

News Release

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Health benefit cost growth accelerates to 6.9% in 2010, after nearly a decade of stable or slowing increases

- Total health benefit cost rises 6.9% in 2010, up from 5.5% in 2009.
- With reform requirements adding 1-2% to cost in 2011, employers say cost would rise by 10% next year if they made no changes, but hope to hold increase to 6.4% on average
- Large employers added consumer-directed health plans in 2010, helping to push up enrollment in these high-deductible plans to 11% of all covered employees
- Taking a cue from PPACA, more employers are giving employees financial incentives to participate in wellness or health management programs
- Prevalence of retiree medical plans falls to lowest level in almost 20 years; nearly one in ten large employers instead provides retirees with a subsidy to purchase individual coverage

New York, November 17, 2010 @ 10 a.m. EST

2010 is Year Zero for health reform – the year against which the effects of the new Patient Protection and Affordable Care Act (PPACA) will be measured. Growth in the average total health benefit cost per employee, which had slowed last year to 5.5%, picked up steam, rising 6.9% to \$9,562, the biggest increase since 2004, according to the National Survey of Employer-Sponsored Health Plans, conducted annually by Mercer and released today. Health benefit cost rose three times faster than the CPI in 2010.

Employers expect high cost increases again in 2011. They predicted that cost would rise by about 10% if they made no health program changes, with roughly two percentage points of this increase coming solely from changes mandated by PPACA for 2011. However, employers expect to hold their actual cost increase to 6.4% by making changes to plan design or changing plan vendors (Figure 1).

Mercer's survey included public and private organizations with 10 or more employees; 2,836 employers responded in 2010.

"Employers did a little bit of everything to hold down cost increases in 2010," said Chris Coté, a Principal in Mercer's Providence office. "The average individual PPO deductible rose by about \$100 (Fig. 2). Employers dropped HMOs, which were more costly than PPOs this year. Large employers added low-cost consumer-directed health plans and found ways to encourage more

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employees to enroll in them – even sometimes dropping all other plan options. And more employers provided employees with financial incentives to take better care of their health.”

Large employers experienced a sharper cost increase than smaller employers in 2010. Cost rose by 8.5% among employers with 500 or more employees, but by just 4.4% among those with 10-499 employees (Fig 3).

“Large employers may have been taken by surprise by the uptick in the cost increase this year,” said Mr. Coté. “In last year’s survey, they predicted cost would rise by less than 6%. Higher prices for health care services seem to be part of the equation, but if the recession caused a slowdown in utilization last year, we may also be seeing the effect of employees getting care they’ve been putting off.”

Large employers most often are self-insured, which means they pay the actual cost of claims as they are incurred. If health benefit utilization is higher than expected, or the price of health care services rises, actual cost could exceed predicted cost. Small employers typically offer fully insured plans, in which premium cost is fixed in advance.

Enrollment in CDHPs offered by the nation’s largest employers jumps sharply in 2010

Overall enrollment in high-deductible, account-based consumer-directed health plans (CDHPs) grew from 9% of all covered employees in 2009 to 11% in 2010. CDHP enrollment has risen by two percentage points each year since 2006 (Fig. 4).

CDHP enrollment rose fastest this year among the largest employers, those with 20,000 or more employees – a group that tends to set trends for other employers. Over half of these employers offered a CDHP in 2010 – 51%, up sharply from 43% last year. Enrollment rose even faster, swelling from 9% to 15% of covered employees (Fig. 5).

With the cost of HSA-based CDHP coverage averaging just \$6,759 per employee among all employers in 2010 – almost 25% lower than the cost of PPO coverage – the appeal of these plans is clear (Fig. 6).

“As both employers and employees become more comfortable with high-deductible plans, we’re seeing more organizations willing to commit to the consumerism concept,” said Mr. Coté. “Over the past few years employers have worked on finding a balance between giving employees more responsibility for their health care spending and providing the incentives, resources and support to help them succeed.”

