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What Makes a Winner?

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Capstone Research Project

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Introduction: What Makes A Winner?

Health insurance costs are one of many unremitting pressures on corporate profits, but the pressure is not suffered evenly throughout the market. Company A might get a 10 percent increase on health insurance rates year after year, while Company B could see a string of 20 percent increases. What is the difference between Company A and B in their methods for managing health insurance costs? Do they apply different resources? Does the differential application of resource have an impact?

Health insurance rate increases clearly vary among employers. In a study by Watson Wyatt[1], the lowest quartile of employers had an average health insurance rate increase in 2002 of 10.6%. The median rate increase was 14.7% and the 75th percentile was 18.0%. An employer has a valuable cost advantage when its health care costs are increasing much more slowly than its competitors'.

Unlike other business expenses, health insurance does not lend itself to many cost strategies that are within the company's direct control. Employers have lost confidence in their ability to manage health care costs at all. A mere 18 percent of employers surveyed stated they were "very confident" about managing health costs. Less than half

[1] "Creating A Sustainable Health Care Program: Eighth Annual Washington Business Group on Health/Watson Wyatt Survey Report," 2003

of the survey respondents were confident that their company would provide health benefits in 10 years. [2]

This attitude marks the end of an 8-year expansion of employer-provided health benefits. From 1993 to 2001, the percentage of workers offered health insurance and the percentage actually covered climbed steadily.[3] For at least part of this same time period, managed care kept health insurance premiums in check. But managed care began a steady decline and premiums resumed their steep climb by the late 1990s. As Alain Enthoven described it in a recent Health Affairs article, "Employers' efforts to control costs through the use of 'managed care' were *temporarily* successful in the 1990s." (emphasis added).[4]

The millennium found employers once again searching for new solutions. This qualitative study sought to discover what employers are doing now, and what differentiates a successful player, defined as an employer whose health insurance premiums grew more slowly than the overall market. The study also sought to explore if there is any association between the methods and premium cost increases.

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[2] Ibid.
[3] Fronstin, "Trends in Health Insurance Coverage: A Look at Early 2001 Data," Health Affairs Volume 21, No. 1
[4] Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" Health Affairs, Web Exclusive 2003

Background: Employer Strategies and Resources for Managing Health Insurance Costs

In the United States, health care expenditures per capita increased 69%, from 1990 to 2000.[5] Employers – whose health benefit plans cover the majority of working age people plus family members – bear much of the cost increases. Employers have the conflicting priorities of attracting workers (by offering a "good" health benefit plan) and maintaining profits (by keeping the health benefit plan costs as low as possible).

Historically, the health insurance market provided some product resources to employers in their effort to control health care costs. These are described below and summarized in Table I.

Managed Care: The 1980s brought managed care, which implemented new processes to control health care costs. One of the major elements of this strategy was the requirement imposed upon patients to consult a primary care physician for care or referrals to specialists. The "gatekeeper" model would reduce costs by having the primary care physician coordinate and manage access to more expensive treatments.

[5] Centers for Medicaid and Medicare Services, Office of the Actuary

Employers who wanted affordable health insurance turned to managed care plans for their workers. By 1995, managed care plans had enrolled 73 percent of all Americans who got their coverage through employer-based plans.[6]

During the late 1980s to the mid-1990s, health insurers competed for customers, keeping price increases relatively low. Employers nationwide reported an average rate increase in 1996 of 0.8%.[7]

Notwithstanding this success, consumer resistance to gatekeeper models increased by the mid 1990s and expressed itself in the popular press as well as state legislatures, which began imposing minimum access requirements on the industry. In response, new models, called Preferred Provider Organizations (PPOs) and Point of Service plans (POS), came out and gave consumers more flexibility but still managed care to some extent. PPOs and POS plans did not require the patient to consult a gatekeeper, although both gave some incentives (i.e. higher benefits) for using network providers and for getting care referrals.

Annual health insurance rate increases began climbing again in 1998 (See Exhibit I). Experts date the beginning of managed care's downfall to around this same time period. By 1998 – 99, with managed care growth fading, providers changed course. Narrow provider networks were out of favor, and preferred provider organizations (PPOs) with broad provider networks became the rising star.

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[6] Jensen et al, "The New Dominance of Managed Care: Insurance Trends in the 1990s," Health Affairs, January 1997.
[7] Kaiser/HRET Employer Health Benefits 1999 – 2002 Annual Surveys.

Health Maintenance Organizations, the original and strictest model of managed care, had not controlled premium increases, and fewer consumers were willing to live within its constructs. HMO participants, in theory, should have consumed less care and less expensive care as they followed the guidance of their primary care gatekeeper. In practice, their service use was slightly higher for physician office visits, and virtually the same for hospital, surgical, and emergency room services as the service use in indemnity ("unmanaged") plans.[8]

Self Insurance: Many employers made their health benefit plan self-insured in the 1980s and 1990s, eliminating the insurer's profit margin on routine, non-catastrophic care. Employers typically kept the same benefit design, and merely changed the financing mechanism. Self-funding the benefit plan gives the employer more control over benefit design elements, such as office visit co-pays and deductibles. In theory, a self-funded plan design can be adjusted to respond better to its covered population. In practice, self-funded plan designs closely mimic the overall market so that the employer's plan is competitive with other employers.

