MARSH & McLENNAN COMPANIES

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# Health Reform and American Businesses: Critical Partner for Success

## A PUBLIC POLICY POINT OF VIEW

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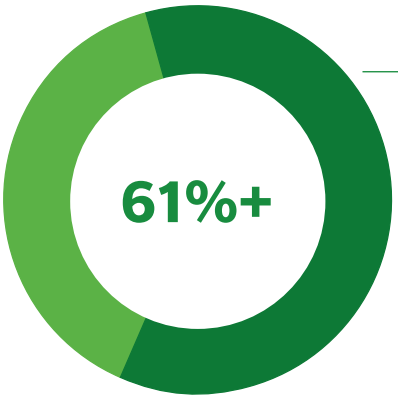
# OBJECTIVE

As the debate over health reform again takes center stage among US policymakers, it is important to remember the significant role American businesses play in our healthcare system. Approximately 177 million Americans (61 percent of covered Americans) get their health coverage through an employer.[1] That's nearly 16 times the number of people who get their coverage through the ACA federal or state exchanges.[2] Moreover, in 2015, employers collectively spent $668 billion on health benefits[3] (more than federal spending on Medicare),[4] and on average, they spend about 13 percent of payroll on healthcare.[5] Therefore, as we move to strengthen the individual market, we should simultaneously take action to preserve and expand employer-sponsored health coverage, and enact policies that promote efficiency and quality in the larger US healthcare system. We are on the cusp of a major transformation in how people access care and how care is delivered. It will be led by those employers and innovative providers that harness technology, consumerism, and advances in value-based reimbursement. The potential savings are vast, and would help achieve the important goal of expanding health coverage to more people while preserving the employer-based system that Americans value so highly. In this paper, we present four recommendations to achieve these goals:

1. Address healthcare cost growth and avoid shifting costs to private payers;
2. Maintain favorable tax treatment of employer-sponsored benefits;
3. Update health savings account rules;
4. Create a "President's Healthcare Leadership Council".

**EMPLOYER CONTRIBUTIONS TO US HEALTHCARE**




More than 61% of covered Americans (177 million people) get their health coverage through an employer...

**$668 B per year**

...with employers collectively spending $668 billion on health benefits each year.

1 US Census Bureau, Current Population Survey, 2016 Annual Social and Economic Supplement, Table HI01. Health insurance coverage status and type of coverage by selected characteristics: 2015, http://www2.census.gov/programs-surveys/cps/tables/hi-01/2016/hi01_1.xls

2 Centers for Medicare and Medicaid Services, March 31, 2016 Effectuated Enrollment Snapshot, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

3 US Bureau of Economic Analysis reports employer contributions for group health insurance were $668 billion in 2015. Table 6.11D. Employer contributions for employee pension and insurance funds, revised Aug. 3, 2016, https://www.bea.gov/iTable/iTable.cfm?ReqID=9&step=1#reqid=9&step=3&isuri=1&903=219

4 The Centers for Medicare & Medicaid Services reports 2015 Medicare spending was $646 billion. National Health Expenditure Accounts (NHEA), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

5 Mercer, 2016 National Survey of Employer-Sponsored Health Plans.

# INTRODUCTION

Given the number of Americans they insure and their collective purchasing power, employers are pivotal players in today's healthcare system. In fact, because of their significant role in the marketplace, employers are uniquely positioned to help control healthcare spending and promote positive health outcomes.

Employers have long been providing the tools employees need to become smart, fiscally responsible insurance consumers, and employers are a trusted source of health information and resources.