Communication appears to be an important component of success. The employers that engage in the most extensive communication efforts aimed at encouraging health-conscious behaviors report higher levels of employee satisfaction. Among HSA sponsors with “very extensive” communication, 46% say employee response to the plan has been “strongly positive,” compared to 25% of those that make little or no effort with communication.

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As HMO cost rises, employers move on to other options

Offerings of HMOs fell from 28% of all employers to 26% in 2010. Cost was undoubtedly a factor: HMO coverage cost about \$100 more per employee than PPO coverage (\$8,892 compared to \$8,781). HMO enrollment peaked in 2001 at 33% and has been eroding ever since, sliding from 21% to 19% of all covered employees in 2010.

“The movement out of HMOs and into PPOs has been going on for nearly a decade, largely because PPOs offer employers more flexibility in sharing cost with members,” said Mr. Coté. “Now the growth is in consumer-directed health plans, in which high deductibles are made more palatable with an account that allows employees to accumulate health care dollars by using health services more wisely.”

HMOs remain more popular in the Northeast and West regions, where they are offered by 44% and 33% of employers, respectively.

Already committed to employee health management, employers add financial incentives to build participation

Employers will soon be more limited in how they can shift cost to employees. Starting in 2014, PPACA sets minimum standards for “plan value” (the percentage of health care expenses paid by the plan) and “affordability” (the employee’s share of the premium relative to household income), starting in 2014 employers will be limited in the extent to which they can shift cost to employees. These changes are bringing greater focus on improving workforce health as a way to control health benefit cost.

Over the past decade employers have been adding a wide range of programs under the employee health management or “wellness” umbrella, from health risk assessments (offered by 69% of large employers in 2010) to disease management programs (73%) to behavior modification programs (50%).

Results are encouraging: For a second year in a row, medical plan cost increases in 2010 were about two percentage points lower, on average, among employers with extensive health management programs than among those employers offering limited or no health management programs.

But cost savings are only possible if employees choose to participate in the programs, so in 2010 more employers added incentives or penalties to encourage higher participation rates: 27% of large employers with health management programs provided incentives, up from 21% last year (Fig 7). In addition, the incentives are becoming more substantial. Three years ago, a token gift like a hat or water bottle was the most common incentive for completing a health risk assessment; now it is cash (typically, \$75) or a lower premium contribution (typically, a reduction of \$180).

Nearly two-thirds of employers that have measured the return on their investment in health management programs say they are satisfied with the year-over-year savings, lower utilization rates or improved health risks.

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Very large employers are also increasingly willing to reward employees who demonstrate responsibility for their own health. More than a fourth of those with 20,000 or more employees require lower premium contributions from nonsmokers – 28%, up from 23% last year. An additional 6% provide other incentives to nonsmokers (Fig. 8).

“As employers see tangible evidence that health management can bend medical trend and contribute to a more productive workforce, they’re more willing to spend money to get their people into the program,” said Mr. Coté. “And because PPACA allows employers to use much larger incentives than we typically see, there’s still plenty of room to raise the bar on rewarding behavior change.”

Employers drop retiree medical plans in favor of subsidizing individual coverage

The prevalence of retiree medical plans slid to its lowest point ever in 2010, with just 25% of large employers offering a plan to retirees under age 65 (down from 28% in 2009) and just 19% offering a plan to Medicare-eligible employees (down from 21%). Even among the largest organizations, where retiree medical plans were once nearly universal, just 46% and 38% of employers, respectively, provide coverage to retirees under age 65 and those 65 and older.

Some employers that stop offering a plan on an ongoing basis (a plan for which new hires are eligible) continue to offer coverage to employees retiring or hired after a specific date; an additional 10% of all large employers offer coverage to such a closed group.

A diminished tax break for employers who provide retiree drug plans and the anticipated availability of better Medicare coverage as the government shrinks the so-called "doughnut hole" gap in prescription drug coverage are among the factors that have employers reexamining their retiree health programs.

As some employers take the step of terminating group coverage for retirees, they are softening the blow with a subsidy to help pay for individual coverage. Nearly one in ten of the largest employers (those with 20,000 or more employees) now provide such a subsidy in lieu of a group plan.

