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# Think Piece: Employers Beware: Three Masked-Myths about Curtailing Health Costs

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For at least the last eight years, health care and health insurance have been caught in the political crosshairs of conflicting ideologies. Nearly one-fifth of the economy has become the perennial punching bag for both political parties. A demarcation line exists between enhanced federal control versus private-market forces at local levels.

In the meantime, employers and their employees must navigate through uncertain waters on how to pay escalating health care costs. To date, employers continue to rely on “cost-cutting” assumptions that appear to be both intuitive and rational: forcing employees to have more “skin in the game”; initiating wellness programs to curtail health costs; and waiting for policymakers to “repeal, replace or repair” Obamacare. This last implied assumption suggests that by fixing the individual insurance markets, the entire health care system in the U.S. will be miraculously resuscitated.

On the surface, all three assumptions appear to have merit. But, when assessing the facts, employers should be cautious about these “solutions.” At the bare minimum, these assumptions — or possible myths — deserve more scrutiny.

**Myth #1: “Skin in the Game”**

Employer-sponsored health plan deductibles in the U.S. have been dramatically increasing for a number of years. Since 2004, in Iowa alone, employer deductibles have increased by 185 percent. Iowa workers now pay single and family averages of $1,627 and $3,400, respectively. Nearly a quarter of Iowa employers offer high-deductible health plans (HDHP) which usually include qualified spending accounts, such as health savings accounts or health reimbursement arrangements. A general belief of offering high-deductible plans is that employee cost-sharing obligations (e.g. having “skin in the game”) will encourage employees and family members to scrutinize the cost and quality of care from various health providers.

It is true that high-deductible, consumer-driven health enrollment is associated with lower health care spending, particularly in outpatient care and prescription drugs. But data from health insurance claims indicate that this lower spending is primarily derived from decreased use of care, not because enrollees are switching to lower-cost alternatives. In some cases, this decreased care might be for unnecessary services — which is a good thing. However, if necessary care is being skipped because patients are paying more out of pocket, there is a great risk that delaying care may actually cause health costs to rise sometime later, when the medical condition has become more acute.

A few years back, when researchers surveyed 2,000 18- to 64-year-olds covered by insurance, they compared those with HDHPs to those with more traditional (lower deductible) plans to determine health care shopping frequency rates. The findings revealed that HDHP enrollees, although having more out-of-pocket exposure, showed little evidence of making higher-value purchase decisions compared to those with less financial risk. Additionally, given the scarcity of information on specific health costs and provider outcomes, patients obtaining care are not truly informed decision-makers.

Even when plan participants have access to health care prices, this information does not ensure that patients will spend less, especially in monopolized markets. A 2016 study published in The Journal of the American Medical Association investigated the Truven Treatment Cost Calculator, a website that provides users with costs on over 300 services. It found that the cost calculator was not popular with participants and that price transparency did not reduce outpatient spending — even for those patients with HDHPs.

Some health plans now provide price transparency tools to their enrollees. Unfortunately, as with the Truven study, a very small percentage of enrollees actually use them. Aetna, for example, offers a price transparency tool to 94 percent of its commercial market customers, but only 3.5 percent use it. Part of the reason could be that health care choices are driven by physician referrals, and options provided throughout the care process may be deemed too complex and overwhelming. According to at least one analysis, only 40 percent of health care spending is amenable to shopping. If out-of-pocket costs are the same at both a high-cost and a low-cost provider, there is little incentive to pay the cheaper cost if insurance will pay the difference.

**The Skinny:** Merely providing employees with HDHPs to have more “skin in the game” will not make them more informed consumers. It may actually make them more frustrated. Transitioning health care “users” to “consumers” will continue to evolve over time, whether by educating them on how insurance works, or by targeting them to find higher-quality providers and services. One promising approach is reference-based benefits, which are preset dollar limits an insurer places on certain medical services or procedures. Under this approach, employees will pay the difference if they select a service or procedure above the reference price. The key to this approach is full transparency of the reference prices.

