

## Private Health Insurance Exchanges and Defined Contribution Health Plans: Is It Déjà Vu All Over Again?

*By Paul Fronstin, Ph.D., Employee Benefit Research Institute*

This *Issue Brief* examines issues related to private health insurance exchanges, possible structures of an exchange, funding, as well as the pros, cons, and uncertainties to employers of adopting them. A summary of recent surveys on employer attitudes are examined, as are some changes that employers have made to other benefits that might serve as historical precedents for a move to some type of defined contribution health benefits approach.

### AT A GLANCE

- The combination of insurance market reforms and the embodiment of the exchange structure in the Patient Protection and Affordable Care Act (PPACA) has brought a renewed focus on limiting employer's health care cost exposure.
- The key provisions of PPACA influencing these considerations are not the availability of exchanges per se, but a number of insurance market reforms that are combined with the exchanges, such as guaranteed issue, modified community rating, premium and cost sharing subsidies, and increased choice of health plan.
- Following the growth of defined contribution (DC) retirement benefits, DC health benefits were seen as promising tools to help control employer benefit costs by capping the employer's per-worker insurance contribution and engaging workers in their health care choices.
- Employers never moved in the direction of giving workers a defined or fixed contribution to purchase health insurance for a number of reasons: They were hesitant to drop group coverage in favor of offering individual policies, and they were concerned that many employees would not be able to secure coverage in the individual market.
- Employer issues addressed with an exchange/fixed contribution approach include cost certainty, total compensation transparency, uniformity of benefits in multi-state environments, COBRA costs, the looming excise tax on high cost coverage (the so-called "Cadillac tax") under PPACA, the potential for reduced administrative costs, and higher employee satisfaction.
- Employer issues that need to be addressed in adopting a private exchange/fixed contribution approach include plan design, implications of adverse selection, setting the level of fixed contribution, the amount of plan choice, and geographic cost variation.
- Issues not addressed by an exchange/fixed contribution approach include worker preference of, and satisfaction with, employment-based coverage, group purchasing efficiencies, the role of employer as advocate in coverage disputes, delivery innovation and health care quality, and health literacy issues.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research. The author wishes to thank Bob Galvin, Charles Clark, Dallas Salisbury, David Call, David Guilmette, Jeff McGuinness, Ken Sperling, Linda Mendell, Michael Guyette, Nevin Adams, Paul Landgraf, and Steve Wetzell for useful comments on an earlier draft of this paper.

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**Recommended Citation:** Paul Fronstin, “Private Health Insurance Exchanges and Defined Contribution Health Plans: Is It Déjà Vu All Over Again?” *EBRI Issue Brief*, no. 373 (July 2012).

**Report availability:** This report is available on the Internet at [www.ebri.org](http://www.ebri.org)

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## Introduction

It was only about a decade ago that defined contribution (DC) health plans—arrangements that effectively shift choice of health insurance from employers to workers—were the focus of much attention (Fronstin 2001a) (Nichols 2002) (PriceWaterhouseCoopers 2000) (Sullivan, Jr., et al. 2000) (Trude 2001) (Trude and Ginsburg 2000). Following the growth of defined contribution retirement plans, defined contribution health plans were seen as promising tools to help control employer benefit costs by engaging workers in their health care choices. As far back as 1998, 60 percent of human-resource executives at midsized companies wished they could have empowered their employees to make their own benefit decisions.<sup>1</sup>

Furthermore, at the time, more than 62 percent of health-care leaders predicted that employers would move to DC health plans by 2010 (PricewaterhouseCoopers 1999). However, interest waned (Fronstin 2001a), and employers never adopted DC health plans, at least not en masse.

Some of the reasons were undoubtedly definitional: It was clear a decade ago that the term "DC health" meant quite different things to different people, and may still today (Fronstin 2001a). For some, "DC health" evoked images of individuals selecting their preferred plan from among the range of products available in the nongroup market, with fixed-dollar contributions from their employers to help defray the costs of health insurance.

Alternatively, some had in mind circumstances where the employer effectively creates consumer-driven competition among the health plans it offers to workers (as the federal government does within the Federal Employees Health Benefits Plan). In these cases, the employer contribution is fixed and predetermined, with workers using that contribution to purchase coverage within a private health insurance exchange, although workers can choose to pay more out of their own pocket for more expensive plans. In this version of "DC health," all plans offer benefit levels that are set by the sponsoring employer (or an entity working on behalf of the employer or a group of employers), but may cost more in total than the employer's contribution.

Employers never moved in the direction of giving workers a fixed contribution to purchase health insurance for a number of reasons. They were hesitant to drop group coverage in favor of offering individual policies because the nongroup market was not considered a viable alternative to the employment-based system. They were concerned that many workers would not be able to secure coverage in the individual market. On the other hand, they continued to offer coverage because of the tax-free nature of the benefit and because it was a benefit valued by workers. They also viewed employment-based group plans as effective tools to promote improved worker health status and productivity.

Today, despite record costs and recent high unemployment, employers have continued to offer group coverage for the reasons cited above and, at least in part, to remain competitive in the labor market. In addition, rather than giving workers fixed allowances for health insurance premiums a decade ago, some employers redesigned their plans by making contributions to accounts that could be used to accumulate funds to cover cost sharing for health care services—such as deductibles and co-payments—first in the form of health reimbursement arrangements, (HRAs) (Fronstin 2002), then more recently through health savings accounts, or HSAs (Fronstin 2004).<sup>2</sup>

Recently, the combination of insurance market reforms and the embodiment of the exchange structure in the Patient Protection and Affordable Care Act of 2010 (PPACA)<sup>3</sup> has brought a renewed focus on an approach that limits employers' health care cost exposure by providing fixed-dollar contributions that workers could use to purchase individual policies. The vehicle that some employers are interested in using for providing coverage is a private health

insurance exchange (Davis 2011) (Kramer 2012) (“Health Care Reform,” Mercer 2011) (Orszag 2011) (Sperling and Shapira 2011) (Sperling 2012). Through these exchanges, in tandem with a DC funding approach, employers can accelerate the drive toward a more mass, consumer-driven insurance market and gain more control over their health care contribution costs, capping their contributions, and shifting to workers the authority to control the terms (and to some extent, the costs) of their own health insurance.

This *Issue Brief* examines the issues related to private health insurance exchanges, the possible structure of an exchange and how it can be funded, as well as the pros, cons, and uncertainties to employers of adopting private exchanges. A summary of recent surveys on employer attitudes are examined, as are some changes that employers have made to other benefits that might serve as historical precedents for a move to some type of defined contribution health benefits approach.

## What is an Insurance Exchange?

Insurance exchanges are rooted in the decades-old concept of “managed competition.” Alain Enthoven, building on earlier efforts by a number of analysts, developed the concept known as managed competition in the late 1970s as an alternative to the markets for health insurance and health care services.<sup>4</sup> The basic element of managed competition is the involvement of sponsors that act as collective purchasing agents for groups of individuals (Fronstin and Ross 2009). These sponsors would negotiate with insurers to construct a menu of choices among different plans through some type of exchange. Individuals could then purchase health insurance through the exchange, relying on information provided about each plan’s options, quality of care, and price. The exchange could also provide information on consumer satisfaction, provider networks, provider choice, benefits covered, specialized care programs, geographic coverage, coverage exclusions, and other various measures of quality.<sup>5</sup>

A health insurance exchange could be organized publicly—at the national level, state level, some combination of the two—or privately. Ultimately, the goal of a health insurance exchange is to shift the market for health insurance from competition based on risk (where insurers compete primarily by trying to enroll healthy individuals) to competition based on price (Custer 1994). Proponents hope that the resulting competitive insurance markets will drive more price competition in the health-care-services markets as well, resulting in lower prices and/or better offerings. Indeed, obtaining the benefits of competition would require that insurance policies be readily comparable to facilitate consumer choice, consumers be given a financial stake in their choice, and quality measures be developed that can be used to make informed decisions. Further, guaranteed issue and/or some form of risk-adjustment methodology would also be required to eliminate competition among plans based on risk avoidance.

