

LESSONS FOR SMALL BUSINESS: INCENTIVE HEALTH CARE AND RISK RATING PRACTICES

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ABSTRACT

As the health care system reform debate continues, the central challenge of bringing nearly 38 million uninsured American workers under a quality health care plan remains the goal. Another objective that remains clear is that the plan to be implemented will follow the employer-based model which Americans' employers have crafted for over fifty years. Small business owners will be mandated to provide health insurance to all workers, including those who work part-time. This paper examines the health care incentive measures and risk rating practices perceived to be effective cost control mechanisms for small business firms. Conclusions concerning a well-designed incentive program are offered within the context of the Americans With Disabilities Act.

INTRODUCTION

Large double-digit annual increases in health care costs have taken place over the last ten to fifteen years resulting in proportional, profit-draining expenditures by nearly all American businesses (Herzlinger, 1985; Vickery, 1994). Health care expenditures in 1985 cost employers an average of 1,724 per employee. U.S. employers now spend an average of \$3,573 per worker to purchase health insurance and it is predicted that this figure will exceed \$4,800 by the end of 1995 (Nations Business, 1992). Forecasters have observed that "If current laws and practices continue, health expenditures in the United States will reach \$1.7 trillion by the year 2000, an amount equal to 18.1 percent of the nation's gross domestic product (GDP). By the year 2030, as America's baby boomers enter their 70s and 80s, health spending will top \$16 trillion, or 32 percent of GDP" (Burner, 1992).

As U.S. companies continue to face ever greater competitive challenges from international markets and uncertain health system reform, business owners are focusing more attention on containing health care costs. Small business employers are studying and implementing a range of strategies to control the rising health costs (Vaughan and Reed, 1992).

The cost-control strategies typically adopted address the supply side of the medical economic equation and result in "benefit take-aways" from employees (William, 1992). These include limitations on access to providers, pre-hospitalization certification, mandatory second

opinion, concurrent utilization review and cost shifting through higher deductibles for employees. However, health promotion is a cost containment strategy that address the demand side of the cost equation.

Health promotion is broadly defined as "any combination of educational, organizational, economic and environmental supports for behavior conducive to health" (Green and Johnson, 1983). "Contrary to other reports on cost management initiatives, studies show that health promotion is perceived by employees as a valuable benefit and typically has very few of the negative associations of other cost control strategies (Penzkover, 1989). In addition to a warm reception by employees, studies show promising results on the economic impact of corporate health promotion programs (Warner, 1988).

COST CONTROL MEASURES

Over the last several years, a few small business firms have attempted to leverage their health promotion strategies by implementing programs with financial incentives (and disincentives) to motivate their employees to change their "unhealthy" lifestyle habits and maintain good health habits (Muchnick-Baku, 1992). These incentive programs target risky employee health behaviors that could potentially end up costing both the owner and employee money.

The practice of requiring employees with high risk behaviors to shoulder a greater share of their health care costs has become known as "risk rating". Risk rating can be applied in the form of differential premium contributions, copayments, differential deductibles, cost sharing structures or other benefit enhancements based upon an individual's modifiable health risk characteristics, (Chapman, 1992). Specific examples of small business risk-rating strategies include insurance discounts or surcharges, cash rebates or awards for meeting individual or group health goals, contributions to an employee's health care spending account and preadmission reviews, second opinion options, the addition or subtraction of vacation days (Vaughan and Reed, 1992). Some companies choose to adopt only one or two of these strategies while other companies integrate all of them into one plan.

Trends in Risk Rating

Small business insurers report that among client firms, 12 percent either offer a discount or impose a surcharge on employee contributions to life or health insurance plans based upon certain behaviors (Woolsey, 1992). In addition, 6 percent plan to adopt some type of financial incentives over the next two years, and another 19 percent are considering it.

There is little published data documenting the outcomes of risk rating by small business firms, but preliminary data from several business insurers with established small business risk rated health insurance programs indicate that the cost savings may be quite favorable (Muchnick-Baku, 1992). The Adolph Coors Company estimated an average annual medical cost reduction of \$150 per "at-risk" employee three years after their risk-rated program was introduced. Other firms which implemented health incentive plans in the mid 80's, report

experiencing a five percent increase in the cost of their health care plan since 1987 compared to 20 percent increases experienced by non-incentive plan employers (Muchnick-Baku, 1992).

The Foldcraft Company cited less formal results from the implementation of their program in 1990 but states that the "donut index" had decreased significantly. That is the number of donuts ordered as an incentive for injury free work weeks was reduced by half and the "fruit index" increased proportionately when a health promotion and risk rating incentive program was launched (Muchnick-Baku, 1992).