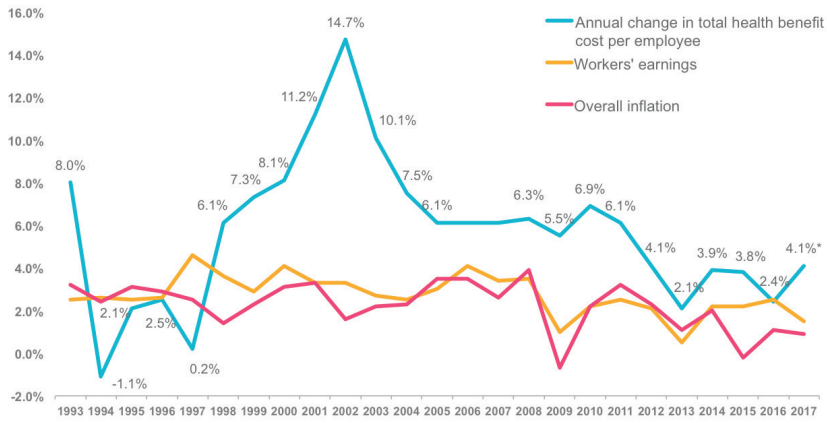
Health-benefit costs outpace inflation – often by three times or more – and rising benefit costs can act as a drag on business results (Figure 1). In addition, American businesses help fund care for Medicare and Medicaid beneficiaries, as providers often charge private payers higher rates to help cover underpayments for these populations. The American Hospital Association estimates that combined Medicare and Medicaid underpayments totaled $57.8 billion in 2015.[6] Our nation's employers are implicitly subsidizing these programs.

For those reasons, legislators must consider the economic impact that policy changes may have on employers, as well as the many ways that employers have and will continue to improve healthcare value, quality, and consumer experience in America. American businesses can play a meaningful role during this transformational change. Actively engaging employers now will be critical to the long-term success of any reform efforts.

As the world's largest employee benefits consultant for America's businesses, Marsh & McLennan Companies (MMC), the parent company to Mercer and Oliver Wyman, provides this initial set of four recommendations for policymakers to consider as they pursue reform.

FIGURE 1
**HEALTH BENEFIT COST CONSISTENTLY OUTPACES INFLATION**

Change in total health benefit cost per employee compared to CPI, workers' earnings




* Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1993-2016; Bureau of Labor Statistics, Seasonally Adjusted Weekly Earnings from the Current Employment Statistics Survey (April to April) 1993-2016.

6 American Hospital Association, Underpayment by Medicare and Medicaid Fact Sheet, December 2016, http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf

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## RECOMMENDATION

**AVOID POLICIES THAT MERELY SHIFT COSTS TO PRIVATE PAYERS AND ADOPT POLICIES THAT ADDRESS THE UNDERLYING CAUSES OF HEALTHCARE COST GROWTH**

## COST SHIFTING IS NOT THE WAY TO CREATE A SUSTAINABLE AND AFFORDABLE HEALTHCARE MARKET

Congress should maintain Medicaid expansion and funding levels. Block granting Medicaid and rolling back the expansion would likely result in an increase in uninsured and lower payments to Medicaid providers. Both of these scenarios may lead providers to hike rates for private payers, thereby shifting more costs to employers.

An estimated 12.9 million Americans could be at risk of losing coverage if the Medicaid expansion is repealed.[7] A spike in the number of low-income uninsured people increases provider risk for uncompensated care. (The total cost of uncompensated care for the uninsured was $84.9 billion in 2013.)[8]

Employers have carried the burdens of explicit and implicit cost-shifting. Through the ACA's Transitional Reinsurance Program (TRP), American businesses contributed more than $16 billion to support the individual health insurance market, with several billion in 2016 contributions still to come.[9] Although price hikes in the individual marketplace generated headlines, employers had to cope with the high cost of their own health benefit programs while also contributing money behind the scenes to help cover insurance company losses through the TRP. This explicit cost-shifting approach did not make the individual market successful and is not a sustainable strategy.

Implicit cost-shifting could result from several of the ACA reform plans under consideration. Some propose rolling back the ACA's Medicaid expansion and allowing states to choose between block grant and enrollment-based financing. Moving to block grants would reduce federal involvement in Medicaid and offer states added flexibility to administer their programs. However, it likely would also mean a reduction in total federal funding. A 2013 analysis by the Bipartisan Policy Center estimated that a proposal to block grant Medicaid would reduce federal funding for the program by $160 billion in 2022.[10]

Cost-shifting does not address the underlying causes of healthcare cost growth, and increasing burdens on employers will simply make it harder for them to provide affordable coverage to their employees.

