that exist do not require extensive market reform, private sector mandates or complicated tax legislation. They do require consumer demand (which will increase as the current system continues to falter), private sector partnerships (employers, health plans, and providers), and the related interactions of a free market.

The barriers and possible solutions are as follows:

Public Perception

From a large employer perspective, the most significant barrier to a consumer-driven health care system is the current sense of entitlement that surrounds group health care coverage. The intuitive desire to create an adequate consumer-driven market and a system to support it is typically overwhelmed by the fear of negative public reaction. This fear is legitimate, considering the emotion that surrounds health care, the tenure of the present group health care system, and recent public reactions to employer actions in retirement income plans (e.g., the negative public reactions to Cash Balance designs and broader concerns about employee investment controls). Communicating the long-term consumer advantages of a consumer-driven

HC system will not be enough to overcome a public outcry that inaccurately describes this approach as an employer “cut and run” strategy.

The solution to this barrier will come in the form of corporate leaders (individual companies or small “affinity groups” of employers moving together within select markets) who simply accept this challenge to move the system forward. A second, more global solution could manifest itself if Federal legislation is enacted shifting a much greater burden for malpractice liability to employers. Either event would drive employers to this system, in the same way that the managed care markets were embraced by employers in the mid-1980s in response to massive cost inflation.

Market Resistance

A second barrier that is frequently described but not adequately explored is the markets’ resistance to individual versus group health care risk. The current individual market is a very poor proxy for a future consumer-driven system. Costs in today's individual health care market are driven up because the individuals who turn to it generally have no access to employer coverage and a defined health care need.

While health plan leaders are initially concerned about the financial effects of a consumer-driven market, they are generally able to define rational selection controls and, more importantly, envision the opportunity for product cross-selling and long-term consumer loyalty that does not exist today. A health plan’s ability to retain a customer over a long period of time is uniquely correlated with profitability. In today's group market, consumers are moved between plans as a result of annual employer contracting, design, and contribution decisions. In a consumer-driven system, plans that can retain members will reap long-term profits from preventive care and disease management efforts.

The basic solution to the market resistance barrier consists of simple pricing and design controls that allow health plans and providers to price risk fairly. Critical components of these uniform market controls, that can be imposed through private sector contracts and/or public sector legislation, include:

—*Risk Adjusted Premium Payments:*

The simplest risk adjustment system might prospectively adjust plan premium payments for every insured life based on standardized demographic factors. Under this model, plans would follow a standard slope in setting premium rates, by age and gender. For example, if we define the expected health risk for a 40-44 year old male with single coverage at 1.0, then the risk factor for a 25-29 year old female with family coverage would be 2.8 (or 180 percent more costly). An individual or family within a market would face the same premium slope between competing plans and alternative plan designs. This system would not attempt to control the average premium rate of a plan. The health plan price controls would be limited to prospectively defining the relationship (slope) among premium levels based on age and gender.

More refined risk adjustment methodologies would adjust plan premium payments for each insured life based on an analysis of historical claims data (e.g., prescription drug data).

—*Mandated Coverage:*

Where private or public subsidy funds are available to individuals, a minimum level of coverage (e.g. catastrophic coverage with a \$500 annual premium) would be mandated to limit the current “uninsured” cost shift and ensure a full risk pool for competing health plans.

—*Opt-up Restrictions:*

These restrictions would limit an individual consumer's ability to obtain significantly richer coverage within a short time frame. Since a significant amount of health care treatment

can be deferred, it is important to protect providers and plans from ongoing coverage and related premium changes that meet only current patient health care needs. An example of this restriction would limit an individual's moving from a catastrophic plan to a comprehensive (full coverage) plan within a six-month period.

Consumer Information

A third barrier to a consumer-driven health care system is the complexity of the health care environment and a lack of faith in the average consumer's ability to operate independently within it without employer oversight and decision making. In reality, however, employers provide very limited health management information to their insured populations today and individuals are forced to gather health care management information from a variety of public and private sources. The current group system does not create adequately informed consumers as health plans view employers as their customers and employers are reluctant to provide detailed coverage information (e.g., specific clinical protocols) or aggressive disease management intervention as a result of liability and employee privacy concerns.

In a consumer-driven system, smart health care buyers with financial incentives will demand quantitative and qualitative information on competing health plans, design options, providers, and specific health care treatments. Plans and providers will be motivated incentives to supply this information in order to manage utilization and cost and to maintain market share.

The Internet will play a key role in plan enrollment, ongoing administration, customer service, and consumer research. With or without a consumer-driven model, the Internet can ultimately remove employers from tactical plan administration and customer service tasks. Most employers have not yet embraced a full "self-service" consumer model because they felt it was unreasonable to expect that anything approaching 100 percent of employees would have Internet

access. The growing popularity of e-commerce among working Americans, along with the recent trend toward heavily subsidized PC purchases in return for long-term commitment to Internet access programs, leads one to conclude that nearly universal employee Internet access is within the grasp of the determined employer. This access would have a dramatic impact on the delivery of health care and other benefits, and would dramatically alter how employers and employees go about defining and executing the employment relationship in the future.

