

Who Helps Employers Design Their Health Insurance Benefits?

More than half of employers use outside consultants when designing health benefits, but this practice does not result in a different type of benefit package.

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MANY SPECIALISTS HELP employers to design health insurance plans, but little is known about the number and characteristics of employers nationwide that depend on these specialists to help them make decisions. Moreover, we know little about the relationship between use of these specialists and the resulting characteristics of health benefits plans.

Jon Christianson, in his case studies of employers' role in twelve community health systems, offers some hypotheses about the use of outside advisers.¹ He found that it was common for small employers to use "intermediaries" in dealings with health plans, whereas most large employers did not appear to use them. In some communities purchasing coalitions, often sponsored by chambers of commerce, served small businesses, while in other communities insurance brokers served the small-employer market. This suggests that purchasing coalitions and brokers may serve as substitutes in helping small employers to make decisions about health benefits. Regardless of the type of intermediary they used, employers saw the intermediary's role as helping to locate low-cost insurance. Extrapolating from this observation, we might expect that other factors that lower the price or reduce price variation in insurance—such as states' small-group rating reforms—would reduce

employers' need for outside advisers.

The work of Deborah Garnick and colleagues on insurance agents in New Jersey, while primarily focused on the individual market, also offers some hypotheses about outside advisers.² They cite a national trend of decline in the use of agents, resulting from the growth in availability of managed care to small employers and the fact that health maintenance organizations (HMOs) do not use agents as frequently as indemnity insurers do. They also discuss the potential interaction of insurance market reform and the use of agents in the individual market. The standardized benefit packages, rating reforms, and improved consumer information that are often a part of insurance market reform should mean that consumers (and, analogously, employers in the small-group market) will have less need for agents and brokers to provide information and advice. Yet despite the strict reforms in New Jersey's individual market, 71 percent of new policyholders in the individual market used an insurance agent. Might we expect a similar result in the small-group market?

This paper takes advantage of a new national survey of employers to address these issues.

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Methods

We used data from the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey to measure the extent and effects of employers' use of outside consultants in health insurance benefits decisions. The survey interviewed 21,545 private employers throughout the nation, drawn from the Dun's Market Identifiers national census of employment establishments. The sample was concentrated in the sixty communities followed by the RWJF Community Tracking Study and in twelve states having significant small-group insurance reforms.³ Within geographic units the samples were further allocated to strata defined by the number of workers at the establishment. The sample establishments were weighted for these analyses to represent all private employment establishments in the continental United States that have at least one employee and that offer insurance.

Data were collected by computer-assisted telephone interviews averaging thirty minutes each. The interview was conducted with the person or persons in each establishment most knowledgeable about health benefits and firm and worker characteristics. The response rate was 60 percent.

■ **Outside consultants.** A number of specialized concepts and definitions are used in this work. We asked all employers that offer insurance, "Are the decisions regarding your health insurance benefits based on input primarily from internal staff, primarily outside consultants, or both?" We then classified employers as basing decisions on input from internal staff only or on input from external consultants, the latter including businesses using primarily outsiders and those using both internal and external parties. When external consultants were used, we further classified employers by the type of outsider used: insurance agent or broker, third-party administrator (TPA), or professional benefits con-

sultant. We emphasize that the focus of these questions was on substantive decision making about the design of benefits. An employer might answer "internal staff only" but use an insurance agent or broker to arrange for the purchase of a health plan.

Although the sample and analysis unit is the establishment—a physical location of business—for many analyses we categorized establishments according to the size of the firm, which includes employees at all loca-

tions nationwide. Insurance decisions typically are made at a regional or national level for firms with several establishments.