Survey methodology

The Mercer *National Survey of Employer-Sponsored Health Plans* is conducted using a national probability sample of public and private employers with at least 10 employees. More than 2,800 employers completed the survey in 2010. The survey was conducted during the late summer, when most employers have a good fix on their costs for the current year. Results represent about 800,000 employers and more than 104 million full- and part-time employees. The error range is +/-3%.

The full report on the Mercer survey, including a separate appendix of tables of responses broken out by employer size, region and industry, will be published in late March 2011. The report costs \$600 and the report and tables cost \$1,200. For more information, visit www.Mercer.com/ushealthplansurvey or call Tara Lewis at 212/345-2451.

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Notes for editors

Health maintenance organizations (HMOs) use a network of health care providers and do not cover care provided outside of the network.

Preferred provider organizations (PPOs) utilize a network of providers. There may be incentives for members to use the network providers, but they are covered for care received outside the network. **Point-of-service plans** are included.

A **consumer-directed health plan (CDHP)** is a medical benefit design in which employees use spending accounts – **Health Savings Accounts (HSAs)** or **Health Reimbursement Arrangements (HRAs)** – to purchase routine health care services directly. Non-routine expenses are covered by traditional insurance after members meet a generally high deductible. Online health and financial tools are generally provided. With an HSA, employees may contribute pre-tax dollars into the account; an employer contribution is optional, but employees have full control over all money in the account. With an HRA, only employers may fund the account and they decide whether money left in the account at the end of the year may roll over.

