The Changing Landscape of Health Insurance in the United States

Paul B. Ginsburg, Ph.D.

Presentation to symposium sponsored by Center for Health Program Development and Management, UMBC, June 13, 2006

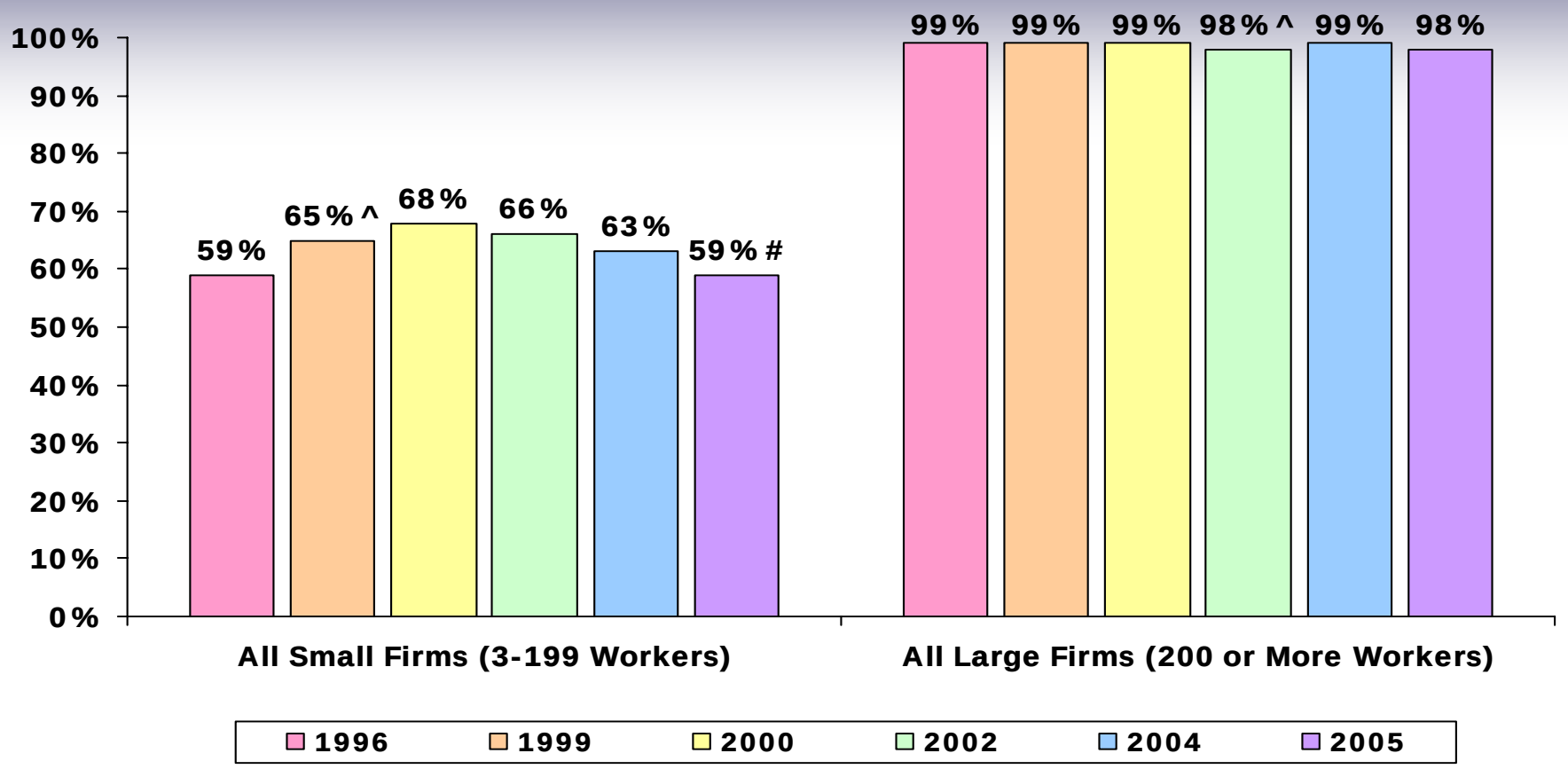
Key Developments in Health Insurance

- Erosion of employer-based coverage
- Benefit designs based on greater patient financial responsibility
- Expansions of Medicaid/SCHIP
- New ideas for public efforts to expand coverage

