King County

Metropolitan King County Council
Committee of the Whole

STAFF REPORT

Agenda Item No.:	**7**	**Date:**	**20 Sep 2010**
Proposed Motion No.:	**2010-0431**	**Prepared by:**	**Nick Wagner**

SUMMARY

Proposed Motion 2010-0431 (pp. 5-7 of these materials) would ask the Executive to transmit to the Council, by 1 February 2011, a report on "the feasibility of offering consumer-directed health insurance options, such as health savings accounts and health reimbursement accounts, to King County employees."

BACKGROUND

King County continues to experience major fiscal challenges, with a $60 million deficit projected for the 2011 General Fund if the current level of operations were maintained. The county's employee benefit costs have risen from $158 million in 2005 to a projected $222 million in 2010—an average annual increase of about eight percent.

Although King County employees are sharing an increasing portion of their health care costs through higher co-payments and deductibles, which took effect in 2010 and are projected to save $37 million from 2010 through 2012, employee benefit costs are expected to continue to rise.

Among the cost-reduction strategies that have been adopted by some public and private employers are Consumer-Directed Health Plans (CDHPs), which include Health Savings Accounts (HSAs) and Health Reimbursement Accounts (also known as Health Reimbursement Arrangements) (HRAs). Such accounts combine a high-deductible health plan with a tax-advantaged account that enrollees can use to pay for health care expenses. A table comparing HSAs, HRAs, and other varieties of CDHPs is included in these materials at pp. 9-10.

According to a report published recently by the Kaiser Family Foundation, the percentage of large-firm workers enrolled in a health plan with an annual deductible of $1,000 or more for single coverage increased from 6% in 2006 to 17% in 2010. A summary of the report's findings is included at pp. 11-20 of these materials (*see* especially Ex. E on p. 14).

Mercer (formerly Mercer Human Resource Consulting), a consulting firm that describes itself as "a leading global provider of consulting, outsourcing and investment services," reported in September of 2008 that its annual survey of employers indicated that "[w]hile it's too early to make a final assessment of how well this new plan model [i.e., CDHPs] works, among the survey respondents that currently offer a CDHP the predicted 2009 cost increase averaged 4.5 percent compared to 6.4 percent for respondents not offering a CDHP" (p. 21 of these materials).[1]

According to a recent GAO report, CDHPs have both proponents and critics:

> Debate surrounding CDHPs has grown as more employers offer them to their employees. Proponents contend that the plans can help restrain health care spending, arguing that the high deductibles and ability to carry over balances give enrollees an incentive to seek lower-cost health care services and to obtain services only when necessary. Critics are concerned that these plans may attract healthier enrollees who use fewer health care services or may discourage enrollees from obtaining necessary care.[2]

THE PROPOSED LEGISLATION

Proposed Motion 2010-0431 (pp. 5-7 of these materials) would ask the Executive to transmit to the Council, by 1 February 2011, a report on "the feasibility of offering consumer-directed health insurance options, such as health savings accounts and health reimbursement accounts, to King County employees." The motion would require the report to identify the available options and to include:

1. "Any benefits and risks associated with consumer-directed health insurance options";

2. "Potential implications of federal healthcare reform on the feasibility of implementing a consumer-directed health insurance option";

3. "Analysis of potential cost savings to the county";

4. "Discussion of any impacts to King County employees";

5. "Information on how other cities, counties and states have implemented consumer-directed health insurance options and the savings achieved"; and

6. "A plan and timeframe for potentially implementing a consumer-directed health insurance option to reduce the rate of growth of King County employee healthcare costs."

[1] http://www.mercer.com/summary.htm?idContent=1319885.
[2] "Consumer-Directed Health Plans: Health Status, Spending, and Utilization of Enrollees in Plans Based on Health Reimbursement Arrangements," GAO (July 2010), http://www.gao.gov/new.items/d10616.pdf.

INVITEES

1. Kerry Schaefer, Strategic Planner, Benefits Unit, Operations Section, HRD, DES
2. Karleen Sakumoto, Project Director, Health Reform Program, Operations Section, HRD, DES

ATTACHMENTS

Page

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King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

September 17, 2010

Motion

Proposed No. 2010-0431.1 **Sponsors** Phillips and Dunn

A MOTION requiring the executive to transmit a report on the feasibility of and potential savings from offering consumer-directed health insurance options, such as health savings accounts, to King County employees.

WHEREAS, King County is experiencing sustained fiscal challenges resulting in a $60 million shortfall in the amount of funding needed to sustain the current level of general operations in 2011, and

WHEREAS, King County employee benefits costs rose from $158 million in 2005 to a projected cost of $222 million in 2010, a forty-one percent increase, driven by growing medical claim costs, and

WHEREAS, the cost of providing benefits to employees has increased by an average of eight percent annually since 2004 compared to a national inflation rate of three percent, and

WHEREAS, continued increases in employee benefits costs are anticipated despite increases in employee cost sharing through higher copays and deductibles that took effect in 2010 and are projected to save $37 million from 2010 through 2012, and

WHEREAS, other jurisdictions and private sector employers have begun offering consumer-directed health plans to help reduce the cost of providing health coverage for employees, and

WHEREAS, Mercer Consulting's nationwide survey on employer-sponsored health benefits found that the predicted 2009 cost growth for surveyed employers offering consumer-directed health plans, such as health savings accounts, was four and one-half percent compared to six and four-tenths percent for employers not offering such plans;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The executive is requested to transmit a report to the council on the feasibility of offering consumer-directed health insurance options, such as health savings accounts and health reimbursement accounts, to King County employees. The report shall identify the consumer-directed health insurance options available to the county and shall include:

1. Any benefits and risks associated with consumer-directed health insurance options;

2. Potential implications of federal healthcare reform on the feasibility of implementing a consumer-directed health insurance option;

3. Analysis of potential cost savings to the county;

4. Discussion of any impacts to King County employees;

5. Information on how other cities, counties and states have implemented consumer-directed health insurance options and the savings achieved; and

6. A plan and timeframe for potentially implementing a consumer-directed health insurance option to reduce the rate of growth of King County employee healthcare costs.