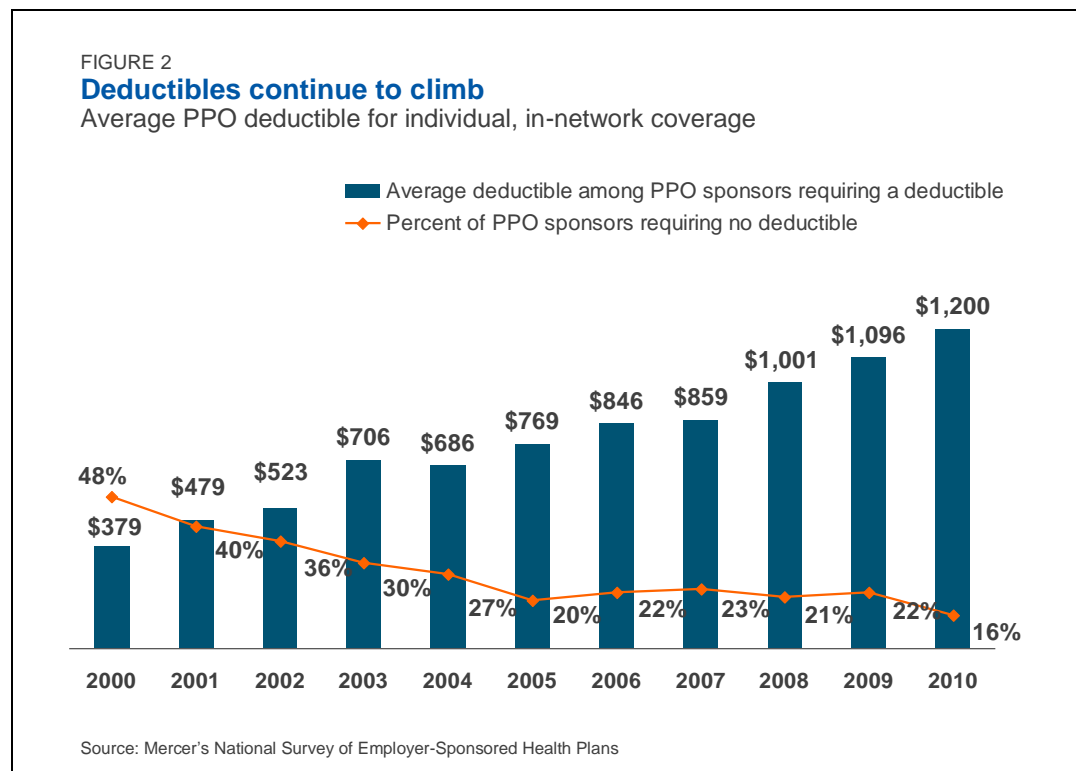
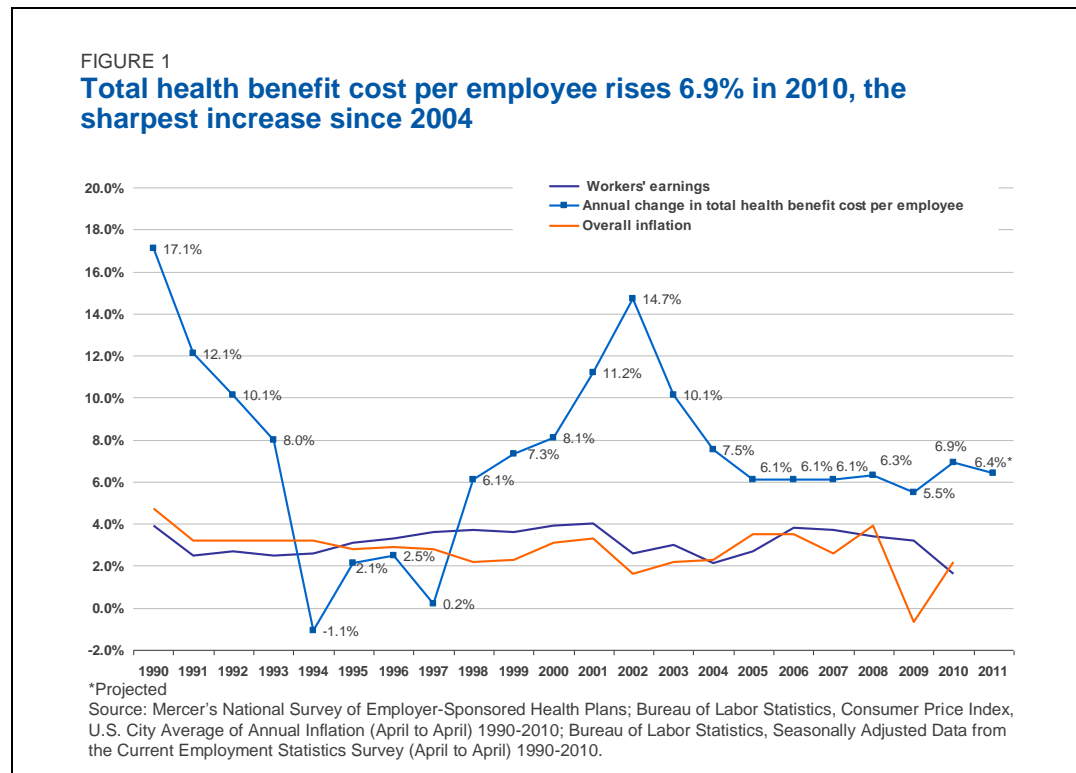
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