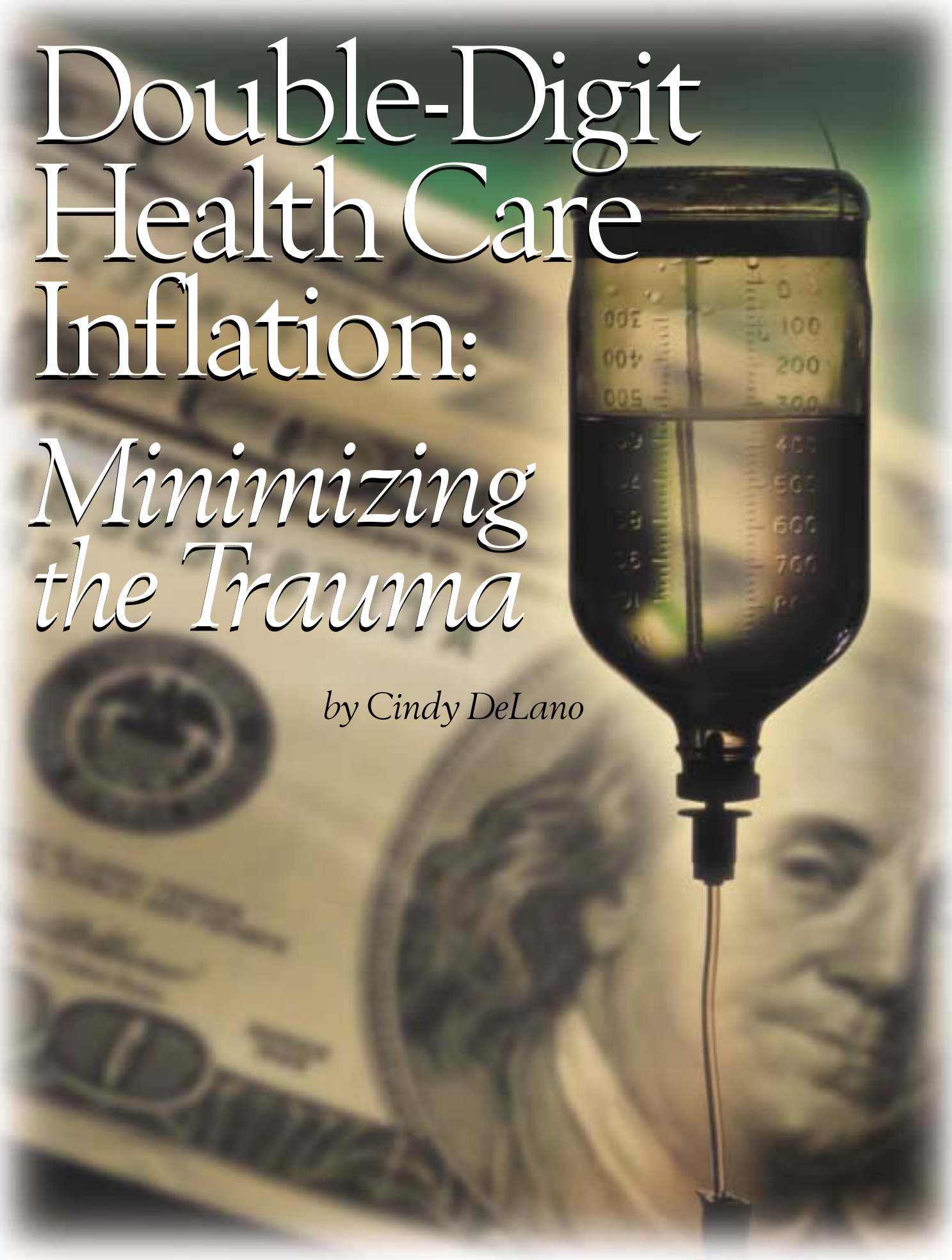
Double-Digit Health Care Inflation: *Minimizing the Trauma*

by Cindy DeLano



It's not news that health care costs have been rising. During the 1990s, when the economy was booming and competition among employers for workers was fierce, most companies balanced the need for cost containment against the necessity of satisfying the appetite of a mobile workforce for quality health care coverage. Now that unemployment is rising and the economy has slipped, both employers and employees are taking a harder look at health care costs.