Many recent descriptions of managed competition use the terms health insurance “exchange” interchangeably with the term “sponsor.” However, the roles of sponsor and exchange would be distinct. The sponsor would be an entity that would have oversight over the creation and continued functioning of the health insurance exchange. The sponsor would serve as the knowledgeable negotiator with health insurance plans participating in the exchange and/or the overseer of competitive bidding by the health insurance plans. In the case of a private exchange, a group of employers could act as the sponsor, or could contract with a third party that would act as the sponsor. The exchange would ensure that the rules of participation were known and adhered to by plans.

If implemented as passed, under PPACA, workers will be able to purchase health insurance directly from a health insurance exchange under certain circumstances described below, as well as via their employer; however, the key provisions of PPACA are not the exchanges per se, but a number of insurance market reforms that are combined with the exchanges, such as guaranteed issue, modified community rating, premium and cost-sharing subsidies, and increased choice of health plans. In order to be eligible for subsidies, workers must either be ineligible for employment-based coverage or, where workers are eligible, their share of the premium must exceed 9.5 percent of their income or the actuarial value of the plan must be below 60 percent of what is deemed to be minimum creditable coverage.

In a DC health model that relies on an insurance exchange for the delivery of health coverage, employers would provide workers with defined or fixed contributions to be used solely to purchase health coverage in the exchange.

Workers could then use those funds—as well as additional personal contributions, if needed—to purchase the health plans of their choice on the exchange from the available options.

## **Employer Issues Addressed With Private Exchanges and Fixed Contributions**

PPACA calls for the establishment of state-based exchanges, with the federal government filling gaps in states that do not establish exchanges in a timely fashion, according to the law. Initially, the exchanges will be open only to small employers and individuals purchasing coverage in the nongroup market. In 2017, states will have the option of allowing large employers into the exchanges. However, large employers can effectively take advantage of these public exchanges prior to 2017 if they chose to stop offering group coverage and instead provide taxable payments to employees to help them purchase coverage through those exchanges. In fact, private exchanges are already in development in part because of the uncertainty related to the status of state-based exchanges. Development of several of the state-based exchanges was held up, pending resolution of the PPACA's constitutional challenge, and there also is concern that some state exchanges will not be prepared to launch on time. As recently as March 2012, the majority of states had still not taken the necessary steps to establish exchanges.<sup>6</sup>

As noted above, if a state fails to establish an exchange in accordance with the provisions of the PPACA, a federally facilitated exchange will be implemented. As a result of all of the uncertainty related to whether employers can join these public exchanges, the readiness of public exchanges, and the prospects for federally facilitated exchanges, many employers may see private exchanges as the only viable option. Additionally, benefit outsourcing vendors, brokers and other entities view this as an emerging-market opportunity, which is leading some to proactively develop private exchange capabilities.

Large employers may also view private exchanges as a viable alternative to the penalty under PPACA for not offering coverage unless they offer plans and contribution strategies that meet the requirements of the law. An employer that provides a defined contribution to purchase coverage through a public exchange would be subject to the \$2,000-per-worker penalty under PPACA. However, an employer offering access to a private exchange would be considered to be offering health coverage and would therefore not be subject to the penalty. Further, the employer could continue to provide pre-tax subsidies to its workers to help them buy coverage through the private exchange (however, doing so may preclude the ability of lower-income workers to take full advantage of government-paid premium subsidies for those who enroll through public exchanges). PPACA does not permit the employer to deduct this \$2,000 penalty as a business expense, so the true cost to the employer is \$2,000 grossed up by the corporate tax rate. (Not-for-profit entities are unaffected by this provision in the law.)

*Cost Certainty*—Moving to a DC model where workers receive fixed contributions has the potential to allow employers to better predict their costs, a key concern because employer spending on health benefits has been both higher and more variable than the overall inflation rate (Figure 1). Setting the defined contribution at a fixed dollar amount, or even at an amount that increases with inflation, might help control employer outlays over the long run. Employers could also better control costs by limiting their contributions to employee-only coverage. However, if employers tie their contribution to the lowest-cost plan on the exchange, and if premiums for that plan continue to rise faster than inflation, their contributions will likely continue to increase with the rate of premium increases even if they enjoy a one-time savings. There is also an expectation that the creation of competition at the consumer level fostered by the exchanges will mitigate premium increases and that carriers might offer plans pegged to the employer contribution.

There is a question as to whether employers will be able to maintain contribution levels with no increase, or increase them only at the rate of inflation, if premiums in the exchange are rising faster than inflation. If the worker share of health coverage exceeds 9.5 percent of income, then the worker will be eligible for subsidized health coverage through an insurance exchange (per PPACA). Employers with 50 or more workers will be subject to a \$3,000 penalty for each employee receiving subsidized coverage on the exchange. Employers will have to weigh this penalty against their contributions to health coverage.

## The Economy, Health Costs, and Health Care Coverage

Historically, there are examples where the comprehensiveness of benefits ebbed and flowed with the economy and unemployment rates. Between 1998 and 2000, when the economy was growing, the percentage of employers offering health benefits increased from 55 percent to 69 percent.<sup>7</sup> Unemployment was 3.8 percent in April 2000 and was 3.9 percent during the fall of that year. In contrast, during the 2007–2009 recession, many companies suspended employer matches to 401(k) plans, and reinstated them only when the economy improved.<sup>8</sup> There is no reason to believe that employer contributions for health insurance would not be similarly affected by economic conditions.

However, there are lessons to be learned from how private employers have changed their retiree health care funding strategies in the face of liabilities that would have hit their balance sheets when Financial Accounting Statement No. 106 (FAS106) became effective. Since that time, many employers have ceased to offer access to any form of retiree health care benefits, and of those that still do, the majority have firm contribution caps in place.<sup>9</sup> Many employers have taken this approach a step further, offering their Medicare-eligible retirees access to private exchanges that have individual policies. The lesson here is that once the cost of coverage for active employees reaches a level that employers consider fundamentally unsustainable, the appetite for placing caps on employer contributions will likely increase significantly. This is noteworthy, since there is broad consensus that PPACA did very little to reign in health care costs and inflation. Changes to retiree health benefits as a historical precedent are discussed in more detail below.

Also, health coverage is arguably a form of compensation. When unemployment is high, employers will likely be more inclined to stick with a hard cap on contributions or increases in contributions. However, when unemployment is lower, employers might have to raise their contributions to a rate above overall inflation (to something closer to the rate of premium increases), certainly if premiums are increasing faster than inflation. One might speculate that continued high unemployment will make it easier for employers to hold the line on contributions.

*Total Compensation Transparency*—Under PPACA, most employers will have to report the total cost of employees' health coverage on the 2012 Form W-2 (which will be issued to employees in 2013). In theory, better educating workers about the full cost of their health coverage could encourage them to seek or demand lower-cost plans, which in turn could help contain growth in spending. However, it remains an open question as to whether disclosure of the total cost of coverage would do anything to change worker behavior, certainly contrasted with increasing cost sharing, which has been found to have a direct impact on the use of health care services. In the case of a defined contribution approach, workers would know the total amount of health insurance because they would be required to shop for insurance directly from an insurer (albeit through an exchange). Workers would

be able to compare the prices on the exchange with the amount of the employer contribution and choose the plan that they preferred, given the available resources. Also, including the value of employment-based health benefits on the W-2 form would make it easier to calculate any tax due, if Congress were to subsequently change the tax treatment of health coverage.

To the degree employers fund their contribution through HRA-type accounts that allow rollovers of unused funds, workers have an incentive to use the money responsibly. For example, workers might choose less expensive coverage now, reserving funds in the account for future years or to have on hand in case premium increases outpaced employer-contribution increases. If there was a use-it-or-lose-it rule, workers would have an incentive to spend the entire contribution each year, the HRA-type accounts may not be an optimal solution for all employers. For instance, there are strict rules regulating the interaction between HRAs and HSAs.

*Uniformity of Benefits*—Federal law (The Employee Retirement Income Security Act of 1974, or ERISA) provides a legal framework for the uniform provision of benefits by employers doing business anywhere in the United States. This uniformity allows multi-state organizations that self-insure, wherever they happen to be located, to offer consistent benefit packages, which can provide both ease of administration and lower expenses. However, offering workers access

benefit packages, which can provide both ease of administration and lower expenses. However, offering workers access to a private exchange may not allow an employer to continue to provide uniform benefits. A private exchange would be offering plans that would have to comply with state benefit mandates and potentially varied definitions of what is deemed "essential health benefits;"<sup>10</sup> therefore, coverage and program options would vary from state to state. (An employer may be able to offer a fully insured plan across state lines that adheres only to state-mandated benefits required by the state in which the insurance contract is provided.) However, an employer might view its contribution as a way of continuing to provide a uniform contribution, rather than a uniform benefit, regardless of where an employee lives or works.