Trend in Employer-Sponsored Health Insurance

- Slow long-term erosion of coverage
  - Decline from 62.1% in 1987 to 59.8% in 2004
  - Trend overshadowed by strong responses to economic cycle and health care price trends
  - See Reschovsky, Strunk and Ginsburg, Health Affairs May 2006 for decomposition of 1996-2003 period

Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2005



^ Estimate is statistically different from the previous year shown at p<0.1.

The 2005 offer rate for All Small Firms is not statistically different than the 2004 offer rate for All Small Firms at p<.05. The difference between the offer rate for All Small Firms in 2000 (68%) and the offer rate for All Small Firms in 2005 (59%) is statistically significant at p<.05.

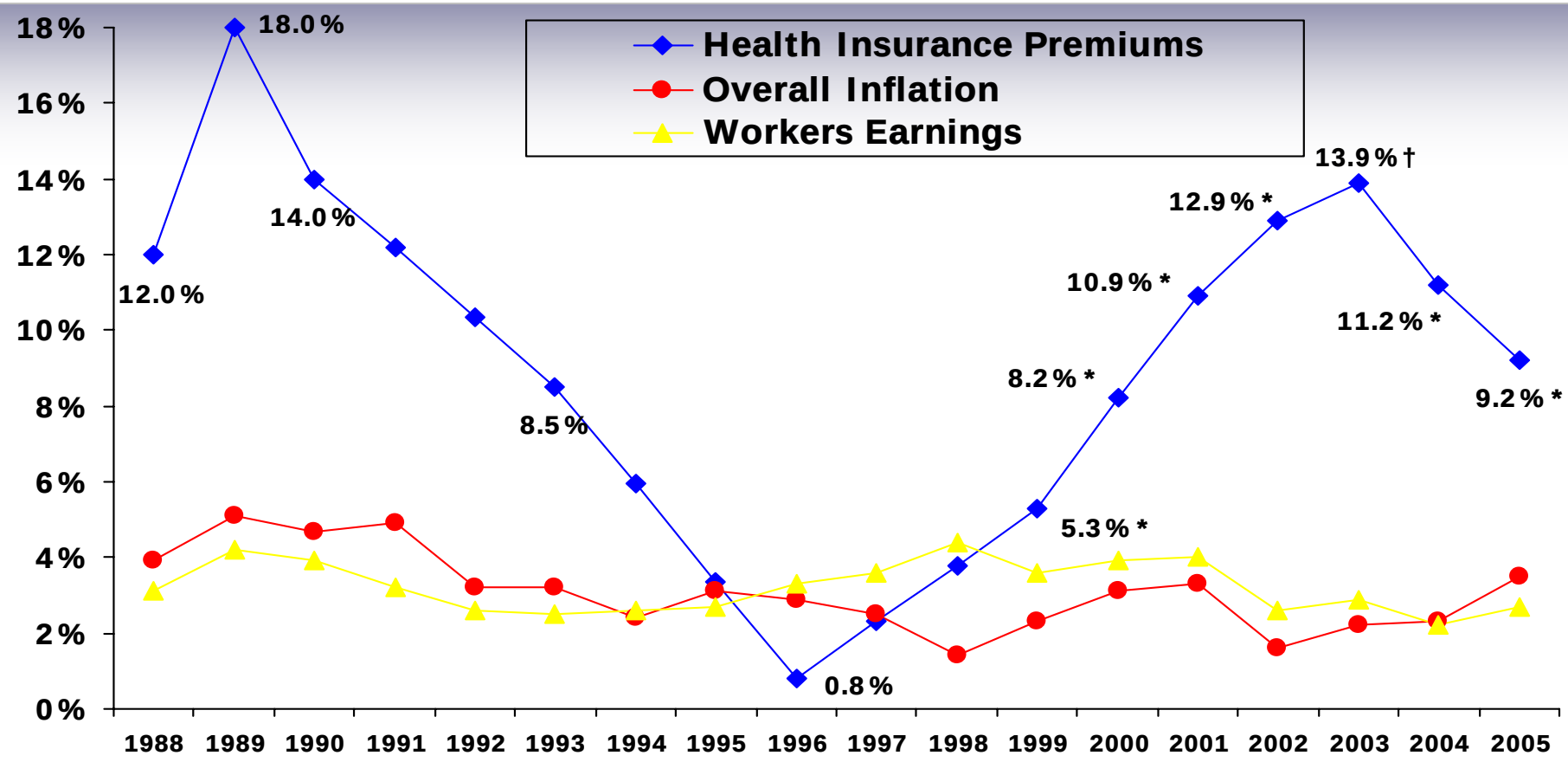
Note: The percentage of All Large Firms (200 or more workers) offering health benefits in 1999 was 99%, not 100% as reported last year.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1996.