Unfortunately, answers to the question of how to control these costs are difficult. The combination of newer, more expensive procedures and drugs and the number of people demanding acccess to them has strained the limits of traditional cost controls.

Managed care has not been a panacea to rising costs, either. The most prominent of these types of plans—health maintenance organizations (HMOs—see sidebar on p. 13 for plan definitions)—have fallen into disfavor with employees because of a lack of choice in doctors and inflexibile health care options.

Additionally, insurers are now trying to recoup lost profits. Over the past decade, many insurance companies lowered their premiums to attract more customers on the theory that the additional business would offset their premium losses. Now these losses are being passed to consumers in the form of higher premiums, along with rising costs of various benefits. In fact, Watson Wyatt Worldwide, a global human resource consulting concern, reports an expected increase in health plan costs of about 14 percent in 2002.

But the news is not all gloomy. There are some steps your club can take to hold down the spiraling cost of providing health care coverage to your employees. With a little give and take between the club and its workforce, employees can still get good coverage without breaking the payroll budget.

Health Insurance in the Club Industry

Today, according to a survey conducted by the Kaiser Family Foundation and the Health Research and Education Trust (Kaiser/HRET), 65 percent of small employers (3–199 employees) and 99 percent of large employers (200 or more employees) offer health insurance coverage to their employees.

NCA's *2000 Club Compensation and Benefits Report* notes that approximately 96 percent of full-time club staff receive health benefits. Considering the average size of the full-time workforce of most clubs—golf and country, 61 employees; city/athletic, 99 employees; and specialty clubs, 24 employees—most clubs, statistically speaking, are small businesses.

The two most common types of medical coverage found among golf and country clubs are HMOs and preferred provider organizations (PPOs). About 70 percent of golf and country club employees also receive prescription drug benefits as part of their health insurance coverage.

For city/athletic clubs, the most common types of medical coverage offered to employees are HMOs, PPOs, and point-of-service (POS) plans. Two-thirds to three-quarters of staff at city clubs receive prescription benefits. For specialty clubs, the most prominent types of medical coverage offered are HMOs and POS plans. As many as 80 percent of staff at specialty clubs receive drug coverage.

Feeling the Pain

Several recent studies address the rise of health care costs across the U.S. According to the Kaiser/HRET survey, monthly premiums for employer-sponsored health insurance increased by 11 percent from the spring of 2000 to the spring of 2001, the largest increase in premiums since 1992. This increase drove the average monthly premiums shared by employers and employees to $221 for single coverage and $588 for family coverage. Last year's premium increases averaged 8.3 percent nationally across all regions and industries of the U.S., up from 4.8 percent in 1999. Smaller companies (3–199 workers) experienced a 12.5 percent increase in premium costs compared with a 10.2 percent increase for larger companies (200 or more workers). The smallest businesses (3–9 workers) saw the largest average increase in

premium costs, at 16.5 percent.

Another survey performed by the New Jersey Business & Industry Association (NJBIA), reports that employers paid an average of $5,445 per employee for health care coverage in 2000, an 8.8 percent increase from $5,005 in 1999. This is significantly higher than the 6.6 percent and 3.3 percent rates of inflation found in their 1999 and 1998 surveys. Small employers with 2–19 employees paid the highest premiums—an average of $5,719 per employee, nearly $600 more than larger companies. Half of the businesses responding to the survey reported that their health plan costs rose by 10 percent or more, making double-digit inflation a painful reality. Many companies reported increases of 20 percent or more.

Employers and industry analysts expect the cost trend to contunue. According to a survey conducted by Watson Wyatt Worldwide, employers expect health plan costs for employees to rise 13.6 percent in 2002, up from 12.2 percent in 2001, and 8.1 percent in 2000. The cost of prescription drug benefits is expected to rise an average of 17 percent. Among the four major types of health plans, employers are expecting indemnity plans to experience the highest increases at 14.4 percent. The cost of managed care plans is also expected to increase—by 13.9 percent.

Why the Double-Digit Increase?

Employers responding to the Kaiser/HRET survey most often cited prescription drug spending as contributing "a lot" to premium increases. Other factors mentioned by employers as contributing to the increases were higher spending for hospital care (57 percent) and physician care (45 percent), higher insurance profits (31 percent), better medical technology (29 percent), and richer benefit packages (14 percent).