*COBRA Costs*—The continuation of coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct. While COBRA ensures that people who lose their employer-based health insurance coverage can continue it for up to 36 months in some cases, it does not require employers to continue paying for this insurance; the entire health insurance premium is typically paid by the individual electing COBRA. In fact, a qualified beneficiary can be charged 102 percent of the employer's cost, with the additional 2 percent being allowed to cover the employer's administrative costs. In the case of an individual considered disabled for Social Security purposes, 150 percent of the employer's cost may be charged for the 19th month through the balance of the COBRA period for that individual and other family members who also qualify for this continuation of coverage.

While employers are able to cover the full "premium" under COBRA, those that are self-insured, on average, pay out in claims more than they take in in premiums. On average, COBRA claims costs are around 50 percent higher than the active-employee claim costs (CCH 2009). If a self-insured employer moved its workers to a private exchange with fully insured arrangements and a fixed contribution, the cost of adverse selection would be borne by the plans providing coverage in the exchange. Ultimately, any adverse selection costs associated with COBRA would then be spread across all of the workers with coverage in the exchange through higher overall premiums.

*Excise Tax on High-Cost Coverage*—Starting in 2018, an excise tax will be imposed on high-cost health plans (the so-called "Cadillac tax"), a nondeductible 40 percent excise tax on the portions of health coverage costs that exceed \$10,200 per year for single coverage and \$27,500 for family coverage. (These thresholds will be \$1,650 higher for single coverage and \$3,450 higher for family coverage for early retirees and individuals in high-risk professions.) Adjustments to the total cost of the plans will be allowed for the age and gender mix of workers. In determining the portion of health coverage costs subject to the excise tax, reimbursements from flexible spending accounts (FSAs) and HRAs and employer contributions to HSAs will also be counted.

The tax burden will fall on the issuer of the plan. In the case of a fully insured plan, the insurance carrier will be responsible for paying the tax. In the case of a self-insured plan, if the employer uses a third-party administrator (TPA), then the TPA will be responsible for paying the tax. If the plan is self-administered, the employer will be responsible for paying the tax. When both a health plan and a stand-alone FSA are offered, the tax will be apportioned to the respective issuers. As such, when an FSA is offered with a fully insured plan, the insurer and the FSA administrator will each be responsible for part of the excise tax. It is assumed that insurers and TPAs will try to pass the tax onto employers.

Employers will be able to avoid the tax by moving to a fixed contribution. If insurers raise premiums to cover the tax or add the tax as a separate line item on insurance invoices, workers will be responsible for paying the tax using the employer contribution and their own contributions. Employers will be responsible only for their contribution. However, as mentioned above, external factors, such as a strong economy and low unemployment, may mean that employers feel compelled in some situations to increase their contributions to cover taxes that are passed directly to workers.

*Potential for Reduced Administrative Costs*—Employers may be able to reduce their administrative costs by moving workers to private exchanges while providing some type of defined contributions to those programs. Employers would no longer need to expend resources for things like employee and dependent eligibility, enrollment, plan selection,

compliance, employee education, and employee claims questions. Resources could be redeployed into other areas, such as employee education about making good coverage decisions and budgeting, although the private exchanges may assume some of those functions and costs.

*Higher Worker Satisfaction*—In 2011, with most workers covered by traditional health plans, 23 percent of individuals with employment-based coverage were extremely satisfied with their health coverage, while 37 percent were very satisfied, 29 percent were somewhat satisfied, and 11 percent were not too or not at all satisfied (Fronstin 2011). There are, however, a number of reasons why workers might be more satisfied with a defined contribution that could be used to purchase coverage through an exchange.

Many workers do not have a choice of health plans, and when they do have a choice, they typically can choose from only two or three options from the same carrier (Fronstin, 2012). Employers decide which health plan to offer workers and whether to offer a choice of plans at all. In 2011, 47 percent of workers with health insurance were employed by firms that offered only one health plan; 36 percent were offered two plan types; and 18 percent were offered three or more.<sup>11</sup> Often times the choices available vary only by cost sharing (which means there is no choice of network), although sometimes workers get a choice of some combination of a health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS) or consumer-driven health plan (CDHP). Individuals with a choice of health plans are more likely than those without a choice to be satisfied with their health plans and health care along a number of dimensions (Fronstin 2010). Offering workers access to health insurance exchanges would allow them to choose from the plans available there. The choice of health plans in private exchanges would likely be much greater than what employers currently offer, which might drive rates of satisfaction higher.

Workers may like the portability of health insurance that an exchange approach provides. They would not necessarily have to change health plans when they change jobs, though this would only be true if the workers moved to new employers that participated in the same exchange.

Workers may also be more satisfied with private exchanges and defined contributions because many already are familiar with those types of retirement benefits. Nearly 60 percent of private-sector workers with health coverage also have retirement plans,<sup>12</sup> with most of those having DC retirement plans.

Additionally, an exchange could also offer an accountable-care organization as one of the plan choices. A single employer may not be able to have much of a positive impact on such an organized delivery system, but a group of employers that banded together could have such an impact.

## **Issues Employers May Still Need to Address With a Private Exchange and Fixed Contributions**

There are a number of issues that employers would need to consider in terms of their involvement when it comes to private exchanges.

*Plan Design*—Employers would have to decide how much involvement, if any, they want to have over plan-design choices offered in the exchange. Would employers be able to choose to offer only certain plans to their employees, or would they have to offer all plans available in the exchange? Would employers have any influence on the number of carriers, the number of plans, and the kinds of plans that are offered?

*Implications for Adverse Selection*—All of the plans in the exchange would be offered on a fully insured basis. Would the plans in a private exchange be subject to risk adjustment? Would premiums vary by employee population as opposed to the entire exchange population?

Similarly, would the exchange be open to all employers? If not, what would the selection criteria look like? Could employers with fewer than 50 employees be excluded from private exchanges because of the availability of public

exchanges? Would employer groups be required to meet certain underwriting provisions so that the exchange does not attract only employers with poor worker health status?

*Level of Fixed Contribution*—As mentioned above, there is a question whether employers would be able to maintain their contributions with either no increase, or with increases at the rate of inflation, if premiums in the exchange are rising faster than inflation. There are also questions regarding whether individuals choosing family coverage would get higher contributions than those choosing individual coverage. And if there are plans with premiums lower than the employers' contributions, would workers be able to roll over unused contributions?

When it comes to workers, there is a question regarding how much flexibility they would have using the employer contributions. Would all family members have to enroll in the same plan, or could workers choose different plans than their family members and allocate the employer contributions as they see fit? If workers and their dependents could choose different plans, would there be implications for adverse selection?

*Plan Choice*—How much plan choice should participants in the insurance exchange have? Research from behavioral economics has found that more choices are not necessarily better. For example, in retirement plans, research has shown that the greater the number of investment options offered, the less likely a worker will participate in the plan and the more likely that those who do will invest all or most of their assets in the most conservative option(s) available (Iyengar and Kamenica 2006) (Iyengar, Jiang and Huberman 2004).

Concerning experience with Medicare Part D (prescription drug) plan choice, there are a number of studies that question whether too many plan choices are harmful, although the findings across the studies are not necessarily consistent. One study found that when people are given additional drug coverage options, most pick the plan with the longest list of items covered without regard to coverage and cost of the most relevant drugs.<sup>13</sup> A study conducted soon after the availability of Medicare Part D concluded that "consumers are likely to have difficulty choosing among plans to fine-tune their prescription drug coverage, and do not seem to be informed about or attuned to the insurance feature of Part D plans" (McFadden 2006), and a later study found that Part D beneficiaries often select inexpensive plans in circumstances where plans with more expensive and comprehensive coverage are actuarially favorable to the beneficiaries (Heiss, McFadden and Winter 2010). Another (Thaler and Sunstein 2009) concluded that it is "really hard" to choose the right prescription drug plan and discussed lessons learned from the rollout of the Medicare Part D program and how better "choice architecture" could help—points of view that private exchanges could use to improve functionality and plan choice for participants.