Promoting Good Health: Wellness programs are another cost management tool. Programs that focus on primary prevention – such as supporting weight management, providing nutrition education, or facilitating sports teams – have a direct impact on the population's health and therefore on medical costs. Secondary prevention programs

[8] Kemper et al, "Insurance Product Design and Its Effects: Trade-Offs Along The Managed Care Continuum," Inquiry Vol. 39, Summer 2002

strive to minimize the cost of a chronic condition. An example is self management education for diabetic patients.

There is no universal definition of a "wellness program," so tracking trends is difficult. If the term includes disease management programs, then according to the Wellness Council of America, more than 80 percent of employers had a wellness program in 2003. If the term includes only those programs that focus on primary prevention and physical fitness, the percentage is undoubtedly much lower.

Primary prevention programs require money and patience. Investing in programs and facilities means that the company spends even more than just its current health care costs. Results from the programs occur years later; according to one study, most of the gains from a wellness program occur three to four years after the program begins. At four years, this study concluded that participants spent $224.66 less per year on medical care than non-participants.[9]

While instituting a wellness program focuses on long-term results, purchasing health insurance coverage is a short-term problem placed in a short-term bottom-line context. Business reports its results and profits one to four times each year. It selects its health benefit plan once a year. The popularity of shorter-term strategies is, thus, not surprising.

[9] Ozminkowski et al., "Long-term impact of Johnson & Johnson's Health & Wellness Program on health care utilization and expenditures," Journal of Occupational and Environmental Medicine, Volume 44 No. 1, January 2002.

Health Education: Many insurers offer health education support, such as periodic newsletters featuring health topics and showcasing preventive care benefits. For example, plans will pay for the employee to enroll in a diabetes self-management class or a smoking cessation program. The hope is that participants will make better health choices, given the information and support to do so.

Employers can support health education by offering fitness classes, Weight Watchers clubs, or other health promotion activities on site. By making such activities convenient, the employer hopes to encourage participation and thereby, better health.

Cost Sharing: A shorter-term strategy is to have employees pay more toward their own health care costs. Raising the employee's deductible from $200 to $500 annually has an immediate impact on the insurance costs. Increasing the amount that employees pay for office visits, emergency room visits, and prescriptions also slows down rate increases. According to a recent study, these strategies can shave two to nine percentage points off of the plan's rate increase.[10] Employees may also become more cost-conscious, as they pay more of their own medical bills, providing a longer-term effect.

Another short-term strategy is to have employees pay more toward the health insurance premiums. Eighty-three percent of employers in 2002 planned to have employees pay more toward the health insurance premium, according to the Watson Wyatt study.[11] This

[10] Trude et al., "Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes," Health Affairs Vol 21, Number 1

[11] "Creating A Sustainable Health Care Program: Eighth Annual Washington Business Group on Health/Watson Wyatt Survey Report," 2003

strategy allows the employer to continue offering a richer benefit plan, while sensitizing employees to the insurance costs. On the whole, however, employees pay a small and declining percentage of insurance premiums. Trude et al found, "From 1996 to 2000, the average percentage of premiums paid by employees with single coverage dropped from 21 percent to 14 percent."[12]

Many employers offer more than one health insurance plan. Employees select the plan with the most attractive cost-benefit combination. The process of making the choice educates employees and could make them wiser consumers.

Group Purchasing: Other strategies include joining a health care purchasing collaborative, or a trade-association health benefits plan. Both of these types of groups consolidate the members' purchasing power, in order to command better prices. Federal legislation that would allow association health plans more flexibility is being considered by Congress. Trade associations do typically provide services to help members assess and select their health benefit plan, however. Many trade associations conduct benefit surveys, allowing members to compare their plans and costs to their peers.

Information Resources: Most employers also use an insurance broker, who can provide market comparisons on benefit designs and prices. The broker can have various insurers bid on the employers' plan, giving the employer a first hand look at the market options. The employer could also have more than one broker compete for the health plan. This

[12]Trude et al, Ibid.

approach gives the employer the widest range of options, as each broker attempts to outdo his competitor.

Human resource officers and financial officers can join professional associations, which support education and peer networking. These associations typically hold annual meetings, where health insurers and health care providers are speakers or exhibitors. These meetings can be a valuable resource for staff to learn what the market is offering, and to compare strategies with other companies.

Other Health-Related Programs: Employers may offer other benefit programs that promote health. For example, medical flexible spending accounts allow employees to set aside tax-free dollars to pay medical expenses. These accounts may make employees more aware of their health care costs, since employees who enroll estimate their out-of-pocket medical costs for the upcoming 12 months. A savvy employee might choose to enroll in a less generous health insurance plan, and fund a flexible spending account with part of the savings.

Overall, it is a small subset of employees who use reimbursement accounts. According to the U.S. Bureau of Labor Statistics, in 1999, 15% of the non-union workers nationwide had the opportunity to enroll in a reimbursement plan.[13] Of those with the option available, approximately 20 to 30 percent enroll.[14]

[13] 1999 Current Population Survey, Bureau of Labor Statistics (BLS), Department of Labor as quoted by the Employers Council for Flexible Compensation at http://www.benefits.net/pubs/fbb.htm.
[14] Based upon consultant surveys, quoted by the Employers Council for Flexible Compensation at http://www.benefits.net/pubs/fbb.htm.

