Business Solutions to the Health Care Crunch

Innovations in Health Care Insurance Plan Design

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This paper is a publication of the Health Care Initiatve, which is focused on Medicaid and Health Care budget busters, specifically the cost of Medicaid programs, and long-term care and insurance reforms, cost containment by providing ideas to help businesses, large and small, compete by reducing their health care costs, and tracking the progress of the landmark Massachusetts health care reform.

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Introduction

The Massachusetts health reform law has not fulfilled its promise for many small employers and their employees. As in the years before the 2006 reform, small employers on average, continue to pay higher premiums than mid-sized and large companies, and their premiums continue rising more quickly (after adjusting for variations in geography, demographics, and benefits).

While the state's Commonwealth Care subsidized program, has experienced 5 percent annual premium rate hikes, rates for small businesses have increased 15 percent per year over the past five years.[2] Small employers in Massachusetts have been hit particularly hard by these rapidly rising health care insurance premiums, and daily face the difficult decision of whether to continue sponsoring employee health benefits.

Some large employers have responded by implementing innovative insurance plan designs. Their goals are primarily to control costs and further engage their employees in health care decision-making, with the belief that greater consumer engagement in making decisions about purchasing insurance and consuming health services can lead to lower health care costs and spending. These plan design strategies include:

- moving from a defined benefit to a defined contribution strategy,
- restructuring cost sharing by adding a deductible,
- promoting the use of high-value and cost-effective providers and health services, and
- sponsoring a wellness program.

Small employers typically lag behind larger employers in implementing these strategies because they lack necessary in-house human resources expertise and up-front financial resources; they are burdened by numerous state mandates; and operating in a community-rated state, they have little financial incentive to manage their employees' health.[3] As costs continue to rise, however, smaller employers are seeking alternative approaches to financing and managing employee health benefits.

Business Solutions to the Health Care Crunch describes trends in employer-based health insurance plans that have the potential to contain escalating health care costs. It includes case studies of Massachusetts firms that have implemented innovative insurance plans and have experienced resulting reductions in health care spending growth as well as positive health effects.

- SmallCorp Frames (Greenfield, MA)
- EMC Corporation (Hopkinton, MA)
- Botanic Gardens Children's Center (Cambridge, MA)
- Anna Jaques Hospital (Newburyport, MA)

Business Solutions to the Health Care Crunch is meant to spark a dialog about existing actions that smaller businesses can take to maintain a healthy workforce and improve their bottom line.

Massachusetts' Governor Patrick and the General Court are currently debating a payment reform bill that, at best, will have a cost impact no

Table 1: Changes in Health Care Insurance for Employers Sized 2-50, 2001-2009[1]

	2001	2003	2005	2007	2009
Offer (%)	67.3	66.0	68.1	72.2	73.2
Individual premium per month ($)	254	312	365	418	442
Individual employer contribution (%)	86	80	79	76	73
Family premium per month ($)	650	819	950	1068	1194
Family employer contribution (%)	75	75	75	75	68

Source: DHCFP, Massachusetts Employer Surveys, Available on DHCFP Publications Website

sooner than 5-10 years from now. The complex discussions necessary to institute payment reform suggest that some forms of payment reform may in fact further distance health care consumers from important care decisions. Alternative payment methodology may one day induce providers to contain health care costs, but small businesses and consumers cannot wait that long. They need relief now.

The examples highlighted in this brief should encourage policymakers to take action to allow more flexibility for small employers and their employees to design more affordable health plans. Strategies to reduce health care costs for small businesses in the private sector are especially relevant given that 85 percent of the roughly 185,000 businesses in Massachusetts are small companies, which historically create two-thirds of all new jobs in the state.

Insurance Plan Design Elements

High-Deductible

Engaging Patients as Cost-Conscious Consumers

High-deductible plans offer flexibility and customizability while allowing employers to forego much of the responsibility and expense of managing employee health benefits.[5] In recent years, there has been a significant increase in the use of high-deductible plans by employers, both nationwide and in the Commonwealth. Massachusetts saw enrollment in these plans nearly double in one year from 50,000 in 2009 to 93,000 individuals in 2010.[4] Under a high-deductible plan, an employer purchases a benefit package with a minimum deductible of $1,200 (individual) and $2,400 (family). The employer and/or employee also may contribute to a Health Savings Account (HSA) or Health Reimbursement Account (HRA) that can be used to pay for some services before the deductible is met. To ensure that employees have the information and support necessary to purchase and manage their health benefits independently, this model often relies on Internet-based tools.