B. The executive is requested to transmit the requested report by February 1, 2011. The report shall be transmitted in electronic form, along with one paper copy, to

the clerk of the council, who will electronic forward copies to each councilmember and to the lead staff for the government accountability and oversight committee or its successor.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Robert W. Ferguson, Chair

ATTEST:

_____

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Dow Constantine, County Executive

Attachments: None

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Consumer-Directed Health Plans At-A-Glance

	HRA **Health Reimbursement Arrangement**	**HSA** **Health Savings Account**	**FSA** **Flexible Spending Account**	**RRA** **Retiree Reimbursement Account**
Who is eligible?	All employees	Any individual covered by a qualified high-deductible health plan	All employees, except those self-employed	All employees as designated by employer
Who can contribute?	Employer only	Employer, individual, or both	Employer, individual, or both	Employer only
What are the funding options?	Typically paid as incurred	Funded account with real dollars	Funded account with real dollars	Typically paid as incurred
Does the balance carry over?	Unused fund balance carries over to the next year – plan can define carry-over limit.	Unused fund balance carries over to the next year.	Use it or lose it arrangement – balance does not carry over.	Unused fund balance carries over to the next year.
Are rollovers permitted?	Rollovers are not permitted to HSAs.	Rollovers are permitted from MSAs & HSAs.	Rollovers are not permitted.	Rollovers are not permitted to HSAs, but are permitted from HRAs.

Consumer-Directed Health Plans At-A-Glance

	HRA Health Reimbursement Arrangement	HSA Health Savings Account	FSA Flexible Spending Account	RRA Retiree Reimbursement Account
Is the fund or account portable?	No, but may be allowed to roll over to RRA.	Yes	No	No
Are there interest or investment earnings?	No	Yes	No	No
What are the tax advantages?	• Employers may deduct reimbursed employee medical expenses as a business expense. • Reimbursements are excludable from the employee's gross income.	• Account earns tax-free interest. • Employee contributions through a cafeteria plan are pre-tax. • Other contributions are tax deductible. • Employers with a cafeteria plan enjoy FICA tax savings. • Qualified withdrawals are not taxed. • Non-qualified withdrawals subject to income tax and 10 percent penalty.	• Employee contributions are made on a tax-free basis. • Employers with a cafeteria plan enjoy FICA tax savings.	• Employers may deduct reimbursed employee medical expenses as a business expense. • Reimbursements are excludable from the employee's gross income.

Source: Aetna (www.planforyourhealth.com/family/consumer/)

Employer Health Benefits

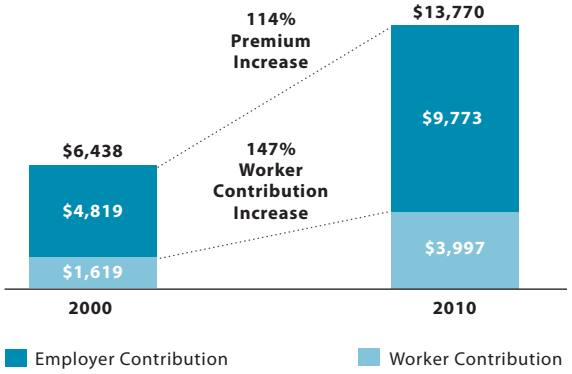
2010 Summary of Findings

Employer-sponsored insurance is the leading source of health insurance, covering about 157 million nonelderly people in America.[1] To provide current information about the nature of employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual national survey of nonfederal private and public employers with three or more workers. This is the twelfth Kaiser/HRET survey and reflects health benefit information for 2010.

The key findings from the 2010 survey, conducted from January through May 2010, include increases in the average single and family premium as well as in the amount workers pay for coverage. About a quarter (27%) of covered workers have a deductible of at least $1,000 for single coverage, and a greater proportion of workers are enrolled in high-deductible health plans with a savings option (HDHP/SO) than in 2009. Firms responded that they increased cost sharing or reduced the scope of coverage, or increased the amount workers pay for insurance as a result of the economic downturn. The 2010 survey continues to track the percentage of firms offering wellness benefits or health risk assessments and also included questions on health plan quality indicators and benefit changes made as result of the Mental Health Parity and Addiction Equity Act.

EXHIBIT A

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2000–2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000–2010.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

The average annual premiums for employer-sponsored health insurance in 2010 are $5,049 for single coverage and $13,770 for family coverage. Compared to 2009, premiums for single coverage are 5% higher ($4,824) and premiums for family coverage are 3% higher ($13,375). Since 2000, average premiums for family coverage have increased 114% (Exhibit A). Average premiums for family coverage are lower for workers in small firms (3–199 workers) than for workers in large firms (200 or more workers) ($13,250 vs. $14,038). Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit B). For PPOs, the most common plan type, the average family premium topped $14,000 annually in 2010.

As a result of factors such as benefit differences and geographical cost differences, there is significant variation around the average annual premium. Twenty percent of covered workers are in plans with an annual total premium for family coverage of at least $16,524 (120% of the average premium), while 19% of covered workers are in plans where the family premium is less than $11,016 (80% of the average premium) (Exhibit C).

In 2010, covered workers contributed a greater share of the total premium, a notable change from the steady share workers have paid on average over the last decade. Covered workers on average contribute 19% of the total premium for single coverage (up from 17% in 2009) and 30% for family coverage (up from 27% in 2009). As with total premiums, the premium shares contributed by workers vary considerably around these averages. For single coverage, 28% of workers pay more than 25% of the total premium while 16% make no contribution.

Fifty-one percent of workers with family coverage pay more than 25% of the total premium; only 5% make no contribution (Exhibit D).