An Employee Assistance Plan (EAP) provides mental health services to employees and family members, usually without any copayment from the patient. This benefit is in addition to the mental health benefits covered by the health insurance plan. Research contends that high quality mental health services – especially for depression -- can lower disability and absenteeism costs[15,16]; studies have not addressed the effect on health care costs.

Table I – Cost Management Strategies

Tactic	Goal
Managed Care	Optimize utilization of health services
Self-insurance	Eliminate profit margin on routine and predictable care. Gain control over plan design.
Health Promotion	Minimize need for medical care.
Cost Sharing - medical services - premiums - multiple plan options	Encourage wiser use of medical services. Share the cost burden with employees. Allow employees to make a cost/benefit trade off.
Group purchasing	Pool purchasing power with other employers.
Information resources	Improve negotiating skills and tools to reduce rates.
Offer a medical spending account	Encourage employees to plan for medical expenses.
Offer an Employee Assistance Plan	Make mental health more accessible.

[15] "Study finds financial return from mental health benefits," Diane Cadrain, Society for Human Resources Management, 11/6/03, http://www.shrm.org/hrnews_published/articles/CMS_006178.asp.
[16] "Targeting Depression: An Employer's Approach," Chelle Dianas, PhD and Laura Beien, LCSW, Business and Health Institute, May 15, 2003 at http://www.businessandhealth.com/be_core/MVC?mag=b&action=viewArticle&y=2003

Data Gathering

Selection of Participants

The study proposal was submitted to the University's Institutional Review Board to determine whether informed consent was necessary. The IRB exempted the study on August 20, 2003. A copy of the evaluation notice is included in Appendix I.

Prospective participants were screened using a structured questionnaire. The questionnaire included

1) the number of benefit eligible employees;
2) the longevity of the health benefit plan;
3) nature of work performed
4) percentage of population that is female;
5) the average age of the employee group; and,
6) average health insurance rate increase for the previous 5 years.

In order to participate, a prospect had to have at least 50 benefit eligible employees and have offered a health benefit plan for at least the previous 5 years. The remaining items determined whether the prospect was comparable to another prospect, as the study matched each participant to a partner similar in size, nature of work, and demographics.

While the market provides a wide variety of resources, the size of the workforce influences which resources are offered and are appropriate. An employer with fewer than

50 employees, for example, might not find it productive to join a data analysis collaborative. Conversely, a large employer might find little value in having an insurance broker. By ensuring that the matched pairs had similar numbers of employees, the study can safely assume that each participant had similar resources and options available.

Matching the participants' nature of work was important, as different demographic groups could have different health care cost trends. Insofar as the insurance carriers may rate industries differently, each matched pair would get similar treatment by the various insurers.

The demographics, including gender mix and average age, are commonly used by the insurance industry for rating purposes. Participants' demographics were matched to ensure that their different cost trends were not a result of having a younger, higher percentage male group.

Prospects were recruited through the Greater Portland Region Chamber of Commerce and personal referral. Approximately 15 businesses were screened. I screened prospective participants by talking with the firm's human resource officer by telephone. Four businesses were then matched into two pairs.

In each pair, one has a five-year average annual rate increase of 16% or more (the "average performers"); and one has a five-year average rate increase of at least 4% lower than the matched participant (the "high performers"). For the second pair, participants

#2A and #2B, the rate difference covers a three-year span; the discussion section describes this variance in more detail. See Table II below.

Table II - Dyad Matching Criteria

Dyad #1 Matched for industry category, size of workforce, demographics	High Performer #1A (Average five-year rate increase =< 12% or 4% less than dyad partner)	Market Performer #1B Participant #1B (Average five-year rate increase => 16%)
Dyad #2 Matched for industry category, size of workforce, demographics	High Performer #2A (Average three-year rate increase =< 12% or 4% less than dyad partner)	Market Performer #2B (Average three-year rate increase => 16%)

None of the participating employers had a union or collective bargaining unit for its health benefit plans.

The first pair, designated as High Performer #1A and Market Performer #1B, was two law firms both located in the same urban area. The second pair, #2A and #2B, was two manufacturing/production organizations; one had various locations in the state and the other had one site in a rural area. See Exhibit II for a summary of the screening criteria.

High Performer #2A reported a higher percentage of the work force being female than its matched partner. A higher percentage of females could have influenced #2A's claims

experience and therefore its health insurance rates. Females, at least during child bearing years, are more expensive to insure than males; so #2A's population, with more females, would have been expected to have higher costs and trends. High Performer #2A had lower rate trends than #2B, and so was selected to participate.

Structured Interviews

After the four participants had been screened, matched, and selected, an in-person interview was scheduled. I devised a matrix with which to gather the data. (See Exhibit III) Using this matrix, I covered the topics.