These plans have evolved to allow for preventive care to be covered outside the deductible. In addition, employers can customize their health spending accounts (HSA/HRA) and cover a specific set of services. For example, employers may designate "nondiscretionary" services–e.g., prescription drugs for chronic diseases, outpatient surgeries–and designate how these types of services are covered (with no deductible, at a set coinsurance rate, etc.). The extent to which employees "own" their health spending accounts can be customized, as well. Funds available at the end of a benefit year can roll over; employees can contribute to a "personal medical fund" established within the account; the account can be interest bearing; or upon leaving the plan, the employee can retain the balance.

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Strengths & Limitations

High-deductible plans have significant potential to make employees more aware of health care costs and to promote the development of user-friendly Internet-based health tools. As beneficiaries become more careful consumers, their utilization of health services decline, which will ultimately lead to reduced overall health care costs. Most studies conducted to date show at least a short-term reduction in health care utilization and spending under high-deductible plans compared to plans without a deductible.[6]

However, these plans may also present drawbacks. Beneficiaries may be unable to adequately evaluate and manage their health information, and developers of relevant technologies and tools

needed to support consumers have been slow to adapt to market changes.[7] Finally, employers in Massachusetts have been slow to adopt plans with a deductible. In 2009, only 43.1% of Massachusetts private-sector employers were enrolled in a plan with a deductible compared to 73.8% of employers nationally. Massachusetts residents enrolled in high deductible plans account for only 2 percent of those with health insurance, placing the Commonwealth with one of the lowest percentages of residents enrolled in these plans in the nation.[9] If the recent trends in enrollment in these plans continue, it is likely that more information and tools to assist consumers will become available, making these plans more attractive to employers and consumers alike.

As beneficiaries become more careful consumers, their utilization of health services will decline, which will ultimately lead to reduced overall health care costs.

Defined Contribution

401(k) Model for Health Insurance

One approach to controlling health care spending is the defined contribution model. The general concept of "defined contribution" is that an employer gives each employee a fixed dollar amount to purchase insurance rather than paying the cost of providing specified benefits (a "defined benefit"). This strategy has become more widespread in the area of retirement benefits where employers have moved from funding benefit-defined pensions to 401(k) contributions. From 1980 through 2008, the proportion of private wage and salary workers participating in only defined contribution pension plans increased from 8 percent to 31 percent.[10]

With health insurance, defined contribution models have primarily been used by larger employers who offer their employees several health plan options and typically contribute a percentage towards the least expensive plan. With such an arrangement, employees have a financial incentive to choose the lowest cost plan since they pay the difference in premiums for more expensive plans. Importantly, the employer fixes a dollar amount to contribute each year, and health insurance therefore becomes a much more predictable expense for the employer, with increases directly controlled by the employer.

In general, smaller employers have not adopted these plans because carriers require them to choose a single plan for their employees. Former Governor Romney's original vision for the Massachusetts Connector was to create a mechanism whereby a defined contribution model could be established for small employers. However, during the implementation of Massachusetts health reform, this strategy was abandoned by the staff and/or Board of the Connector.[11]

Under the federal health care reform law, the Massachusetts Connector could choose to implement a defined contribution model in a Small Business Health Option Programs (SHOP) exchange whereby an employer would contribute a defined amount into a tax-free Health Reimbursement Account, which the employee could use to buy an individual health insurance plan through the Connector. A defined contribution model could also work for small employers without the Connector's specific involvement. In this scenario, an intermediary like the Massachusetts Business Association or Small Business Servicing Bureau could help to facilitate the adoption of defined contribution plans by small employers in Massachusetts by providing the support and education that the employers and employees may require to move towards this arrangement. Of course, some small employers could choose to establish this model independently.

Strengths & Limitations

Advocates of defined contribution plans believe that this health benefit model may help to

reform some of the negative incentives that prevent transparency in the current health system.[12] As insurers face greater competition, the development of more creative and flexible plans will be essential to maintaining market share. Additionally, as the marketplace moves from group to individual insurance, providers will face increasing pressure to be more efficient and to improve access and convenience of health information and services.[13] Defined contribution plans also lend employers greater predictability in their sponsorship of health insurance and may potentially allow employers facing difficult economic circumstances to continue to offer health benefits.[14] Moreover, removing business owners from decisions related to their employees' health insurance is an important benefit of this approach. Each of these benefits marks a positive step toward containing rapidly rising health care spending.