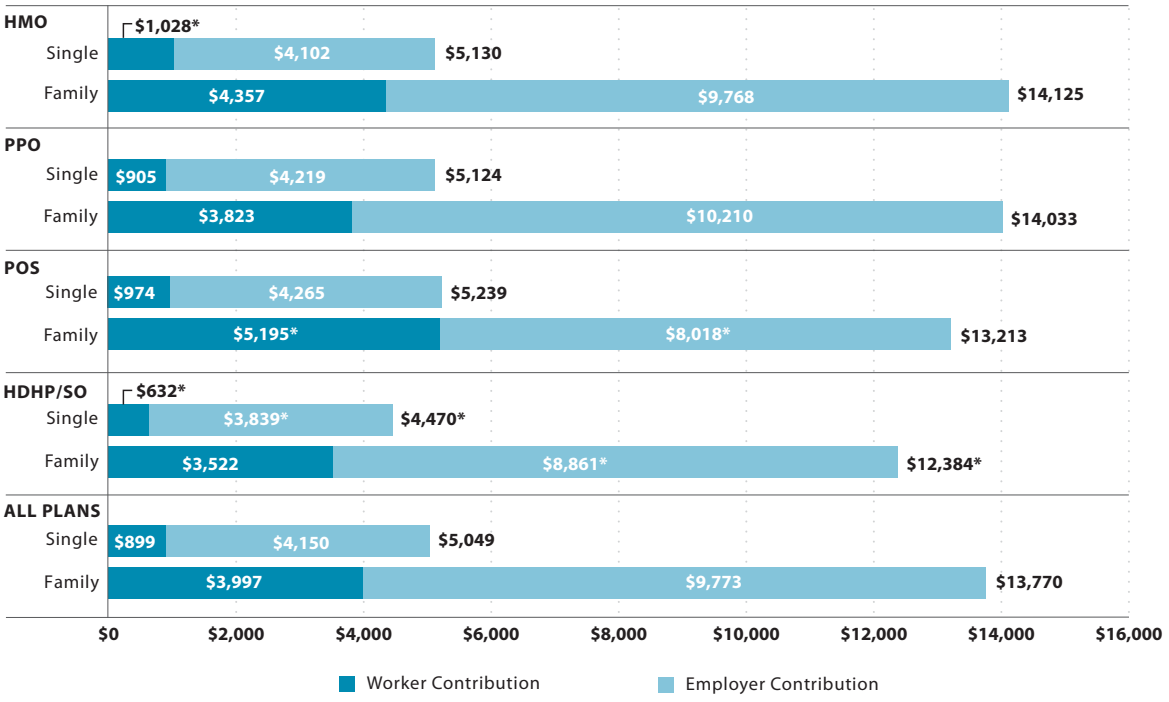
Looking at dollar amounts, the average annual worker contributions are $899 for single coverage and $3,997 for family coverage, up from $779 and $3,515 respectively in 2009.[2] Workers in small firms (3–199 workers) contribute about the same amount for single coverage as workers in large firms (200 or more workers) ($865 vs. $917), but they contribute significantly more for family coverage ($4,665 vs. $3,652).

PLAN ENROLLMENT

The majority (58%) of covered workers are enrolled in preferred provider organizations (PPOs), followed by health maintenance organizations (HMOs) (19%), HDHP/SOs (13%), point-of-service (POS) plans (8%), and conventional plans (1%). Most notably, the percentage of covered workers in HDHP/SOs rose from 8% in 2009 to 13% in 2010.

EXHIBIT B

Average Annual Employer and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2010



*Estimate is statistically different from All Plans estimate by coverage type (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

EMPLOYEE COST SHARING

Most covered workers face additional costs when they use health care services. Most workers in PPOs (77%) and POS plans (66%) have a general annual deductible for single coverage that must be met before all or most services are payable by the plan. In contrast, only 28% of workers in HMOs have a general annual deductible for single coverage, although it is up from 16% in 2009. Many workers with no deductible have other forms of cost sharing for office visits or other services.

Among workers with a deductible, the average general annual deductible for single coverage is $675 for workers in PPOs, $601 for workers in HMOs, $1,048 for workers in POS plans, and $1,903 for workers in HDHP/SOs (which by definition have high deductibles). As in recent years, workers in small firms (3–199 workers) with single coverage have higher deductibles than workers in large firms (200 or more workers). Average deductibles for single coverage do not vary by region for any plan type. The percentage of covered workers in a plan with a deductible of at least $1,000 for single coverage grew from 22% to 27% in the past year. Covered workers in small firms remain more likely than covered workers in larger firms (46% vs. 17%) to be in plans with deductibles of at least $1,000 (Exhibit E).

Most plans cover certain services before the deductible is met. For example, in the most common plan type, PPOs, 91% of covered workers with a general annual deductible do not have to meet the deductible before preventive care is covered. Seventy percent of covered workers in PPOs do not have to meet the deductible before physician office visits are covered, and 92% do not have to meet the deductible before prescription drugs are covered.

The majority of workers also have to pay a portion of the cost of physician office visits. For example, 75% of covered workers pay a copayment (a fixed dollar amount) and 16% pay coinsurance (a percentage of the charge) for a primary care office visit, and for specialty care visits, 73% of covered workers pay a copayment and 17% pay coinsurance. Most covered workers in HMOs, PPOs, and POS plans face copayments, while covered workers in HDHP/SOs are more likely to have coinsurance requirements or no cost sharing after the deductible is met. Covered workers with a copayment pay an average of $22 for primary care and $31 for specialty physicians for in-network office visits, compared to $20 and $28 respectively for 2009. For covered workers with coinsurance, the average coinsurance is 18% both for primary care and specialty care. The survey collects information on in-network cost sharing, but we note that out-of-network cost sharing is often higher.