Reasons for Risk Rating

Escalating health care costs are the main reason that small business firms are exploring additional cost containment strategies. A number of reports establish a clear link between certain health characteristics and health care costs (Brink, 1987 and Yen, et. al, 1991). These characteristics, or "risk factors", are directly linked to the behaviors an individual voluntarily choose to adopt, such as exercise, seat belt use, smoking and alcohol consumption (Golaszewski, 1992).

A highly regarded 1987 study of Control Data employees shows a clear scientific association between the presence of specific risk factors and health care costs. This study concluded that a significant difference exists in the utilization and cost of medical care by health status. Generally, high-risk persons utilize more medical care than other persons and generate higher claim costs (Brink, 1987).

As a result business insurers and small business employers have begun to define employees with "high risk" lifestyles or health status as financially burdensome and have structured their health plans to ensure that these employees will pay more for their projected expenditures. In addition to cost containment, other reasons often cited for implementing risk-rated health insurance and benefit incentive programs are: 1) to protect or improve the health of individual employees; 2) to better serve customers and to protect or improve the health of the entire group; and 3) to fairly distribute the costs associated with risk behavior (Priester, 1992). Of these reasons, cost containment and employee health improvement are the most frequently cited reasons for implementing risk-rating strategies in the small firm.

Small Business Workplace Reception

As with most new ideas, risk rating has received mixed reviews from employers and employees. It has been embraced by new-age employees as a creative and effective strategy for motivating healthier behaviors and distributing health care costs more equitably among the most likely users. However, risk rating has also been severely criticized for discriminating against victims of poor health or unfortunate genetic inheritance. These employees feel risk rating unfairly shifts costs to employees on the basis of insufficient research, and some feel it is a "deliberate rupture of the health insurance contract" (Priester, 1992).

SMALL BUSINESS RISK-RATING: THE PROS AND CONS

Cost Containment

In considering risk rating for cost containment purposes, there is convincing evidence that risky lifestyles and unhealthy behaviors do indeed result in higher health care costs. For example, the State of Kansas compared for three years the medical claims of smokers and non-smokers. The study showed that smokers incurred 33 percent more hospital admissions than non-smokers, also, smokers averaged 41 percent more days in the hospital than non-smokers. And smokers had total average medical claims that were approximately \$300 a year higher (Penner, 1992).

In addition to smoking, other lifestyle habits impact health care costs as well. One study found that persons who did not exercise had 114 percent higher non-maternity medical claims costs, used 30 percent more hospital days, and were 41 percent more likely to have annual claims of more than \$5,000 than those who moderately exercised, (e.g., the equivalent of climbing 15 flights of stairs or walking 1.5 miles three or more times a week) (Brink, 1987).

There are several snags in the cost containment argument which small business employers should be aware of in their examination of risk rating. One important consideration is the extra (investment) cost of conducting and maintaining a risk rating program. If the cost of the incentives needed to stimulate and verify the behavior change is greater than the savings from a difference in lifestyle, then risk rating may actually add to the total cost of health care (Kaelin, 1992). Additionally, the costs of supporting and maintaining healthy employee habits at the worksite must be considered if a health promotion program is not already in place. These lifestyle management programs might include weight management, smoking cessation or subsidizing healthier food choices in vending machines.

A pitfall in the cost containment argument is the premise that the "unpreventable claims" which would replace the "preventable claims" would be cheaper, i.e., healthy lifestyles may merely change the causes of death and disease to those which are not preventable (Kaelin, 1992). These new causes of disease and death may generate additional health care costs.

Risk rating for small business firms may be a justifiable model of minimizing and/or spreading health care costs. However, there is much justification for not focusing solely upon cost containment outcomes in the evaluation of risk rating.

Voluntariness

It is essential, especially among small business firms, to examine the voluntary nature of risk in the assessment of risk rating. Establishing the voluntary nature of risk is critical to the determination of financially fair incentives. If behavior is not under one's control, it would be difficult to be held accountable and even more difficult to enforce penalties for those behaviors.

Most believe that health behaviors are under one's control, however, there are a large number of observers who believe that this is not the case (Priester, 1992).

Many argue that one's hereditary makeup is a major determinant of lifestyle and that lifestyles are really not freely chosen at all. For example, it could be argued that alcoholism is a disease, not willfully chosen. Therefore, a criterion of "moderate alcohol consumption" may not be within the control of the alcoholic. Also, a recent study based on a survey of twins, links smoking with an individual's genetic history (Stone, 1993). These voluntary behaviors seem to be heavily impacted by social norms, family and work pressures, as well as economic and political environments (Eisenberg, 1987).

Others believe that behavior is virtually all self-determined with little or no influence from any internal or external forces. A case for this belief is made by pointing out that lifestyle behavior varies widely from individual to individual within families as well as within social classes (Veatch, 1980). Thus, if behavior is strictly hereditary, one would find the same lifestyle behavior among families and classes. Since this is not true, social factors and hereditary factors cannot by themselves explain lifestyle. Therefore, these health behaviors are at least partially free-will choices.