7 Blumberg, Linda J., Matthew Buettgens, and John Holahan, "Implications of Partial Repeal of the ACA through Reconciliation," Urban Institute, December 2016, http://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_0.pdf

8 Kaiser Family Foundation, "Uncompensated Care for the Uninsured in 2013: A Detailed Examination," May 2014, https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf

9 Uberoi, Namrata K. and Edward C. Liu. "The Patient Protection and Affordable Care Act's (ACA's) Transitional Reinsurance Program," Congressional Research Service, November 16, 2016, https://fas.org/sgp/crs/misc/R44690.pdf

10 Bipartisan Policy Institute, "Paul Ryan's Fiscal Year 2014 Budget: The Details," March 21,2013, http://bipartisanpolicy.org/blog/paul-ryans-fiscal-year-2014-budget-details/

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## RECOMMENDATION

# MAINTAIN THE FAVORABLE TAX TREATMENT OF EMPLOYER-SPONSORED BENEFITS

## THE EMPLOYEE TAX EXCLUSION BENEFITS AMERICAN WORKERS

Under current law, nearly all premiums for employer-based insurance are excluded from federal income and payroll taxes. The Congressional Budget Office (CBO) estimates this tax exclusion cost the federal government $250 billion in fiscal year 2016. But it also helped to lower the average American worker's health insurance costs by about 30 percent.[11]

Some of the proposed reform plans suggest limiting or eliminating the employee tax exclusion on the grounds that it has led to a shift in compensation from taxable cash wages to overly generous health benefits. However, this point of view doesn't take into account that health benefit cost is affected not just by plan design, but by factors outside an employer's control, such as the age and health of their workforce and local health market conditions.

Mercer calculated the impact of the ACA's excise tax on high-cost plans and found that the plans most likely to hit the excise tax threshold were those that covered higher proportions of older workers, females, families, and part-time workers. Importantly, average actuarial value is only slightly higher among employers with plans at risk for the tax – demonstrating that plan design is only one of several factors that might lead to hitting the tax threshold (Figure 2).

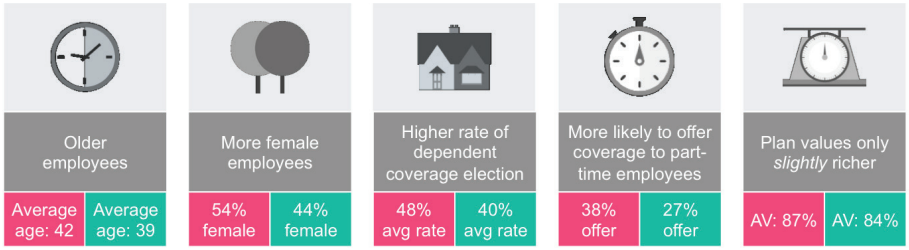
Like the ACA's excise tax on high-cost plans, limiting the tax exclusion will have a substantial, negative financial impact on workers. As employers scale back health plan benefits to minimize adverse tax impacts of coverage costs, employees take on more risk for out-of-pocket expenses. Those that use the most healthcare – generally, people with chronic conditions and families with young children – will be hit the hardest.

FIGURE 2

**FACTORS THAT AFFECT PLAN COST**

**NOT JUST PLAN DESIGN–DEMOGRAPHICS MATTER**

Characteristics of employers' plans that **will reach** versus **won't reach** the Cadillac tax threshold in 2020:




Like the Cadillac tax, capping the exclusion will penalize older workers, women, people with families, and employers who provide health benefits to part-time employees…

*…And there is little difference between the plan designs of those employers who will reach the threshold and those who won't.*

Source: Estimates based on data from Mercer National Survey of Employer-Sponsored Health Plans 2016; premium trended at 6%, tax threshold trended at 3% in 2021 and 2% in future years.

11 Congressional Budget Office, "Private Health Insurance Premiums and Federal Policy," February 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf

In fact, Mercer has evaluated the impact of the proposed caps on the federal income tax exclusion set forth in the Empowering Patients First Act ($8,000 individual/$20,000 family). By 2020, more than 30 percent of households will exceed the cap, with that number increasing to 85 percent of households by 2030 (Figure 3).