■ **Employer characteristics.** We classified employers as self-insured if they offer at least one self-insured plan, based on the respondent's assessment.⁴ Several other classifications were based on the respondent's self-assessment,

including participation in a pooled purchasing arrangement and whether a plan is an HMO.⁵

Employers are classified as "offering a choice of plans" if they offer two or more plans, whether of the same or a different type and whether through the same or different carriers. We grouped employers as "carving out" special benefits—specifically, mental health or prescription drugs—if they offer a separate single-service plan for these benefits or if they separately contract for these benefits with specialized providers as part of their self-insured plan. Employers offering a choice of plans were classified as "incorporating managed competition incentives" if they pay the same dollar amount for single coverage under each plan, with the employee paying the full difference between the total premium and the employer amount. This provides employees with an incentive to choose lower-price plans.

■ **Quality.** We also report whether employers shop for quality in the plans they choose to offer and whether employees are

"There is no systematic relationship between the use of external consultants and employers' plan costs."

provided with comparative quality information to facilitate their choice of plan. The survey collected these data only for firms having 500 or more employees nationwide. For the latter variable the respondents were further restricted to firms offering a choice of plans. The specific types of information considered for these variables are enrollee satisfaction ratings and plan performance measures.

■ **Premium levels.** We measured both the current health insurance premium level and the change since the past year. The current premium level is based on plan-specific data, reported separately for single and family rates. Some employers offer coverage for special services, such as dental care or prescription drugs, in plans that are separate from the general medical plan. We constructed premiums for the package of benefits offered by adding together the premiums paid for the general medical plan and the plans covering special services.⁶ We adjusted the reported premiums to control for differences in the quantity of coverage provided by different establishments—that is, we report a “quantity-adjusted” premium.⁷ The measure of change since the past year is based on an establishment-level question about change in total health insurance cost per enrollee since the previous year.

■ **State small-group reform.** Finally, we classified establishments by the degree of small-group reform in their state, measured as the interaction of whether all insurance products must be guaranteed issue and how tightly premium rates are regulated, if at all. We define three classes: high (all products are guaranteed issue, and rates cannot be based on health status, as well as limited or no age variation), medium (all products are guaranteed issue, and rates cannot be based on health status, but no or limited restriction on age variation), or low (everything less restrictive or no restrictions).⁸

We explore the relationship between whether external consultants participated in employers’ decision making and the characteristics of the health insurance plans offered by employers. We caution that even if an as-

sociation is found, the direction of causation is not clear. On the one hand, any difference might be the result of the advice offered by the external consultant. On the other hand, it could just as easily reflect the fact that employers that are inclined to choose a particular plan feature will seek the advice of outsiders with expertise to help them to achieve their goal.

Results

Fifty-four percent of all employers nationwide use external consultants to help make decisions about health benefits (Exhibit 1). Employers’ reliance on outside experts increases with firm size. While fewer than half of employers with fewer than twenty-five employees rely on input from external sources, nearly two-thirds of those with 500 or more employees involve consultants in their decision-making process.

■ **Determinants of consultant type.** Among employers depending on external consultants, both the type of specialist and whether more than one type is used vary with firm size (Exhibit 1). Small employers (fewer than 100 employees) generally use only one type of outside adviser, and this consultant is nearly always an insurance agent or broker. Even when more than one type is consulted, an agent or broker is generally involved in the decisions. Medium-size businesses (100–499 employees) also show considerable reliance on agents and brokers, but they are more likely to call on others in addition. TPAs are more likely to be used by self-insured employers. Large employers (500 workers or more) show a greater tendency to rely on benefits consultants to help with health insurance decisions, both exclusively and in combination with others.

It may seem surprising that fewer than half of all small businesses report using an agent or broker to design their benefit plan. However, employers’ responses to this survey may not reflect whether insurance was purchased through an agent—an insured health plan typically can only be obtained from a licensed agent. Rather, the results likely indicate em-

EXHIBIT 1
Participants In Employers' Decisions On Health Insurance Benefits, 1997