Source of Erosion of Coverage: Rising Costs

- 30 year trend in national health expenditures
  - 2.5 percentage point per year differential
- Kronick and Gilmer
  - Decline in coverage of workers from 1979 to 1995 almost entirely accounted for by gap between trends in health spending and personal income

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



* Estimate is statistically different from the previous year shown at p<0.05. No statistical tests were conducted for years prior to 1999.

† Estimate is statistically different from the previous year shown at p<0.1. No statistical tests were conducted for years prior to 1999.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2005.

Retiree Health Coverage (1)

- A major issue of transition
  - No employer would initiate retiree health benefits today
    - Unpredictability of health spending and life expectancy
    - Vulnerability to shrinking workforce
    - FASB and GASB requirements
- Offers of coverage very uneven
  - Sharply higher rates for
    - Public employers
    - Very large private employers
    - Higher wage firms

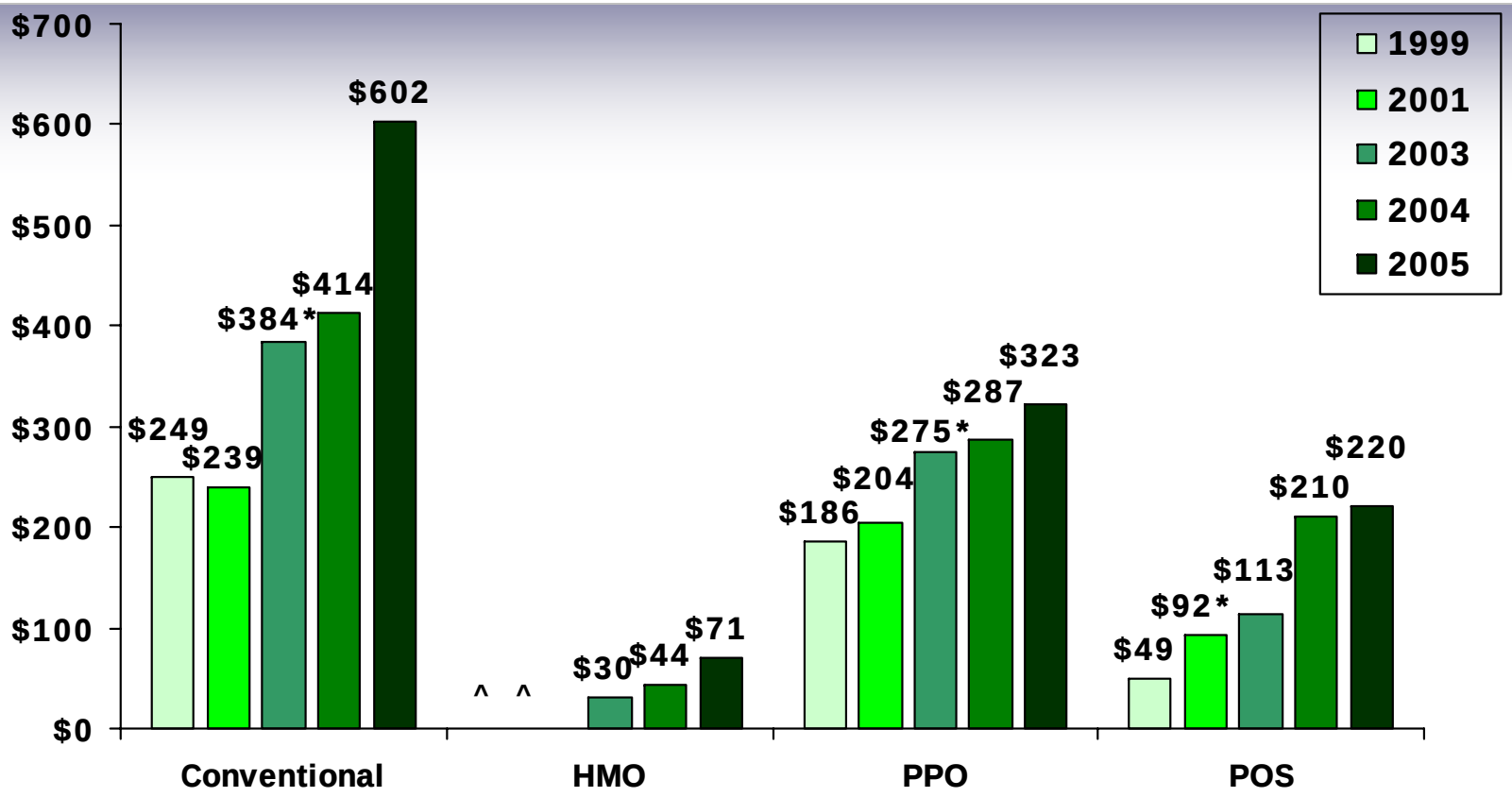
Retiree Health Coverage (2)

