BENEFIT
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Employers Charged More For Health Care Due To Low Medicare And Medicaid Payments

Medical providers levy higher charges on private insurers to compensate for low Medicare and Medicaid reimbursement rates, adding a cost burden of more than $900 per private family plan per year, according to a study conducted by Milliman Consultants and Actuaries for Seattle-based Premera Blue Cross.

Researchers analyzed Washington State hospital financial statements and physician fee schedules from 1995 to 2004. Results showed that, in 2004, commercial payers generated 56% of net patient service revenue reported by hospitals, but accounted for only 48% of hospital expenses. Meanwhile, Medicare and Medicaid generated 43% of hospital revenue, but represented 52% of hospital expenses.

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In aggregate, the analysis showed, hospitals had a -15.4% margin on Medicare business, a -15.6% margin on Medicaid business, and a 16.4% margin on commercial business. If each segment had supplied revenue in proportion to expenses, according to the analysis, Medicare and Medicaid would have paid an additional $510 million and $227 million, respectively, but commercial insurers would have paid $738 million less than the actual figures.

For Washington hospitals to maintain the aggregate 2.4% net revenue margin they reported for 2004, Medicare and Medicaid payments would have to rise by 18.2% and

J & D Goodliffe Associates, Inc.

P.O. Box 1309
Mountainside, NJ 07092

908•233•2800 - Phone
908•233•2804 - Fax
judie@goodliffeassoc.com

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18.5%, respectively, but payments by private insurers could fall by 14.3%, according to the study.

The additional levies on private insurers amounted to 13% of all commercial hospital and physician costs, adding $902 to the cost of each private family health insurance contract in 2004. Cost-shifting attributable to underpayments by Medicare and Medicaid accounted for 29.9% of the increase in hospital costs paid by Washington employers, the study concluded.

"Some call it Medicare and Medicaid cost-shifting; others call it a hidden tax," said Gubby Barlow, Premera CEO. "By any name, it's a billion-dollar burden for Washington employers and policyholders, and that burden is growing every year. It threatens to undermine efforts by employers, employees and health care providers to moderate the growing costs of medical care."

Other research across the country has produced similar results. A comparable study in California, also conducted by Milliman Consultants, found that private insurers were charged an additional $738 billion for hospital care in 2004 to compensate for Medicare and Medicaid underpayments. This study did not account for physician charges. According to Kenneth E. Thorpe, a health care economist at Emory University, unpaid hospital bills across the nation, a majority of which are for the underinsured, cost around $45 billion annually, adding around 8.5% to the cost of health insurance for those who do pay their bills.

Employers Trying New Approaches To Control Health Care Costs

Having concluded that cost-shifting to employees alone is not enough to bring their health care benefits expenditures under control, some large employers are testing new health care purchasing models, according to a report on health insurance benefits strategies by Deloitte Consulting LLP and the Deloitte Center for Health Solutions.

A survey of 152 large employers indicated that most respondents currently offer PPOs (86%) and HMOs (57%) to some or all of their employees. In addition, 24% of respondents reported they are now offering a consumer-directed health plan (CDHP) as a benefit option. While the majority of employees of the companies surveyed chose to participate in PPO or HMO plans in 2006, results showed that 6% of employees had enrolled in CDHPs.

When asked which type of health plan they believe offers the most effective approach for managing costs and maintaining quality, 40% of respondents chose a CDHP; 35%, a PPO; and 18%, an HMO. Noting that a significant percentage of respondents who rated CDHPs as effective do not yet offer them, researchers speculated that growth in CDHP adoption will continue.

When asked to identify the primary driver for their company's health care strategy in 2006, 87% of respondents cited cost; 11%, employee recruitment and retention; and 3%, the cost of health plans for retired employees. When asked which issue has the greatest impact on their health care costs, 31% named rich plan design; 22%, increasing utilization; 21%, catastrophic claims; and 16%, prescription drugs.

Shifting costs to employees was found to be the common strategy for controlling health care expenditures, with 49% of respondents citing either changes in plan design or increases in employee contributions as their primary method for controlling costs. However, researchers noted, 65% of respondents in a 2003 survey reported using cost-shifting as their main strategy, suggesting a fundamental shift in strategic direction could be underway.

The findings also indicated that growing numbers of employers are

encouraging employees to become better health care consumers, while instituting wellness and disease management programs. Nearly three-quarters (74%) of respondents said they offer a disease management program, either through their health plan or a specialty carrier, and 93% reported offering some sort of wellness program, such as a flu shot, smoking cessation program, or fitness program.

