

Health & Benefits Perspective

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Improving the value and cost of US health benefits: Could shifts in the employer role provide the solution?

As debate about US health care reform intensifies, employers are re-examining their role in helping employees obtain and maintain health coverage. Traditional – and still important – organizational objectives for offering employee health benefits include attracting and retaining qualified workers, driving productivity gains through a healthier workforce and providing a financial safety net for employees and their families. However, rising health plan costs, administrative burdens and employee dissatisfaction with offerings have employers of all sizes asking hard questions: What's the value in offering health coverage? Are there new approaches that might offer better cost and strategic value?

The emerging answers to these questions are revealing radically different philosophies about the role of employers in the US health care system:

- Some employers are demanding greater health care efficiency and quality, along with launching efforts to improve their workforce's health status.
- Other employers are cutting back health expenses and increasing employee premiums.
- A number of employers are dropping coverage for all or some of their workforce – for example, part-time staff or retirees.

This *Perspective* examines the history of employer-sponsored health coverage and its current environment. Along with reviewing the different changes that employers are debating, we discuss the health policy and insurance market developments needed for significant shifts in the role employers play. In addition, we offer practical considerations for employers contemplating near-term change.

Roots of the US health insurance system

The earliest precursor to health insurance in this country appeared in the early 20th century, when religious, membership and other organizations used member tithes, charitable gifts or endowments to finance hospital-based health care.

By the mid-1930s, local organizations, such as precursors to today's Blue Cross Plans, began to emerge to provide hospital insurance for many Americans. Similar organizations, such as precursors to Blue Shield Plans, were established to provide insurance for physician services.

Passage in 1932 of the National Labor Relations Act, with its mandate for management to bargain with labor over "wages and benefits," set the stage for wider adoption of employer-based health coverage. World War II brought strict enforcement of price and wage controls, leading employers to compete for workers on the basis of employee benefits. Employment-based health coverage became increasingly prevalent during subsequent decades.

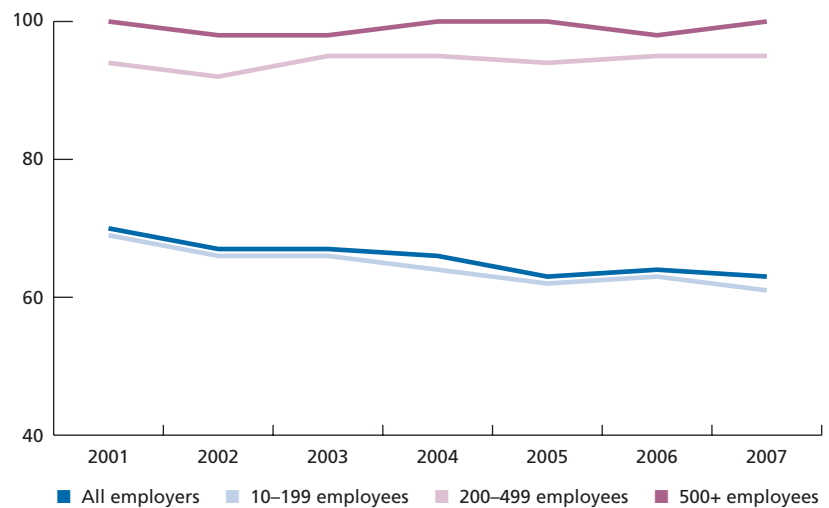
Throughout this history, policy-makers have debated the scope of accountability individuals should bear for their health care.

Evolution of the employer role in health benefits

Employer-sponsored health benefits are widespread in today's workforce, but this hasn't always been the case. Health insurance as a significant "fringe" employment benefit didn't emerge in the US until World War II, when wages were frozen and employers needed ways to compete for scarce labor. This expansion of employer-sponsored health care coverage effectively triggered a decline in the retail health market, where individuals had paid directly for the cost of their insurance or their health services. (See left panel for the historical development of the private insurance market.)

By the last part of the 20th century, health care benefits had become a core part of employees' total compensation package offered by the majority of employers. As the 2007 *Mercer National Survey of Employer-Sponsored Health Plans* shows, this trend has continued into the 21st century, with nearly universal coverage among employers with 200 or more employees. However, just 61 percent of employers with between 10 and 199 employees now provide coverage, down from 69 percent in 2001.

Percentage of employers offering health insurance, by employer size



Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2007

These findings signal that most employers – and almost all large employers – continue to view health benefits as an ongoing business reality. However, employers' involvement in employee health coverage varies widely. Some simply select a health insurance carrier and pay part of the premium, while others design and self-fund multiple benefit options. Some even supplement the health plan with on-site or near-site clinical services or programs to address health risk assessment, disease management or other special health needs.