At least one study has found that there are positive effects from increasing the number of health plan choices (Besedes, et al. 2012). It found that among seniors, when the number of health plan options is increased, the odds of picking the best plan fall, but the odds of picking an option in the top quartile of all options increase.

On the other hand, it may not be the number of plan choices that causes people to make bad decisions, but the tools that people have at their disposal to help them navigate their options. Recent research found that in the absence of a health-comparison tool, plan "participants do only slightly better than chance at selecting the best plan."<sup>14</sup>

*Geographic Cost Variation*—Employment-based plans almost universally charge workers the same premium for the same coverage even though costs may vary widely based on where the employees live. Under an exchange model offering individual policies, workers would be exposed to these regional price variations unless employers varied their subsidy by location.

## **Issues Not Addressed With a Private Exchange and Fixed Contributions**

There are a number of issues that either would not be resolved or might cause new issues if employers moved to a private exchange model with some type of defined contribution.

*Worker Preference for and Satisfaction with Employment-Based Coverage*—According to the 2011 EBRI/MGA Health Confidence Survey (HCS), most individuals with employment-based health benefits are satisfied with their coverage and are confident that their employers or unions will continue to offer health insurance for their workers

(Fronstin 2011). They are not, however, highly confident that they could choose the best available health insurance plans on their own if their employers or unions stopped offering health insurance. Less than 3 in 10 are extremely or very confident (27 percent), and more than one-third are somewhat confident (35 percent), but 36 percent are not too or not at all confident that they would be able to do so.<sup>15</sup> It may take a change in culture before workers are ready to accept something other than the current employment-based health benefits system. Any fundamental change in the way employers provide access to health benefits may be seen by workers as a reduction in benefits unless strong decision support tools are included.

*Group Purchasing Efficiencies*—The existence of economies of scale in the purchase of group health insurance coverage generally results in lower average premiums for employment-based plans. Additionally, when economies of scale do exist, the average administrative costs of insuring a group make up a smaller percentage of the cost of health insurance. As a result, large firms, which are better able to exert market influence, are more likely to offer health benefits than small firms because they can purchase the same plan at a lower cost. In addition, employers may be better at searching or negotiating for lower-cost health plans than workers would be in the individual market. Providing

### **Interest in Private Exchanges...**

Interest in exchanges, combined with fixed-dollar employer contributions, made a resurgence among employers even before the 2010 passage of PPACA. In June 2007, the ERISA Industry Committee (ERIC), a membership organization representing the employee benefit plans of some of the largest corporations in the United States, released a position paper entitled “New Benefit for Life Security.”<sup>16</sup> In it, ERIC outlines a proposed structure that employers could use as an alternative to the way in which they currently provide both health and retirement benefits. The proposal outlined an exchange (“benefit administrator”) combined with fixed contributions from participating employers. That structure provides for portability of health insurance and permits individuals and small businesses to buy into a much larger pooling arrangement than exists today. The benefit administrator would take on most, if not all, of the administrative responsibilities now borne by employers, who would pay for benefits chosen by their workers through the fixed-contribution mentioned above. Under this scenario, employers would continue to be responsible for due diligence and monitoring of the benefit offerings by competing benefits administrators.

In October 2007, the Committee for Economic Development (CED), an organization of business leaders and educators, released its recommendations for replacing employment-based health benefits with a system of independent regional exchanges from which individuals (who would receive fixed contributions) could purchase health insurance from competing private health plans.<sup>17</sup> The exchanges would set standards for the insurers and conduct an annual open-enrollment season when individuals could change health plans. The exchanges would manage risk adjustments for insurers, but no one could be denied coverage because of age or prior illness. At some point after the exchanges were established, each family would receive a fixed-dollar tax credit sufficient to pay the premium on the basic, low-cost plan in its region such that the family could be insured without cost to them. Any higher-cost policy would be paid by individuals with after-tax dollars. The current tax preference for employment-based health coverage would be eliminated in order to finance the fixed-dollar tax credit.

Since the release of these positions and passage of PPACA, interest in private exchanges and fixed-dollar contribution models for active workers and/or retirees has continued. In June 2011, the global benefits-consulting firm Mercer found that 28 percent of U.S. employers were interested in some type of defined contribution model (Figure 2) (Mercer 2011). About one-quarter of employers surveyed were interested in providing fixed contributions for the plans that the employers offered (such that workers would pay more if they chose more expensive coverage) and 9 percent were interested in providing workers with fixed-dollar subsidies to purchase coverage on their own.

Benefits consultant Towers Watson found that 5 percent of employers were very confident and 25 percent were somewhat confident that health insurance exchanges would provide a viable alternative to employment-based health benefits for active workers in 2014 or 2015 (Figure 3) (Towers Watson 2011). It also found that 16 percent of employers were very confident, and 37 percent somewhat confident, that health insurance exchanges would provide a viable alternative to employment-

employment-based health insurance also benefits employers because it can serve to reduce quit rates and turnover costs, especially during periods when workers value these benefits highly.

A private health insurance exchange may or may not replace the group purchasing efficiencies of an employer group, and it may not be able to provide lower premiums, especially if limited to smaller employers and groups of individuals. The theory behind the exchange is that aggregating smaller groups will bring down the cost of coverage because of group-purchasing efficiencies. However, to the degree exchange members disperse into different types of plans within the exchange, both the larger and smaller groups may not add up to the efficiencies of one large group. At the same time, states already restrict premium variation to various degrees, which more or less already serves to pool smaller groups into a larger group within the confines of rating bands.

There is also the issue as to whether PPACA's individual mandate will be effective in bringing more people, and in sufficient numbers to have an impact, into the insured pool. By 2016, individuals without coverage will be required to pay a penalty of 2.5 percent of income up to a maximum of \$2,085 per family. Individuals may go uninsured, pay the penalty, and wait until they get sick to buy insurance.

### ....and Fixed Contributions

based health benefits for early retirees. The survey also found that 12 percent of employers were very likely and 9 percent were somewhat likely to replace their health plans for active workers employed 30 or more hours per week with financial subsidies.

The HR Policy Association found perhaps the strongest interest in moving toward a defined contribution approach over the next decade. The survey of chief human resource officers found that 36 percent of respondents were giving serious consideration to moving to a defined contribution strategy for active workers (Figure 4). However, it might be argued that the so-called "C-suite" (top corporate officers) may be naturally more open to embracing defined contribution strategies that would fundamentally change the role of employers in providing health care benefits than are benefit consultants and benefit professionals—whose jobs depend on the continuation of employment-based group plans.

Even the Republican Study Committee (RSC) in the U.S. House of Representatives has taken the position that the Office of Personnel Management should change the formula used for providing health coverage to federal employees. Currently, for most federal workers, the government contributes roughly 72–75 percent of the cost of a health plan regardless of the plan chosen. The RSC has proposed a fixed contribution of \$5,000 for employee-only coverage and \$11,000 for family coverage regardless of the health plan chosen.<sup>18</sup>

Some employers view PPACA as providing an opportunity to get out of the business of providing employment-based, group health benefits. Benefits consultant Lockton found that 16 percent of its employer client companies reported that the option to terminate coverage because employees will have other options was one of the most beneficial potential benefits of the PPACA (Lockton Companies, LLC 2011).

It should therefore come as no surprise that employers have expressed a growing skepticism that health benefits will be offered in the workplace a decade from now. Between 2007 and 2011, the percentage of employers reporting that they were highly confident that they would be offering health benefits a decade later fell from 70 percent to 23 percent (Figure 5)—a sharp contrast with the continued confidence of workers that their employers will continue to offer these programs.<sup>19</sup>

While surveys of employers cannot necessarily predict their behavior two or three years from now, collectively they show that a significant number of employers are interested in the concept and may continue to show interest as long as they are examining new ways to manage the cost of providing health coverage. As a result of such interest, a number of private exchanges are currently in development.<sup>20</sup> Most recently, Aon Hewitt, one of the developers of a private exchange, reported that 44 percent of employers interviewed for a recent survey believe private health insurance exchanges will be the preferred approach to offering health care benefits to workers in three to five years.<sup>21</sup>

Finally, broker's fees and commissions would also have to be considered. Private exchanges currently operated for Medicare eligible retirees are largely financed on commissions paid by insurance carriers to licensed agents employed by these exchanges. These commissions are added to the premiums paid by the individuals who purchase coverage through the exchanges.