One group of believers in the free-will concept take the argument one step further by casting a moral quality upon one's lifestyle decisions. As one commentator writes, "Why spend money on a system which taxes the virtuous to send the improvident to the hospital?" (Knowles, 1977) Similarly, another writes, "the concept of insurance is to spread risk from unknown causes, but not to subsidize the exorbitant costs of those who, through their own decisions, fail to take reasonably good care of themselves" (Williams, 1992).

Another problem, especially in small groups of employers, is the rewarding of individuals who meet certain standards but are not practicing positive lifestyle behaviors. For example, one employee may happen to have healthy genes and is allowed to receive an incentive for meeting the standard while doing nothing to contribute to their healthful state.

There is no definitive answer on whether lifestyle risks are freely chosen. However, it is certain that small business financial incentive health care programs should be based upon behaviors that are clearly voluntary with allowances for behaviors which may be hereditary in nature. For this reason, "cafeteria plans" were considered relatively effective and "somewhat surprising given the frequent complaint of high administrative costs for small employers adopting cafeteria plans (Vaughan and Reed, 1992).

Probability of Risk

A third issue to be considered by small business employers in evaluating the fairness of risk rating is the relationship between risk factors and probability of disease. A risk factor does not cause a condition to occur. Risk is not a causal condition, but is merely an indicator that one probability may be greater than another (Stone, 1981). Even genetic markers do not predict with certainty whether a person will in fact develop the disease or disorder in question.

It is common for epidemiologist, physicians and insurance health care policy makers to treat an estimate of the likelihood of something happening (a risk factor) to an individual as though it were a fact (Terry, 1991). These estimates or predictions become attributes and qualities by which employees are judged. For example, an employee with hyperlipidemia is commonly treated as a "high-risk" employee. This is because individuals with cholesterol levels above 200 are considered to have 10 times the risk of an individual with levels below 200. Yet there are individuals with extremely high cholesterol levels who will not develop atherosclerosis or any other form of vascular disease over their lifetime.

Many individuals with unhealthy lifestyles habits will never contract the diseases assigned to their risk category, or someone thought not to be at risk who contracts the disease or illness, e.g., the non-smoker who contracts lung cancer (Terry, 1991). Since it is impossible to predict the occurrence of a disease, it seems unfair to charge companies and individuals more for health insurance when their actual health experience may never warrant it.

Risk Measurement and Standards

Still another issue to examine in the scrutiny of small firm risk rating practices is the measurement and establishment of small group risk standards and behaviors. Who sets the standards by which risk is measured? Many professional health and medical associations differ in their screening guidelines and health recommendations. For example, some health experts assert that obesity should not be considered a health risk unless it is accompanied by other primary risk factors or is coupled with the presence of related chronic health problems (Terry, 1992). Yet, many of the risk-rated programs use percent body fat and weight-height ratios as part of the risk formula.

Health standards are continually being modified as new data becomes available. The American Heart Association has recently elevated a sedentary lifestyle from that of a secondary risk factor for heart disease to that of a primary risk factor along with smoking, hypertension and elevated cholesterol. Therefore, lack of exercise is now considered an even greater risk for heart disease than it has been in the past.

Given the absence of one generally accepted standard, it may be unfair to hold employees to a standard that is not universally recognized or not supported by sufficient evidence. Closely linked with the need to set fair standards is the need to quantify these standards. For example, using height-weight tables or body mass index is the subject of great debate among experts. Many argue that there are not measures of obesity that are practical and reliable enough to predict health risks. Specifically, height-weight tables cannot provide information about the percent of body fat or where the fat is stored, both of which are thought to influence the development of chronic health problems.

LEGAL ISSUES AND CONSIDERATIONS

Discrimination

The question of possible discrimination is certainly a factor that must be examined by the small business owner in light of the recent Americans with Disabilities Act (ADA) and the current wave of corporate risk rating. The ADA is essentially designed to open up employment opportunities for disabled Americans (Brislin, 1992 and Lewis, 1992).

One potential concern is the ability of smokers, obese individuals, or other high-risk employees, to use the ADA to strike down adverse decisions regarding their employment. Under the ADA, an employee (or prospective employee) is protected if they are rejected or treated differently because he or she is "regarded as having an impairment" (Sugarman, 1992). An employee who is treated differently because of small business employer fears that higher costs in the future from health claims, absenteeism or turnover from conditions brought about from a smoker or an overweight employee may be seen as having an impairment and protected by the Act (Brannen and Begley, 1995).

Most experts believe that it is still too soon to tell how the courts will treat these types of problems. Some experts have suggested that in enforcing the ADA, the EEOC will, in the early years, focus on those who are clearly disabled now, and will tend to steer clear of the "regarded as having a disability provision" (Sugarman, 1992).