Importantly, the employer fixes a dollar amount to contribute each year, and health insurance therefore becomes a much more predictable expense for the employer.

Currently, under Massachusetts law, employers with eleven or more full-time equivalent employees (FTEs) that do not make a "fair and reasonable" contribution toward the employers' "group health plan" are charged an annual per employee fee of $295 ($73.75 quarterly). An employer is considered to be offering a "fair and reasonable contribution" if 25% of full-time employees are enrolled in the employer's group plan or if the employer contributes at least 33% of each employee's individual premium. Employers with fifty or more employees must fulfill both tests unless 75% of employees are enrolled; at this level, the 33% contribution level does not apply. For many small employers offering a defined contribution towards health insurance may not constitute making a fair and reasonable contribution towards a group health plan. In such cases, the small employer would be subject to the penalty. Employers with fewer than 11 FTE's could consider a model like this and even with this limitation, it might make financial sense for employers with more than 11 FTEs to move from a defined benefit to a defined contribution.

Under the Patient Protection and Affordable Care Act (PPACA) employers with fewer than fifty employees are exempt from any penalty; for these employers, a defined contribution model could work well. It is not clear yet how Massachusetts will adapt to the PPACA provisions regarding penalties for employers. However, maintaining a state penalty in addition to the federal penalty would likely be a difficult position for policymakers to defend and may drive small employers out of the state.

[D]efined contribution plans…help to reform some of the negative incentives that prevent transparency in the current health system.

Health and Wellness Incentives

Rewarding Healthy Living

Health and wellness initiatives are an increasingly popular strategy for larger employers, particularly those that are self-insured. The Kaiser Family Foundation found that 74% of firms that offer health benefits also offer one or more employee wellness programs, and 48% of firms that offer health benefits also offer wellness programs to employees' spouses and families.[15] Wellness programs aim to engage employees in healthy behaviors in order to promote health, encourage reduced health services utilization, and lower health care spending. Health and wellness features can enhance health benefits plans in many ways; they may include economic incentives for employees who maintain or improve health or participate in lifestyle and chronic disease programs. Also, employers may offer a variety of

health services not traditionally included in the employee benefit plan.

Employers may offer a Health Risk Assessment to acquire employee-generated data indicating the health needs and interests of their workforce. Human resources or management can then use this data to institute population-specific health and wellness initiatives, create effective target incentives, and optimize employee engagement.

Typical wellness programs and services include weight loss/control, exercise and fitness training, smoking cessation, substance abuse counseling, personal health coaching, nutrition education, stress management, and accident prevention training. Many firms also provide web-based health resources, produce a wellness newsletter, and provide discounted gym memberships or access to on-site exercise facilities.

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There are numerous ways to customize an employee wellness program, depending on the work environment and the specific needs and interests of the workforce. Some employers customize their health and wellness programs by incorporating economic incentives. They may link incentives to participation in the Health Risk Assessment, to enrollment in a chronic disease management program, or as additional employer contributions to an employee's Health Savings Account for meeting certain health benchmarks. A 2010 Kaiser Family Foundation survey found a 14% increase in participation in employee wellness programs when an incentive to enroll was offered.[16]

In Massachusetts, small employers have had their insurance rates subjected to a modified community-rating[17] since the mid-1990s, and have thus had fewer financial incentives to offer wellness programs. That is, even if an employer decreases the utilization of health services by its employees through wellness programs, that employer does not receive lower premiums. However, under the PPACA, the federal government proposes to provide assistance to smaller employers (<100 employees) to promote wellness and workplace health programs.[18] To be eligible for an award, an employer's wellness program must be rooted in evidence-based best practices and include health education and awareness initiatives, efforts to promote employee engagement in the program, unhealthy behavior interventions (e.g., counseling, health coaching, self-help materials), and workplace policies that support the wellness program. As wellness programs can reduce employers' health care costs and engage employees in health and workplace improvement, this support may provide some relief for small employers. In addition, the Public Health Service Act was amended by the PPACA to allow employers to offer larger employee discounts to employees who achieve positive changes in their health status.[19]