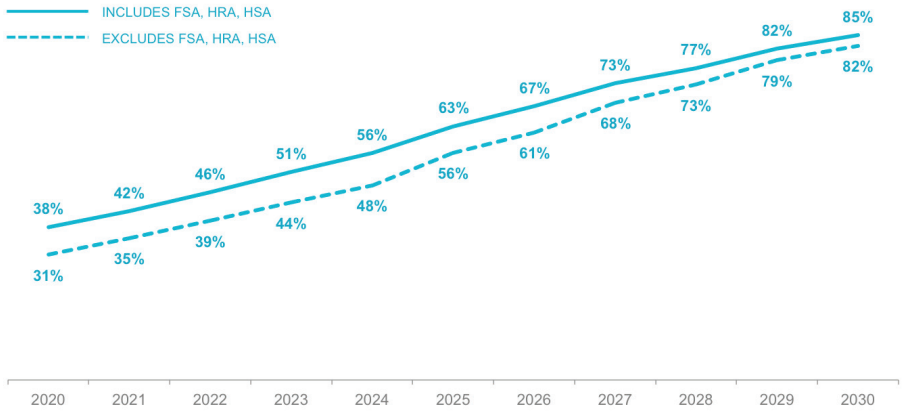
What's more, a cap on the exclusion would have the biggest impact on lower-income workers. Mercer looked at the impact the caps proposed by the Patients First Act would have on taxpayers in 2026. We estimate that the effective tax rate of families in the $20,000-$30,000 income bracket would increase by 23 percent, while rates for high income taxpayers would go up by only 5 percent (Figure 4). Low-income families are already struggling to manage healthcare costs without new taxes increasing their burdens.

American businesses are highly motivated to control health costs while maintaining a healthy, engaged workforce. Placing arbitrary limits on the tax exclusion hinders their ability to offer a sustainable benefit package that meets the needs of their employee population.

FIGURE 3

## UNDER PATIENTS FIRST ACT, MAJORITY OF HOUSEHOLDS WILL BE TAXED ON MEDICAL BENEFITS BY 2023

Percent of households exceeding cap is expected to increase significantly over time:

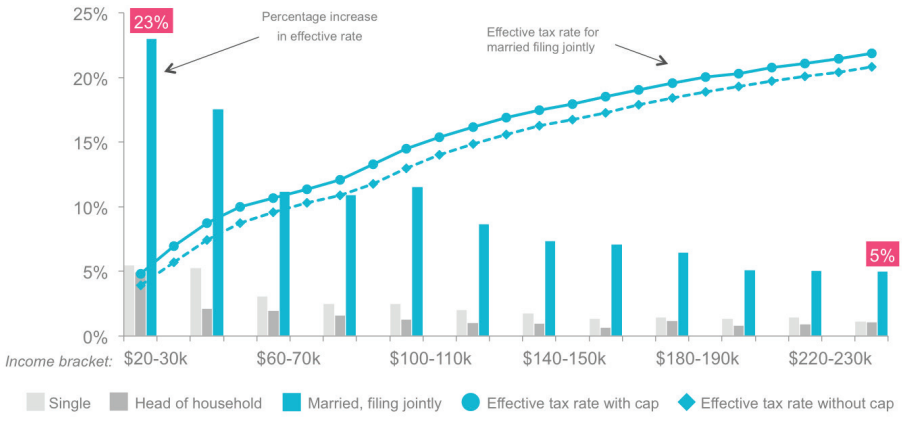



Source: Based on a Mercer proprietary database of 600,000 members' salary and benefits. Salary information used as proxy for household income. Proposed caps of $8,000 individual/$20,000 family indexed at CPI% (CPI assumed to be 2%). Medical plan trend assumed to be 5.5% is based on current plan design.

FIGURE 4

## EMPOWERING PATIENTS FIRST ACT
## LOW INCOME FAMILIES HIT HARDEST

Cap will result in **increased income tax liability** for middle-income Americans




Source: Based on a Mercer proprietary database of 600,000 members' salary and benefits. Salary information used as proxy for household income. The bars represent the percentage increase in income tax liability in 2026. Payroll taxes not included. Proposed caps indexed at CPI% (CPI assumed to be 2%); medical plan trend assumed to be 5.5%. Projects the impact of including account contributions – FSAs, HRAs and HSAs – in value of coverage.

