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## **News**

# **Worker Health Costs Begin to Level Off in Tight Job Market**

Posted Aug. 6, 2019, 5:46 AM

- Total health-care costs for family of four top \$28,000
- Companies are re-examining move to high-deductible plans

After years of shifting more health-care expenses to workers to keep their own costs in line, companies are beginning to pull back on raising employee premiums and out-of-pocket charges.

Confronted by a tight jobs market, companies are reconsidering their reliance on high-deductible plans that force employees to pay large up-front costs before services are covered. They're also becoming more active in seeking out ways to reduce costs for themselves and their employees.

Controlling health-care costs is a vital but illusive issue for companies, who provide coverage for about [153 million people](#). Medical costs continue to outpace inflation, putting stress on both employers and employees.

Health-care costs are growing an estimated 3.8% in 2019, compared with general inflation of about 2%, according to the Milliman Medical [Index](#). The index, produced by the actuarial firm Milliman, measures health-care costs for people covered by employer-sponsored plans.

The total annual average cost of health care for a hypothetical family of four in an employer-sponsored preferred provider organization plan is \$28,386, according to the report.

In contrast to most prior years, employers took on more of the cost increase than employees—4% compared with 3.6% respectively.

That still leaves families shouldering a total of \$12,275 in premiums and out-of-pocket costs for such things as deductibles, copayments, and coinsurance, while employers pick up \$16,111 of the tab, Milliman said.

## **A Change in Direction**

Over the past 19 years, employers have moved a significant share of rising health-care costs onto their workers.

But in 2018 the trend shifted, with employers increasing their contributions by 5.1% while the employee cost grew by less than 1%, according to the Milliman report.

From 2017 to 2019, average total employee costs rose an estimated 4.8% while employers experienced an 8.9% increase in their portion of employee health-care costs, the report said.

“That was almost certainly related to the tight labor market, but it probably won’t continue forever in that direction,” Chris Girod, co-author of the report and a principal with Milliman, said in an interview.

“Employers can only take on so much,” Girod said. “And they want employees to have a little bit of skin in the game as well.”

## Narrower Networks

Lincoln Financial Group, a financial services company based in Radnor, Pa., with about 12,000 employees, hasn’t changed the rate at which it subsidizes employee health care.

But it is “consciously stepping away from some of the prior cost-share activities that we as Lincoln and we as the larger benefit community have relied upon,” George Murphy, a senior vice president who is in charge of the company’s benefits, said in an interview.

In 2018 Lincoln Financial implemented a “slightly narrower network” in its New Hampshire operations that saved the company and employees a total of a little over a half-million dollars, Murphy said.

The company is looking at implementing “a few more narrower networks” for 2020, he said. Narrower networks typically reduce costs by limiting covered providers to those selected by the payer based on discounts and on meeting quality standards.

Murphy said Lincoln Financial has been able to keep its cost increases down to about 3% a year over the past five years while most other companies have had higher increases.

## Rethinking High Deductibles

Meanwhile, benefits professionals also are re-examining the reliance on high-deductible plans, Murphy said.

“One of the fears of the high-deductible plans was always that it would in fact prevent people from getting the appropriate care,” he said.

Lincoln Financial, whose workers include about 1,000 lower-paid call center employees, has joined a group of companies in the Health Transformation Alliance purchasers coalition that is conducting an expanded study of the issue. The results should be available within the next quarter, he said.

“I think that will lead to thinking on potential changes to benefits design in the future” for Lincoln Financial, he said.

The changes could entail different deductibles and copayments, as well as full coverage of prescription drugs to cover chronic conditions, he said. Direct contracting with medical providers or narrower networks could also be on the table, he said.

## Tackling Drug Prices

Other employers are focusing on prescription drugs as they take steps to avoid shifting greater costs onto their workers.

Members of the Midwest Business Group on Health are particularly concerned about the cost of specialty drugs, President and CEO Cheryl Larson said in an interview. The Chicago-based organization represents about 125 companies that spend nearly \$5 billion a year covering some 5 million people.

“We’re at the tipping point for what’s in the pipeline” for drugs for diseases such as cancer, Larson said. Some of the miracle cure drugs being developed can cost more than \$1 million.

Some MBGH members are working with the business group to move away from traditional pharmacy benefit manager contracts to ensure that contract terms include pricing that is clearly defined. Pharmacy benefit managers are the middlemen who negotiate prices between drugmakers and insurers. The new contracts also require that any money received by the PBM from drugmakers be passed onto employers.

In addition, companies are narrowing their pharmacy networks through direct contracts with retail pharmacies and for specialty drugs, Larson said. They also are removing low-value drugs from formularies, which determine which drugs are covered, Larson said.

## Away From Fee-for-Service

Members of the Pacific Business Group on Health are among companies trying to move away from traditional fee-for-service payments for medical services, Bill Kramer, executive director for health policy, said in an interview. The San Francisco-based organization represents about 40 companies that spend \$100 billion annually covering over 15 million people nationwide.

Under a fee-for-service arrangement, medical practitioners are paid for specific services, giving them an incentive to perform more services rather than provide more efficient care.

Some PBGH members are entering contracts with accountable care organizations, groups of clinicians who instead are reimbursed for keeping their enrollees as healthy as possible, Kramer said.

Member companies have also made investments to improve chronic care management, preventive services, and primary care, Kramer said. In many cases companies have reduced cost-sharing for enrollees to use the services, he said.

“So you’ve got both investments by the employer in improving those services upfront, reduction in cost-sharing to encourage employees to use those high-value services, and we know there will be improvements if done right,” which will reduce costs over time, Kramer said.

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