Strengths & Limitations

Wellness programs may generate cost savings for employers, particularly when they include chronic illness prevention and management programs. Health plan enrollees with high health risks (for heart disease, stroke, etc.) consume as much as 25-30% of employers' annual health insurance costs.[20] Prevention and management programs for chronic diseases can promote regular blood pressure and cholesterol screening, encourage drug compliance, and support lifestyle and behavior changes to improve employees' health. In addition, health and wellness initiatives and incentives also have a positive impact on the work environment, demonstrated by increased productivity and greater reported job satisfaction.[21]

A 2009 study by Medco indicates that nearly 60% of employers that offer health insurance cite

wellness programs as the single most important factor in containing health care costs.[22] A review of thirty-two studies of large employer wellness programs found remarkable savings: overall claims costs were reduced by 27.8%; physician office visits declined 16.5%; hospital admissions decreased by 62.5%; disability costs were reduced by 34.4%; and the incidence of injury declined by 24.8%.[23] Furthermore, a meta-analysis of the employee wellness program literature found that medical costs decline by approximately $3.27 for each $1 spent on health and wellness programs,[24] and the cost of absenteeism declines by about $2.73 for $1 spent on employee wellness programs.[25] Studies also indicate that employers' return on investment is recognizable within one to two years of program implementation and optimal savings can be achieved in the program's third or fourth year.[26]

[M]edical costs decline by approximately $3.27 for each $1 spent on health and wellness programs, and the cost of absenteeism declines by about $2.73 for $1 spent on employee wellness programs.

However, up-front employer investment is necessary to implement wellness programs, and some ongoing investment may be required to promote and evaluate the program. Employers may not see a return on their investment if, for instance, the firm has high turnover rates or if it employs individuals who work remotely or on a part-time basis. Moreover, there is potential for under-enrollment in a wellness program if it is not sufficiently promoted or relevant to employees' needs and interests. Though there is a lot of potential for savings through employee wellness programs, their success is dependent on employer and employee engagement.

Value-Based Insurance

Changing Behavior with Copays

Research indicates that as patients' copayments increase, drug compliance declines, and conversely as patients' copayments decline, drug compliance increases.[27] Value-based insurance incentivizes high-value medical interventions that have the potential to improve health and reduce health care spending. Value-based insurance design also starts to address the fundamental moral hazard of health insurance: those who are insured tend to use more health services because they do not pay for those services and are, in general, not aware of the true cost of most health care services.

Value-based insurance designs structure cost sharing and coverage levels to incentivize treatments and interventions that are effective and discourage inefficient, ineffective, or discretionary treatments. This approach motivates compliance, rewards efficient provider networks, and engages beneficiaries in health care decision-making.

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Value-based insurance design can be very influential in promoting chronic disease management and prevention. For instance, copayment tiers for prescription drugs are a widely used form of value-based benefit design. By linking prescription drug copayment levels to the value of a given treatment, entire classes of prescription drugs--e.g., statins to manage cholesterol--can be set at reduced copayment levels to encourage their use. Statins are a high-value therapy for managing cholesterol, so

although on an individual level, patients may benefit more or less from the therapy, limiting the out-of-pocket expense for all patients in need of the drug can promote compliance and reduce overall adverse health events. Value-based insurance designs may also include financial incentives for enrollees who participate in high-value wellness programs and chronic disease prevention and management programs.

Similarly, a plan may increase or decrease copayment levels, depending on the benefit of a particular treatment for a patient with a specific health profile (e.g., certain medications for an individual at risk for cardiovascular disease). Though this approach is not as efficient as setting copayments for therapeutic classes, the patient-specific strategy may ultimately lead patients and providers to be more sensitive to the costs and benefits of an intervention.[28]