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## RECOMMENDATION

## UPDATE HSA RULES TO MAKE THEM MORE FLEXIBLE AND USEFUL FOR LONG-TERM SAVINGS

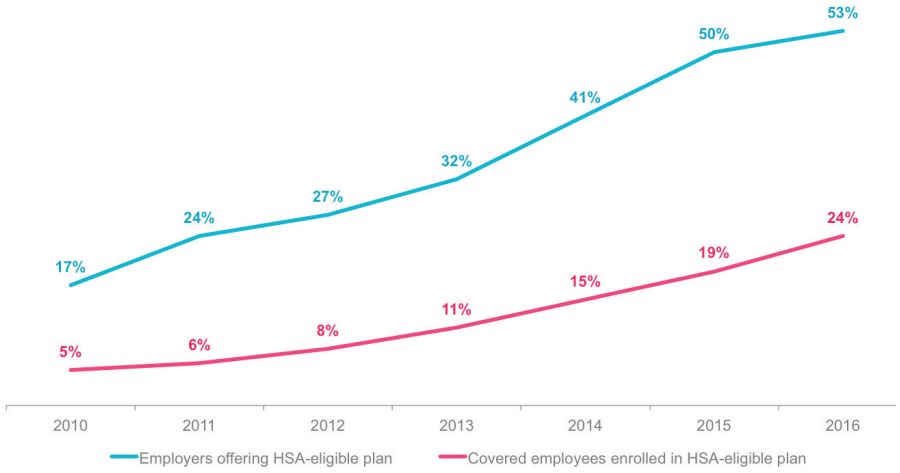
## HEALTH SAVINGS ACCOUNTS PROMOTE RESPONSIBLE USE OF HEALTH RESOURCES, BUT OUTDATED REGULATIONS PREVENT ACHIEVING THEIR POTENTIAL

Health Savings Accounts (HSAs) put employees in charge of their own health dollars and can lead to more responsible use of health resources. Consumer-directed health plans, where HSAs are coupled with high-deductible health plans, have been shown to have a real impact on consumer behavior, decreasing total healthcare spending about 5 percent in each of the three years after a plan is introduced.[12]

Adding well-designed transparency tools and consumer education helps ensure that members are equipped to make better healthcare decisions.

FIGURE 5
**HSA-ELIGIBLE PLAN OFFERINGS AND ENROLLMENT**

Employers with 500 or more employees




Source: Mercer National Survey of Employer-Sponsored Health Plans 2016.

HSAs have been gaining in popularity in recent years, and more than half of large employers (53 percent) now offer an HSA-eligible plan to their employees (Figure 5). This trend is likely to continue as more mid-size employers follow large employers' lead.

Still, most consumers underutilize their HSAs, even though they are the most tax-efficient savings vehicle available. One reason may be that relatively low annual limits make it hard to accumulate meaningful amounts for post-retirement medical expenses, especially because individuals are not permitted to make contributions once enrolled in Medicare. They might also be more attractive if eligibility rules were modernized to allow alternative, cost-effective care delivery, such as onsite medical clinics and telemedicine, and if funds could be used for over-the-counter drugs.

Policies that would make HSAs more useful include:

- Increasing the annual HSA limits to align with high-deductible health plan out-of-pocket maximums;
- Encouraging the use of HSAs to save for medical expenses in retirement;
- Modernizing eligibility rules to allow access to innovative alternative care models; and
- Enacting legislation that boosts transparency in healthcare and requires hospitals and health insurers to provide healthcare cost information to patients and beneficiaries before the point of care.

With proper policy and regulatory support, the HSA could be a key vehicle for improving costs across Medicaid, Medicare, individual market, and employer populations.

12 Do "Consumer-Directed Health Plans Bend the Cost Curve Over Time?," National Bureau of Economic Research, http://www.nber.org/papers/w21031

4

## RECOMMENDATION

**THE ADMINISTRATION SHOULD CREATE A "PRESIDENT'S HEALTHCARE LEADERSHIP COUNCIL" TO DRIVE TRANSFORMATIVE CHANGE AND BOOST TRANSPARENCY IN HEALTHCARE**

## INNOVATIONS SUCH AS VALUE-BASED CARE HAVE PROVEN SUCCESSFUL, BUT REAL PROGRESS WILL REQUIRE WIDE-SPREAD ADOPTION

There is a movement underway in the US healthcare system to improve efficiency by focusing on quality and value. New, risk-bearing provider organizations are redesigning care models and achieving cost savings and improved outcomes.