- Decline in offer rate is slow, but masks other erosion
  - Sharp increases in retiree premiums
    - Employer contributions have hit caps
    - 79% large private employers increased retiree contributions last year--Kaiser/Hewitt 2004 Survey
  - Sharp buy-downs in benefits
- Will government financial reporting impact public employers the way corporate financial reporting impacted private employers?

Making Coverage More Affordable

- 1990s model: restrictive models of managed care
  - Narrow provider networks
  - Extensive authorization requirements
- 2000s model: buy-down of benefits through increased patient cost sharing
  - Cumulative buy-down since 2002-2005—around 10%
  - Higher deductibles for hospital and physician services and higher copayments for drugs
  - Little change in shares of premiums paid by employers and employees

Average Annual Deductibles for Single Coverage, by Plan Type, 1999-2005



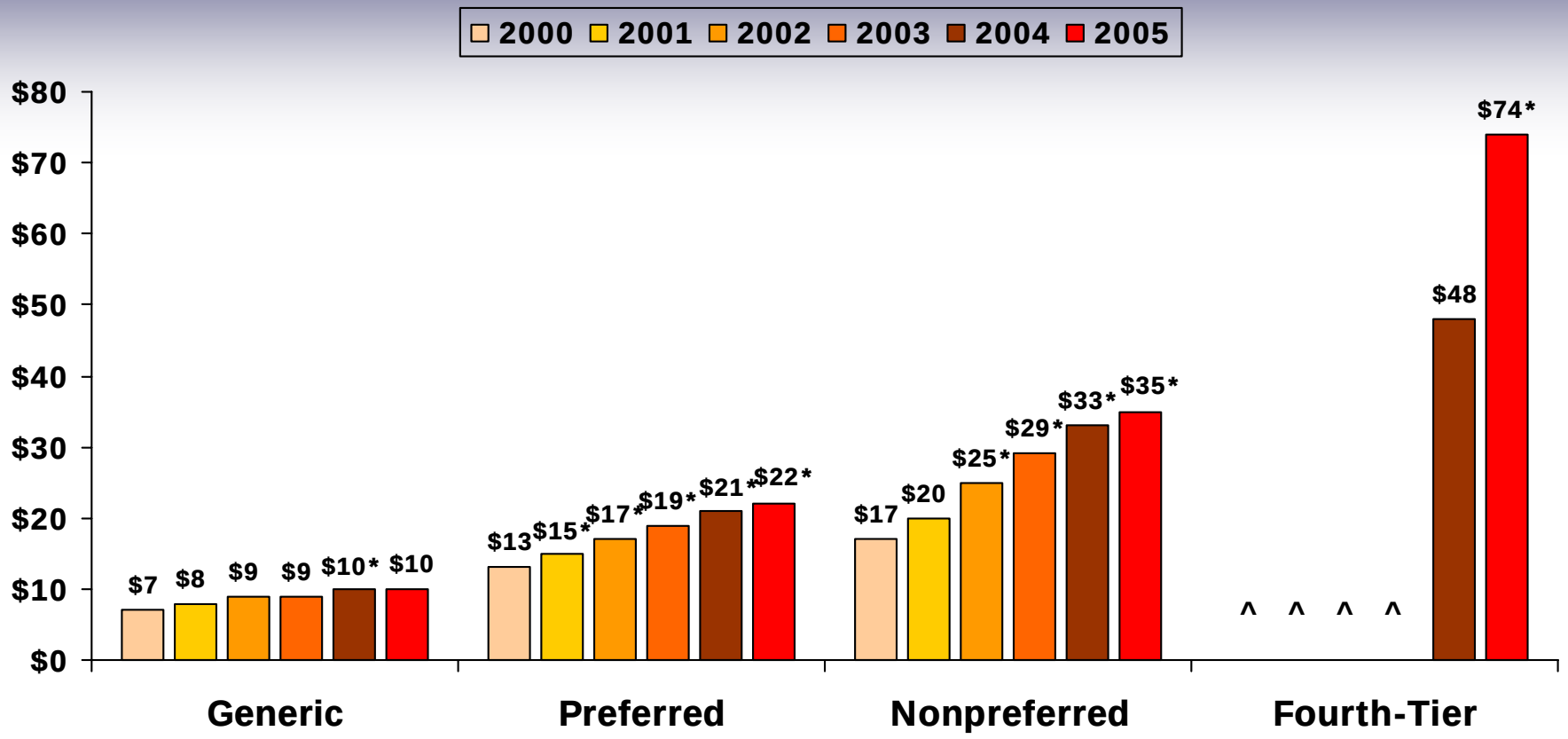
* Estimate is statistically different from the previous year shown at p<.05.

^ Information was not obtained for HMO single coverage prior to 2003.

Note: Average deductibles for PPO and POS plans are for in-network services. Averages include covered workers who do not have a deductible. If covered workers with no deductible are excluded from the calculation, the average deductibles for single coverage for 2005 are as follows: conventional - $671; HMO - $568; PPO -$445; POS - $495.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005.

Among Covered Workers Facing Prescription Drug Copayment Amounts, Average Copayments, 2000-2005



* Estimate is statistically different from the previous year shown at p<.05.

^ Fourth-tier copayment information was not obtained prior to 2004.

Note: Average copayments for generic, preferred and nonpreferred drugs are calculated by combining the weighted average copayments for those types of drugs among firms with a single copayment amount or a multi-tier cost sharing structure. The average copayment for fourth-tier drugs is calculated using information from only those plans that have a fourth-tier copayment amount.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000-2005.

Consumer-Driven Health Plans (1)

- Attention capture has been enormous
  - Enrollment capture dramatically lower
- What is a CDHP?
  - Combination of substantial patient cost sharing and an account to fund spending
  - Information support for patients: price and quality
    - Tools usually available throughout product line
  - Most CDHPs include PPO networks
  - Cost shifting often not a major component
    - But shifting among employees a staple
      - Losers are those who have high medical needs

Consumer-Driven Health Plans (2)

- CDHPs will reduce health care costs
  - Big question is magnitude of potential accomplishment
- Health care demand not highly sensitive to price
  - But choice of providers or treatment alternatives might be much more sensitive
- Limited by capacity of employees to bear financial risk
  - Those with chronic disease
  - Those with low incomes
- Large proportion of spending not subject to large deductibles and other incentives

