Rising Premium Costs Outpace Wage Increases

BY NASEEM S. MILLER

For the first time in several years, U.S. workers are footing nearly the whole bill for the premium increases associated with their employer-provided health insurance. According to a nationwide survey, employers are declining to take more than a tiny share of the load.

The Employer Health Benefits 2010 Annual Survey shows that the average annual premium for employer-provided family health insurance is $13,770 this year. Of that, employees are paying an average of $3,997, an increase of $482, or 14%, from 2009, according to the survey by the Kaiser Family Foundation and the Health Research & Educational Trust.

"It's the first time that I can remember seeing employers cope with rising health care cost by shifting virtually all of the cost to the workers and it just speaks to the depths of recession and the pressure that employers have been under to hold the line on cost while trying as best as they can to avoid layoffs," Drew Altman, Ph.D., president and CEO of the Kaiser Family Foundation, said during a press briefing. "It also of course means added economic pressure and insecurity and burdens for working people in an already tough economy."

The survey authors note that employer-provided health insurance is one piece that has not received enough attention in the health reform debate. They predicted that the increased out-of-pocket cost for employees is not going to stop in the next few years, despite implementation of the Affordable Care Act.

"The longer term trend is that what workers pay for health insurance continues to go up much faster than their wages, while at the same time their insurance continues to get less comprehensive," Dr. Altman said. "So the insurance that workers get just looks less and less like the more comprehensive coverage that their parents got."

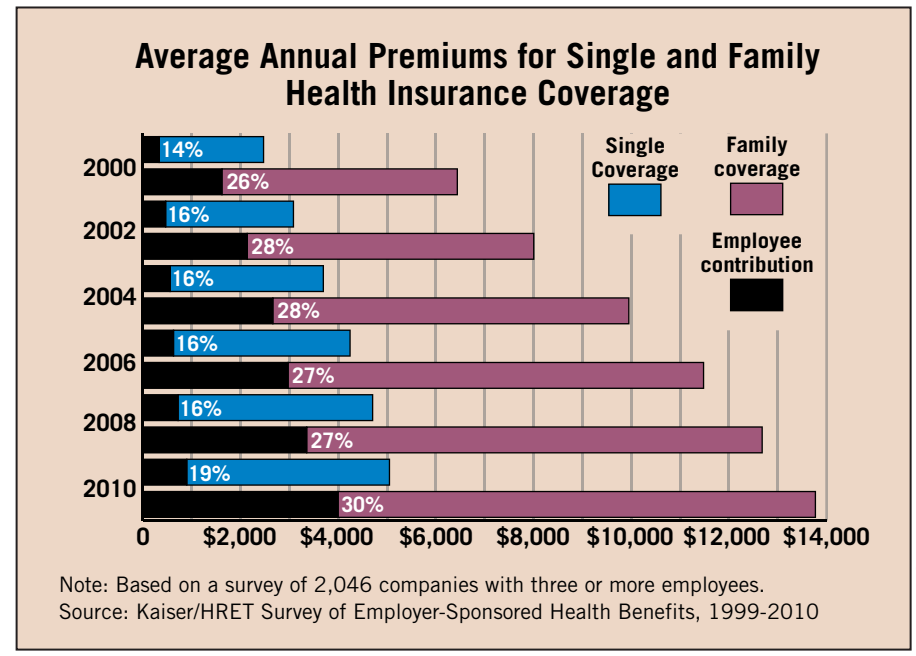
The telephone survey, conducted between January and May 2010, involved benefit managers for 2,046 randomly selected, nonfederal public and private companies with three or more employees.

The survey findings showed that the average annual cost of premiums for single coverage was $5,049 in 2010, up 5% from 2009. The average premium for family coverage rose 3% to $13,770.

The average primary care office visit copayment increased from $20 in 2009 to $22 in 2010, and from $28 to $31 for a specialist office visit.

"High out-of-pocket expenses and premiums affect health care decisions for patients," Maulik Joshi, Dr.P.H., president of Health Research & Educational Trust, said in a statement. "If premiums and costs continue to be shifted to consumers, households will face difficult choices, like forgoing needed care, or re-examining how they can best care for their families."

The survey showed the impact on mental health coverage since passage of the Mental Health Parity and Addiction Equity Act of 2008. The law applies to firms with more than 50 workers; 31% of such firms reported that they had changed their mental health coverage because of the law. Two-thirds of the 31% reported that they had eliminated limits on mental health coverage, 16% reported increased utilization management for mental health benefits, and 5% said they had dropped coverage.