The matrix summarized

1) the participant's relationship with insurance carriers;
2) types of plans offered (HMO, POS, PPO, etc.);
3) rate increase history;
4) employee contributions toward the premium costs;
5) the plan design of the health plan that covered the majority of employees;
6) other health-related programs offered; and,
7) resources applied to health benefit cost management.

The data gathered covered a 5-year period, from 1999 through 2003. All participants' data matched this time period.

The increase in the health plans' costs is the entire plan premium cost, not just the portion paid by the employer. This approach neutralized the effect of shifting premium costs to

employees. The employees' contribution toward premium costs is listed separately on the matrix.

For the category of "Other Programs," I listed a few examples, such as an Employee Assistance Plan (EAP), wellness program, and health-related benefits. This section of the interview was open-ended as any one participant could have a variety of informal and formal programs offered.

Subjects described what resources they draw upon and how they value the resources' input. An employer may have an insurance broker, but may rely much more heavily on their professional trade association for ideas. Each resource has its limitations. Subjects were also asked whether they perceive and compensate for such shortcomings. Such skepticism is widely acknowledged: a recent Harris Poll found that only 7% of respondents (U.S. adults) considered the health insurance industry trustworthy and honest, and 59% supported more regulation of it.[17]

Next, the subjects listed the strategies they have applied in the past five years. Plan design and insurance carrier changes were summarized in the matrix. Other tactics were discussed in a somewhat less structured fashion, as these could take a variety of forms.

Limitations on Data and Data Sources

The participants by no means are representative of a broad cross section of employers. The data collected are peculiar to these four participants; though subject to the same

[17] Harris Poll #19, April 2, 2003

marketplace trends, these four are not strictly comparable to other similar sized employers in the state or in other states. This study is primarily qualitative; the quantitative data relating to rate increase histories were used only to match the participant to another with contrasting performance.

Participants gave rough estimates of their demographic factors, and this data were not verified. An overview of other health-related programs was given by participants; though this section of interviews was open-ended, participants may have omitted an important fact that in turn affected their performance.

In addition, exhaustive benefit plan design detail was not gathered. Since the state has few insurers and a narrow range of plan designs, it was assumed that the participants had purchased a plan that had not been extraordinarily customized. Such customization could have necessitated a regulatory filing with the state government, a step that is not routinely taken. Nevertheless, it is possible that some difference amongst the plan designs is a confounding factor.

These limitations influence the data and the ability to generalize the results of the study.

Findings

Insurance Carrier Relationships

Each participant listed its insurance carrier for each year of the study period. High Performer #1A changed carriers in the second year; High Performer #2A changed carriers in the third year. Market Performer #1B did not change insurers, and Market Performer #2B changed in the fifth year. See Exhibit IV for a summary of the participants' insurance carrier tenure.

Health Insurance Plan Options Offered

All participants offered employees a choice between at least two health insurance plans. All four had a Health Maintenance Organization (HMO) plan as one option; three had a Point Of Service (POS) plan as the second option. Each participant reported that the HMO plan covered the majority of the employees; thus, the plan design history section focused on the HMO plan option.

The highlights of the HMO plan designs were captured on the matrix. Since all four participants offered an HMO plan design, all had the same deductible ($0) and hospital benefit (no co-pay required for hospital visits). The other plan design features were selected for the summary, since these features have a significant affect on the plan's rates.

In addition, these features are the most common to be adjusted when an employer is trying to manage a rate increase. Table II summarizes the plan designs and how these features changed over the five-year study period.

Table III –Plan Design Summary

Plan Design Features	The A Team	The B Team
HMO OV copay 1999	$10	$10
HMO OV copay 2003	$20	$20 (2B stayed at $10)
Rx copay 1999	$10/ $15/ $20	$5/$15/$25 (1B) $1/$3/$5 (2B)
Rx copay 2003	$10/$20/$40, $7/$15/$35 (2A decreased its copay)	$10/$25/$40 (1B) $7/$15/$35 (2B)
ER copay 1999	$30	$50 (1B)/ $35 (2B)
ER copay 2003	$100 (1A); $50 (2A)	$100 (1B)/ $50 (2B)

Employee Contributions

All participants had employees pay toward the premium cost. High Performer #1A is the only one that did not increase the employees' contribution for single coverage over the 5-year study period. Employees at #1A did not pay anything toward covering themselves.

Three participants required employees to pay toward their families' coverage for the entire five-year period. Only Market Performer #2B began the study period with family coverage offered for no charge; during the period, participant #2B introduced and increased the employee contribution for family coverage.

Other Programs Offered by Participants

Participants provided information about what other health-related programs were available to employees. Exhibit VI summarizes the programs offered. These were grouped into three broad categories and nine types:

Additional or Related Health Benefits

1) Medical Flexible Spending Accounts.

   All four participants offered this type of benefit.

2) Employee Assistance Plan (EAP).

   Only one participant offered this benefit, and this participant was a lower performer. The EAP might have caused more patients to use the health benefit plan's mental health services, thus increasing costs. Conversely, the EAP services could have substituted for services covered by the health plan. Without detailed claims data, the effect of offering an EAP can only be speculated.

Fitness and Wellness Programs

3) Gym memberships. Employees could get a membership at a fitness club subsidized by the employer.

