Employer Responses to Increasing Health Care Costs

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August 7, 2003

Introduction

Health care expenditures in the U.S. have risen dramatically over the past five years, leading to increases in health insurance premiums. In the late 1980’s and early 1990’s, employers responded to rising premiums by turning to managed care policies. However, recent trends show that managed care coverage is declining and employers, instead, are choosing policies which shift more health care expenses onto workers. This paper summarizes the trends in health care expenditures, the underlying causes of recent increases, and how employers are responding to rising premiums. The paper concludes with a broader discussion on how these changes affect the U.S. health care system.

Background on Health Insurance

Health insurance is primarily designed to reduce the financial risk which may result from uncertain future health care needs. Premiums, or payment for health insurance, reflect the average expected cost of medical care across a group of individuals, with a mark-up to cover administrative expenses and profit. As per capita health care expenditures rise, premiums will increase to cover the increasing expected average cost.

Under standard fee-for-service plans, there are no restrictions on what care the insured can seek, which doctors are covered, etc. For those fully insured under such a plan, there are no out-of-pocket costs to the individual for services, once the premium has been paid. This leads to the common result that fully insured individuals tend to over-utilize health care services. For example, it may cause people to see a doctor for trivial illnesses or injuries, where they likely would not if they were paying for care directly. Alternatively, individuals may be willing to undergo unnecessary tests as a precautionary measure, even in the absence of symptoms or risk-factors for a condition. This behavior leads to very high levels of health care utilization and, as a result, very high premiums for this type of insurance policy.

One way to minimize such over-utilization is to implement cost-sharing measures, where the insured is partially responsible for payment of services. These measures include deductibles, coinsurance rates, and copayments. With deductibles, the individual pays up to the deductible amount out-of-pocket, with no payment made by the insurer. Once the deductible has been met, though, the individual faces no additional out-of-pocket expenses, and is essentially fully insured. Under policies using coinsurance rates, the insured is responsible for a set fraction of any covered expense. A related cost sharing measure is the use
of copayments. Rather than paying a set percent of the cost, the insured pays a set total amount per unit of service. For example, many policies have copayments of $5 per office visit, $25 per emergency room visit, $10 per monthly dosage of prescription drugs, etc. Under copayments, the insured faces less potential financial risk than with coinsurance rates, in the event that expensive care is needed. Most policies have some combination of cost-sharing measures which help alleviate the problem of over-utilization that occur under full insurance. However, high levels of cost-sharing measures may also cause some individuals to forgo non-trivial medical services as well. If cost-sharing measures are increased, this results in lower premiums because the insured pay a greater amount of covered services out-of-pocket, and is likely to use fewer services, on average.

Another option to reduce premiums is through managed care policies, which restrict the scope of covered services, rather than increasing cost-sharing measures. Standard health maintenance organizations (HMOs) negotiate preferred rates with a network of specific providers of medical services. Those covered under the HMO policy are only covered for services from providers within the network. Additionally, HMOs have played an active role in determining which services are appropriate, rather than leaving this up to the patient and doctor alone. In general, all forms of managed care place restrictions on the choice of provider and/or the amount of control patients and doctors have in determining which specific services which will be covered. This allows the managed care providers to hold costs down, resulting in lower premiums. However, there is much concern that the limitations on coverage under managed care may reduce the quality of care, potentially harming the health of enrollees relative to those with traditional insurance. Empirical studies have shown that managed care is effective at reducing cost. However, there is little empirical consensus on whether managed care hinders the quality of care received. Most studies have shown little or no differences between health outcomes of those with managed care coverage versus traditional insurance. Of those that do show differences in quality, they are divided on whether better quality is achieved through managed care or traditional insurance. These studies have found that those with managed care coverage tend to be less satisfied with their insurance provider, since specialized care often requires the individual to obtain approval prior to receiving care. However, the lower levels of satisfaction are coupled with lower premiums for coverage1.