*Employer as Advocate*—Employers often act as advocates for workers during coverage disputes between the insured and insurer. For example, an employer experiencing widespread dissatisfaction among its workforce with a specific health plan will generally either find a new health plan or threaten to do so unless the insurer responds to the issues. Insurers are more likely to respond to the collective voice (and checkbook) of an employer than to an individual because of the risk of losing a large group contract. Were exchange administrators to play this role, employer intervention might not be required, but if exchanges merely act as administrative agents, employers might still feel obligated to continue to provide either insurance outside the exchange or health advocacy services for their employees. And because the licensed agents in these exchanges are paid based on how many policies they sell, rather than on customer service/satisfaction, they may not be as effective in the role of consumer advocate as employers have been historically.

*Delivery Innovation and Health Care Quality*—Employers frequently involve themselves in matters of quality assessment of care and influencing health care matters in the policy development arena. With the rise of health care costs in the 1970s and 1980s, large employers began to pay closer attention to health care quality. One aspect of this increased attention was the formation of coalitions of employers to facilitate the sharing of information about health care quality and health care providers in order to allow employers to contract with the best insurers and providers. Many believe that employers are better equipped than individuals to monitor the quality of health care. The presence of exchanges and health options would not eliminate the ability of employers to add value here, and carriers would have an even greater reason to continue this trend of sharing information, because they would bear the risk associated with unhealthy members. Ultimately, exchanges may play the role of independent parties in standardizing and evaluating health care quality across plans and providers.

*Health Literacy Issues*—Previous research has found that few individuals were extremely or very confident that they could choose the best available health plans in the nongroup market (Fronstin 2011). In fact, the Institute of Medicine (2004) concluded that nearly one-half of all adult Americans were health illiterate, citing studies that determined that limited health literacy has been shown to be associated with worse health status, higher use of health care services, and worse clinical outcomes. It also found that individuals with limited health literacy and with chronic illnesses have less knowledge of disease management than those with higher health literacy. While the report did not examine the impact of health literacy on knowledge of health insurance and purchasing decisions, the report raises the obvious question of how well-served individuals would be in the nongroup market, and how long it might take for individuals and insurers to match themselves up with appropriate products.

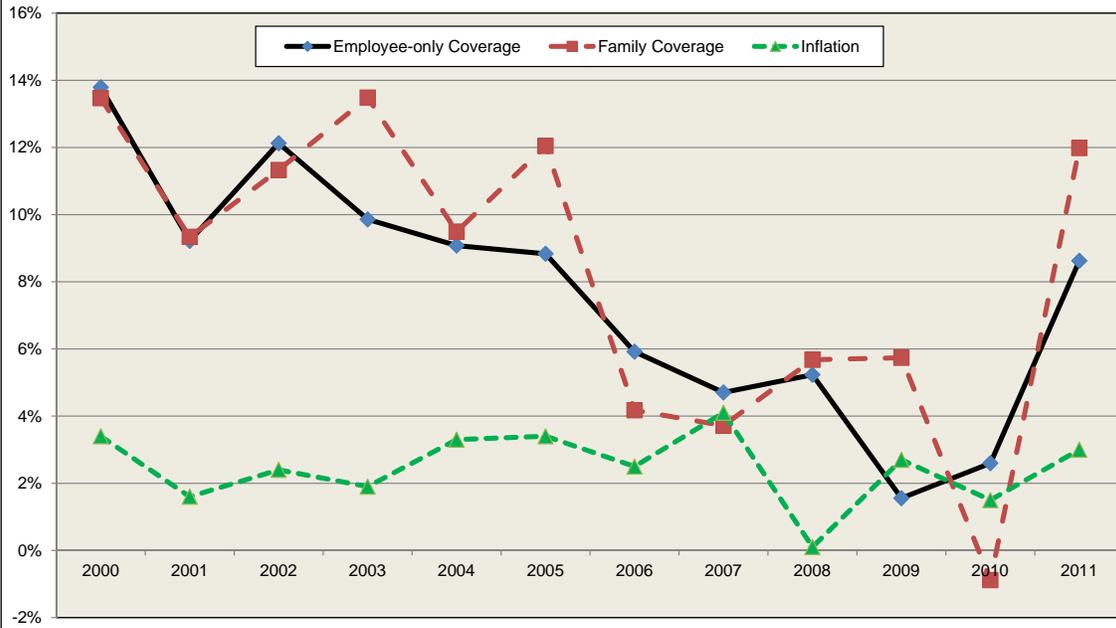
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## Historical Precedents

### Defined Benefit Pension Plans

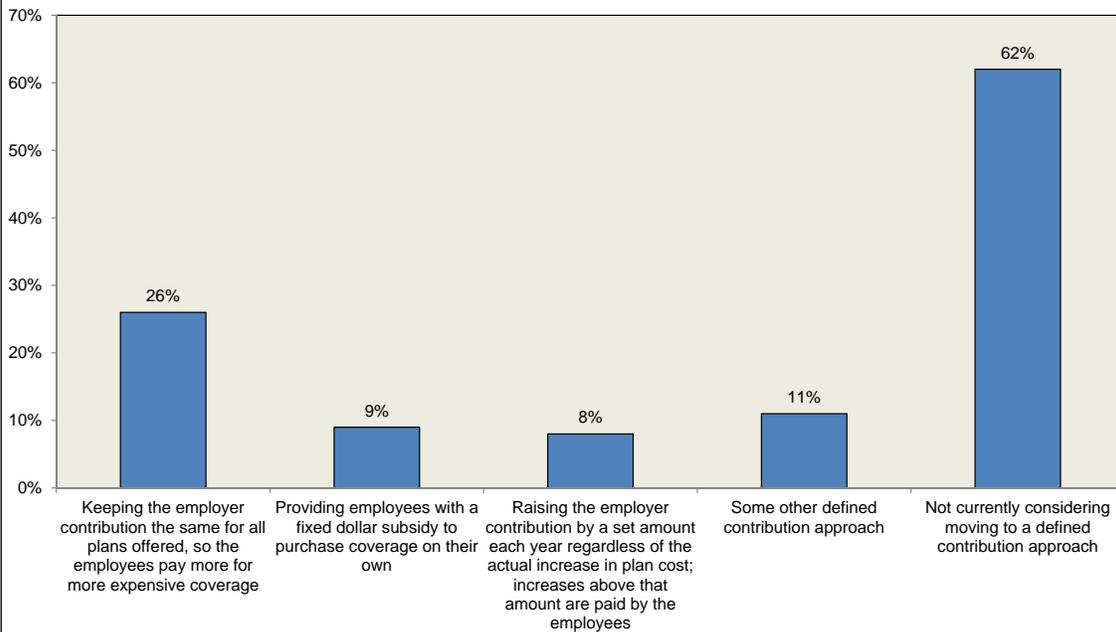
The movement from defined benefit (DB) pension plans to defined contribution (DC) retirement plans offers insights into how employers fundamentally redesigned a type of benefit. In 2010, 7 percent of private-sector workers with a retirement benefit were participating in only DB plans, down from nearly 62 percent in 1979 (Figure 6). In contrast, the percentage of private-sector workers with retirement plans participating in only DC plans increased from 16 percent to 69 percent. The percentage with both DB and DC plans was 22 percent in 1979 and 24 percent in 2010 and peaked at 35 percent in the mid-1980s. Furthermore, even among workers with defined benefit pensions, many of those plans have been “frozen”—a term used to describe a limit on some or all future accrual of benefits under the plan. In 2008, the U.S. Government Accountability Office (GAO) reported that about one-half of all defined benefit sponsors had frozen one or more of their DB plans (U.S. Government Accountability Office 2008). Overall, 21 percent of all active participants in a single-employer DB plan were affected by such a freeze.