	Size of firm (number of employees)						All employers
	Fewer than 25	25-99	100-499		500 or more		
			Fully insured	Self-insured	Fully insured	Self-insured	
Who helps to design benefits?							
Internal staff only	54%	42%	35%	29%	38%	35%	46%
External consultants	46	58	65	71	62	65	54
Type of external consultant							
Only one type							
Agent/broker	71	61	46	25	31	7	52
TPA	3	7	3	14	3	12	6
Benefits consultant	5	5	14	14	32	32	13
Multiple types							
Agent/broker and TPA	5	7	10	24	4	7	7
Agent/broker and benefits consultant	7	8	8	2	7	2	6
TPA and benefits consultant	2	4	7	9	16	28	8
All three types	7	7	12	12	7	12	8

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

NOTE: TPA is third-party administrator.

ployers' perceptions of the sources of information they use in planning the type, scope, and breadth of benefits to offer.

We expected that use of external sources of information might be more common among employers that were redesigning their insurance benefit package or designing it for the first time. However, only among large employers was there evidence that external sources were used more frequently if a recent change had been made in the benefit package. Among employers with 500 or more workers, 84 percent that had changed their offerings in the past year used consultants, in contrast to 61 percent of other large employers.

We also looked for evidence that participation in purchasing alliances or other forms of pooled purchasing might substitute as a source of information, and thus employers using these purchasing mechanisms would be less likely to report using agents, brokers, or other third parties in designing their benefit plans. However, those in purchasing alliances or other purchasing pools were as likely as employers not participating in pools were to report using external sources (not shown).

■ **Plan characteristics and use of consultants.** We found little association between plan characteristics and the participation of external consultants in the decision-making

process (Exhibit 2).⁹ Contrary to the notion that growth of managed care obviates the need for agents and brokers, we found essentially the same rate of offering an HMO among employers that use internal staff only as among those that use outside consultants in three of four size groups.

Employers using external consultants are somewhat more likely to offer a choice of plans. On the other hand, the association with carving out a special benefit, incorporating managed competition incentives, and using quality measurement is either inconsistent across the size groups or is not in the expected direction. There is no systematic relationship between the use of external consultants and employers' plan costs, whether measured by current premiums or change over the past year.

■ **Effect of small-group reforms.** In states with the strongest small-group insurance reforms there is somewhat less use of consultants by small businesses than in states with medium or low reforms (Exhibit 3). This is not a reflection of the general patterns in these groups of states, as indicated by the estimates for larger businesses. Nonetheless, outsiders are still used by more than 40 percent of employers in these states. Therefore, even with reforms that guarantee access and limit

EXHIBIT 2

Characteristics Of Health Plans Offered, By Participants In Employers' Decisions, 1997

	Size of firm (number of employees)							
	Fewer than 25		25-99		100-499		500 or more	
	Internal staff only	External consultants	Internal staff only	External consultants	Internal staff only	External consultants	Internal staff only	External consultants
Offer an HMO	40%	39%	45%	44%	51%	43%	33%	31%
Offer a choice of plans	7	9	16	21	23	30	34	36
Carve out a special benefit ^a	1	2	1	2	6	9	22	20
Incorporate managed competition incentives ^b	20	18	22	29	23	29	43	35
Employer shops for quality ^c	-	-	-	-	-	-	48	46
Offers quality information to employees ^c	-	-	-	-	-	-	32	20
Quantity-adjusted single employee premium	\$188	\$184	\$170	\$175	\$168	\$171	\$188	\$173
Change in premium costs since previous year	2.3%	2.6%	3.4%	2.4%	2.1%	1.9%	2.5%	2.9%

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

NOTE: HMO is health maintenance organization.

^a Includes offering a single-service plan or separately contracting for mental health care or prescription drugs as part of a self-insured plan.

^b If offering a choice of plans.

^c Using patient satisfaction measures or performance measures (such as Health Plan Employer Data and Information Set, or HEDIS). Questions were asked only of employers having 500 or more employees; not applicable for all others.

price variability, a sizable share of employers apparently believe that they need help in acquiring information about options and choosing the right plan or plans.

