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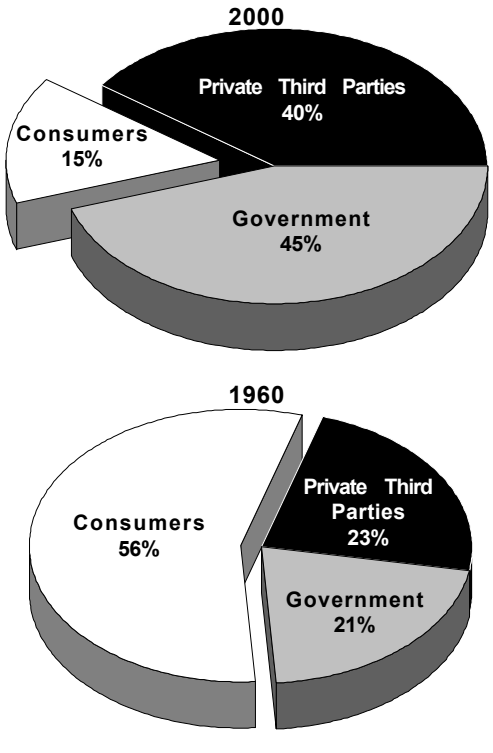
Increasing Consumer Choice in Health Care: Five Steps Employers Can Take Now

by Greg Scandlen

The essential problem in our health care system is that consumers are divorced from the cost of the services they consume. We have become so dependent on third-party payment that patients pay directly for only about 15 percent of total health care services, down from 56 percent in 1960. Eighty-five percent of health care is now paid for by third-parties — insurance companies, the government or employers. [See the Figure.]



Source: Office of the Actuary, Health Care Financing Administration.

Moreover, the 15 percent paid directly by consumers is at the margins of the health care system — alternative medicine, over-the-counter medications, vision and dental care and cosmetic surgery. Costs have not risen much for these types of care because consumers are careful in how they spend their money; they have been far more successful than third-party payers in holding down cost increases.

Beyond Managed Care. For a few years, employers used managed care successfully to hold down costs. However, the consumer backlash against bureaucratic restrictions on care led employers to largely abandon "gatekeepers" and preapprovals for hospital admissions and expensive diagnostic tests. Employers now realize that the only sensible strategy to control costs is to rely on consumers to balance cost against value. Consumers are willing to spend money on things that are important to them, but they resist spending on things that are of marginal value. That is, they resist *provided* they know what the cost is and that they will bear it directly.

Some employers would like to get out of health care altogether. It is not something they know much about, it is complicated and, because the regulations that govern it are ever-changing, it is a very difficult way to compensate workers.

Other employers are willing to continue providing health benefits but would like to infuse their programs with more consumerism. This is easier said than done, however. Employers have relied on managed care and other external controls to hold down costs and utilization. Now that all those techniques have largely failed, employers are not sure what to do next. How do they restore consumer sensitivity in a system that has all but eliminated it? Do they have to go to Congress for new legislation?

The short answer is "No," at least not yet. Under current law, employers can take many actions to restore consumers' awareness of cost and empower them to make decisions. Here are five of them.

1. Let employees know what health care costs. Put the information on pay stubs and provide annual summaries. Make sure Explanations of Benefits (EOBs) include cost information. In most companies today, employees don't have a clue what their health benefits actually cost until they leave the job and have to pay COBRA premiums to continue coverage for a time (under the Comprehensive Omnibus Budget Reconciliation Act). To restore consumerism, at a minimum, consumers must know how much

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employers are spending on their behalf. If employees complain that the cost is too high, employers can begin a dialogue with them about health care costs.

2. Allow Cash-Outs. Workers should be allowed to opt out of health benefits if they believe the benefits are not valuable to them and they can obtain coverage elsewhere. Employers have an interest in making sure their workers have coverage — it reduces sick leave expenses and increases productivity. But workers may find they can do better in the individual market, through an association health plan or under a spouse's health plan. Or both spouses may want to opt out of their employers' coverage to purchase their own policy — one that will stay with them regardless of their employment situation.

3. Eliminate Community Rating. Many employers are proud that they use community rating, charging each worker the same premium regardless of age or health status. But community rating works no better in a company than it does in the individual insurance market. Younger workers consume far less in health care services than do older workers, on the average. They cost the company less, and the company should want to keep them in the program. But because younger workers pay the same premium contribution as older workers, they are far more likely to decline workplace coverage. Thus, only 29 percent of 25-year-olds have employer-based coverage in their own names, compared to 56 percent of older workers. By adjusting the premium contribution for age, employers may find many fewer young workers declining coverage, which would bring better risks into the pool and lower average costs for the whole group. Cash-out allowances also should be adjusted for age, with younger workers getting a smaller amount than older workers.

4. Increase Employee Choice. Many employers are reducing the choices available to their workers in order to gain more leverage over health plan premiums. That is the wrong strategy. If employers provide a fixed contribution, rather than 100 percent coverage or a percentage of the premium, they will find employees choosing lower-cost plans voluntarily. Workers who prefer richer plans should be able to choose them, but at no extra cost to the company. Some insurers are developing programs that enable employers to make a fixed contribution but allow workers to choose from a variety of benefit packages, paying any extra premium through a tax-advantaged Section 125 premium conversion plan.

5. Increase Direct Pay. Enabling workers to pay directly for services rather than processing everything through an insurance mechanism should help instill cost sensitivity and lower administrative costs. Physicians and other health care providers are beginning to encourage cash-paying patients to avoid insurance bureaucracies and lower overhead costs. In some cases, they will charge cash-paying patients half of what they bill insurance companies for the same service.

There are many ways to structure direct pay programs — among them, Medical Savings Accounts (MSAs) for small employers, Personal Health Accounts (PHAs) for larger employers or shared-deductible programs for any employer. They usually involve raising deductibles and making the premium savings available to employees to pay directly for routine services. Typically, the premium savings will not fully cover the deductible in the first year; but if the employee is able to curtail spending, the money left over can be applied to the next year's deductible. In some cases the employer can structure the deductible so that certain valued services are covered on a first-dollar basis.

Conclusion. All of these programs encourage consumers to be thrifty users of health care services. All can have a significant impact on utilization and prices. They also enable employees to access the health care services they value most, rather than being confined to the benefits preferred by the employer or insurance company. This increased flexibility should reduce the impulse of Congress and the states to mandate coverage of specific benefits.

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