Figure 1  
**Percentage Change in Employer Spending on Health Coverage, 2000–2011**



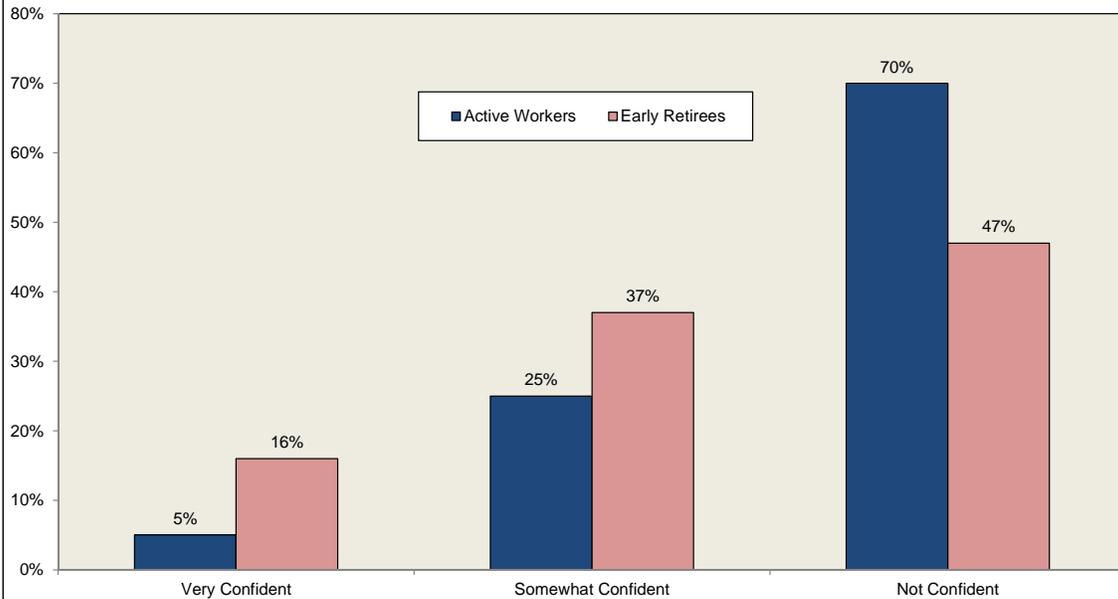
Source: Calculated from Exhibits 6.3 and 6.4 in <http://ehbs.kff.org/pdf/2011/8225.pdf>

Figure 2  
**Percentage of Employers Interested in Various Types of Defined Contribution Models**



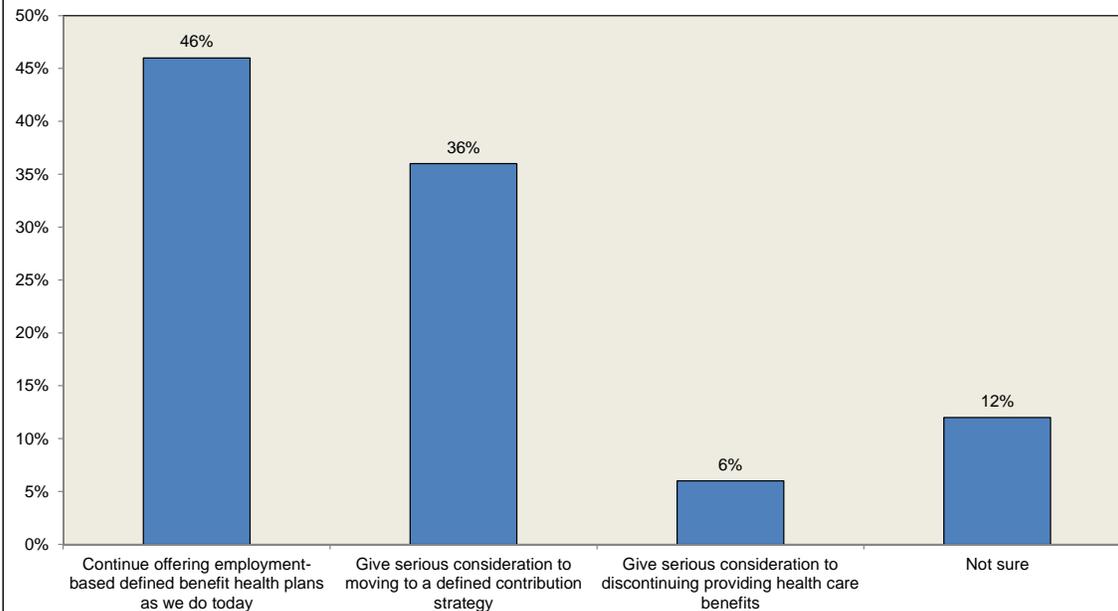
Source: Mercer, 2011.

**Figure 3**  
**Employer Confidence that Health Insurance Exchanges Will Provide a Viable Alternative to Employer-Sponsored Coverage For Active Employees and Early Retirees in 2014 or 2015**



Source: Towers Watson, 2011.

**Figure 4**  
**Company Strategy Relating to Health Benefits for Active Employees Over Next 10 Years**



Source: HR Policy Association, 2011.

DB plans steadily lost ground as the preferred plan type for a number of reasons:

- Government regulation had a profound impact on plan choice (Clark and Schieber 2000) (Ippolito 2002) (VanDerhei and Copeland 2001).
- Changes in the work place may have contributed to the rise of DC plans, including increased worker and employer appreciation and demand for DC plans (Gale, Papke and VanDerhei 1999) (Ostaszewski 2001).
- A number of economic explanations have been proposed as well (Brown and Liu 2001) (Ostaszewski 2001) (Salisbury 1997) (VanDerhei and Copeland 2001), including a changing business environment and the risk associated with funding and managing pension plans; issues with firm size; and the increase in global competition faced by employers in recent years, which has led to the subsequent need for more flexibility in retirement plan design.

While many employers did not set out to shift the cost of retirement planning onto workers, an end result was that all of the investment risks and all or most of the funding and administrative costs were transferred to workers in DC retirement plans, whereas under most private-sector defined benefit pensions, employers had assumed those costs. In short, DC retirement plans allow employers to exercise more control and predictability over most or all of the costs associated with providing retirement benefits to employees (Nichols 2002), which helps to explain why employers were interested in the same concept for health benefits a decade ago (Fronstin 2001).

### **Retiree Health Benefits**

As mentioned before, one of the most important factors (if not the single-most important) that has affected how employers provide retiree health benefits was a 1990 rule change issued by the Financial Accounting Standards Board (FASB) that required employers to report their retiree health liabilities. The approval of FAS 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," in December 1990 triggered many of the changes that private-sector employers have made to retiree health benefits since the early 1990s. FAS 106 requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. The immediate income statement inclusion and balance sheet footnote recognition of these liabilities dramatically affected companies' reported profits and losses. The impact was greatest on large employers, since smaller ones were much less likely to offer retiree health benefits and therefore did not have to report the liability.

With this new visibility of the cost—and the increasing cost—of providing retiree health benefits, many private-sector employers overhauled their retiree health programs in ways that controlled, reduced, or eliminated these costs. FAS 106 and the rising cost of providing retiree health benefits resulted in fewer employers offering retiree health benefits. Between 1993 and 2011, the percentage of employers with 500 or more employees offering retiree benefits to early retirees fell from 46 percent to 24 percent (Figure 7),<sup>22</sup> and the percentage offering retiree health benefits among private establishments with 1,000 or more employees fell from 53 percent to 34 percent between 1997 and 2010.

Among employers continuing to offer retiree health benefits, many have either set some type of defined contribution in the form of caps, or a ceiling that limited their costs, or they chose not to subsidize the cost of retiree health coverage at all. According to Aon Hewitt, 24 percent of employers offering retiree health benefits to early retirees in 2010 had adopted a defined-dollar approach that limited the employers' costs (Figure 8). Another 50 percent required the retirees to pay the full cost of the benefits in 2010. In fact, the percentage of employers with a defined-dollar approach fell from 31 percent in 2005 only because the percentage of employers requiring retirees to pay the full cost increased.

Regardless of the reasons for moving to defined or fixed contributions for retirement and retiree health benefits, employers are better able to predict their costs associated with these programs. Employer experience with these historical precedents may also explain the renewed interest in the concept of a defined contribution approach for health benefits.