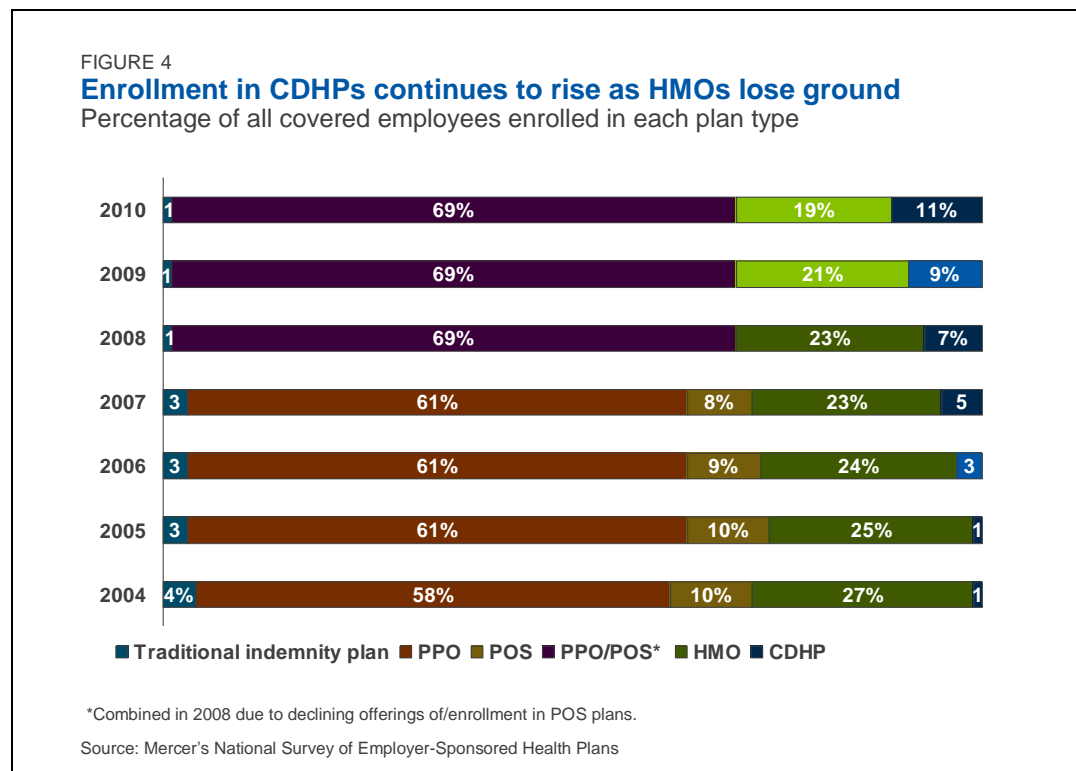
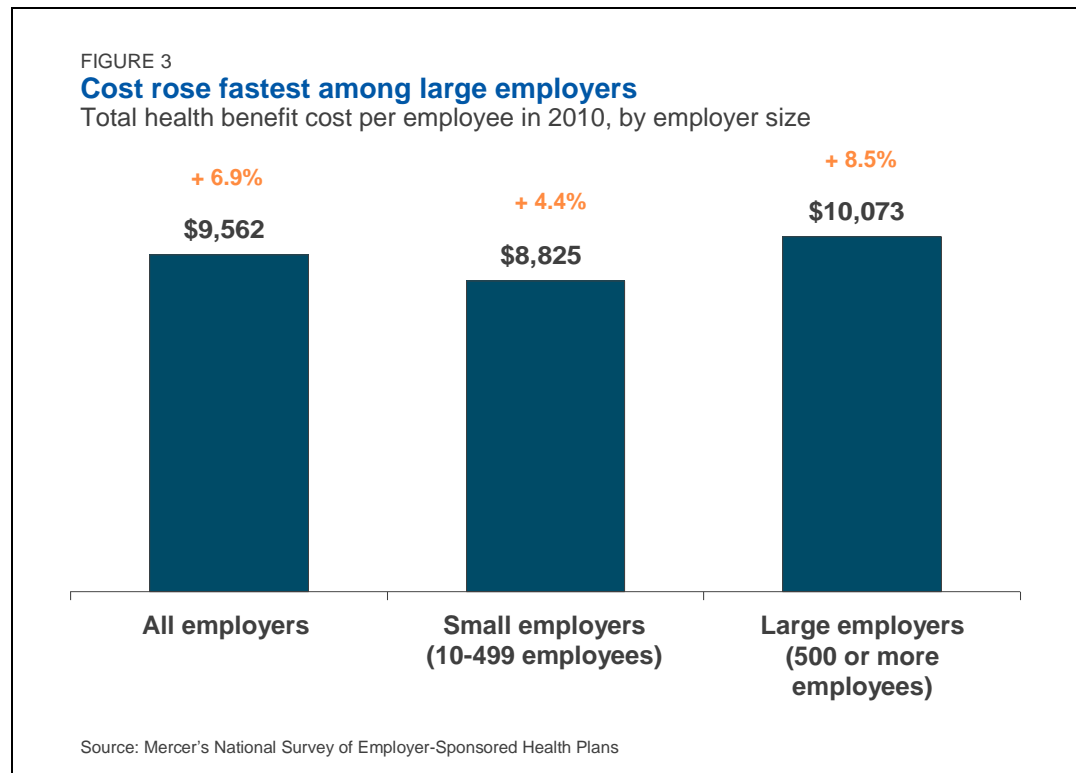
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FIGURE 5