- **Prescription Costs.** One of the primary factors behind rising health care costs is prescription drug expenses. Pharmacy benefit expenses have risen 15–20 percent annually. The cost of a new drug is generally twice the cost of the drug it replaces in the marketplace. These new, high-priced drugs are being used to battle previously untreatable conditions such as AIDS, arthritis and cancer. In addition to drug manufactures creating expensive new drugs, they are substantially increasing their marketing efforts to sell those drugs directly to American consumers. Direct-to-consumer advertising by drug companies increased from $55 million in 1991 to $1.8 billion in 1999. There appears to be no end in sight to the upward spiraling of prescription drug costs. According to a University of Maryland study, prescription drug costs are expected to increase 15 percent to 18 percent annually from 1994 to 2004. Total U.S. drug expenditures during this period are expected to more than double from $105 billion to $212 billion.
- **Aging Population.** The baby boomer generation consists of those who were born between 1946 and 1964. Baby boomers are now between the ages of 37 and 55 years old. This generation has always had a significant impact on society because of its size. Currently, there are 76 million boomers in the U.S. As this generation ages, its members are utilizing health care services with ever-increasing frequency while demanding the latest medical technologies. As boomers age, there is a higher chance that they will develop chronic diseases. It has been estimated that the cost of treating chronic diseases accounts for 60 percent of medical care spending in the U.S. Increased use of health care services and prescription drugs, coupled with an aging population who is susceptible to developing chronic diseases, contributes significantly to the increased cost of health care in the U.S.
- **Improved Technology.** Due to improving medical technologies and procedures, more medical services are available but often at a higher cost. Improved capabilities are more likely to raise costs. Generally, this is because the new technology or new treatment is more expensive than the old one. Better technology also results in more medical intervention and increased utilization of these services. More utilization equals higher cost. With the advent of such information tools as the Internet, consumers are more aware of these new technologies and procedures and are increasingly demanding their use.
- **Legislation.** Health care and health insurance is a highly regulated business. Recent legislation has required managed care companies and employers to expand their coverage. Congress has passed legislation such as COBRA, HIPAA and FMLA that has added to health care inflation. By one estimate, health care legislation has caused 8.6 percent of recent cost increases. State and federal mandates for coverage of specific benefits have often resulted in employers paying a higher cost for health insurance. Federal programs such as Medicare and Medicaid continue to limit reimbursement to providers, thereby putting health care providers under pressure to shift unreimbursed costs to their private-sector patients.
- **Insurers.** The managed care marketplace

Plan Definitions

Cafeteria Plan
A Cafeteria Plan allows employees to have some choice in designing their own benefit package by selecting different types and/or levels of benefits that are funded with nontaxable employer dollars.

FSA (Flexible Spending Account)
A Flexible Spending Account (FSA), also called a flexible spending arrangement, allows employers and employees to use pre-tax dollars to pay for certain personal health care or child care expenses that aren't otherwise covered by insurance. In an FSA, employees agree to payroll deductions to put pre-tax dollars into an account and then use the funds during the year for reimbursement of health care expenses, including insurance deductibles and co-payments. Any money remaining in a FSA at year's end will be forfeited; therefore, employees need to carefully estimate their out-of-pocket medical expenses.

HMO (Health Maintenance Organization)
Health maintenance organizations (HMOs) provide health care for their members through a network of hospitals and physicians. The choice of a primary care provider (PCP) is limited to one physician within a network. The PCP coordinates all care and acts as a "gatekeeper" for medical services of specialists. A member of an HMO cannot see a physician out of the network.

Indemnity Plan
An indemnity plan allows an employee to choose his or her own physician. The employee must meet an annual deductible before the plan will pay toward approved medical expenses. Typically there is an 80/20 coinsurance component, in which the insurance company pays 80 percent of a health care claim and the employee pays the remaining 20 percent.

MSA (Medical Savings Account)
A Medical Savings Account (MSA) is a tax-deferred account in which money is deposited for routine, out-of-pocket health care expenses. Contributions are 100-percent tax deductible. Money remaining in a MSA at year's end is carried over to the following year. MSAs can be purchased only by self-employed people and by workers at businesses with 50 or fewer employees. An MSA must be paired with a major medical health plan, typically an indemnity plan, that has a high deductible with low monthly premiums. The original MSA pilot program was designed by Congress to expire at the end of 2000, but the 2001 budget bill signed by President Clinton extends MSAs for two more years.