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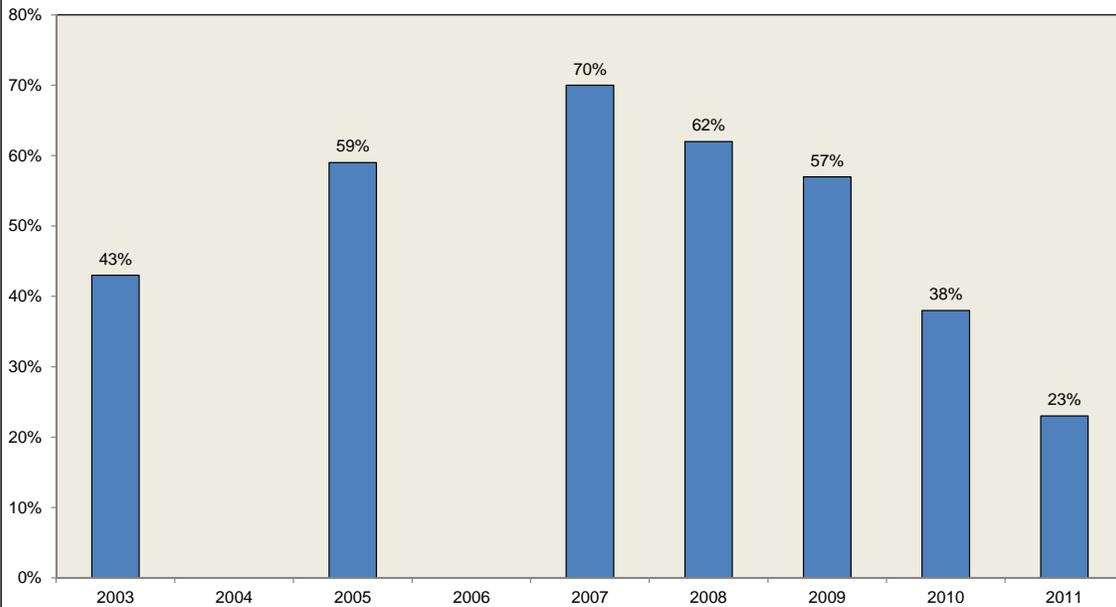
## Conclusion

Surveys collectively show that a significant number of employers are interested in the concept of defined contribution health benefits and that private health insurance exchanges may be the vehicle for the delivery of such benefits, certainly following passage (and the Supreme Court's upholding) of the PPACA. Workers and their dependents would purchase health insurance directly from insurance carriers in private insurance exchanges—a concept that garnered much attention about a decade ago and is showing renewed interest because of the combination of insurance market reforms and the embodiment of the exchange structure in PPACA.

There are a number of potential advantages to both employers and workers in this structure. Employers could benefit from a higher degree of cost certainty, certainly if they were able to fix their costs at the level of their contributions. Workers could benefit from competition among insurance carriers, greater choice of health plans and portability. Issues will arise as well, and some, like increased technology (which has been found to be the primary driver of health care cost increases) or health illiteracy, might not be adequately addressed through such a new plan design. Health exchanges also hold the possibility of significantly increasing the rate of Americans with health coverage. Whether they increase or control the cost of health insurance is unclear.

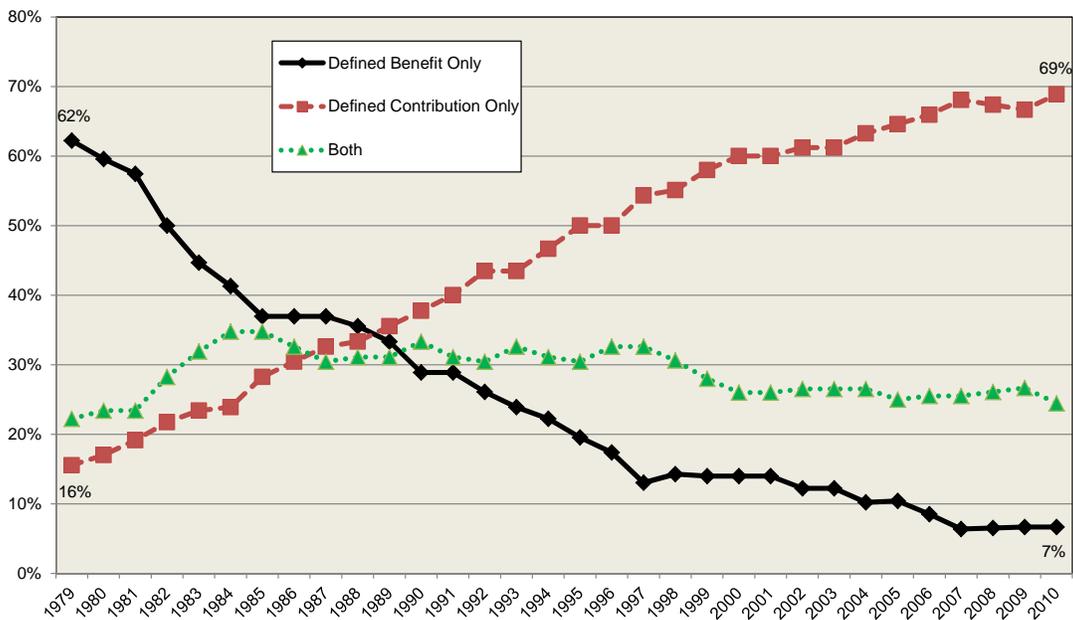
Ultimately, whether and how the movement to private health insurance exchanges and DC health plans will occur is still subject to various influences and remains highly uncertain. But the enactment of PPACA and employers' need to control the cost of their health benefits indicate this is a field that is likely to grow.

**Figure 5**  
**Percentage of Employers Reporting High Confidence That Health Care Benefits Will Be Offered at Their Organization a Decade from Now, Selected Years, 2003–2011**



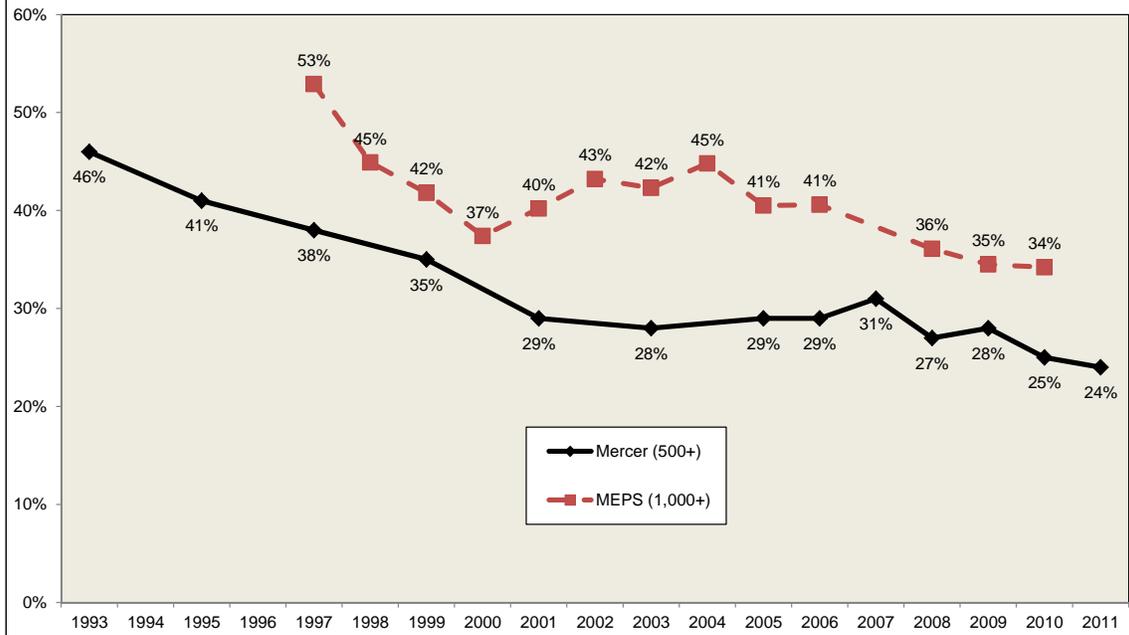
Source: 16th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, 2011.