Only one participant offered this benefit and it was available only for the last 24 months of the study period. The participant who offered this benefit, participant 1B, is in the lower performing group.

4) Insurer sponsored wellness program. This program gives employees and covered family members information and incentives to exercise.

The two participants who offered this benefit were the high performers, and they added the programs at the same time: the last three years of the study period. These two participants had the same insurer during this time period, and thus offered identical wellness programs.

The program offers employees and their family members small gifts when they document an exercise program, such as regular jogging or walking. The program was publicized in an insurer-provided newsletter sent directly to employees' homes. Participant 2A estimated that 15 percent of employees participated in the program; 1A had no estimate.

5) Sports teams/charity participation. The employer either sponsored a sports team on which employees played, or took an active role in sports events sponsored by charities (i.e. Rotary Club road races).

Two participants, High Performer 1A and Market Performer 1B, both encouraged and supported employees' taking part in sports events, teams, and charity events. That neither 2A nor 2B did may show differences in industry norms and habits. Participants 1A and 1B are both white collar professional firms with similar employees and clients; that they both choose charity races for their community outreach is not surprising.

Health Education

6) Information/Support for smoking cessation. The employers either gave information about community smoking cessation programs, or had a benefit that covered nicotine replacement and other smoking cessation products.

   Use of smoking cessation programs also fell along industry lines: both 2A and 2B reported an active program, and neither 1A nor 1B did.

7) Annual enrollment meetings. Each year employees can attend a meeting to discuss the health and other benefit plans. This is also an opportunity for management to explain the cost increases and benefit changes, if any.

   All four participants held annual enrollment meetings.

8) Insurer or Employer Newsletter with health topics. These newsletters, provided by the insurer or the employer directly, give employees information about relevant health topics.

   All four participants offered this resource, though participant #1A did not add it until the third year of the study period.

9) Health Education (on site or benefit). Health education programs, such as Weight Watchers or yoga classes, were either offered at the employer's site or were subsidized by the health benefit plan.

Three out of the four participants offered some form of health education activities either at the work site or off site. High Performer #1A and Market Performer #2B offered such support for the entire five-year study period. High Performer #2A added it in the third year of the study period.

Resources Used

The types of resources used fell into three broad categories:

1) Professional services (insurance broker or consultant);
2) Business groups (trade associations, chambers of commerce); and,
3) Internal staff effort (data analysis, networking with peers).

Each resource is summarized below. An overview of all participants' resource use is shown in Exhibit VI.

Insurance Broker

All four participants used an insurance broker for the entire study period. One participant, Market Performer #1B, opened the health plan to multiple brokers for competitive bid; the incumbent broker won the bid process. That year's renewal brought an 8% increase in premiums, the second lowest rate increase the participant had over the five-year study period.

Consultant

None of the four participants used a consultant to assist with the health benefit plan.

Trade Associations

Industry trade associations were listed separately from general business groups, such as chambers of commerce. Two participants, High Performer #1A and Market Performer #1B, used the industry trade association as a resource, but their strategies varied significantly. Market Performer #1B's plan was purchased through the trade association itself. Thus, the trade association selected the plans available to employer members, negotiated rates, and set all related policies for the program, such as availability of insurer-sponsored wellness programs.

For High Performer #1A, the trade association's health benefit plan was a benchmark for plan design and pricing. The trade association plan gave participant #1A valuable market data.

Neither High Performer #2A nor Market Performer #2B used an industry trade association as a resource.

Employer Coalition

This resource included employer groups formed specifically for health care issues. High Performer #2A and Market Performer #2B both were active in at least one such group. Both of these participants valued the coalition's advocacy role in influencing health care costs in Maine. Neither mentioned skills or tools gained from coalition membership.

Chambers of Commerce

Only one participant, Market Performer #2B, was actively involved with chamber of commerce programs related to health care or health insurance.

Peers and Colleagues

Three out of the four participants valued information gained from their fellow executives from other firms. These mechanisms tended to be informal. One participant's firm, Market Performer #1B, was a member of an alliance of similar firms that did not compete with one another; one purpose of the alliance was to share management knowledge and tools.

Data Analysis

Only one participant, High Performer #2A, reported using any type of data analysis to influence the firm's health insurance premiums. This participant had in-depth knowledge of the health insurance industry, including target profit margins and trends.

The remaining participants reported that no useful data were available to them from their insurer. Two participants described voluminous but meaningless data provided by their insurer.

Specialized Media

Specialized media included publications for business executives that covered health care or health insurance issues. These publications typically have surveys on health insurance rate increases, plan design trends, and other related topics. Knowing the broader industry experience could help the executive gauge the firm's health insurance options.

Two participants reported receiving and using such publications. The two participants were High Performer #2A and Market Performer #1B. The two were not in the same industry, nor was their performance similar in terms of rate increase history.

Educational Seminars

Only one participant, High Performer #2A, reported attending seminars regarding health insurance and health care costs. Such seminars have the potential to give participants knowledge and tools with which to influence their health benefit plans.

Discussion

Participant Selection and Matching

Participant matching was based upon gross indicators, such as which gender the majority of employees were, and the estimated average age. No proof of the quantitative factors was gathered.