POS (Point of Service)
A Point of Service (POS) plan is more flexible than an HMO, but it also requires a member to select a Primary Care Physician (PCP) within a network of providers. Depending on the insurance company's rules, a member may chose to visit a doctor outside the network and still receive coverage—but the amount covered will be less than if the member went to an in-network physician. Some plans stipulate that if a member chooses to see an out-of-network physician and does not receive permission from the PCP to see the outside doctor, the member is responsible for submitting claims for reimbursement and may receive a substantially lower reimbursement.

PPO (Preferred Provider Organization)
A Preferred Provider Organization (PPO) health care plan is a network of physicians and/or hospitals that contracts with a health insurer or employer to provide health care to employees at predetermined discounted rates. A member of a PPO typically pays a low co-payment to see an in-network provider. If a member chooses to see a health provider that is not in the PPO's network, they typically will be responsible for meeting an annual deductible and for paying a coinsurance amount for outside care once the deductible is met.

Internet Resources

The following Web sites contain useful health insurance purchasing and planning information.

Employment Benefits Research Institute (EBRI)—*www.ebri.org.*
The Employee Benefit Research Institute (EBRI) is a nonprofit organization devoted to data dissemination, policy research, and education on economic security and employee benefits.

Employment Policy Foundation (EPF)—*www.epf.org.*
The Employment Policy Foundation (EPF) is a nonprofit public policy research and education foundation that researches many employment-related issues.

Insure.com—*www.insure.com.*
Insure.com is a news organization that provides a wealth of information about all types of insurance.

Kaiser Family Foundation—*www.kff.org.*
The Henry J. Kaiser Family Foundation is an independent philanthropy focusing on health care issues. Through their Health Policy program, they provide facts, analysis, and information on health policy issues to policymakers, the media and the public.

Employment Policy Foundation, U.S. Small Business Administration—*www.sba.gov.*
Specifically look at SBA's report titled, "Managing Employee Benefits," part of the Personnel Management Series.

has seen a rapid consolidation of industry players over the past 10 years. For example, Aetna has purchased U.S. Healthcare, New York Life, and Prudential. The presence of fewer companies means less competition—and less competitive prices—among the remaining companies. Additionally, the one-time cost savings generated by the shift from fee-for-service to managed care plans have already been realized. During the 1990s, when the U.S. was enjoying a strong economy, many managed care programs lowered their premiums to attract more customers. Now those same companies, in a weaker economy, are increasing premiums in an effort to recoup profits.

Minimizing the Pain

Fortunately, there are ways for employers to minimize the effects of rising health care costs. Historically, the cost of health insurance to employers has averaged about 10 percent of payroll. During a tight labor market, few employers feel they can shift costs to their employees because benefits are part of what attract good employees, but in a weakened economy employers may need to resort to passing some of the increase in health care costs to employees.

According to one survey, as premium costs rise and the economy slows, workers may be facing bigger increases in their share of health insurance premiums. Seventy-five percent of large companies and 42 percent of small companies (44 percent of companies overall) reported they are "very likely" or "somewhat likely" to increase employee premium costs in the next year. Since the events of September 11, 2001, it appears even more likely that employers will need to shift a greater portion of health plan costs to employees.

Most employers find that a carefully designed health plan is the most effective way to control costs and meet their employees' needs without breaking the bank. The following strategies will help minimize the effects of rising health care costs.