There are a number of related managed care arrangements which are less restrictive than the standard HMO setup. For example, preferred provider organizations (PPOs) will cover expenses through non-network providers, but require much higher levels of cost-sharing for such services. Rather than restricting care directly, as in HMOs, PPOs provide covered individuals financial incentives to seek care from within the network of providers.
Historical Growth of Employer-Sponsored Health Insurance

The U.S. health care system relies heavily on the fact that most individuals receive access to health care services through employer-sponsored health insurance, either through their own employer or that of a family member. The dominant presence of employer-sponsored health insurance benefits has evolved over the past fifty years, largely in response to government policies which encourage employers to provide health insurance benefits. During and following World War II, the U.S. government had established strict wage and price controls. The wage controls, in particular, made it difficult for employers to attract workers during the labor shortages present at that time. However, the 1942 Stabilization Act allowed employers to enhance wages by offering health insurance benefits (Thomasson, 2003). This allowed employers to use health insurance benefits, rather than wages, to attract new workers without violating wage controls. In addition, a 1943 administrative tax court ruling, later reinforced by the 1954 Internal Revenue Code, stated that health insurance premiums paid by employers were not taxable as employee income (Thomasson, 2003). This provision made it less expensive for workers to enroll in employer-sponsored health insurance plans than it would be to purchase their insurance directly. For example, consider a worker with a choice of receiving a salary of $47,000 plus health insurance benefits costing the firm $3,000 per year, versus a salary of $50,000 with no health insurance benefits. Assuming the worker desires to have health insurance, they are better off under the first option, since their taxable income will be lower, even though the firm pays $50,000 per year for that worker under either option.

The worker’s preference toward employer-sponsored insurance is further reinforced by the fact that larger firms may have access to group rates, not available to individuals. For firms with a large number of employees, the expected health care costs of the employees is fairly predictable. Thus, firms whose workers have lower-than-average expected health care costs (such as a firm with mostly young, healthy employees) can negotiate for lower premiums, compared to premiums based on average health care costs of a broader community. As a result, if the worker from the previous example chose to take the higher wage and purchase insurance directly, the individual would likely have to pay more than $3,000 for the same coverage as well as paying higher taxes. It is difficult for individuals or small groups to achieve similar savings due to the fact that health care costs are more uncertain when pooling across smaller groups.

Large firms can also take advantage of the option of self-insurance. Such firms have commonly opted to self-insure. Typically, a health insurance provider receives a fee to process claims, though all costs for the claims are paid directly by the employer. Self-insurance also avoids state taxes on premiums (assessed from the insurer) and is not subject to state-mandates on private health insurance policies (Henderson, 2003, 188). Because of the relative predictability of health care costs for large groups, larger firms can save by self-insuring and assuming

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the financial risk directly. Self-insurance is a less viable option for smaller firms because they would face a substantial amount of financial risk due to this increased uncertainty of health care costs for smaller groups.

In the absence of these incentives, there would be no advantage for workers to prefer lower wages, along with health insurance benefits, as opposed to a higher wage without benefits. In fact, workers would be better off (or at least, no worse off) by taking the higher wage and choosing the insurance policy which best fits their needs, rather than the one designated by their employer.

**Health Expenditure Trends**

Health care expenditures have been increasing faster than GDP since 1998. The annual growth in per capita health care expenditures peaked at 10% in 2001, compared to an overall increase in per capita GDP of 1.7% (see Table 1). In 2002, per capita health expenditure growth fell to 9.6%, compared to per capita GDP growth of 2.7%. Per capita health care expenditures are rising most rapidly for hospital outpatient services and prescription drugs: 14.6% and 13.2%, respectively in 2002. Growth of hospital inpatient services (6.8% in 2002) and physician services (6.5%) have also contributed to the overall increase in health care expenditures (Strunk and Ginsberg, 2003).

Part of the increase in health care expenditures is due simply to increased utilization of health care services. For example, Strunk and Ginsberg (2003) find that utilization of hospital services have shown the same trends as hospital expenditures. Hospital utilization has increased since 1998, peaking at 8% growth in 2001, and slowing to 5.7% growth in 2002. Increased utilization is also seen in physician services, growing at a rate of 5.3% in 2002. Thus, part of the increase in total health care spending is explained by the fact that we are simply using more services.

However, much of the growth in spending on hospital services can be attributed to rising prices. In fact, hospital prices have increased steadily since 1998, growing at a rate of 3.6% in 2001, and even faster at 5.1% in 2002 (Strunk and Ginsberg, 2003). These increases in hospital prices likely stem from a number of factors. First, hospitals have been facing labor shortages, most notably for nurses, which have resulted in increased payroll costs. Second, hospitals have had more negotiating power, relative to the mid-1990’s with HMOs and related insurance schemes which negotiate discounts with medical care providers (Strunk and Ginsberg, 2003). This negotiating power has been reinforced by consumer and physician backlash against HMOs and new (and pending) legislation aimed at limiting insurers’ ability to restrict access to medical services or providers. HMOs have also recently been less aggressive in limiting care due to increased litigation of cases where care is denied. Finally, hospitals have been continually updating their technology as new or improved medical equipment becomes available. These additional costs have likely been passed
on, in part, to the customers of hospital services. Price increases are also likely
due in part to increasing malpractice insurance premiums.