Almost all covered workers (99%) have prescription drug coverage, and the majority face cost sharing for their prescriptions. Over three-quarters (78%) of covered workers are in plans with three or more levels or tiers of cost sharing that are generally based on the type or cost of the drug. Copayments are more common than coinsurance for all four tiers. Among workers with three- or four-tier plans,

EXHIBIT C

Distribution of Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2010

Premium Range, Relative to Average Premium	Single Coverage		Family Coverage	
	Premium Range, Dollar Amount	Percentage of Covered Workers in Range	Premium Range, Dollar Amount	Percentage of Covered Workers in Range
Less than 80%	Less than $4,039	20%	Less Than $11,016	19%
80% to Less Than 90%	$4,039 to <$4,544	16%	$11,016 to <$12,393	18%
90% to Less Than Average	$4,544 to <$5,049	21%	$12,393 to <$13,770	14%
Average to Less Than 110%	$5,049 to <$5,554	16%	$13,770 to <$15,147	18%
110% to Less Than 120%	$5,554 to <$6,058	10%	$15,147 to <$16,524	12%
120% or More	$6,058 or More	17%	$16,524 or More	20%

Note: The average premium is $5,049 for single coverage and $13,770 for family coverage.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

the average copayments per prescription are $11 for first-tier drugs, often called generics; $28 for second-tier drugs, often called preferred; $49 for third-tier drugs, often called nonpreferred; and $89 for fourth-tier drugs.

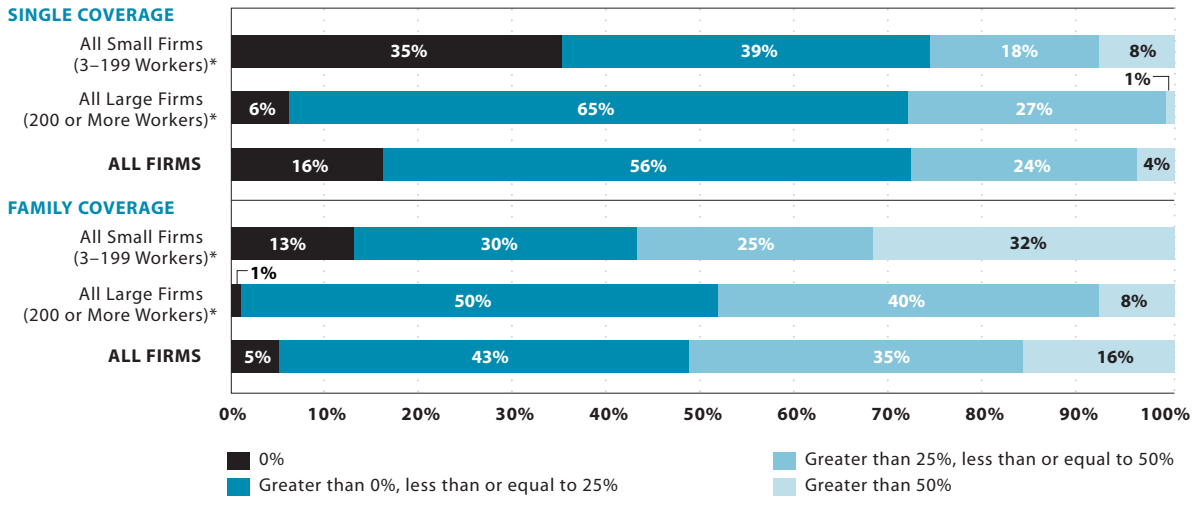
Cost sharing for prescription drugs varies by plan type. Covered workers in HDHP/SOs are more likely than workers in other plan types to be in plans with no cost sharing after the deductible is met or in plans where the cost sharing is the same regardless of the type of drug.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery. For hospital admissions, after any general annual deductible, 53% of covered workers have coinsurance, 19% have a copayment, and 10% have both coinsurance and copayments. An additional 5% have a per day (per diem) payment and 5% have a separate annual hospital deductible. For hospital admissions, the average coinsurance rate is 18%, the average copayment is $232 per hospital admission, the average per diem charge is $228, and the average separate hospital deductible is $723.

Although covered workers are often responsible for cost sharing when accessing health services, there is often a limit to the amount of cost sharing workers must pay each year, generally referred to as an out-of-pocket maximum. Eighty-two percent of covered workers have an out-of-pocket maximum for single coverage, but the limits vary considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 31% are in plans with an annual out-of-pocket maximum of $3,000 or more, and 16% are in plans with an out-of-pocket maximum of less than $1,500.

EXHIBIT D

Distribution of the Percentage of Total Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2010



*Distributions for All Small Firms and All Large Firms are statistically different (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

Even where plans have out-of-pocket limits, not all spending may count toward the out-of-pocket maximum. For example, among workers in PPOs with an out-of-pocket maximum, 74% are in plans that do not count physician office visit copayments, 32% are in plans that do not count spending for the general annual deductible, and 80% are in plans that do not count prescription drug spending when determining if an enrollee has reached the out-of-pocket limit.

Some health plans limit the amount that the plan will pay in benefits for an enrollee in a year. Twelve percent of covered workers are in plans with an annual limit on benefits for single coverage.

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Sixty-nine percent of firms reported offering health benefits, which is significantly higher than the 60% reported last year (Exhibit F). The change is largely the result of a 13 percentage point increase in offering among firms with 3 to 9 workers. While there has been some instability in this size category in the past, this year's change is much larger than previously observed, and the reason for such a change is unclear. Given the slow economic recovery and high unemployment, it seems unlikely that many firms began offering coverage.

A possible explanation is that non-offering firms were more likely to fail during the past year, and the attrition of non-offering firms led to a higher offer rate among surviving firms.

The higher offer rate observed for the smallest firms did not produce a large change in the percentage of workers in firms offering benefits because most workers are employed by large firms. The percentage of workers in firms offering health benefits rose from 91% in 2009 to 93% in 2010.

Even in firms that offer coverage, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Others choose not to enroll, perhaps because of the cost of coverage or their ability to access coverage through a spouse. Among firms that offer coverage, an average of 79% of workers are eligible for the health benefits offered by their employer. Of those eligible, 80% take up coverage, resulting in 63% of workers in firms offering health benefits having coverage through their employer. Among both firms that offer and do not offer health benefits, 59% of workers are covered by health plans offered by their employer, the same percentage as reported last year.

HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

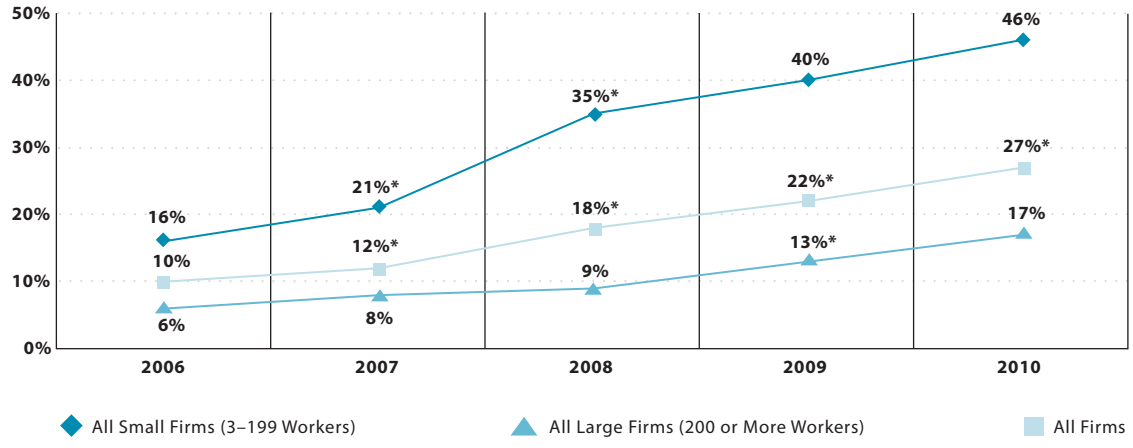
High-deductible health plans with a savings option include (1) health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an Health Reimbursement Arrangement (HRA), referred to as "HDHP/HRAs," and (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to a Health Savings Account (HSA), referred to as "HSA-qualified HDHPs."

Fifteen percent of firms offering health benefits offer an HDHP/SO in 2010. Among firms with 1,000 or more workers, 34% offer an HDHP/SO, up from 28% in 2009 and 22% in 2008.

Thirteen percent of covered workers are enrolled in HDHP/SOs, up from 8% in 2009. Seven percent of covered workers are enrolled in HDHP/HRAs, up from 3% in 2009. The percentage of covered workers enrolled in HSA-qualified HDHPs remained steady at 6%. Nine percent of covered workers in small firms (3–199 workers) are enrolled in HSA-qualified HDHPs, compared to 5% of workers in large firms (200 or more workers) (Exhibit G).

EXHIBIT E

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2006–2010



*Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2010.

Annual deductibles for single coverage for HDHP/HRAs and HSA-qualified HDHPs average $1,737 and $2,096, respectively, similar to last year. Workers in HSA-qualified HDHPs in small firms (3–199 workers) face higher deductibles for single coverage ($2,284) and family coverage ($4,258) than workers with HSA-qualified HDHPs in large firms (200 or more workers), where deductibles average $1,895 for single coverage and $3,734 for an aggregate deductible for family coverage.[3] Like workers in other plan types, workers in small firms covered by an HDHP/HRA face higher deductibles than workers in large firms with these plans for single coverage ($2,119 vs. $1,541).[4]

The distinguishing aspect of these high-deductible plans is the savings feature available to employees. Workers enrolled in an HDHP/HRA receive an average annual contribution from their employer of $907 for single coverage and $1,619 for family coverage (Exhibit H). The average HSA contribution is $558 for single coverage and $1,006 for family coverage. Not all firms contribute to the HSA. About two in five firms offering these plans (covering about 65% of workers covered by HSA-qualified HDHPs) make contributions to the HSAs of their workers. The average employer contributions to HSAs in these contributing firms are $858 for single coverage and $1,546 for family coverage.

The average premiums for single coverage for workers in HSA-qualified HDHPs and HDHP/HRAs are lower than the average premiums for workers in plans that are not HDHP/SOs. For family coverage, the average premium for HSA-qualified HDHPs is lower than the average family premium for workers in plans that are not HDHP/SOs. The average worker contributions to HSA-qualified HDHP single coverage are also lower than the average for non-HDHP/SO plans.

EXHIBIT F

Percentage of Firms Offering Health Benefits, by Firm Size, 1999–2010

FIRM SIZE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–9 Workers	56%	57%	58%	58%	55%	52%	47%	48%	45%	49%	46%	59%*
10–24 Workers	74	80	77	70*	76	74	72	73	76	78	72	76
25–49 Workers	86	91	90	86	84	87	87	87	83	90*	87	92
50–199 Workers	97	97	96	95	95	92	93	92	94	94	95	95
All Small Firms (3–199 Workers)	**65%**	**68%**	**68%**	**66%**	**65%**	**63%**	**59%**	**60%**	**59%**	**62%**	**59%**	**68%***
All Large Firms (200 or More Workers)	**99%**	**99%**	**99%**	**98%**	**98%**	**99%**	**98%**	**98%**	**99%**	**99%**	**98%**	**99%**
ALL FIRMS	**66%**	**69%**	**68%**	**66%**	**66%**	**63%**	**60%**	**61%**	**60%**	**63%**	**60%**	**69%***

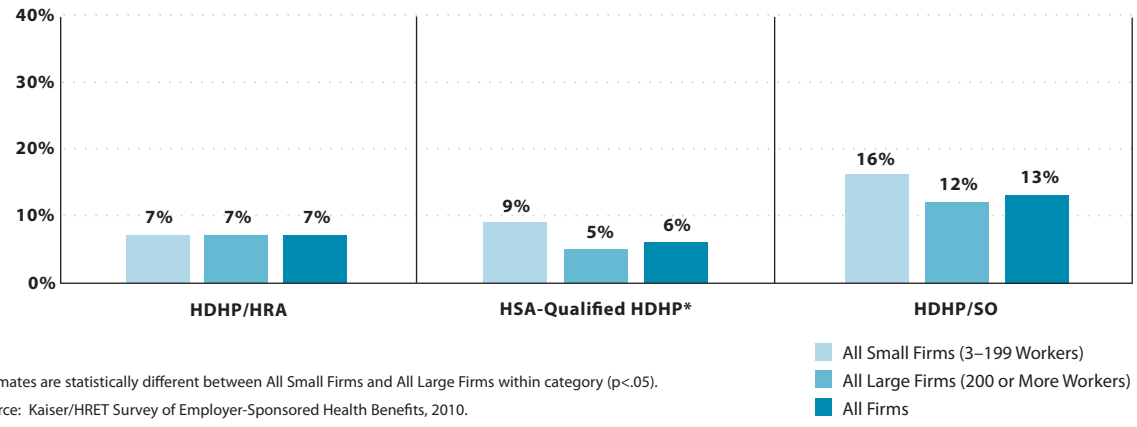
*Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: As noted in the Survey Design and Methods section, estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2010.