Strengths & Limitations

Across the U.S., health plans and employers that have implemented value-based health benefit strategies have achieved impressive savings. For instance, Gulfstream Aerospace Corporation (Savannah, Georgia) eliminated employee copayments for flu shots and offered incentives for generic drug use aimed at improving chronic disease management. As a result, the company's pharmaceutical costs declined significantly, and the company saw a 98.4% generic drug substitution rate.[29] Pitney Bowes (Stamford, Connecticut) reduced prescription copayments for generic and high-value therapies for diabetes, hypertension and asthma. The manufacturer's strategy resulted in a 26% decline in emergency room visits, greater adherence to statins among employees, and slower health care costs growth compared to other similar companies.[30] Pitney Bowes's value-based strategies were particularly effective among diabetics, who enjoyed a 35% decline in emergency room visits. Colorado Springs, Colorado School District 11 applied a value-based insurance design by targeting five common surgeries and providing an incentive to employees to opt for laparoscopic surgery when open surgery was not necessary. Through this single adjustment to its employee health benefits, School District 11 saved over $1 million in hospital and surgical expenses.[31] Value-based insurance designs are gaining a lot of ground; the human resources consulting firm Mercer, conducted a survey which found that 81% of large employers (>10,000 employees) are interested in using value-based insurance in the near future.[32]

However, value-based insurance designs pose challenges to employers. For instance, if negative incentives (e.g. higher copayment for low-value treatment) are not paired with positive incentives, employees may simply view the benefit design as a further reduction in coverage. Similarly, the interventions and treatments that are determined to be high-value are often outside of the employer's domain, making the negative and positive incentives potentially misaligned with the values and perceived health needs of plan enrollees. Addressing these potential issues and ensuring employee confidence in a value-based benefit design may require employers to spend additional time and resources promoting and administering the plan. Moreover, patients tend to trust their physicians' views and the advice of family and friends when making health care decisions. Thus a high-value benefit design may be less effective at reining in health care spending if social, cultural, and clinical trends are not reflected in a plan's incentive structure. Historically, these plans have not been offered to small employers, although Blue Cross & Blue Shield of Rhode Island recently introduced a product for small employers; these products may be more widely offered in the future.[33]

Tiered Networks

Linking Access to Providers to Cost and Quality

Tiered provider networks are designed to contain costs by structuring copayment levels to incentivize patients to visit high-value providers. "High-value provider" is defined differently by various plans, but generally includes a

combination of quality assurance and cost-saving measures. Plans most often select physicians—generally specialists—to form high-performance networks, although depending on the market, hospitals are sometimes used. Decisions about which providers to target for inclusion in a tiered network depend on which providers represent significant variation in costs and quality, generate sufficient claims volume to assess the provider's quality and efficiency, and have established quality measures and/or guidelines to benchmark performance.

Measures of quality may include selected measures from the Health Plan Employer Data and Information Set (HEDIS), the Agency for Healthcare Research and Quality, and specialty society best practices. Measures of cost or efficiency could include price per service, elimination or reduction in the use of health services that have little benefit (such as routine imaging versus selective imaging for reported back pain). Measures for cost and efficiency could include simply the negotiated cost per service or visit, or they may be a more complex algorithm involving episodes of care which are assigned to a responsible provider and billed total costs of care associated with an enrollee, including costs for inpatient and outpatient facilities and prescription drugs.

Strengths & Limitations

By linking a lower copayment to high-value providers, health plan sponsors can support providers that have demonstrated a commitment to efficient, effective high-value health care. Promoting efficiency within the benefit plan's provider network can reduce claims, cut employers' costs, and decrease overall health care spending. These methods also encourage both providers and patients to utilize evidence-based medicine and high-value clinical interventions such as primary care and preventative services.

Tiered provider networks are becoming more popular in the Massachusetts marketplace. The Group Insurance Commission started this trend in 2006 with state and municipal health care. Carriers in Massachusetts have begun to offer tiered network plans and have reported an upsurge in the appeal of these plans.[34] Although employees expect unfettered choice with no cost consequences in the Massachusetts marketplace, as more and more employers select these plans, employees will begin to realize that their health provider choices do affect cost.

By linking a lower copayment to high-value providers, health plan sponsors can support providers that have demonstrated a commitment to efficient, effective high-value health care.

In the Massachusetts marketplace, historically, it has been difficult to move employees to limited network plans. Some employees may be unwilling to accept employer involvement in their provider options. Reminiscent of the managed care era, any effort by carriers to restrict patient choice is often met with resistance. Tiered networks, however, allow employees to maintain relationships with their providers. This approach will undoubtedly require some additional employee education about how these tiered networks work, and how they can lead to a more efficient health care system, but they may require employee participation incentives.