Tax Code

A much discussed barrier to this system is the current health care tax system that allows employers to exclude all health care spending from the income of employees but does not allow full deductions for individuals who purchase their own coverage. The long-term remedy for this barrier is legislation that equalizes the tax treatment on premium payments between individual and group purchasers and potentially allows individuals to roll over unused “health care spending account” balances for use in future years.

A shorter-term employer remedy that does not require legislation is an administrative system that simply provides employees with health care “vouchers” that are paid directly to the plans after an individual has enrolled. This “voucher” system preserves the employer health care deduction, and avoids employee income tax consequences, as there is no “constructive receipt” of compensation on the part of the employee who elects not to participate in the plans. Employee contributions that are required beyond an employer voucher will most likely need to be collected on an after-tax basis through a third-party administrator or directly by the plans, but there is no reason these could not be simplified dramatically for participants by using employer payroll deductions.

The Future of Consumer-Driven Health Care

While employers have a clear interest in maintaining a healthy work force, they are caught up in a group benefits system that is terribly flawed. A consumer-driven system will provide individuals with improved financial flexibility, and, in turn, force positive changes within a highly fragmented managed care industry and an inefficient provider system. Complex Federal or State legislation that attempts to mandate a consumer-driven model will fail against the legitimate interests of the health plan and provider industry. Employers focused on overcoming current barriers (real or perceived) to a consumer-driven system will ultimately lead this change.

APPENDIX

THE GROUP SYSTEM EVOLUTION

Virtually all large employers offer group health care options to their employees today, with an average financial subsidy of 85 percent.¹ This trend began with the enactment of tax-deferred health insurance through employers as a perk to offset employee wage caps in 1942. From this point, the industry evolved along the following basic lines:

- Payors, employer and government-based systems, and the insurance industry that emerged to supply them unwittingly created an economic model that limited the supply and demand interaction that exists in traditional consumer-to-supplier relationships.
- Consumer indifference to price, coupled with a public perception that the medical establishment's goals were purely aligned with the patient and that individual practitioners' opinions were unassailable, contributed to an environment that fostered great advances in medical science with little or no regard to cost or recovery of R&D expense. This prolonged period of medical and technological advances led to significant health care cost increases within traditional fee-for-service options.
- Dramatic health care cost increases during the economic downturn of the late 1980s led employers to deploy a wide variety of cost management techniques with a heavy emphasis on managed care delivery systems.
- Large employers encouraged managed care migration by offering multiple choices and rich plan designs.

¹ Source: 1999 Hewitt Health Value Initiative™

- Consumers were further distanced from the actual cost of health care as managed care benefit levels were enriched relative to indemnity plans.
- Because the health plans were able to negotiate prices with providers that were significantly lower than the cost of delivering traditional fee-for-service benefits, plans that were attractively priced to employers earned significantly higher margins than old-line indemnity insurance.
- This short-term arbitrage advantage led a large number of managed care organizations to enter markets and to compete aggressively for enrollments or market share. This proliferation of players is reflected in the fact that the average large employer currently offers employees three to four health care options.²
- As managed care enrollment grew, providers believed it was increasingly important for them to contract with numerous health plans. Similarly, employers were reluctant to contract with plans that did not offer a broad network to employees. To protect their revenue and patient volume, physicians and hospitals signed up with multiple managed care options, which were more than happy to add them to their panels. Employers were then convinced that the access to an almost universal list of local providers coupled with significantly lower costs was the answer they were looking for and quickly moved to encourage greater employee participation in managed care (either through plan consolidation or contribution strategy).
- While rapid managed care migration reduced purchaser costs as both employers and consumers took advantage of first-time provider discounts and medical management initiatives (relative to the unmanaged fee-for-service model), it did little to address

² Source: 1999 Hewitt Health Value Initiative™

the fundamental issues of provider overcapacity, price elasticity, and ever-increasing advances in technology.

- Price competition for market share among an excess of managed care plans and a growing recognition of relative leverage within the provider community led to declining managed care industry profits and significant cost escalation beginning in 1997.
- Like any industry with over-capacity, the managed care industry began to experience a rash of consolidation and exits by marginal competitors. Unlike any other industry, however, this led to a broad public reaction that things had gone awry. The public had not yet fully accepted the new delivery model and viewed much of this consolidation (and the corresponding collapse of what had been, at best, a marginal customer service infrastructure) as an unprecedented threat to the public health. It is interesting to note here that most employees view their own plan as being “safe,” yet are quick to express great concern about the ability of “the industry” to adequately care for the best interests of members.
- These recent events have led to broader media coverage of patient dissatisfaction, which has fueled the underlying and never quite resolved quality of care concerns with managed care. The political outcome is a Federal and State reform focus.