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Employer Perspectives on Health Insurance and the US Healthcare System

Key Takeaways:

- Approximately 152 million non-elderly individuals in the US are covered by employer-sponsored insurance plans – almost double that of Medicaid, the next largest source of healthcare coverage.
- Many employers are opting to take on financial risk for their own employees in order to achieve more flexibility in benefit design. Insurers and Third Party Administrators are limited to administrative roles with limited profits.
- While some cost control strategies have led to more limited growth of healthcare costs, the majority of those savings are not passed on to employees, whose wages have remained stagnant while healthcare costs have risen.
- Large employers are looking into innovative approaches and pilot programs that could better control costs in the long term.

Introduction

The majority of Americans, 56 percent of the population, receive their health insurance through employers. Despite this, the role of employers as a key player in the healthcare sector is not well understood. Employers serve as both purchasers and influencers of health insurance and care delivery in the US, touching on issues such as purchasing, pharmaceutical rebates, quality measures, employee wellness and social determinants of health, and the outlook on a potential shift toward single-payer health insurance. Most employers aren't at all active or innovative in healthcare, with the exception of large employers, who themselves are limited in their opportunity to influence the broader system because they have relatively small employee populations that often are geographically dispersed. Employers often chafe against high healthcare costs they usually feel that they must offer attractive benefits in order to recruit and retain employees, being far more interested and expert in whatever business drives their profits than in employee healthcare expenditures. However, there are trends and examples of employer innovation.

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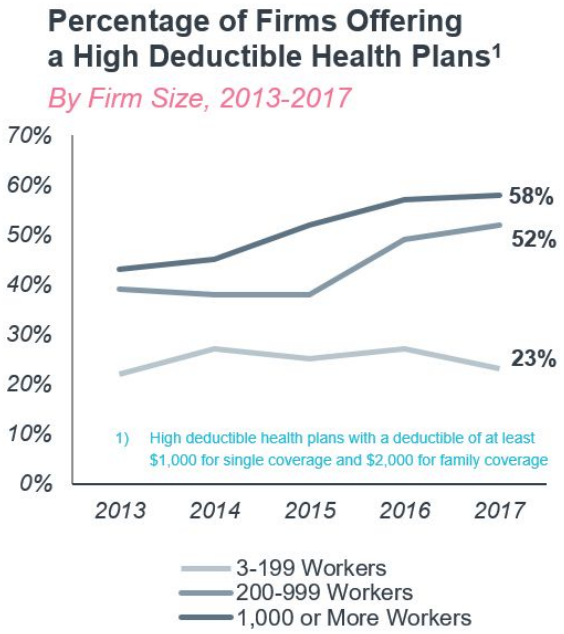
History and Context

The employer-sponsored health insurance model emerged post-WWII as an alternative means for businesses to offer attractive compensation packages to a newly expanded labor force. While wage freeze regulations prevented employers from offering salary increases outright, health insurance became a key incentive and also provided employers with the added benefit of tax subsidies for eligible costs. Currently, approximately 152 million non-elderly individuals in the US are covered by employer-sponsored insurance plans – almost double that of the next largest form of healthcare coverage (Medicaid, with approximately 70 million beneficiaries).

The Evolving Landscape of Employer-Sponsored Health Insurance

While employer-sponsored insurance remains a core form of coverage for majority of Americans, there have been substantial changes in the way that benefit design and plan offerings are structured. Key points to note:

- Many employers are opting to take on financial risk for their own employees: according to the Kaiser Family Foundation 2018 Employer Health Benefits Survey, 61 percent of covered workers, including 13 of covered workers in small firms and 81 in large firms, were enrolled in plans that are either partially or completely self-funded last year. This limits the insurer/Third Party Administrator to an administrative-only role and limits its profits, while providing the employer the ability to develop more tailored benefit designs for its employees.