EXHIBIT G

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, by Firm Size, 2010



*Estimates are statistically different between All Small Firms and All Large Firms within category (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

RETIREE COVERAGE

Twenty-eight percent of large firms (200 or more workers) offer retiree health benefits in 2010, which is not statistically different from the 2009 offer rate of 30%, but down from 34% in 2005.[5] Only a small percentage (3%) of small firms (3–199 workers) offer retiree health benefits. Among large firms that offer retiree health benefits, 93% offer health benefits to early retirees (retiring before age 65) and 75% offer health benefits to Medicare-age retirees.

WELLNESS BENEFITS AND DISEASE MANAGEMENT

Workplace wellness programs are seen by some to be an important tool for improving the health behaviors and health of workers and their families. Almost three-fourths (74%) of employers that offer health benefits offer at least one of the following wellness programs: weight loss program, gym membership discounts or on-site exercise facilities, smoking cessation program, personal health coaching, classes in nutrition or healthy living, web-based resources for healthy living, or a wellness newsletter. The percentage of firms offering wellness benefits increased in the past year (from 58% in 2009), however the increase was primarily the result of a higher percentage of firms (51%) reporting the availability of web-based resources for healthy living in 2010 than in 2009 (36%). Firms offering health coverage and wellness benefits report that most wellness benefits (87%) are provided through the health plan rather than by the firm directly. Only a small percentage of firms (10%) offering health benefits and one of the specified wellness programs offer incentives for workers to participate in the wellness program.

Health risk assessments provide a way for employers and plans to identify potential health risks and needs of covered workers. Eleven percent of firms offering health benefits give their employees the option of completing a health risk assessment, and over one-half (53%) of these firms use health risk assessments as a method to identify people for participation in a wellness program.[6] Large firms (200 or more workers) are more likely to offer a health risk assessment to employees than small firms (3–199 workers) (55% vs. 10%).

Twenty-two percent of firms offering health risk assessments offer financial incentives for workers to complete them. Large firms are more likely than small firms to offer financial incentives (36% vs. 19%). Among firms that reported offering financial incentives to employees that complete a health risk assessment, 39% of firms reported that they offer gift cards, travel, merchandise, or cash;[7] 14% of firms reported that employees pay a smaller share of the premium; 8% reported employees have a smaller deductible; and 1% reported employees have a lower coinsurance rate.

Thirty-one percent of firms offering health benefits reported that their largest plan includes one or more disease management programs, similar to the 26% reported in 2008 when the question was last asked. Large firms (200 or more workers) are more likely than small firms (3–199 workers) to include a disease management program in their largest plan (67% vs. 30%).

EXHIBIT H

Average Annual Premiums and Contributions to Savings Accounts for Covered Workers in HDHP/HRAs or HSA-Qualified HDHPs, Compared to All Non-HDHP/SO Plans, 2010

	HDHP/HRA		HSA-Qualified HDHP		Non-HDHP/SO Plans[§]	
	Single	Family	Single	Family	Single	Family
Total Annual Premium	$4,702*	$13,068	$4,233*	$11,683*	$5,136	$13,979
Worker Contribution to Premium	$799	$3,604	$444*	$3,457	$939	$4,069
Firm Contribution to Premium	$3,903	$9,464	$3,789*	$8,225*	$4,197	$9,910
Annual Firm Contribution to the HRA or HSA[‡]	$907	$1,619	$558	$1,006	NA	NA
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	$4,810*	$11,083*	$4,347	$9,231	$4,197	$9,910
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA, if Applicable)	$5,608*	$14,687	$4,791*	$12,688*	$5,136	$13,979

*Estimate is statistically different from estimate for All Non-HDHP/SO Plans ($p<.05$).

[‡] When those firms that do not contribute to the HSA (60% for single coverage and 61% for family coverage) are excluded from the calculation, the average firm contribution to the HSA for covered workers is $858 for single coverage and $1,546 for family coverage. For HDHP/HRAs, we refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount that they commit to make available to their employees through an HRA. Therefore, the employer contribution amounts to HRAs that we capture in the survey may exceed the amount that employers will actually spend.

[§] In order to compare costs for HDHP/SOs to all other plans that are not HDHP/SOs, we created composite variables excluding HDHP/SO data.

NA: Not Applicable.

Note: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. This is relevant for Total Annual Premium, Total Annual Firm Contribution, and Total Annual Cost.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

OTHER TOPICS

Health Plan Quality. In 2010, we asked firms whether they review performance indicators on health plans' clinical and service quality. Large firms (200 or more workers) were more likely to review performance indicators than small firms (3–199 workers) (34% vs. 5%). Among those who reported reviewing performance indicators, the most common indicators used were the Consumer Assessment of Healthcare Providers and Systems (CAHPS) (77%) and hospital outcomes data (61%). Seventy-four percent reported that they were "somewhat satisfied" or "very satisfied" with the information available on health plan quality. However, only 49% reported that the information was "somewhat influential" or "very influential" in their decision to select health plans.