Small Employers With Poor Benefits Risk Losing Employees

Employees of small companies are far more likely to express dissatisfaction with their employer-provided benefits than workers at larger companies, which could make it difficult for small businesses to retain valued employees, according to MetLife's annual Employee Benefits Benchmarking Report.

Surveys of 1,213 full-time employees and 1,514 employers showed that 57% of small companies (with under 50 employees) cite "retaining employees" as their most important employee benefits objective. However, of the small company employees surveyed, just 29% indicated they are satisfied with their employer-provided benefits, and only 16% said their employer is effective in educating them about benefits. In contrast, 48% of surveyed employees at the largest companies (with more than 25,000 employees) reported feeling satisfied with their benefit packages, and 39% said they consider their company's benefits communications to be effective.

"To some extent, employers need to shoulder responsibility for this disconnect in employees' appreciation of benefits programs, since less than one-third of employees believe their benefits communications effectively educate their workforce," said Randy Stram, vice president, institutional business, MetLife. "Many companies are falling short in their benefits program goals to increase participation and satisfaction. All too often, benefits communication is pushed to the back burner, yet it is often the backbone of a successful program."

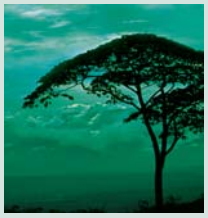
Results also showed that big employers are more likely to offer a greater variety of work/life benefits than small companies. While 54% of the largest companies surveyed said they encourage telecommuting and other flexible working practices, just 35% of the smallest companies reported offering similar benefits.

"The competition for talent is expected to intensify, and with benefits high on employees' priority lists, employers should re-examine areas for improvement and consider using new strategies such as targeting benefits information to employees at different life stages," Stram said. "Helping employees understand the value and cost of their benefits will go a long way in meeting cost and retention objectives."

Government Panel Advocates Basic Universal Health Care

In an interim report released in June, a committee set up by Congress to gauge public opinion on the current health care system and formulate a plan for achieving reform advocated providing basic universal health care coverage for all Americans by 2012.

Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and appointed by the U.S. Comptroller General, the Citizens' Health Care Working Group is made up of 14 members chosen to represent diverse perspectives, including those of consumers, business, labor, health care providers, and the disabled. In addition to hearing



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the testimonies of health care experts and public officials, the panel collected extensive input from the public through community hearings, surveys, and individual commentaries on health care matters.

The group will present its final recommendations to the president and Congress following a 90-day public comment period ending August 31. The president will then submit a report on the recommendations to Congress within 45 days of receiving them, and five congressional committees will hold hearings on the findings.

The panel asked members of the public for their opinions on what health benefits should be provided, how health care should be delivered, how coverage should be financed, and what trade-offs in benefits or financing would be justifiable to ensure access to affordable, high-quality health care coverage and services.

"A picture has been sketched for us of a health care system that is unintelligible to most people," panel members said in the report."They see a rigid system with a set of ingrained operating procedures that long ago became disconnected from the mission of providing people with humane, respectful and technically excellent health care."

The group recommended that Americans be provided with access to a set of affordable and appropriate core health services by 2012, with financial assistance given to those who need it. Across every venue, the report said, the panel heard a common message: "Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security."

In their report, the group acknowledged that new dedicated revenue streams would likely be needed to support these comprehensive health care initiatives, which may include enrollee contributions, income taxes, business or payroll taxes, or value-added taxes. At the same time, panel members emphasized the need for broad strategies to improve quality of care and efficiency.

To ensure that no one is impoverished by health care costs, the panel recommended the establishment of a national program, private or public, that would offer financial protection for all Americans. The program would provide universal coverage, protection against very high out-of-pocket medical costs, and additional assistance for low income individuals and families.

The group also called for the creation of a "core" package of physical, mental, and dental health benefits that would be established using a fair, independent, transparent, and scientific process. In addition, the group advocated the development of integrated community networks of health care providers aimed at providing care to vulnerable populations, and a restructuring of the financing and provision of end-of-life services, to better accommodate the individual wishes of the terminally ill.

"We recognize that the issues involved are complex and challenging, and that it will take time and a great deal of technical expertise, as well as political will, to make the changes we think are necessary," panel members said in the report.

Over the 90-day comment period, the members added, "we will continue to actively pursue public input as we deliberate and further refine these proposals. During this process, we will provide greater detail and explanation of our recommendations, as well as further analysis of what we are hearing from the American people, before issuing the final recommendations to the Congress and the President."

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