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Among the surprising findings of the survey was a significant increase in the percentage of companies offering health benefits in 2010 (69%) compared with 2009 (60%). The researchers attributed the increase to the fact that a greater percentage of very small companies – those with three to nine employees – offer health insurance as a benefit. Why the increase occurred was unclear, they noted. One possible explanation was that more very small companies that previously did not offer health insurance as a benefit have failed, shrinking the pool of companies to measure.

Meanwhile, the percentage of workers enrolled in consumer-driven health plans – such as health savings accounts or health reimbursement arrangements – rose from 8% in 2009 to 13% in 2010.

More than 150 million nonelderly Americans have employer-sponsored health insurance, making it the leading source of coverage.

"We've been very focused on expanding coverage and other things in the health reform debate, and I think we've missed beneath that the nature of health insurance in the country has been changing," Dr. Altman said at the briefing. "But we should have a clear national discussion about what we actually think health insurance should be in the country." ■

Health Care Reforms Expected to Save Billions for Medicare

BY MARY ELLEN SCHNEIDER

Provisions of the new Affordable Care Act, coupled with other payment changes, will save Medicare nearly $8 billion over 2 years and extend the solvency of the Medicare Trust Funds by 12 years, according to a report from the Centers for Medicare and Medicaid Services.

The immediate savings come from cuts to Medicare Advantage payments, competitive bidding for durable medical equipment, changes to how Medicare pays for advanced imaging services, productivity improvements in the hospital, and efforts to reduce waste, fraud, and abuse. These changes are expected to save $7.8 billion for the Medicare program by the end of next year.

The report analyzes cost-cutting provisions that the CMS has already implemented or will be implementing soon.

"For too long, we've paid too much for health care, gotten too little in return, and watched the situation get worse each and every year," Health and Human Services Secretary Kathleen Sebelius said at a press conference to release the report. "The Affordable Care Act is already putting our health care system on a new course, bringing down costs while improving the quality of care and giving all Americans more value for their dollars."

Ms. Sebelius noted that the new law will protect Medicare beneficiaries by maintaining current benefits and adding new ones such as free preventive care and the eventual closing of the Medicare Part D prescription drug doughnut hole.

Over the long-term, CMS officials estimate that Medicare savings will exceed $418 billion by 2019. Some of those savings will come from reducing hospital readmissions and hospital-acquired infections, bundling payments for end-stage renal disease care, promoting Accountable Care Organizations, and improving quality reporting by physicians. The CMS also expects the establishment of the Independent Payment Advisory Board (IPAB), which will recommend payment changes aimed at slowing growth in Medicare spending, to contribute to those savings by cutting Medicare costs by about $23 billion by 2019. The IPAB may pose problems for physicians down the road, Robert Doherty, senior vice president for governmental affairs and public policy at the American College of Physicians, said in an interview. Many physician groups have been critical of the IPAB, saying that Congress has placed too much authority in the hands of an unelected body. Under the Affordable Care Act, the IPAB's recommendations will take effect unless Congress passes legislation that meets the same budgetary targets.

Accountable care organizations could benefit physicians by paying them to coordinate care and reimbursing them for work that keeps costs down.

However, the payment changes being touted by Medicare could be good news for office-based physicians, Mr. Doherty said. For example, under new models such as bundled payments and accountable care organizations, office-based physicians who help to reduce preventable hospital readmissions could see a share of the savings from that improved care.

"Right now under Medicare, Part B is Part B and Part A is Part A, and never the twain shall meet," Mr. Doherty said. "No matter what physicians do to reduce Part A expenses by managing care more effectively, there's no mechanism under the existing Medicare payment system for physicians to benefit from that."

The current payment system misaligns the financial incentives, paying for volume rather than quality of care, Dr. Lori Heim, president of the American Academy of Family Physicians, said in an interview. Concepts such as accountable care organizations, which are still in their infancy, could benefit physicians by paying them to coordinate care and reimbursing them for work that keeps costs down for the health care system as a whole, she said.

"We know that to really coordinate the care, to work with the patient's family, to create the community environment and really help to manage these patients, a lot of that is not in the face-to-face visit that we're currently being paid for," Dr. Heim said. ■