Need to Reshape Benefit Structure

- Emphasize incentives to use efficient providers
  - Providers have the most potential to make care more efficient
- Avoid discouraging important services of penalizing those who need them
  - Protect regimens for chronic disease management
  - Low cost sharing for other essential care
- Focus cost sharing on services with unknown or marginal benefits
  - “Evidence-based benefit design”

Stimulate Productivity Gains by Health Care Providers

- Replicate success of modern management techniques in other service industries
- Providers need to feel competitive pressure on price and quality of their care
  - Publication can help on pressures to improve quality
  - Market forces can intensify pressures
- Can only be achieved through benefit design
  - High-performance networks
  - Narrow networks

High-Performance Networks

- Focus is on specialty physicians/practices
  - Broad measures of efficiency
    - Per episode
    - Per month for chronic disease
  - Patient incentives developed by employers
  - Blend of narrow networks and consumerism
- System impact
  - Change in provider volumes motivate practice improvement
  - FFS pricing patterns a barrier to providers
  - Limited by sample size: access to Medicare data would address

Disease Management

- Increasingly part of the landscape of health benefits
  - Useful but not a silver bullet
- Evolution to much greater targeting
  - Conditions prevalent in company's workforce
  - Those with more severe chronic disease
- Challenge to assess cost impact
  - Rapid changes in methods and little solid literature
  - Application to specific employer limited
  - Few employers can quantify impacts on productivity and disability

Wellness

- Increasing recognition of importance of healthy lifestyle for productivity and health costs
  - Broad change in thinking about personal responsibility now underway
  - Incentives for healthier lifestyle
  - Programs to help improve lifestyle
  - Significant public sector role likely
    - Progress over decades in smoking
    - In initial stages on obesity
- Employer decisions on wellness like those on DM
  - But at much earlier stage

Potential Application of Consumerism in Medicaid

- Consumerism a more radical departure for Medicaid
  - RAND experiment results show more downside with low-income persons
- Potential models with scaling patient cost sharing
  - Scale a $30 private coverage copayment to a $3 Medicaid copayment
- Issue of provider financial burdens
  - Possible need to boost reimbursement rates

Implications of Consumerism Trend for Medicaid

- Contrast to the managed care era
  - Transferability of some tools
  - But evolution to separate managed care contractors
- Pressure from contrast between Medicaid benefit structure and that in small group and individual coverage
  - This segment of private coverage has increasingly limited benefit structure
  - Inevitable response is varying benefit structure within Medicaid program
    - What are the practical ways of doing this?

Potential for Medicare to Improve Entire Health System

- Reporting incentives will stimulate IT and provide quality data for other payers
  - Health plan access to Part B data would be a major asset to private payers
- Refinements in reimbursement will likely be followed by private payers
  - Reduce differences in profitability by service and patient
  - Avoid incentives for expansion of specialty facilities

New Ideas on Expanding Public Coverage

- Less comprehensive Medicaid benefits for higher-income beneficiaries
- Individual responsibility for obtaining coverage
- Fees charged to employers that do not provide coverage
- Exchanges for purchase of health insurance
- Many are components of Massachusetts plan

Individual Responsibility

- Motivations
  - Paternalism
  - Prevent free riding
  - Make public dollars go further
- Essential accompaniments
  - Subsidies for low income
  - Reforms of individual insurance markets to permit creation of pools
- Enforcement
  - Tax system

Employer Fees

- Modulate magnitude
- Potential to base on payroll
  - Transform health insurance from a fixed amount per worker
- Reduce magnitude of crowd out from subsidies to individuals

Health Insurance Exchanges (1)

- Objectives
  - Promote plan choice
    - Enhance competition
    - Allow more differentiation of insurance products
    - Better match plans to individuals
  - Reduce administrative costs
    - Efficiency in distribution
  - Permit pooling
    - Increases ability of those with high expected service use to afford coverage

Health Insurance Exchanges (2)

- Critical elements
  - Incentives/requirements for employers/individuals to use exchange
    - Tie subsidies or tax credits to the exchange
    - Massachusetts offers to exclude individual contributions from tax
  - Mechanism for pooling
    - Entity to calculate risk adjustments and transfer funds among insurers