Business rationale for employee health benefits

Many employers see health coverage as an important competitive tool for attracting and retaining employees, and some employers use comprehensive and integrated health programs as a strategic resource for improving productivity. The aging workforce, coupled with higher rates of obesity and associated health risks, has made employers keenly aware of the need to improve employee health. Aside from any health plan savings, a healthier workforce that has less sick time can yield a measurable competitive advantage. Conversely, a workforce that has high rates of illness, time off and on-the-job “down time” due to health problems creates an economic disadvantage. But not all employers adopt such a macro perspective when evaluating the return on investment from offering health coverage.

Apart from any business reasons for employee health benefits, some employers feel a moral obligation, believing that providing health coverage is the “right” thing to do. An employer that espouses a caring philosophy and a commitment to be an “employer of choice” would be hard-pressed to leave employees facing catastrophic expenses without a financial safety net. Yet, given more marketplace options for employees to buy affordable health, life and retirement plans, these employers might have a different opinion.

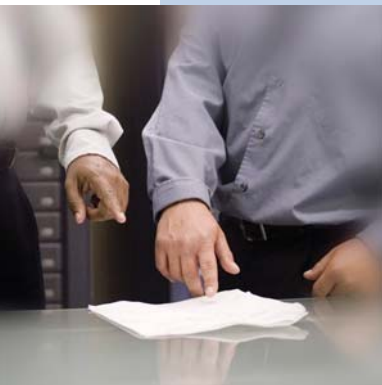
Today’s state of play

Despite the business and moral case for offering health coverage, ever-increasing health care expenses and regulatory requirements have begun to tip the cost-benefit balance. Many small employers – and even some large employers in retail and other industries with high turnover and relatively low-paid employees – view health care benefits as an unaffordable expense, an onerous administrative burden or a source of employee dissatisfaction. At most organizations, the employer role in sponsoring and contributing to employee health coverage is an increasingly common topic of conversation among CEOs, CFOs and human resource executives.

As a result, many employers are taking steps to change their role in sponsoring and financing health care coverage. Examples include:

- Making employees more aware of the cost of health care services and encouraging them to take more responsibility for managing their own health care
- Adopting a defined contribution approach, under which the employer contributes a set amount toward health coverage for each employee and the employee is responsible for costs above that amount
- Cutting back coverage to a core or catastrophic level and offering health reimbursement arrangements (HRAs) and health savings accounts (HSAs) so employees can pay pretax for non-insured medical expenses





While some employers are even terminating all health benefits, the health insurance market is far from ready to accommodate a mass exodus of employer health plan sponsors. Individual insurance is difficult and expensive to purchase, even for someone in good health. For the large numbers of individuals with health, age or other risk factors, obtaining affordable insurance is nearly impossible, except in Massachusetts and a few other states that have adopted viable options for individual health coverage. Exacerbating this situation, federal tax and many state insurance laws continue to favor employer-provided coverage.

Some signs suggest that the individual insurance environment is beginning to change. For example, some carriers are beginning to develop consumer-oriented plans tailored to the unique needs of different demographic groups, such as Medicare-ineligible retirees under age 65 or the self-employed. In addition, state and federal policymakers are debating ways to increase access to affordable health insurance. However, considerable policy and marketplace reforms must occur before viable options emerge to facilitate transforming the role of employers as the primary source of health insurance for working Americans.

Policy issues affecting the health care role of employers

Health care reforms under consideration at the federal and state levels may significantly influence any changes in employers' sponsorship of health coverage. Many proposals focus on individual responsibility and market-based reforms that could bolster employers' efforts to limit their involvement in sponsoring or managing health benefits. For example, many policymakers support federal tax reforms that would remove the income tax exclusion for employer-sponsored coverage and replace it with tax breaks for anyone buying coverage – a move that would ease the financial consequences to employees of migrating away from employer-based coverage. Other reforms, already adopted in Massachusetts and proposed elsewhere, aim to make individual coverage more accessible and affordable through centralized health insurance purchasing markets.

Other policy initiatives include play-or-pay proposals similar to the ones enacted by Massachusetts and San Francisco, which require employers that do not provide a certain level of health coverage to pay into state or local government programs. However, Mercer's survey shows that half of employee health plan sponsors disapprove of these measures, and only 23 percent approve (the rest are neutral). This is likely because many employers want to retain flexibility and control over the coverage provided to employees, and multistate employers prefer to avoid the burdens and complications of complying with numerous state or local mandates.

A handful of states have already adopted and others are considering various cafeteria plan mandates. These measures generally require most employers to give employees the option of using pretax dollars through

a cafeteria plan to pay health insurance premiums. While cafeteria plan mandates may not require employers to provide coverage, they would have to process and administer pretax salary reductions for employees' coverage. Employers wanting to exit the health benefits game altogether may be thwarted by these measures.