Massachusetts Employers: Case Studies

SmallCorp Frames (Greenfield, MA)

Utilizing a Deductible

Company Size: <50
Insured Status: Fully Insured

For many small firms, after salaries, employee health benefits are the greatest expense in their budgets. Increasing health care premiums often require small companies to reduce or discontinue employee health coverage to remain viable. SmallCorp Frames, a custom frame and museum case manufacturing company, is one example of this trend. Since founding their company in 1972, Molly and Van Wood have offered health insurance to their employees. As small business owners, they believed that offering health insurance would allow them to retain the highly skilled employees they needed to build first-rate custom products. In 2010, however, SmallCorp's insurance company – in response to rapidly rising health care costs – raised the company's premiums by 30%. Ms. Wood estimated that the premium increase would result in an additional $85,000 a year in health insurance expenses, a price that the small company could not afford. The company faced a difficult dilemma: it could cut employee health benefits, or continue to offer health insurance using a revised benefits package.

The Woods now offer a new benefits plan in which employees' co-pay levels remain the same but employees carry a deductible of $500 per person per insurance year. The plan also limits benefits; some particularly costly services (such as CT scans or ultrasound) are no longer covered.

Though this approach shifts health care costs to SmallCorp employees, the Woods have been able to continue to offer their employees health coverage and retain the highly skilled employees on which the company depends.

EMC Corporation (Hopkinton, MA)

Wellness Programs and Health IT -
Driving Partnership in Health

Company Size: 48,500
Insured Status: Self-Insured

EMC Corporation began exploring employee health benefit innovations in 2002 after the company assessed health care expenditures and found that its 15% annual health insurance price increases could double the cost of benefits within five years. The primary goals of EMC's innovative policy, Driving Partnership in Health, are to cut insurance costs by reducing disease risk, and encourage best practices treatment for existing diagnoses. To achieve these goals, Driving Partnership in Health actively engages employees and their families in health improvement and encourages a conservative use of health services.

As a leading information technology developer, EMC is well equipped to incorporate cutting-edge technologies into its plan design. For example, the company is the first company worldwide to offer an electronic Personal Health Record (PHR) system. The PHR automatically updates personal medical information and clinical data, allowing employees to actively manage their health and health services. New technologies and information sharing form the basis of HealthLink, EMC's online Personal Health Manager. The system can be accessed any time, from home or work, and provides targeted health messages and health alerts. Additionally, EMC offers

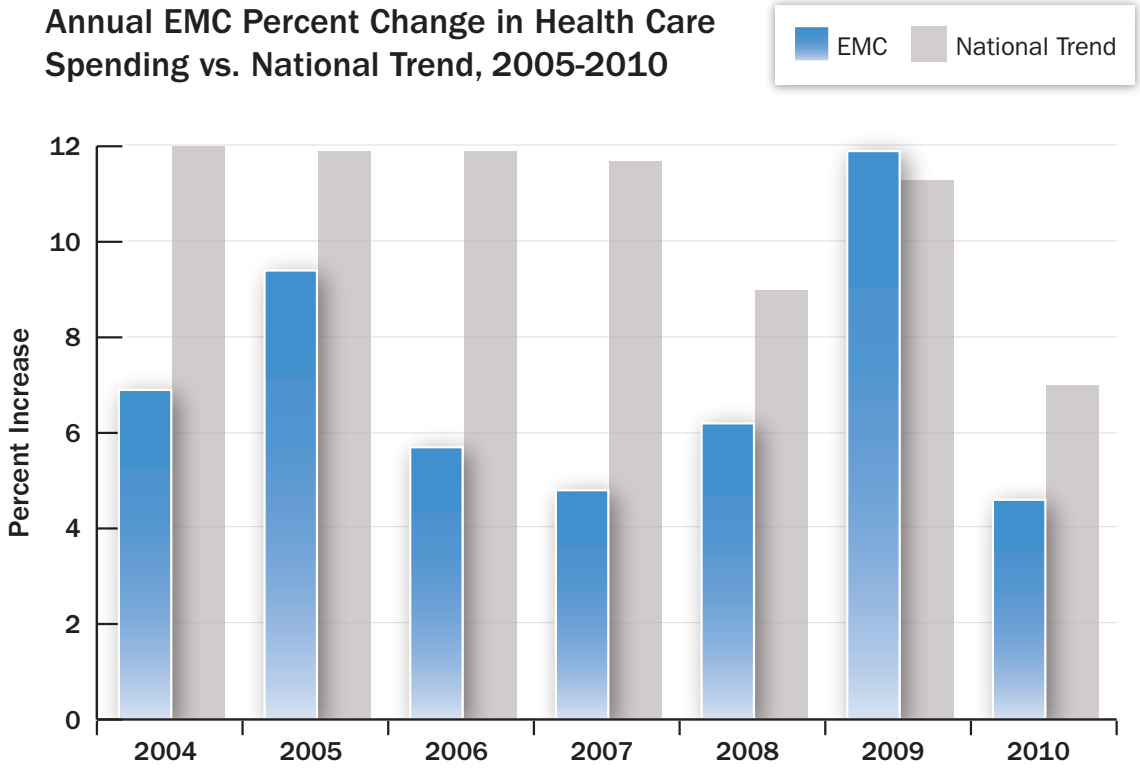
employees a premium incentive to complete a Health Risk Assessment each year. The confidential data gathered from the PHRs, HealthLink and the Health Risk Assessment (which has a 90% completion rate), allows EMC to engage employees effectively in health management and efficiently target health initiatives and programs.