Discussion

The use of outsiders to help design health benefits is extensive, and it occurs across all sizes of businesses. In fact, the use of outside consultants is more prominent among large businesses than small ones, in contrast to reports from studies of selected communities.

Contrary to our expectations, there is not

nearly as much difference in the characteristics of health benefits between employers that use internal staff only and those that use external consultants. That is, their involvement does not seem to make a difference, at least in the observable characteristics we measured. However, there may be more subtle differences that we could not observe. Apparently, the majority of employers would rather pay outside consultants to acquire information and design plans than to use internal resources for this process, even though resultant plan designs do not differ.

EXHIBIT 3

Percentage Of Employers Using External Consultants, By Extent Of Small-Group Insurance Reform, 1997

Extent of reform	Size of firm (number of employees)	
	Fewer than 50	50 or more
Low	48%	63%
Medium	52	69
High	41	64

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

NOTES: Medium reform if guaranteed issue of all plans and moderate rate regulation (FL, KY, NH, OR, VT, WA). Moderate rate regulation if health status is not allowed, but no or limited restriction on age variation. High reform if guaranteed issue of all plans and tight rate regulation (ME, MD, MA, NJ, NY). Tight rate regulation if health status not allowed and limited or no age variation. Low reform includes sampled employers in all other states.

Our findings suggest that small-group reform may permit some employers to stop using outside consultants. These results come only a few years after the reforms were passed, however. This is an area that deserves to be monitored over time as state regulations continue to evolve and as employers and markets have more experience under them.

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 This research was supported by Grants no. 028651 and no. 031565 from the Robert Wood Johnson Foundation (RWJF). Any views expressed herein are solely those of the authors, and no endorsement by the RWJF or RAND is intended or should be inferred. The authors thank Linda Andrews and Roald Euler for their efforts in preparing the survey data files on which this paper is based.

NOTES

1. J.B. Christianson, "The Role of Employers in Community Health Care Systems," *Health Affairs* (July/Aug 1998): 158-164.
2. D.W. Garnick, K. Swartz, and K.C. Skwara, "Insurance Agents: Ignored Players in Health Insurance Reform," *Health Affairs* (Mar/Apr 1998): 137-143.
3. The survey methods are described in Research Triangle Institute, *1997 Employer Health Insurance Survey: Final Methodology Report* (Research Triangle Park, N.C.: Research Triangle Institute, 1998). The Community Tracking Study is described in P. Kemper et al., "The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People," *Inquiry* (Summer 1996): 195-206. The states are California, Colorado, Connecticut, Florida, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Vermont, and Washington.
4. The question was, "Is this a plan that is purchased from an insurance company or HMO, or is it a self-insured plan?" For further discussion of self-insured employers, see M.S. Marquis and S.H. Long, "Recent Trends in Self-Insured Employer Health Plans," *Health Affairs* (May/June 1999): 161-166.
5. All establishments that offer insurance were asked, "Does your company purchase health insurance through: a health insurance purchasing cooperative or alliance; a business coalition; a multiple employer trust or a multiple employer welfare association; or a trade or professional association or other membership organization?" For further discussion of pooled purchasing arrangements, see S.H. Long and M.S. Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs* (July/Aug 1999): 105-111.
6. For establishments offering multiple plans, we computed an average premium for the establishment by weighting the premiums for the separate plans by the number of enrollees.
7. To do this, we measured the actuarial value of the plan benefits by estimating the expected share of a standardized expenditure distribution each plan would cover. The adjusted premium was then measured as the observed premium multiplied by the ratio of the average share of benefits paid by all plans to the expected share of benefits paid by this plan.
8. Based on a review of legislation in all states for 1990-1997 by the Institute for Health Policy Solutions. See R. Curtis et al., "Health Insurance Reform in the Small-Group Market," *Health Affairs* (May/June 1999): 151-160. See notes to our Exhibit 3 for a list of the states in the high and medium groups.
9. The estimates control for firm size because both the likelihood of using external participants and the characteristics themselves are correlated with firm size.