

MERCER

Health & Benefits

News Release

Contact:

Dawn E. Dagg

+1 617 450 6422

dawn.dagg@mercer.com

Monday,

November 20, 2006

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

- **Small employers are most affected; their average cost rose 7.0%, faster than last year**
- **Employers take a break from traditional cost-shifting, focus on tactics to improve employee health and make them better health care consumers**
- **Enrollment in consumer-directed plans triples**

New York, EMBARGOED from release before November 20, 2006

Total health benefit cost rose by 6.1% in 2006, the same pace as last year, to an average of \$7,523* per employee, according to the *National Survey of Employer-Sponsored Health Plans*, conducted annually by Mercer Health & Benefits LLC and released today. With nearly 3,000 employer participants in 2006, it is the largest and most authoritative annual survey on the topic. All employers (private and public) with at least 10 employees are included in the survey sample.

This represents the end of a three-year period in which employers succeeded in reducing the rate of growth in health benefit costs, which hit a 12-year high of 14.7% in 2002 and slowed to 6.1% by 2005 (Fig. 1). Employers with fewer than 500 employees saw costs rise by 7.0% in 2006, however, which was a faster rate than last year (Fig. 2). Employers predict another 6.1% increase in average cost for 2007. With employee cost-shifting off the table for many employers, reducing this rate further, or even maintaining it, will require other cost management strategies, Mercer says.

In 2006, cost-shifting to employees was less of a factor in reducing health benefit cost increases than in past years. Average deductibles, copays and out-of-pocket maximums, which rose rapidly from 2000–2005, showed only modest growth last year, according to Mercer's data (Fig. 3).

**This figure includes the cost of all medical and dental plans, for employees and all covered dependents; employee premium contributions are counted but not their out-of-pocket costs.*

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

“So, the multi-million-dollar question for employers is: If cost growth in health benefits has stopped slowing, will it now start to accelerate?” said Deborah Wozniak, a consultant at Mercer Health & Benefits and one of the study’s authors. “With less cost-shifting to employees going on, we’ll see how well the leading-edge strategies for longer-term cost management—care management and consumerism—are working.”

Rising rates for fully insured plans, which are most commonly offered by small employers, also provided upward pressure on cost in 2006. However, employers applied downward pressure in other areas. Prescription drug benefit cost increases for large employers continued to slow, from 11.5% in 2005 to 10.4% in 2006, as employers added multiple payment levels to encourage employees to buy generic or preferred brand-name drugs.

In addition, enrollment in consumer-directed account-based health plans, the least expensive type of medical plan by far, is increasing. As employees shift from more expensive plans into less expensive ones, the average cost per employee drops.

Finally, employers continued to add care management features to their plans in 2006—in particular, health risk assessments, now offered by 22% of all employers and 53% of large employers—and to add incentives for employees to use care management. Survey results suggest that employers are increasingly able to measure a return on their investment in care management. Nearly a fourth of all large employers, and half of those with 20,000 or more employees, have attempted to measure ROI on various care management programs. Of those, the great majority—79%—are satisfied or very satisfied with ROI.

Asked to rate the importance of six cost management strategies to their organization over the next five years, care management and consumerism were each rated important or very important by 43% of all employers (and about two-thirds of those with 500 or more employees). Only 31% of all employers (37% of large employers) believe shifting cost to employees or scaling back benefits will play an important role in controlling cost in the near future (Fig. 4).

Shift to consumerism as a solution; small employers add CDHPs

The percentage of all employers offering a consumer-directed health plan (CDHP) based on either a health reimbursement account (HRA) or a health savings account (HSA) tripled in 2006, from 2% to 6%, as small employers began adopting the new plan type in significant numbers for the first time. Growth was also strong among larger employers. CDHP offerings rose from 5% to 11% among employers with 500 or more employees, and from 22% to 37% among jumbo employers (20,000 or more employees), the first to embrace the model. Nationally, enrollment in CDHPs jumped from 1% to 3% of all covered employees (Figs. 5 and 6).

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

“Some industry watchers look at the low enrollment in CDHPs and conclude that employees aren’t accepting the model,” said Ms. Wozniak. “But a three-fold increase in one year suggests otherwise.”

CDHPs delivered substantially lower cost per employee than either PPOs or HMOs in 2006. CDHP cost averaged \$5,770 per employee, compared to \$6,616 for HMOs and \$6,932 for PPOs (but just \$6,019 for PPOs with comparable deductibles of \$1,000 or more). The average CDHP cost is 5.3% higher than last year’s average cost of \$5,480. It should be noted that CDHP cost includes the employer account contribution and that many of the new plans added in 2006 were HSAs, which don’t require an employer contribution. Cost rose more rapidly for both PPOs and HMOs: 7.0% and 6.5%, respectively (Fig. 7).

“The lower cost increase is encouraging news for CDHP fans, but it’s a little early to celebrate,” said Ms. Wozniak. “Most employees in CDHPs have the option of selecting another type of medical plan, so you have to think about who is choosing the CDHP—it may be those with lower-than-average health risk.”