However, innovation around care delivery and payment models is mostly occurring in silos. Like CMS, commercial payers are testing value-based payment models through a variety of pilot programs. But shifting to a value-based model requires a significant tactical and philosophical pivot, as well as cross-industry collaboration and consensus on what constitutes value and how to measure it. Lacking this, it has proven difficult for the commercial market to garner necessary investment to implement such programs on a national basis.

In fact, Oliver Wyman analysis shows that while 23 percent of managed care revenue is tied to some value or outcome payment, only 10 percent has a risk-sharing element.[13] And Mercer research shows that among the nation's largest employers (those with 20,000 or more employees), just 15 percent incent employees to use an accountable care organization; 20 percent offer an expert medical opinion program; and 16 percent provide devices to transmit health data to providers.[14] Individual employers have had striking success with such innovative programs, but only as their use spreads will we see measurable improvement in outcomes and efficiency on a national level.

Even when employers wish to move to value-based models, they are handicapped by the opaque health system. Transparency in healthcare cost and quality – critical to the success of value-based models – is not progressing quickly enough. At the consumer level, cost and quality information supports cost-conscious decision-making. At the purchaser level, price transparency is necessary to address wide price variation and reduce waste.

There is evidence that value-based payment models combined with population health-based clinical models can drive quality and value. A recent study published in *JAMA* showed that value-based care models are successfully reducing costs without sacrificing quality.[15] However, to have a transformative impact on health outcomes and cost in the US, these programs need to be scaled – and that will require full participation and collaboration of all stakeholders. Providers and payers (both commercial and government) must align interests and be transparent about metrics, measures, and performance. In setting health policy for the coming years, the federal government has an important opportunity to support the collaboration needed to drive value throughout the entire health system.

13 Oliver Wyman analysis; Barclays. U.S. Healthcare Distribution & Technology HCIT: What We Talk About When We Talk About Population Health. March 4, 2014; "An emerging consensus: Medicare Advantage is working and can deliver meaningful reform" American Enterprise Institute; HHS – "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value"

14 Mercer, 2016 National Survey of Employer-Sponsored Health Plans.

15 McWilliams JM, Gilstrap LG, Stevenson DG, Chernew ME, Huskamp HA, Grabowski DC. Changes in Postacute Care in the Medicare Shared Savings Program. JAMA Intern Med. Published online February 13, 2017. doi:10.1001/jamainternmed.2016.9115, http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601418

# CONCLUSION

MMC and its clients, America's businesses, are looking for healthcare reform that will help employees stay healthy and productive, enable innovation, and lower costs so that employers can focus on growth to create new jobs for the American public. We believe that these policy recommendations are a starting point for a new era of healthcare regulation that will enable these shared goals.

While we have focused here on issues that most directly affect American businesses, we – and our employer clients – are also concerned about the impact of health policy changes on people who do not have access to employer-sponsored coverage. Many of them are part of the workforce as part-time employees, early retirees, and the growing number of contingent workers. Consequently, their health and well-being directly affects productivity and business success.

Beyond that, as a corporate citizen, we urge that changes affecting the health coverage of so many Americans be made without undue haste and with careful consideration of the many complex factors at play in the US healthcare system. We offer our experience and expertise to assist in any way.

## ABOUT MERCER AND OLIVER WYMAN

**Mercer** is the largest health benefits consultancy in the United States. This leadership position has been achieved by providing a broad array of consulting and brokerage services that are tailored to the specific needs of an organization – which range from the largest and best known companies in the country to small entrepreneurial firms. Mercer is also bringing its knowledge, insights and expertise to drive sustainable, systemic, employer-driven change into US healthcare reform via advocacy, intellectual capital and stakeholder engagement. For more information, visit www.mercer.com and follow @Mercer. For the latest health news and analysis, visit ushealthnews.mercer.com. Follow Mercer's Health insights on Twitter @MercerUSHealth.

**Oliver Wyman** is a global leader in management consulting that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Oliver Wyman launched the Health Innovation Center (OWHIC) in 2011 dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today's and tomorrow's challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas. For more information, visit www.oliverwyman.com and follow @OliverWyman. For the latest on the business of transforming healthcare, visit health.oliverwyman.com. Follow Oliver Wyman Health on Twitter @OWHealthEditor.

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