**Figure 6**  
**Distribution of Private-Sector Active Participants in an Employment-Based Retirement Plan, by Plan Type, 1979–2010**



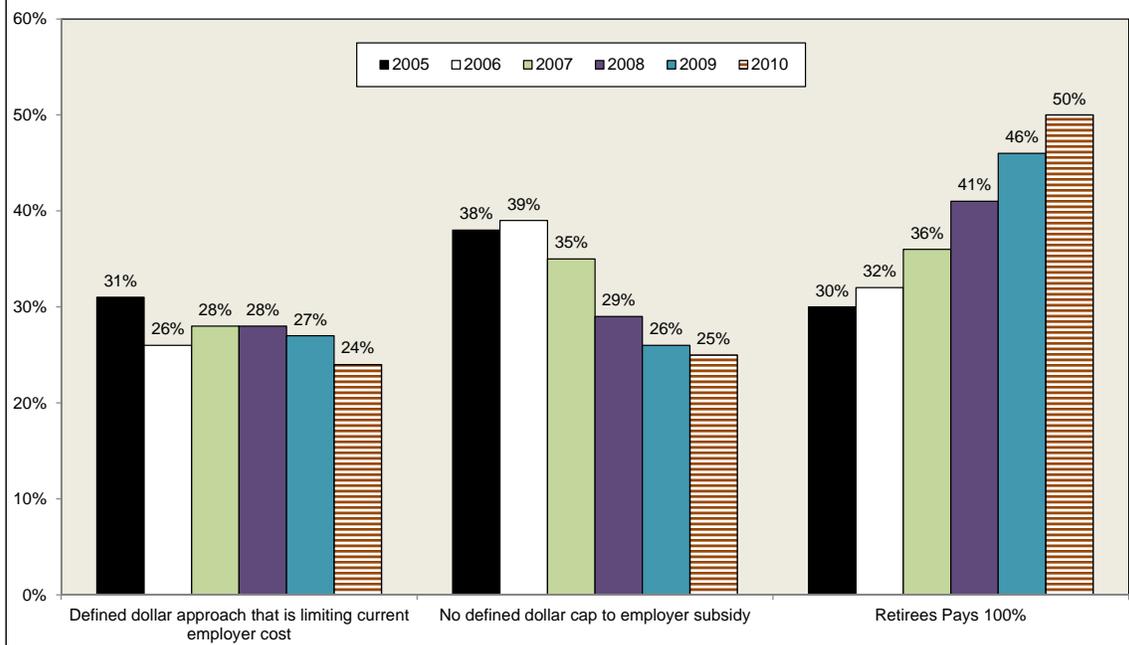
Source: U.S. Department of Labor Form 5500 Summaries 1979–1998, Pension Benefit Guaranty Corporation, Current Population Survey 1999–2011, EBRI estimates 1999–2010.

Figure 7  
**Percentage of Employers Offering Health Coverage to Early Retirees, by Firm Size, 1993–2011**



Source: Mercer and Medical Expenditure Panel Survey.

Figure 8  
**Distribution of Various Ways in Which Employers Subsidized Early Retiree Health Benefits, 2005–2010**



Source: Aon Hewitt, *Spec Summary: US Salaried, 2010* (formerly known as the Hewitt *Benefit SpecSelect: SpecSummary*).

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## Endnotes

<sup>1</sup> See [www.thefreelibrary.com/HR+Execs+Want+to+Empower+Employees+to+Make+Own+Benefits+Decisions,...-a053081371](http://www.thefreelibrary.com/HR+Execs+Want+to+Empower+Employees+to+Make+Own+Benefits+Decisions,...-a053081371)

<sup>2</sup> It can be argued medical savings accounts (MSAs) represent the first employer attempt to give workers money to purchase health care services. The Internal Revenue Service found that only 22,051 MSAs had been opened by June 1997. See [www.gao.gov/assets/230/225032.pdf](http://www.gao.gov/assets/230/225032.pdf)

<sup>3</sup> P.L. 111-148, enacted in 2010 and upheld by the Supreme Court, June 28, 2012.

<sup>4</sup> See Enthoven (1978a, 1978b, 1988) and Enthoven and Kronick (1989a, 1989b).

<sup>5</sup> See <http://healthaffairs.org/blog/2012/02/29/helping-consumers-choose-health-plans-in-exchanges-best-practice-recommendations/> for a more detailed treatment of the types of information that exchange participants would find useful.

<sup>6</sup> See [www.kff.org/healthreform/upload/8213-2.pdf](http://www.kff.org/healthreform/upload/8213-2.pdf)

<sup>7</sup> See Exhibit 2.1 in [www.kff.org/insurance/7315/upload/7315.pdf](http://www.kff.org/insurance/7315/upload/7315.pdf)

<sup>8</sup> See [www.towerswatson.com/united-states/newsletters/insider/5641](http://www.towerswatson.com/united-states/newsletters/insider/5641)

<sup>9</sup> See Fronstin (2001b).

<sup>10</sup> See [http://ccio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) for the various ways in which states can determine essential health benefits.

<sup>11</sup> See Exhibit 4.2 in <http://ehbs.kff.org/pdf/2011/8225.pdf>

<sup>12</sup> EBRI estimates from the March 2011 Current Population Survey.

<sup>13</sup> Reuters, "NIH-funded Vanderbilt Research Seeks Ways to Avoid Information Overload in Health Care Choices Among Seniors," March 5, 2008, [www.reuters.com/article/pressRelease/idUS176431+05-Mar-2008+PRN20080305](http://www.reuters.com/article/pressRelease/idUS176431+05-Mar-2008+PRN20080305)

<sup>14</sup> See [www.pbgh.org/storage/documents/HIXPlanChoiceProjectUpdate\\_113011.pdf](http://www.pbgh.org/storage/documents/HIXPlanChoiceProjectUpdate_113011.pdf)

<sup>15</sup> See question 34 in [www.ebri.org/pdf/surveys/hcs/2002/hcs02pq.pdf](http://www.ebri.org/pdf/surveys/hcs/2002/hcs02pq.pdf)

<sup>16</sup> See [www.eric.org/forms/uploadFiles/b86a00000009.filename.ERIC\\_New\\_Benefit\\_Platform\\_FL06060.pdf](http://www.eric.org/forms/uploadFiles/b86a00000009.filename.ERIC_New_Benefit_Platform_FL06060.pdf) This proposal also provides for retirement plans for all workers and calls for subsidies for low-income workers who cannot afford to save for retirement.

<sup>17</sup> See [www.ced.org/images/library/reports/health\\_care/report\\_healthcare07.pdf](http://www.ced.org/images/library/reports/health_care/report_healthcare07.pdf)

<sup>18</sup> See [www.washingtonpost.com/blogs/federal-eye/post/new-gop-budget-proposal-would-change-federal-retirement-health-contributions/2012/03/27/gIQA0ovgeS\\_blog.html?hpid=z4](http://www.washingtonpost.com/blogs/federal-eye/post/new-gop-budget-proposal-would-change-federal-retirement-health-contributions/2012/03/27/gIQA0ovgeS_blog.html?hpid=z4)

<sup>19</sup> See [www.towerswatson.com/assets/pdf/6556/Towers-Watson-NBGH-2012.pdf](http://www.towerswatson.com/assets/pdf/6556/Towers-Watson-NBGH-2012.pdf)

<sup>20</sup> See [www.usatoday.com/money/smallbusiness/2011-04-28-small-business-insurance\\_n.htm](http://www.usatoday.com/money/smallbusiness/2011-04-28-small-business-insurance_n.htm),  
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<sup>21</sup> See [www.aon.com/attachments/human-capital-consulting/Corporate\\_Exchange\\_Survey\\_Report\\_Final\\_2.pdf](http://www.aon.com/attachments/human-capital-consulting/Corporate_Exchange_Survey_Report_Final_2.pdf)

<sup>22</sup> Mercer information can be found at <http://www.mercer.com/press-releases/1434885?siteLanguage=100> The MEPS data reflect EBRI estimates from various tables at [http://meps.ahrq.gov/mepsweb/data\\_stats/quick\\_tables\\_search.jsp?component=2&subcomponent=1](http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1)

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