Increases in prescription drug expenditures have contributed significantly to the
overall increases in health care expenditures. However, they have been
declining from a high of 18.4% growth in 1999 to 13.2% in 2002. Thus, the
downward trend began much earlier than in other areas of health care. Strunk
and Ginsberg (2003) attribute this downturn in the trend to a number of factors.
There appears to be a related slowdown in the pace of technological innovation
over this period, shown by a drop in the number of newly approved medications.
Additionally, a number of drugs have recently had their patent expire, leading to
the availability of lower-priced generic alternatives. Finally, many health
insurance plans that cover prescriptions now offer lower copayment rates for
generics, compared to name-brand prescriptions, to encourage use of lower-cost
alternatives.

These increases in health expenditures have naturally led to increases in health
insurance premiums. Premiums for active employees increased 8.3% in 2000,
11% in 2001, and 12.7% in 2002 (Kaiser Family Foundation, 2002). While the
increase itself is not surprising, it is interesting to note that premiums are
increasing at a faster rate than health care expenditures. This would indicate
that profit margins are increasing for insurers, though it is unclear whether these
increases are due to increased market power, or simply to recoup losses from
previous years. Because health care expenditures have recently risen at rates
higher than expected, it is likely that insurers have been facing higher-than-
expected payouts for claims. This would naturally lead insurers to try to increase
premiums to compensate for losses, or at least, lower-than-expected profits.

**Employer Responses to Rising Premiums**

In the extreme, some employers may simply choose to drop health insurance
benefits completely. In fact, the percent of the population covered by
employment-sponsored health insurance fell from 63.6% in 2000 to 62.6% in
2001 (Kaiser Family Foundation, 2002). However, it is unclear whether this drop
is due to fewer firms offering health insurance benefits, or fewer employees
enrolling in plans that are offered. For example, there has been some concern
that increased availability of public health insurance (such as Medicaid) is
causing some individuals to substitute public coverage for private coverage
(Cutler and Gruber, 1996).

For employers that continue to offer health insurance benefits, there are a
number of options to help lower premiums, including:

- Increased cost-sharing
- Increased employee contributions for premiums
• Self-insurance

• Changing the type of plan offered (traditional, PPO, HMO, etc.)

For the most part, firms that are large enough to benefit from self-insurance have already done so, making this option less viable for fighting the current trend in increasing premiums.

Employers had previously responded to rising health insurance premiums by switching to greater use of HMO coverage in the late 1980’s and early 1990’s. More recently, however, HMOs have been less successful in keeping costs down, due to consumer and physician backlash, new regulatory restrictions, and increased litigation over refusal of services. Premiums for HMOs have become fairly comparable to other forms of coverage, making their restrictions on services even more unattractive. The percent of covered workers enrolled in HMO’s has fallen from 31% in 1996 to only 26% in 2002. Simultaneously, less restrictive PPO plans have increased in popularity from 28% in 1996 to 52% in 2002 (Kaiser Family Foundation, 2002).

Employers have begun shifting some of the higher premiums onto worker contributions. The average monthly worker contribution for health insurance premiums have increased from $28 in 2000 to $38 in 2002 for single coverage, and from $138 in 2000 to $174 in 2002 for family coverage.

The level of cost sharing has also recently increased. For workers covered by PPO’s, now the most common type of employer-sponsored coverage, average deductibles for care from network providers have increased from $201 in 2001 to $276 in 2002. Average deductibles for care from non-network providers increased from $407 in 2001 to $488 in 2002. In addition, 45% of those enrolled in PPO’s in 2002 faced coinsurance rates of 30% or more for care received from non-network providers (Kaiser Family Foundation, 2002). Thus, while PPO’s provide greater access to non-network providers, compared to HMO’s, the cost of doing so may be too burdensome for many families.