Health insurance reforms needed

For employers to redefine their role as health coverage sponsors or purchasers, the health insurance market must evolve dramatically. Significant developments in information and resources will be needed to transition employers' financial and other decision-making responsibility to individuals. Changes in supply, demand and technology will be essential to reshape the market and enable a structural migration from employer-based benefits to an individual consumer market.

To make this shift successfully, the insurance market would have to offer widespread guaranteed-issue policies, risk-adjusted or community-rated premiums, or similar measures that ensure access to multiple, affordable insurance products, regardless of an individual's health status. Other reforms would be needed to facilitate the transition away from an employer-based health care system:

- Limited mandated benefits would help ensure products are affordable for individual consumers.
- Technology changes would have to occur to support enrolling individual consumers and other operational matters.
- Tax laws would need to provide the same incentives for purchasing individual or group coverage, and the use of HSAs or other tax-favored savings vehicles to help cover individuals' medical expenses would have to broaden.
- Robust information systems to support informed consumer choices would have to emerge, providing easy access to data on the price and quality of insurance products, health care providers, and health care services; treatment effectiveness and other outcomes; personal medical records; and other tools and resources.
- Extensive cost and quality measures would need to be standardized.
- Individuals would need to understand their own health status and have sufficient tools to manage and improve it.

Today's market is far from ready to support these changes.



A changing employer role

As employers reconsider their role in health coverage, market realities are one of many factors to assess. The scope and cost of an employer's involvement are significantly influenced by the type and number of benefits the employer offers, its level of financial commitment, and the number of employees and family members eligible for coverage. Yet successfully introducing plans that increase individual responsibility usually requires employers to expand some administration functions as employees learn to navigate more complex coverage options. On the other hand, not sponsoring any plan and simply contributing toward coverage that employees obtain on their own eliminates most administrative obligations for employers.

At first blush, the idea of an exit strategy may seem appealing – a path to relief from all the administrative and financial burdens of providing employee health coverage. However, for many employers, health plan sponsorship is more than a mechanism to offset employees' health care expenses. As noted earlier, employer-sponsored health benefits can help attract and retain employees, manage employee health and productivity, influence health care provider behavior, provide valuable compensation in a tax-efficient manner, and achieve other business objectives.



To help employers decide whether to retain their current role in providing employee health coverage but at lower cost, move toward more employee responsibility, or pursue an exit strategy, the following chart lists some factors to consider.

Employer role: Sponsoring a health plan	
Opportunities	Challenges
<ul style="list-style-type: none"> ■ Attraction and retention tool ■ Means to improve employee health and workforce productivity ■ Consistent with paternalistic approach to workforce ■ Favorable tax treatment under current law ■ Fulfillment of existing commitments ■ Enhanced employee satisfaction 	<ul style="list-style-type: none"> ■ Not core business ■ High administrative burden ■ Compliance risks ■ Competitive disadvantage in global marketplace ■ Cost increases exceeding general inflation
Employer role: Implementing an effective exit strategy	
Opportunities	Challenges
<ul style="list-style-type: none"> ■ Leaders better able to focus on core business ■ More predictable labor costs (by avoiding volatility in health care costs) ■ Reduced administrative costs ■ Empowered employees ■ Avoid compliance risks 	<ul style="list-style-type: none"> ■ Productivity losses if employees go without coverage and necessary medical care ■ Significant barriers to insurance access in individual market ■ Fewer tax incentives for individual coverage under current law ■ Less incentive for providers to change behavior when no group purchaser ■ Heightened risk of government-run system with employer funding mandate ■ Loss of competitive edge in labor market if competitors do not exit ■ Potential employee relations challenges if exit viewed as a “takeaway” ■ Potential breach of collectively bargained agreements ■ Differential impact on employee groups, with the biggest impact on lower-paid employees ■ Reduction or loss of employer’s ability to influence health status and related productivity levels





For more information

For additional information, please contact your Mercer consultant.

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Besides the factors shown in the table, a number of other considerations influence an employer's assessment. For example, an employer's size can dictate the internal resources available to manage benefit programs. Industry type affects competition for labor, which can in turn influence the scope and design of benefit offerings. Shifting financial responsibilities to employees can raise significant financial and tax implications. And the current uncertainty surrounding national and state health care reform further complicates strategic planning in this area, since employers might be allowed to exit the market or be forced to provide coverage. In the meantime, employers will be better equipped to participate in the ongoing debate – and shape its outcome – if they identify the resources currently spent on employee health coverage and understand the value to their organizations.

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