In the case of the second dyad, the rate increase data had both a similarity and a contrast. The participants High Performer #2A and Market Performer #2B had the same five-year average rate increase: 14 percent. Their performance diverged for the final three years of the study period; Market Performer #2B's three-year average was 21%, and High Performer #2A's was stable at 14%. Since #2B's higher increases occurred in the later three years, its costs were climbing much more steeply: the rate increase is expressed as a percentage of the prior year's rate. Market Performer #2B also perceived its performance as inferior to #2A. In fact, #2B suggested recruiting High Performer #2A's company for the study specifically because of #2A's success.

Because this study was qualitative and focused on the growth rate of premiums, this dyad pair was deemed appropriate. The first dyad pair, High Performer #1A and Market Performer #1B, had similar gross indicators, and their performance contrasted for the entire five-year study period.

Insurance Carrier Relationships

Both of the higher performers, #1A and #2A, changed carriers in the first three years with of the five-year study period. Both of the market performers, #1B and #2B stayed with one carrier for at least four years, and #2B stayed with one carrier for the entire five-year study period. This pattern of insurance carrier tenure shows a difference in the cultural attitudes toward continuity and change.

High Performer #1A described the firm as "not afraid of switching [carriers]" in order to achieve reasonable rates. She also credited the firm's aggressive management style and creativity (see also Resources Used:Professional Services). Similarly, High Performer #2A quoted a predetermined financial threshold that would justify changing carriers; if the rate difference was six percent or more, then he changed insurance carriers.

Market Performers #1B and #2B both mentioned valuing continuity, and fulfilling an obligation to employees. These participants emphasized the "soft" costs of changing the health plan. Market Performer #2B cited an opportunity for a lower rate that the firm rejected, based upon reports of poor customer service. This is not to assume that other participants valued customer service less, but rather to highlight the participant's barriers to change.

Health Insurance Plan Options and Plan Design Changes

All four participants offered a Health Maintenance Organization (HMO) plan, and at least one other plan option. In all cases, the overwhelming majority of employees chose the HMO plan. The HMO plans were similar for all four participants.

Given that the HMO plans offered were similar, the cost management features of the HMO-style plans were not a significant differentiating factor. The higher performers also did not create an advantage by slimming down their HMO plan; that is, the high performers did not reduce the benefits more than the market performers. All participants made similar plan design changes over the course of the study period. In fact, each dyad made identical changes to their plans at virtually the same time. (See Exhibit III.)

Employee Contributions

Other than employees who covered only themselves at High Performer #1A, all employees paid more money toward their health insurance over the five-year period. Only Market Performer #2B introduced a contribution for family coverage; this change did not, however, reduce the size of the group. In other words, the new contribution did not persuade employees to get coverage elsewhere.

Both High Performer #1A and Market Performer #1B began and ended the five-year period with the employees paying same proportionate contribution toward family coverage. Employees paid more each year, sharing the rate increase with the employer.

Raising employees' contribution could have the perverse effect of leaving only the sicker, needier people on the plan. For this reason, insurers set minimum group participation requirements. Insurers also set a minimum percentage of premiums that the employer must pay, otherwise the plan does not qualify for group rates. Nevertheless, a certain number of employees may drop out when the required contribution rises. None of the participants reported this kind of change in their covered population.

As an employer cost management tool, raising employee contributions allows a more generous plan to be offered. The richness of the plan is thus not limited to the employer's willingness to pay the higher premiums.

Flexible Spending Accounts

All four participants offered this type of benefit. The medical FSA was offered, in all cases, along with a generous HMO plan. So, none of the employee groups had a strong incentive to curb their own consumption, to choose a less generous plan, or to fund a high deductible using medical FSA funds. The presence of any one of these incentives might have contributed to a better than average performance.

Employee Assistance Plan

Only one participant, Market Performer #2B, offered this benefit. If this factor had any positive affect on health costs, it was not enough to differentiate this participant's performance.

Wellness and Fitness Programs

Three participants offered some form of wellness program or fitness support, but the programs had been offered for only two to three years. According to one study, most of the gains from a wellness program occur three to four years after the program begins.[18] The wellness program thus likely had little if any effect on the participants' rate increases.

Smoking Cessation

The use of smoking cessation programs differed between the white collar participants and the manufacturing/production industry participants. Prevalence of cigarette smoking tends to be higher amongst the lower social-economic classes in comparison to the higher classes.[19] Given that the average annual wage is lower for the production worker than for white collar professionals, it would follow that tobacco use would be more common for them.

[18] Ozminkowski et al., "Long-term impact of Johnson & Johnson's Health & Wellness Program on health care utilization and expenditures," Journal of Occupational and Environmental Medicine, Volume 44 No. 1, January 2002.
[19] Stellman SD, Resnicow, K., "Tobacco smoking, cancer and social class," IARC Science Publication 1997; (138): 229-50

Not only is smoking more common, but it may have a more severe health impact on the lower social-economic classes. Lower social classes were found to report higher severity of respiratory symptoms than higher classes, after controlling smoking as a variable. Researchers cannot explain how social class influences symptom occurrence and severity.[20]

Having a smoking cessation program did not differentiate Market Performer #2B and High Performer #2A. Similarly, not having a prominent tobacco reduction program did not apparently handicap High Performer #1A and Market Performer #1B, since smoking is not an urgent health concern for their white collar employee populations.