- **Multiple Plans.** One of the trends in health plan design is the creation of multiple health plan options and the provision of a benefit credit to fund those options. In this approach, the employer provides a credit that is generally the same for all eligible employees. The employer then offers two or three health care options such as an HMO, a low-deductible PPO, and a high-deductible PPO plan. The full cost of each plan is paid for by the employee using a combination of the employer credit and the employee's own dollars. The plans that encourage higher utilization will be set at a higher cost to employees.
- **Cafeteria Plans.** Another approach to benefit design is cafeteria plans. These plans offer employees a minimum level or core of basic benefits. Employees are then able to choose from several levels of supplemental coverage or different benefit packages. All packages are of relatively equal value, but can be selected to help employees achieve personal goals or meet differing needs, such as health coverage (family, dental, vision), tax reduction (thrift plans, salary reduction), retirement income (pension plans) or specialized services (day care, financial planning, legal services). Careful planning and communication are the keys to the success of flexible compensation plans. Employees must fully understand their options to make choices of greatest benefit to them and their families. Both employers and employees must fully understand the tax consequences of the various plans.
- **Prescription Management.** As prescription drug costs continue to rise, managing employee purchasing patterns is an effective tool in controlling drug costs. Implementing a tiered co-payment system for prescription drugs provides employees with an incentive to purchase the most cost-effective prescriptions. A three-tier co-payment drug plan consists of varying co-payments for different types of drugs. Under this system, the lowest co-payment (e.g., $7–$10) is used for generic drugs, a higher co-payment ($15–$25) is used for drugs that are on the insurer's formulary list and are proven to be clinically and cost effective, and the highest co-payment ($30–$35) is used for brand-name drugs that are not on the formulary list. Mail order programs are also effective at containing drug costs. These programs are designed to allow employees to purchase a 90-day supply of maintenance medication at a discounted cost. Sixty percent of drug expenditures are related to long-term medications. These medications can easily be purchased through mail order programs.
- **Eliminate Duplicate Coverage.** Many employers pay the majority of the cost of health insurance for employees, and the employee pays for the cost of dependents. Employees contribute an average of $40 a month, or 19 percent of the total cost of their coverage, for employee-only coverage. Employee con-

tributions for family coverage are $130 a month, or 22 percent of the total cost of their coverage. This approach encourages employees who are covered under their spouses' plans to take duplicate coverage through their employer because it is offered at little or no cost. Thus, the employer spends premium dollars and bears claim-pool risk for employees who neither need nor want the coverage but who are considered primary to their employer's plan. A cost-effective way to reduce duplicate coverage is to offer a small amount of money ($600–$1,200) for those who opt out of the plan with proof of spousal coverage, thereby eliminating duplicate coverage.

- **Cost Sharing.** As a recent article in the *Washington Post* stated, "… the economic downturn has largely ended the labor shortage that made many employers extra nice to their employees. Now the companies can pass more of the premium increases to workers, telling them in effect, 'just be glad you have a job.'" Traditionally, employers have resisted sharing health-care cost increases with employees because they feared the negative reactions it might provoke. However, as the economy cools and unemployment increases, employers will be allowed to implement cost-sharing strategies. Passing some of the rising cost of health care to employees may include increasing the employee's share of premiums, raising coinsurance levels, and increasing employee out-of-pocket maximums. Indexing employee contributions each year to the level of cost increase is a very effective solution. Ensuring communication of whatever decisions are made is the key to employee satisfaction.
- **Flexible Spending.** Although health care costs may be passed on to employees, flexible spending options such as Flexible Spending Accounts (FSAs) and Medical Savings Accounts (MSAs) may give employees a way to save money for paying their health care costs.
- **Life/Work Programs.** Employee Assistance Programs (EAPs) have proven to be an effective tool in controlling disability and health care costs. EAPs allow an employee or family member easy access to a network of providers that can assist them with the many life challenges they face. This can result in lower rates of employee absenteeism, fewer workers compensation and health care claims, and an increase in employee productivity.
- **Education.** Employees need to be educated about their health care benefits to effectively use them. Information about benefits and how to use them effectively should be included in orientation sessions for new employees. The educated health care consumer is usually an employer's most cost-effective health care buyer. Employees who understand their benefit plans are also the most satisfied program participants. Newsletters, memos, Web sites, and meetings can all be used to educate employees about health care benefits, to announce changes in health care plans, and to answer employees' questions. Access to HMO and PPO networks is easily provided through the Internet.

Finding the Best Plan for Your Club

Before selecting a health insurance plan, consider what you and your workers want in a health plan. Determine all costs associated with each plan. Investigate the quality of potential insurance carriers. Examine the quality of each plan, including benefits and restrictions such as hospital coverage, outpatient services, physical coverage, substance abuse/mental health treatment, and prescription benefits. Finding a benefit plan that meets your budget constraints and fills the needs of your employees is crucial.

Sources of information about health insurance plans include the local chamber of commerce, independent insurance agents, trade associations, state departments of insurance, community business leaders, and benefit consultants or actuaries. Despite the double-digit inflation rate of health care costs, with careful planning and research, your club can minimize the cost of providing health care benefits to your employees.

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