- Self-insured employers, particularly smaller firms, often purchase a separate stop-loss coverage (also known as "reinsurance") from insurers in order to protect against extremely large losses
- The number of employer-sponsored high-deductible health plans (HDHPs) has increased dramatically over the past 10 years.
- Over the past five years, the average annual deductible among all covered workers has increased 53 percent (KFF)
- Additionally, many individuals that have employer-sponsored coverage have such high cost-sharing that they are effectively classified as “underinsured”
- Large employers also face the added challenge of having to negotiate across multiple regional provider and payer systems, which creates variability in structure and makes it more difficult to estimate and manage exposure

Cost Control

Health insurance continues to be a key cost driver for employer budgets, particularly for large firms (100+ beneficiaries). On average, employers are paying roughly 80 percent of the total annual coverage costs for employees. Employers are looking to payers, PBMs and other entities, including employee benefits consultants, to help develop plans that are more cost-efficient. In order to compete for business, insurers have developed a number of cost-reduction strategies as part of their plan offerings. Some include:

- Network-narrowing/high-performance networks
- High-deductible or catastrophic care plans
- Site-of-care management and telemedicine
- Formulary control and utilization management (i.e. prior authorization)
- Copay accumulator and maximizer programs
- Population health strategies focused on Medicare STAR/NCQA measures
- Direct contracting with providers

While some of these strategies have led to more controlled growth in healthcare costs over the last few years, majority of those savings are not passed on to employees. In the

meantime, wage increases have remained relatively flat. This fundamentally means that a greater percentage of paychecks are going towards healthcare costs.

New Approaches to Employee Benefit Design

While some cost control strategies operate under the traditional managed care framework, some large employers are looking to value-based approaches to control cost in the long term. Many organizations, namely certain large self-insured players such as Boeing and Walmart, have piloted population health and preventative care programs designed to reduce total healthcare cost as well as cost related to lost productivity/absenteeism. These include coverage for retail clinics and urgent care settings, access to nutritionists and lifestyle education, and medication adherence and patient education programs.

The role of the employer in designing and administering employee health benefits has been brought into the spotlight in the last year, particularly due to the announcement of the Amazon/JPM/Berkshire Hathaway venture. This venture integrated the roughly 1.2 million employees of these three large groups into one risk pool. Led by noted healthcare writer Atul Gawande, the new organization intends to fully manage health benefits for these individuals. Services may range from determining what types of coverage will be included in plan offerings and negotiating rates for services to managing risk for covered employees. This approach will attempt to address rising healthcare costs by focusing on three key areas: administrative costs, high prices, and improper health-care usage. While it remains to be seen exactly how the new entity will address some of the primary issues that large employers face when stepping into the role of managed care organizations, a drastically innovative approach may yield scalable and efficient solutions that can translate across the industry as a whole.

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Case Study: Intensive Outpatient Care Program: A Care Model for the Medically Complex Piloted by Employers

Key Feature :Multidisciplinary team-based approach to addressing patients' medical, behavioral, and social needs. At the heart of the Intensive Outpatient Care Program (IOCP) is the care coordinator, who links patients to primary, specialty, and ancillary services; provides tools for effective self-management; guides participants through development of a shared action plan; and provides connections to behavioral, psychosocial, and community services.

Target Population: Medically complex patients at high risk for hospitalization. Risk factors considered include recent hospitalizations or emergency department use, three or more chronic conditions, eight or more medications, and demonstrated fragmentation of care. IOCP participants also are directly referred from primary care physicians or transferred from existing care management programs.

Why it's important: The model has been tested and proven in three populations: the commercially insured (employer-sponsored coverage), Medicare beneficiaries, and Medicaid enrollees.

Benefits: IOCP data in commercial populations show up to a 20 percent reduction in per member, per month spending for medically complex patients. External analysis of a two-year federally funded IOCP study showed improvements in patient activation, mental health, and physical functioning.

Challenges: Receiving timely data from participating medical groups to produce a standard risk score, used to identify patients appropriate for IOCP. Recruiting patients requires going beyond conventional methods, such as phone calls and letters, in favor of face-to-face invitations by primary care physicians, which may include an introduction to an IOCP care coordinator.

From "Intensive Outpatient Care Program: A Care Model for the Medically Complex Piloted by Employers" by Kristof Stremikis, Clare Connors, and Emma Hoo writing for the Commonwealth Fund

Conclusion

Employers play a central role in America's healthcare system. While employer-sponsored insurance remains a core form of coverage for majority of Americans, there have been

substantial changes in the way that benefit design and plan offerings are structured. Many employers are opting to take on financial risk for their own employees in order to achieve more flexibility in benefit design. While some cost control strategies have led to more controlled growth overall healthcare costs, the majority of those savings are not passed on to employees, whose wages have remained steady while healthcare costs rise. Large employers are looking into innovative approaches and pilot problems that could control costs in the long term.

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