With more than half of the nation's largest employers now offering a CDHP, enrollment is climbing

	CDHP* offered in:			Percent of employees enrolled:		
	2008	2009	2010	2008	2009	2010
Small employers (10-499 employees)	9%	15%	16%	6%	10%	12%
Large employers (500 or more employees)	20%	20%	23%	7%	8%	10%
Jumbo employers (20,000 or more employees)	45%	43%	51%	8%	9%	15%

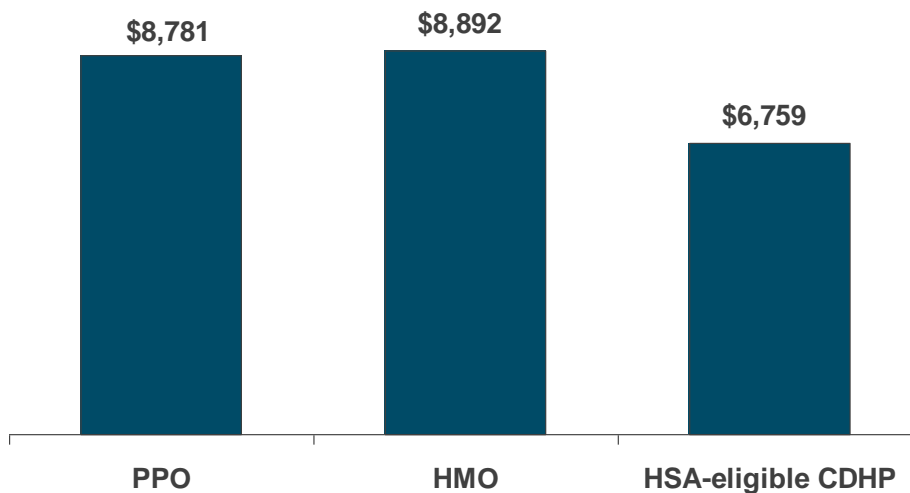
*Based on either a health savings account or health reimbursement arrangement.

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

FIGURE 6

Coverage in an HSA-based CDHP cost nearly 25% less than coverage in other medical plan types in 2010