Armed with employee health data, EMC has initiated a variety of health programs targeted to its employees' specific health concerns, including hypertension, diabetes, asthma, and childhood obesity. The Live Healthy Medical Program provides customized health support for employees and their families who are at risk for or living with a chronic illness. EMC has also initiated health programs that employ strategic partnerships such as Dietary Approach to Stopping Hypertension (DASH), a study led by Boston University School of Public Health, in which employees were invited to participate. In addition to reduced annual health care costs for participants at cardiovascular risk, DASH participants experienced improved diastolic blood pressure. Similarly, EMC joined with Partners Healthcare's Center for Connected Health to include 402 employees in SmartBeat, a six-month clinical trial of a health-monitoring program combining a wireless blood pressure cuff and an online blood pressure self-management system. SmartBeat results indicated significant improvements in systolic and diastolic blood pressure for the intervention group.

In addition to incorporating new health technologies into its benefit structure, EMC has also provided a variety of innovative health programs including onsite fitness facilities, a travel immunization and health program, and health management seminars based on employees' indicated or requested health topics and interests. EMC's innovative connected health technologies and targeted health programs have yielded approximately $112M in savings over five years. And EMC enjoys more than cost savings: employees report high levels of job satisfaction as well as high levels of trust and reliance on HealthLink and EMC for health information and support.

EMC is a large employer that has the resources to implement robust wellness programs, but it serves as a model for smaller employers.

Annual EMC Percent Change in Health Care Spending vs. National Trend, 2005-2010



Source: Data Provided by EMC

Botanic Gardens Children's Center (Cambridge, MA)

Revised Benefit Plan

Company Size: <50
Insured Status: Fully Insured

For Botanic Gardens Children's Center, which employs roughly twenty-two teachers and staff members, the cost of sponsoring employee health insurance has been a significant burden. Facing further premium increases, the Cambridge-based non-profit revised its benefits structure.

The new plan's features include an employer-funded Health Reimbursement Account (HRA) and a high-deductible plan ($1,500 for individual or $3,000 for family coverage). The Children's Center's contribution to the HRA covers the cost of services until the deductible is met. Once the deductible is met, however, the health plan covers any additional costs.

Additionally, there is no cost sharing required of employees for routine and preventative tests and procedures (including mammograms and routine prenatal care). Selected consultations and exams are subject to a $20 copayment, and more complex and costly health services--e.g., diagnostic procedures, treatments, emergency services and hospitalizations--are subject to the employees' deductible.

With this new plan, employees are able to use the same provider network as with their prior health plan. Also, employees do not have to pay for health services up front and later request reimbursement. The employer's insurance carrier bills the Children's Center's HRA directly and sends employees an Explanation of Benefits statement.

Before implementing its new plan in October 2010, the Children's Center director met with employees to explain the coverage changes. To ensure a smooth transition to the new health plan, employees received informational materials, as well as formal and informal support from the Children's Center staff and the health plan. Children's Center will also conduct an annual review to assess the cost savings and gauge employee satisfaction, beginning with the first review this fall. So far, the new plan has been well received by employees and the Children's Center anticipates it will create significant savings. Not only are premiums less costly, but the Children's Center is also protected against the cost of potential acute or catastrophic employee health needs that may surpass the deductible. By revising its approach to sponsoring employee health insurance, the Children's Center has greater flexibility to finance improvements to the services it provides and to its employee benefits.