**Myth #2: Wellness Programs**

Workplace wellness has become a more than $6 billion industry in the U.S. Employers offer these programs with the intent to improve the health and well-being of their employees, which may increase their productivity and also reduce and control costly chronic diseases. Most programs use financial incentives to motivate employees to monitor and improve their health, often through lifestyle-modification programs, such as lowering blood pressure and cholesterol. Common incentives can include discounts on health insurance to employees who complete health risk assessments, or perhaps charging employees more for smoking or having a high body-mass index. There are many different incentivized approaches employers take with wellness programs. But to avoid discriminatory practices, they must be careful about complying with various federal regulations.

During my years as an employee benefits consultant, I often observed that wellness programs were being “sold” to employers with a great deal of positive hype, usually establishing an unrealistic expectation that by merely implementing wellness basics within the workplace setting, rising health costs would soon abate and save employers money.

Do wellness programs save employers more than the cost of implementing them in the workplace? It depends. Contrary to the hefty claims made by wellness vendor studies (which are typically non-peer-reviewed and often unable to produce valid causal savings estimates), many national studies that are peer-reviewed generally suggest wellness programs have little, if any, immediate effect on the amount employers spend on health care.

One important study that resulted from the PepsiCo Healthy Living program suggests that evidence-based wellness programs that target specific diseases, such as asthma, coronary artery disease, stroke, hypertension and low back pain, may possibly provide savings, but only after several years following implementation. For another example, the Rand Wellness Program Study in 2014 concluded that “employers who are seeking a healthy return-on-investment (ROI) on their programs should target employees who already have chronic diseases.” Rand found the ROI for disease management programs was $3.80 for every dollar invested.

When wellness programs are implemented more broadly and focused only on lifestyle management (e.g. smoking, obesity and fitness), which are typical wellness components, savings do not materialize, at least in the short term. Rand found the ROI to be 50 cents for every dollar invested. Evidence-based lifestyle programs, however, may reduce absenteeism and improve productivity, but the ROI may be marginal at best. Given the lack of financial return for lifestyle programs, employers might opt to avoid the cost of screening all employees for health risks, and instead offer healthy food choices and initiate educational campaigns to use the stairs, bike to work, etc.

**The Skinny:** A great body of evidence suggests that implementing just any wellness program by employers will not reduce overall health care spending. However, if a program is designed with specific targeted diseases, some savings may happen in the long run, but not by focusing merely on lifestyle changes. Employers must have realistic expectations and demonstrate a strong organizational commitment for any long-term savings to materialize.

**Myth #3: Repeal, Replace or Repair ObamaCare**
Attacking health care's true cost-drivers — such as unhealthy lifestyles, chronic diseases, misaligned payment incentives to health providers, ineffective and unsafe care, uncoordinated care, and powerful lobbying activities that protect many of these cost-drivers — continue to percolate below the surface and remain mostly hidden from public scrutiny. In some cases, badly needed policy action is required. One major cost-driver is waste, estimated by the Institute of Medicine to be about 30 percent of health spending on unnecessary services, excessive administrative costs, fraud and many other issues. We are far from resolving these problems.

Employer-sponsored insurance covers about 56 percent of the U.S. population, roughly 147 million people. This number dwarfs the individual markets around the country, with the ACA covering about 20 million Americans. Additionally, employers cover more people than Medicare and Medicaid combined. Because of this, employers have a great deal of power and influence over health care reform efforts. For progress to be made, employers will need to coalesce diffused whispers into one loud voice when pushing for similar priorities to control costs and enhance quality. Waiting for the health care industry to reform from within is no good because it will never happen, as it will take purchasers and outside players to disrupt a highly dysfunctional non-system.

The goal of any health care reform effort should include the central focus of improving efficiencies over the entire system, not just with insurance markets. To be fair, the ACA does provide experimentation within Medicare to leverage payment incentives to encourage coordinated care, but much more disruption is needed.

**The Skinny:** Insurance costs are nothing more than a derivative of health care costs. Focusing on the symptoms and ignoring the root causes will not reform nearly one-fifth of our economy. Real, meaningful reform begins with establishing broader coalitions to address the key cost-drivers that make health care delivery so fragmented and costly. The result of this reform will eventually make insurance options more affordable for all payers.

**Note:** As an exercise enthusiast who is insured with a $10,000 family-medical deductible accompanied by a health savings account, my comments may possibly suggest that I am an opponent of wellness initiatives and HDHPs. I am not. But I do believe employers must have realistic expectations about the shortcomings of wellness and cost-sharing plans.