Response to the Economic Downturn. For the last two years we have asked employers about changes that they made to their health benefits in response to the poor economy. This year, 30% of employers responded that they reduced the scope of health benefits or increased cost sharing, and 23% said that they increased the share of the premium a worker has to pay. Among large firms (200 or more workers), 38% reported reducing the scope of benefits or increasing cost sharing, up from 22% in 2009, while 36% reported increasing their workers' premium share, up from 22% in 2009.

Mental Health Parity. The enactment of the Mental Health Parity and Addiction Equity Act in 2008 led firms with more than 50 workers to make changes in their mental health benefits.[8] Thirty-one percent of firms with more than 50 workers responded that they had made changes; large firms (200 or more workers) were more likely to have done so than small firms (51–199 workers) (43% vs. 26%). Among firms that changed their benefits, two-thirds (66%) eliminated limits on coverage, 16% increased utilization management for mental health benefits, and 5% indicated they dropped mental health coverage (Exhibit I).

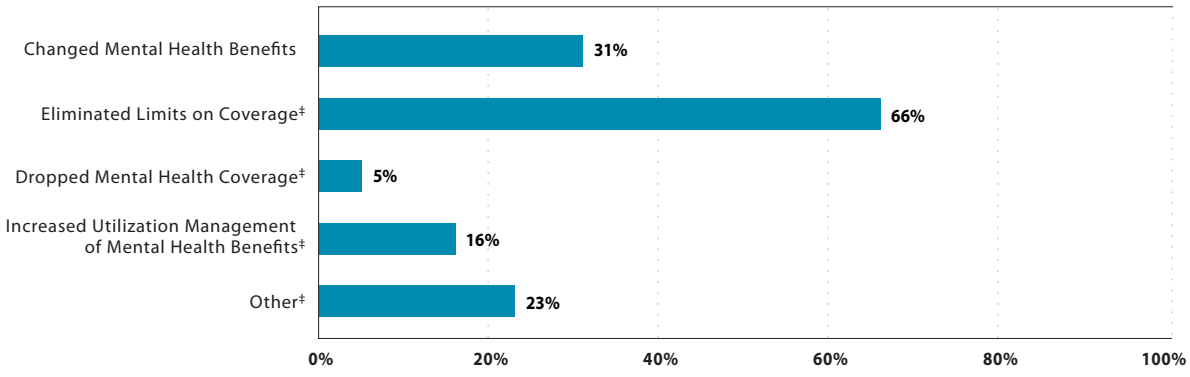
CONCLUSION

The 2010 survey finds a continuation of the modest premium growth we have seen in recent years and higher out-of-pocket costs for employees. Premiums increased just 5% for single coverage and 3% for family coverage between 2009 and 2010. At the same time, workers saw their share of the premiums for single and family coverage grow for the first time in several years. The percentage of workers in plans with a deductible of at least $1,000 for single coverage continues to climb, with over a quarter (27%) of workers in large firms and almost one-half (46%) of workers in small firms in such plans. The percentage of workers in HDHP/SOs rose significantly from 8% to 13% over the last year.

Tracking whether and how worker out-of-pocket costs continue to grow will be an important focus for the survey over the next few years. The slow economic recovery and continuing high unemployment suggests that this trend of increasing out-of-pocket costs will persist, as workers have little clout to demand better benefits or lower costs in the current labor environment.

EXHIBIT I

Percentage of Firms With More Than 50 Workers Reporting the Following as a Result of the 2008 Mental Health Parity and Addiction Equity Act, 2010



‡Among firms reporting they made changes to the mental health benefits they offer as a result of the Mental Health Parity and Addiction Equity Act of 2008.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010.

METHODOLOGY

The Kaiser Family Foundation/Health Research & Educational Trust 2010 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 2,046 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, the National Opinion Research Center at The University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and May 2010. In 2010 our overall response rate is 47%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is 48%.

From previous years' experience, we have learned that firms that decline to participate in the study are less likely to offer health coverage. Therefore, we asked one question of all firms with which we made phone contact where the firm declined to participate. The question was, "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,143 firms responded to this question (including 2,046 who responded to the full survey and 1,097 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate for this question was 73%. Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determined the basic weight, then applied a nonresponse adjustment, and finally applied a post-stratification adjustment. We used the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we used the Census of Governments as the basis for post-stratification for firms in the public sector. Some exhibits in the report do not sum up to totals due to rounding effects and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text use the 0.05 confidence level as the threshold for significance.

For more information on the survey methodology, please visit the Survey Design and Methods Section at www.kff.org/insurance/8085/index.cfm.

[1] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, October 2009.

[2] The average worker contributions include those workers with no contribution.

[3] Data presented are for workers with a family aggregate deductible where spending by any covered person in the family counts toward the deductible.

[4] There are insufficient data for average HDHP/HRA aggregate deductibles in small firms to make the comparison for family coverage.

[5] We now count the 0.46% of large firms that indicate they offer retiree coverage but have no retirees as offering retiree health benefits. Historical numbers have been recalculated so that the results are comparable.

[6] Health risk assessments generally include questions on medical history, health status, and lifestyle.

[7] In 2010, we ask only those firms that offer financial incentives to employees who complete a health risk assessment if they provide gift cards, travel, merchandise, or cash, whereas in 2009, this question was asked of all firms offering health risk assessments, including those who responded that they did not offer financial incentives.

[8] For more information on the Mental Health Parity and Addiction Equity Act of 2008, see www.cms.gov/healthinsreformforconsume/04_thementalhealthparityact.asp.

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The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

The Health Research & Educational Trust is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. Founded in 1944, HRET, an affiliate of the American Hospital Association, collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that help shape the future of health care.

The full report of survey findings (#8085) is available on the Kaiser Family Foundation's website at www.kff.org.
This summary (#8086) is also available at www.kff.org.

The Washington Post

Employers shifting health-care costs to workers, survey shows

By David S. Hilzenrath
Thursday, September 2, 2010; 11:00 AM

Amid high unemployment and a weak economy, employers have been shifting health care costs to workers, according to a study released Thursday.

The premiums that employees pay for employer-sponsored family coverage rose an average of 13.7 percent this year, while the amount that employers contribute fell by 0.9 percent, the survey found.