Annual enrollment meetings

For all four participants, the annual enrollment meeting unveiled management's decisions about the health benefit plan. None of the four had non-management employees participate in the decision making. Involvement by the employees might have led to different and perhaps lower cost decisions.

[20] Trinder PM et al, "Social class, smoking and the severity of respiratory symptoms in the general population," Journal of Epidemiology and Community Health, 2000 May; 54 (5): 340 - 3

Health Newsletters and Health Education

Providing employees information on health topics might increase the group's awareness of health issues, and thereby inspire wiser choices. Making weight loss or other programs convenient could help employees to improve their health, in ways that they would not otherwise have pursued themselves.

Since all four participants offered some form of health education, this was not a differentiating factor.

Resources Used: Professional Services

All four participants used the professional services of an insurance broker. The broker intermediates between the purchaser (the employer) and the supplier (the insurer). Each participant leveraged the broker's expertise and viewed this resource differently.

High Performer #2A described his broker as a partner with whom he exchanged ideas. He or the broker was equally confident to put forward different approaches and tactics. This participant's human resource executive had some technical insurance expertise from his own career. Thus, he could advocate strongly on his employer's behalf and gauge for himself the reasonableness of a proposal. He was, in sum, less reliant upon the broker because of his own expertise. This factor may have contributed to his high performance.

By contrast, High Performer #1A had a very different broker relationship. This participant described the broker as central to the plan's successful negotiations. The broker's superior expertise was given much of the credit for the plan's high performance. The human resource professional also gave credit to her organization for having a cultural environment that supported change. This participant said in describing the firm's approach, "[W]e don't have a culture of having the best [health] plan." This attitude by itself opened up more possibilities for the firm, and for the broker to explore. Openness to change likely contributed to this participant's high performance.

The Market Performers, #1B and #2B, had more similarities in their relationship with their broker. Participant #2B summed it up well, saying, "Trust but verify." Market #1B invited brokers to compete for the health insurance plan in year five. Though the plan stayed with the incumbent broker, that year's rate increase was the second lowest for the five-year study period and was 75% lower than the previous year's increase.

Trade Associations

Neither #2A nor #2B used an industry trade association to help them gain more knowledge or negotiating power for their health benefit plan.

Both High Performer #1A and Market Performer #1B used the same industry trade association, but each in its own fashion. Market Performer #1B purchased its health benefit plan through an employee benefits trust sponsored by the trade association. The

trade association's plan covers many different firms throughout the state, and at least in theory, should be able to negotiate a better rate than each firm could individually. This participant had the advantages of not only an insurance broker, but also the trade association's negotiating expertise and its leverage with the insurer. The disadvantage was that the participant could not get information about her firm's own claims experience, and thereby lost an important negotiating tool.

High Performer #1A used the trade association's health benefit plan as a benchmark. Each year the firm could compare its plan design and its rates to the trade association's plan. Since the firm could have joined the trade association plan at any time, this participant's broker and insurer had consistent competition. This competition may have contributed to the plan's high performance.

Employer Coalitions

Neither High Performer #1A nor Market Performer #1B participated in employer coalitions that focused on health insurance or health care costs.

Participation in such coalitions did not differentiate performance for High Performer #2A and Market Performer #2B. The Human Resource executives from both of these firms participated actively on several of the same statewide coalitions. Both HR executives had a broad knowledge of health care, and state-level dynamics that affect costs. Neither described applying this knowledge to gain advantage for their own health benefit plans.

Chambers of Commerce, Peers and Colleagues

Involvement in local chamber of commerce activities did not apparently give Market Performer #2B a performance advantage. Similarly, networking with peers and colleagues did not differentiate performance for any of the participants. Market Performer #1B had a formal alliance with non-competing firms; this gave the HR representative access to peers who could potentially share in-depth negotiating strategies or other knowledge. The HR executive did not find this alliance to be a useful source of such information.

Data Analysis

High Performer #2A's knowledge and use of loss ratio information is a powerful advantage. The HR executive's ability to speak to the broker and insurer regarding the target profit margin, and his group's performance almost certainly helped this participant achieve a lower rate increase.

While the loss ratio information was theoretically available to three out of the four participants, only High Performer #2A mentioned using this data for negotiating. (Market Performer #1B could not get the firm's loss ratio from the trade association's health plan.) When asked about data available to them, the HR executives found little of use.

In contrast to High Performer #2A, it was not participant High Performer #1A's internal staff, but rather the firm's insurance broker who had the primary knowledge base for negotiating with the insurer. High Performer #1A had internal staff, in addition to the HR executive, who was knowledgeable about health care and health insurance. The internal staff seemed to take a supporting, rather than a leading role in negotiating with the carrier.

Where this expertise lies – with internal staff or contracted professionals – may matter less than the willingness to use it and follow through to better results.