Anna Jaques Hospital (Newburyport, Massachusetts)

HSA Saver Plan

Company Size: 1,000
Insured Status: Fully Insured

Between 2002 and 2007, Anna Jaques Hospital's (AJH) employee health insurance premiums increased an average of 15.2% each year. Facing the unsustainable cost of premiums, AJH implemented the HSA Saver Plan, a new health benefits package that focuses on reducing expenses by promoting healthy lifestyles and increasing employee engagement in health care choices.

The HSA Saver Plan offers a high deductible health plan (individual $1,200 and family $2,400 per plan year) paired with a Health Savings Account (HSA). AJH makes a core contribution to the HSA of $250 for an individual and $500 for two-person or family coverage. Employees have opportunities to qualify for additional contributions by meeting standards for one to four designated health measures: blood pressure, cholesterol, body mass index, and nicotine use. For each health measure met, AJH contributes another $250 toward individual coverage or $500 for two-person or family coverage up to a maximum contribution of $1,000 for an individual and $2,000 for two-person or family coverage each year. Employees who do not meet one or more of the health measures during the annual screenings held in August and September have another chance to meet the health benchmarks in March and may earn additional contributions for making progress toward the health measure.

AJH offers employees a choice between the HSA Saver Plan and a traditional HMO plan. Both plans offer the same coverage within the same provider network. The HSA Saver Plan, however, has added components of coverage for out-of-network services, 100% coverage of in- and out-patient services after the annual deductible is met and the ability to select a healthcare provider without a referral from a primary care physician. Employees enrolled in the HSA Saver Plan have payroll contributions that are 40% less than the alternative HMO option (annual payroll contribution savings are $850 for individual coverage, $1,638 for two-person coverage and $2,537 for family coverage). In addition, the employee owns the HSA; the balance can roll over from year to year and remains available to the employee indefinitely, even after termination or retirement from AJH.

By incorporating lifestyle and health incentives, AJH has effectively engaged employees in health insurance choices, promoted healthy lifestyles and rewarded those who meet and make progress toward health benchmarks. Since 2007, AJH's premium growth has declined by almost 10%. The hospital may also see future savings, as 42% of eligible employees have chosen the HSA Saver Plan over the traditional HMO and the plan has a 99% retention rate. AJH's innovative approach to reducing health insurance claims and premiums has allowed the hospital to continue to offer its employees a competitive benefits package that it and its employees can afford.

Conclusion

While larger employers have engaged their employees in wellness initiatives and consumer-driven approaches, small employers have often lagged behind. Small businesses can, however, adopt these health benefit approaches to address their own rising health care costs. For small employers who wish to maintain ownership of their employees' health plans, a worksite wellness initiative may be advantageous. For employers seeking to provide their employees with greater choice and ownership of their health care decisions, moving towards a defined-contribution model or high-deductible plan may be a good choice. While there is no single approach that small employers can or should take, there are a variety of benefit plan options and innovations that can allow employers to reduce their current health care costs and gain greater control over their health care spending in the future.

**Disclosure: The CEO of Anna Jaques Hospital and the Senior Director of Benefits at EMC Corporation both sit on Pioneer Institute's Health Care Advisory Board.*

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About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.

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The survey is self reported by employers, so results may be over reported or underreported.

2. See Julie M. Donnelly, "Express Delivery: Connector Unveils Health Insurance," *Boston Business Journal*, March 12, 2010, at http://boston.bizjournals.com/boston/stories/2010/03/15/story4.html (August 4, 2010).

3. In the mid-1990s Massachusetts implemented changes to its small group law requiring insurers to offer insurance to all companies (guaranteed issue), and instituting a modified community rating system that excluded underwriting (charging firms with sicker employees more) and restricted rating to certain factors including age, geographic location, type of business, participation rates, and size for firms with 50 or fewer employees. While these reforms certainly helped businesses with difficult-to-insure employees, these rating systems also create an environment whereby employers are left with few incentives to improve employee health or reduce costly, unnecessary utilization.

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