For family coverage, workers are paying an average of $3,997, up $482 from last year, while employers are paying an average of $9,773, down $87, according to the survey by the Kaiser Family Foundation and the Health Research & Educational Trust.

With so many people out of work, employees have little power to demand a better deal, the organizations said.

Overall, premiums for employer-sponsored coverage - the amounts paid by employer and employee combined - rose an average of 3 percent for family coverage and 5 percent for single coverage, the survey found. That was modest by historical standards. But the costs fell disproportionately on employees.

Workers with health benefits are paying an average of 30 percent of the premium for family coverage and 19 percent of the premium for single coverage this year, the highest in 12 years of surveys by the two organizations. Last year, workers were paying an average of 27 percent of the premium for family coverage and 17 percent for single coverage.

Premiums for single coverage rose an average of $225, and employees bore more than half of the increase.

"Many employers looked into their recession survival kit and seem to have concluded that one way to make it through the recession and hang on to as many employees as possible was to pass on their health premium increases to their employees this year," Kaiser Family Foundation President Drew Altman said by e-mail.

How much, if at all, the federal health-care overhaul enacted in March will restrain cost increases over the long run remains to be seen. While experts debate its likely impact, the legislation is "the only thing we have coming on line as a country to control costs other than what now seems like the primary default strategy in the private sector - shifting costs to people," Altman said.

Since 2005, employees' premium payments have gone up 47 percent while overall premiums have risen 27 percent. Over the same period, wages have increased 18 percent and the consumer price index, a measure of inflation, has risen 12 percent, the foundation and trust said in a news release.

Thirty percent of employers offering health benefits reported that this year, as a result of the economic downturn, they reduced the scope of benefits or increased cost-sharing - the amounts employees pay for medical services in co-payments, deductibles and the like.

Increasingly, employers are offering insurance plans with high deductibles. Twenty-seven percent of employees with health benefits now face annual deductibles of at least $1,000, up from 22 percent last year, the organizations said.

The Kaiser Family Foundation, which is not affiliated with the Kaiser Permanente health plan, conducts research on health issues. The Health Research & Educational Trust is an affiliate of the American Hospital Association.

The survey, which covered public and private employers with three or more workers, was conducted by phone from January through May.

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Health benefit cost growth predicted to ease slightly in 2009 as employers shift cost

Early responses to Mercer's annual survey indicate cost will rise 5.7 percent next year

United States
New York , 4 September 2008

After three years of double-digit growth in the first half of the decade, annual health benefit cost increases slowed to about 6 percent in 2005 and have stayed there ever since. Preliminary survey findings released today by Mercer indicate that cost growth is likely to slow a little further in 2009, to 5.7 percent – which would be the lowest increase in more than 10 years. Last year, Mercer's annual survey found that average health benefit cost per employee rose 6.1 percent in 2007.

Mercer's complete survey results won't be released until later in the year, but for the 1,317 employer health plan sponsors that have responded so far, the total cost to renew their current health plans – if they were to make no changes – would grow by nearly 8 percent on average. Small employers (those with 10–499 employees) would see an even higher increase, of about 10 percent. However, the majority of respondents say they will take action to lower their actual cost increases.

"It's a relief to see cost growth trending down, even slightly," said Blaine Bos, a senior Mercer health and benefits consultant based in Minneapolis. "But this is not an unqualified success story. While some employers are holding down cost growth with innovative methods of improving health care quality and efficiency, more typically employers struggling with increases they can't handle resort to the tried and true method of shifting cost to employees."

Well over half (59 percent) of employers taking action to reduce their 2009 cost increase will raise deductibles, copayments, coinsurance or employee out-of-pocket spending limits. Employee cost-sharing has risen sharply over the past five years: Between 2003 and 2007, the median family deductible for in-network services in a PPO (the type of plan offered by the most employers) rose from $1,000 to $1,500.

A smaller number of the employers – 19 percent – say they will lower their 2009 costs by adding a consumer-directed health plan (CDHP), which is a high-deductible plan with an employee-controlled spending account (a health saving account (HSA) or health reimbursement arrangement). Many of these plans give employees an incentive to take cost into consideration when seeking health care services by allowing them to save (on a tax-advantaged basis) account dollars they don't spend in a given year for future needs. While it's too early to make a final assessment of how well this new plan model works, among the survey respondents that currently offer a CDHP the predicted 2009 cost increase averaged 4.5 percent, compared to 6.4 percent for respondents not offering a CDHP.

CDHPs are significantly less expensive than traditional PPOs or HMOs. Last year, 12 percent of all employers – and 20 percent of those with 500 or more employees – said they were “very likely” to implement a CDHP by 2009.

“This opportunity for saving is good news for employers committed to offering health coverage. But even though CDHPs cost about 20 percent less than a typical medical plan, the percentage of very small employers providing employee coverage keeps shrinking,” said Mr. Bos. “This is one of the leading causes of the increase in the number of uninsured over the past few years, and a troublesome finding for policymakers who were counting on these plans – specifically HSAs – to reverse the trend.”

These are preliminary findings from Mercer’s National Survey of Employer-Sponsored Health Plans 2008. The survey is still in the field and complete results, including the actual cost increase for 2008, will be released by the end of the year. The preliminary results discussed above are based on employers who responded by August 25; these results are not weighted and represent only the 1,317 early responders. Ultimately, around 3,000 employers will participate in the survey and the final results will be weighted to be nationally projectable.

About Mercer

Mercer is a leading global provider of consulting, outsourcing and investment services. Mercer works with clients to solve their most complex benefit and human capital issues, designing and helping manage health, retirement and other benefits. It is a leader in benefit outsourcing. Mercer’s investment services include investment consulting and multi-manager investment management. Mercer’s 18,000 employees are based in more than 40 countries. The company is a wholly owned subsidiary of Marsh & McLennan Companies, Inc., which lists its stock (ticker symbol: MMC) on the New York, Chicago and London stock exchanges. For more information, visit**www.mercer.com**.