Specialized Media, Educational Seminars

Neither specialized media nor educational seminars showed any strong pattern of use by the participants. High Performer #2A's attendance at educational seminars may have further strengthened the HR executive's knowledge, and therefore ability to negotiate more aggressively. This participant did not cite such seminars as valuable contributors to his skill, however. High Performer #1A achieved similar results, without the benefit of educational seminars for internal staff.

Conclusions

The participants overall had much more in common than in contrast. They made the same plan design changes at virtually the same time. They used largely the same types of resources, though some to a greater extent and others in a different fashion. None of these features seemed to play a decisive role in improving performance.

Changing insurance carriers early in the study period might have, by itself, created a significant advantage for the high performers. The evidence does not support this conclusion. Both high performers and one market performer switched to the same insurer during the study period. This insurer could have been selling coverage at low rates, in order to gain market share. Following this theory, the switch should have rewarded the employers with a low rate increase – at least for the first year with the new carrier. This was not the case for any of the participants. (See Exhibit VII.)

For High Performer #1A, the first year with the new carrier was the highest rate increase during the 5-year study period. For High Performer #2A, the first year with the new carrier was the second highest rate increase. Market Performer #2B achieved its third highest rate increase the year it switched carriers; since the switch occurred in the last year of the study period, this increase represented the largest dollar jump for the entire study period.

Thus, the differentiating factor was not willingness to change carriers. Changing carriers might have been the best option for a particular year, but the change itself did not create a

better performance. Participants achieved better results and slower rate increases in subsequent years with their insurer, not the first year.

Only one element integral to the participants themselves – attitude toward change – consistently had a positive (lowering) effect on rate increases. This held true for all participants for the entire five-year study period. The higher performers had shorter relationships with insurance carriers, demonstrating their flexibility to change; the lower performers both put a greater emphasis on continuity and had greater reluctance to change.

For High Performer participant #1A, the firm's attitude toward health insurance costs was to seek actively lower cost alternatives. The firm was not hesitant to change insurers, in order to get a lower rate. This participant credited the insurance broker for the high performance. That the firm had an aggressive insurance broker is not surprising: the firm's style led to selecting and then supporting the broker. Thus, its results stem from the overall approach, which in turn influenced what opportunities were sought.

For Market Performer #1B, continuity of the health plan was considered valuable and important. Just as High Performer #1A had selected an approach that supported its style, Market Performer #1B chose a plan where change and competition were somewhat limited. By selecting the industry trade association's health benefit plan, #1B delegated much decision making to the association itself, effectively limiting the opportunities for

change. The venue for evaluating the health benefit plan is created by the firm's own overall attitudes and style.

High Performer #2A had perhaps the most intense level of competition, because the plan competed with the HR executive's own well formed ideal. This executive also had specific criteria for gauging the reasonableness of rate increases and deciding when switching carriers was justified.

Market Performer #2B had greater barriers to change. This participant mentioned foregoing a lower cost plan with a different carrier, because of concerns about customer service quality. With a different approach – one that emphasizes continuity less – the employer might have negotiated for customer service guarantees and taken advantage of the lower cost. Similar to #1B, Market Performer #2B emphasized the value of continuity in the health benefit plan.

Though Market Performer #2B perceived its performance as inferior to its dyad partner, #2B's performance was actually similar over the entire 5 years. This perception of being a lower performer may have itself affected negotiations to some extent.

The attitude toward change and competition is the most salient difference between each dyad pair. This core attitude underlay the participants' perception and application of tools, to a greater extent than their selection of particular tools.

For example, High Performer #2A and Market Performer #2B both served on the same statewide initiatives related to health care costs. Involvement with broader health care cost issues did not differentiate these two participants' performance; however, the inspiration for their involvement could be quite different. One might approach such a forum as an opportunity to create change, while another joins out of sheer frustration with runaway costs. Thus, two participants could apply the same resource in dramatically different ways, based upon their attitudes.

The same holds true for other programs and resources that were common among the participants. The differentiating factor was not which tools and programs were applied, but rather the attitudes guiding the decision. This dynamic could, in turn, influence the response from other parties to the transaction.

Welcoming change appears to be a significant advantage for leashing health insurance rate increases. The employer's attitude toward change directly influences the opportunities for cost management, which in turn shape the benefit plan's long term performance.

Prologue

This research project brought together several areas of my coursework, including economics, politics, health finance, and community health.

Maine's marketplace for health insurance is far from "perfect." Supply is limited, driving up the price even before actual health care costs are weighed. Pricing on insurance products is a complex prediction of consumer behavior, health status, and service use. Health care costs are high for many reasons, not the least of which is that the health services marketplace is not governed by normal supply and demand curves.

Politics shape the interactions between employers, insurers, regulators, and health consumers. Interest groups play a role far beyond lobbying legislators; health organizations are constantly communicating to all of their constituents, strengthening their ties and supporting their mission.

Community health principles also apply to the employer's "community" of people. The employer's community is more homogeneous and to some degree more easily managed for health programs. Interventions via health insurance generally are not tailored for each employer community, but rather are based upon broad averages. For example, raising an Emergency Room co-payment might have no effect on a higher-income group; a difference of even $50 is not as persuasive to them.

The dynamics are layered and complex. The degree curriculum enables me to put all of these considerations together.