There is specific language in the ADA which may exempt certain insurance or health plan pricing practices that have actuarial validity. Thus, small business employers who might be at risk under the ADA for refusing to hire someone, may be able to charge that person a higher, risk-related premium. It is also possible that small business firms will avoid trouble if they offer lower rates to those with current healthy lifestyles habits, and those who are participating in programs to try to decrease their risk levels. One additional consideration would be a waiver or exemption for those people with disabilities who do not have "normal" parameters, e.g., blood pressure, weight, etc. (Brannen and Begley, 1995).

Along with the ADA, Title VII of the 1964 Civil Rights Act may also be invoked to prevent small business firms from imposing risk rated health insurance premium charges on employees. If, for example, black employees or older employees could show that differential premiums for smokers or non-smokers, or for those with high and normal blood pressure, have a disparate impact on them, the use of these premium differentials might constitute illegal employment discrimination (Sugarman, 1992).

Privacy

Along with discrimination and the accompanying potential for legal difficulties, is the issue of privacy and risk rating. Employers who try to regulate employees off-duty conduct may be impinging upon the distinction between private life and work life. A variety of laws recently passed in 21 states prohibit employers from basing employment-related decisions on a worker's off-duty behavior or lifestyle (Woolsey, 1994).

Critics of risk rating plans state that the fact that certain lifestyles increase or decrease health care costs has nothing to do with how many widgets (a worker) can turn out in one hour. The fear is that small business (small group) employers won't just draw the line at the obvious, well-documented risks but will encroach upon any health risk as fair game. Woolsey writes, "Once you start down that road of regulating off-duty conduct, you have almost a limitless supply of areas of discrimination: alcohol use, red-meat diets, even recreational activities like hang gliding or mountain climbing."

It is clear that much work will need to be done before there are definitive answers to the many questions regarding the application of risk rating plans in small businesses and the potential for discrimination in the face of the ADA and Title VII. It is obvious that small firms walk a fine line between helping employees attain better health and interfering with their personal freedom. In reducing health care costs, small business owners must carefully select their standards and take great care in the design of small group risk rated programs to be fair and avoid costly, time consuming legal problems.

CONCLUSIONS

Competitive choices and trade-offs for small business firms today, clearly involve the ability to offer employees health insurance benefit plans. In an era of double-digit annual increases in health care costs, the fear of not being able to afford needed medical treatment (long the problem of the uninsured) confronts the currently insured small business owners and their employees. A well-designed cost containment incentive program can be designed to take into consideration the many pros and cons associated with a fair risk rating plan for small business employees. As more small business insurers experiment with policy design and financial incentives of all types, additional knowledge will be gained that may facilitate designing the best and fairest utilization of risk rating as a positive instrument. Until more research has been done, the following recommendations for small business owners and their employees can serve as a useful starting point in the designing a risk rating plan:

1. Incentives should be habit-based rather than risk-based. To be effective and fair, risk rating should emphasize only those behaviors over which an individual has ultimate control. Examples of these types of habits are: seat belt use, exercise, regular medical checkups, diet and smoking.
2. Employees who are at risk but are attending classes or are actively engaged in reducing their risk through changing behavior should not be penalized for their current risk level. Adequate time should be allowed for employees who are working on behavior change and risk reduction.
3. Program flexibility should allow for individual or special group considerations. Examples of this would be allowing pregnant women a certain length of time to return to original weight and physiological conditions before meeting standards, or creating special standards for handicapped or disabled individuals in terms of exercise and certain physiological parameters.

4. Consideration should be given to the impact that risk standards may have on types of individuals within the firm. Care should be taken so that discriminatory standards are not set that will affect certain demographic groups in a disparate manner.

5. In order to be safe and fair, incentive plans should reinforce long-term behavior change rather than inducing short-term behavior. Setting realistic time frames for employees to meet certain requirements is highly recommended. For example, allowing short time frames within which employees must meet certain weight standards may lead employees to fast or use crash diets, either of which can have a severely negative effect on overall health. While on the surface meeting the requirement of the risk rating plan, the actual outcome may be more costly to the individual and to the plan.

Presently, little data is available supporting the fairness of small business attempts at risk rating plans. With pending national health care reform and as risk rating becomes more pervasive, there will be a continuing need to address the financial, medical, legal and ethical issues these programs create and to refine them accordingly. This will be especially true as we learn more about how the Americans with Disabilities Act will be applied to small business firms.

Regardless of what happens with the concept of risk rating, small business owners can hope that healthy lifestyles will be embraced on their own merit rather than as something to be forced onto an unhealthy workforce. If both small business employees and employers value and work hard at achieving and maintaining health promoting practices, with or without risk rating programs, the competitive enhancement and payoffs can be immense.

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