Conclusion

Rising health care expenditures in the U.S. have led to increasing premiums for employers offering health insurance benefits. In the past, employers responded by switching to cost-saving HMO policies. However, the restrictions on care imposed by HMO’s have come under fire from consumers, physicians, and policy-makers alike. This has led to an easing of HMO restrictions, limiting their effectiveness at controlling costs. The current trends show that employer-sponsored health insurance has been backing away from HMO policies and turning instead to less-restrictive PPO policies. Additionally, the share of premiums paid by the workers and the level of cost-sharing under employer sponsored coverage are increasing, on average, as employers look for ways to reduce premiums. In addition, the percent of Americans covered by employer
sponsored health insurance has begun declining. This may be due either to employers’ decisions to stop offering health insurance benefits, or employees declining coverage available to them in response to higher employee shares of premiums and cost-sharing measures which make the policies less attractive.

From a social perspective, these trends are adding to the strain already present in the U.S. health care system. The U.S. is the only industrialized country that does not ensure universal health coverage of its citizens. Rather, the U.S. has focused on private market provision of health care services, although the government has actively regulated health care providers and health insurers alike. The U.S. government also provides coverage directly for vulnerable populations through the Medicaid and Medicare programs (and others), though this does not guarantee coverage for everyone.

While our market-driven system leaves some individuals uninsured and is less able to control costs, compared with other countries, it does offer some advantages. For those with insurance, or the financial resources to pay for care directly, it is fairly easy to seek care, compared to other countries where patients often have to wait longer to see a doctor or receive specialized care. Our market-driven system is also better suited to encouraging the development of new technologies which improve the quality of care.

However, our current system is being strained by rising health care costs. Our current system relies heavily on the fact that the majority of non-elderly Americans receive health insurance benefits through their employer, or the employer of a family member. However, outside of the state of Hawaii, there is no requirement for employers to provide health insurance benefits. For firms that do not offer health insurance, there is no guarantee that workers and their family members will have access to affordable health insurance elsewhere. In 2001, 62.6 percent of the population had employer-sponsored health insurance, 8.3 percent had other private insurance, 25.3 percent had public health insurance, and 14.6 percent of the population were uninsured (U.S. Census Bureau, 2002)\(^3\). Even though recent legislation has broadened the availability of public health insurance for vulnerable populations, the number with employer sponsored health insurance is falling and the number of uninsured Americans is slowly rising.

As policy makers continue to address the growing number of uninsured Americans, it may become more and more difficult to assume that the majority of workers will continue to hold employer sponsored health insurance policies. Thus, we may have to look at more radical changes than simply expanding existing public health insurance programs. Politically, there has been little momentum for a national health care system, due to problems observed in other countries’ systems and failure of the Clinton administration in putting such a system in place. Recently, there has been increasing momentum toward national health care as candidates prepare for the 2004 presidential election. However, it is still too early to tell if the proposals will gain sufficient support.
Table 1: Annual Percentage Change Per Capita in Health Care Spending and Gross Domestic Product (GDP), 1998-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>All Services</th>
<th>Hospital Inpatient</th>
<th>Hospital Outpatient</th>
<th>Physician</th>
<th>Rx Drugs</th>
<th>Nominal GDP</th>
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<tbody>
<tr>
<td>1998</td>
<td>5.3%</td>
<td>-0.2%</td>
<td>7.5%</td>
<td>4.7%</td>
<td>14.1%</td>
<td>4.3%</td>
</tr>
<tr>
<td>1999</td>
<td>7.1</td>
<td>1.6</td>
<td>10.2</td>
<td>5.0</td>
<td>18.4</td>
<td>4.4</td>
</tr>
<tr>
<td>2000</td>
<td>7.8</td>
<td>2.5</td>
<td>11.5</td>
<td>6.3</td>
<td>14.5</td>
<td>4.8</td>
</tr>
<tr>
<td>2001</td>
<td>10.0</td>
<td>7.1</td>
<td>16.3</td>
<td>6.7</td>
<td>13.8</td>
<td>1.7</td>
</tr>
<tr>
<td>2002</td>
<td>9.6</td>
<td>6.8</td>
<td>14.6</td>
<td>6.5</td>
<td>13.2</td>
<td>2.7</td>
</tr>
</tbody>
</table>

All figures come from Strunk and Ginsberg, 2003.

1 See Henderson, 2002, pages 218-220 for a thorough review of the literature regarding differences between managed care and traditional insurance.
2 It should be noted that current tax code does allow a partial deduction for health insurance premiums for many individuals.
3 Numbers add to more than 100% due to the fact that some respondents reported more than one source of insurance during the year.