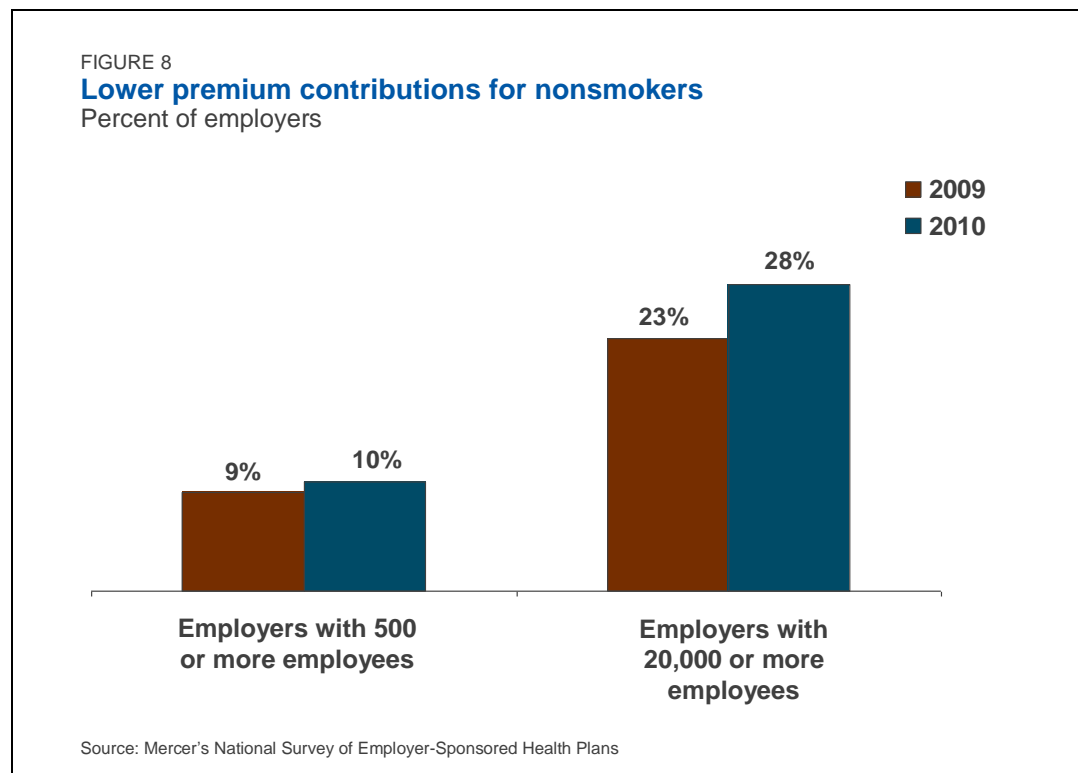
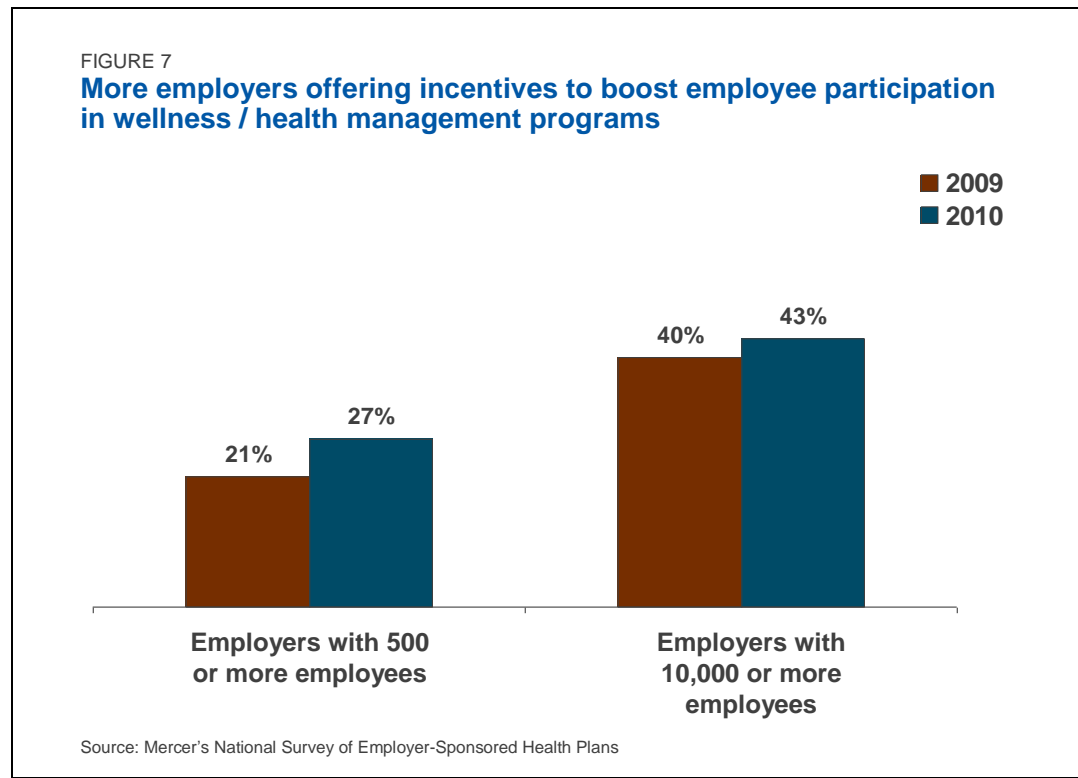
Medical plan cost per employee (includes employer contributions to HSA accounts)



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

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