When a large employer sponsors a CDHP, 9 times of out 10 the CDHP is offered as a choice alongside other medical plan options, rather than as the only plan. Small employers, which typically offer only one plan, are more likely to offer it as the only choice (6 out of 10 sponsors).

HSA-based plans growing faster than HRA-based plans

HRAs have been around since 2001; HSAs were introduced as part of the Medicare Modernization Act at the very end of 2003, too late for most employers to offer in 2004. Last year HRA-based CDHPs were far more common than HSA-based plans. But in just one year HSAs have pulled ahead: 4% of all employers offer one in 2006, while just 2% offer an HRA-based plan. Small employers are showing a clear preference for HSAs, which don’t require an employer contribution to the account. However, even among large and jumbo CDHP sponsors, there is now an even split between the two account types—6% each for all employers with 500 or more employees, and 22% and 21% for HSAs and HRAs, respectively, among those with 20,000 or more employees. In 2007, HSAs will be offered more often by both small and large employers (Fig. 8).

On average, HSA-based plans cost 19% less than HRA-based plans in 2006, \$5,005 compared with \$6,214, respectively. (These and the following figures represent large employers, where the survey results are more robust.) For employees, the lower cost has meant a lower monthly premium contribution: \$41 per month for employee-only coverage in an HSA plan, compared to \$56 for coverage in an HRA plan. (For comparison, the average PPO contribution was \$85 per month; the average HMO contribution, \$76.)

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

HSA benefits are clearly less rich than HRA benefits. Among large employers, only 57% of HSA sponsors make account contributions, and when they do the average amount is lower (\$571 for an individual) than the average HRA contribution (\$648). HSA deductibles are higher as well: \$1,665, on average, compared to \$1,359. In order for a plan to qualify for an HSA, federal regulations require an individual deductible of at least \$1,050; in an HRA there is no minimum or maximum deductible (Fig. 9).

“While we’ve seen a lot of activity in HSAs this year, that doesn’t mean the HRA is on the way out,” said Ms. Wozniak. “The two plans are used for different purposes. I see some large employers offering them side by side.”

Over a third of all large employers offering an HSA (38%) say a very important objective for the plan is to provide a tax-efficient vehicle for savings.

Slower growth likely for CDHPs among large employers

Near-term, 14% of small employers say they are very likely to offer a CDHP in 2007, including those who currently offer one; this figure rises to 16% for 2008 (Fig. 5). This would represent a significant increase from the 5% of small employers offering a CDHP today. Even if not all these employers follow through in 2007 (respondents complete the survey in the late summer, when many small employers in particular have not yet finalized plans for the upcoming year), it is a good indication of their enthusiasm for the new plan type.

While CDHPs initially grew fastest among larger employers, survey results indicate a cooling trend for the next two years. Among employers with 500 or more employees, CDHP offerings are predicted to rise from 11% this year to 14% in 2007 and 19% in 2008—good, but not spectacular, growth. Among jumbo employers, where CDHPs have been embraced the most enthusiastically, growth will be modest, from 37% this year to 39% in 2007 and 43% in 2008.

If these predictions prove accurate, they suggest that the rapid growth in CDHP adoption seen in 2005 and 2006 will slow somewhat over the next two years. “That’s not unusual with a new plan,” said Ms. Wozniak. “By now, the early adopters have already acted; we can expect a pause while employers with more of a ‘show-me’ mindset wait for results.”

However, when asked to think ahead five years and predict what medical plan choices will most likely be offered to their employees, large employers send a clear message: 60% say employees will be offered one or more account-based plans, including 10% that say they will offer *only* account-based plans. More than a third of small employers (36%) believe they will offer account-based plans five years down the road.

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

Survey results suggest that enrollment in the plans already established is likely to continue to rise. Among large employers with CDHPs in place in both 2005 and 2006—excluding full replacement plans—average enrollment rose from 22% to 27% of eligible employees.

More employers drop plans for Medicare-eligible retirees

Perhaps in response to the new Medicare Part D prescription drug benefit, the percentage of large employers providing a medical plan for Medicare-eligible retirees on an ongoing basis dropped from 21% to 19% in 2006 (Fig. 10). An additional 10% provide coverage to a closed group of current or future retirees, but do not offer coverage to new hires.

Survey results suggest that many large retiree plan sponsors changed their approach to providing coverage to their Medicare-eligible retirees in 2006 as they took more time to react to the introduction of Medicare Part D benefit. Last year, 43% continued to provide coverage to retirees without seeking a subsidy, perhaps because of the difficulty or expense of performing the tests required to receive it; by 2006, this figure had fallen to just 25%. Conversely, sponsors receiving the subsidy rose from 44% to 51%, and more employers also chose to provide coverage that wraps around a prescription drug plan (PDP): 13%, up from just 4% last year.

There was no change in the percentage of large employers providing coverage for pre-Medicare-eligible retirees (29%). Again, an additional 10% provide coverage to a closed group.

The future of employer-sponsored retiree medical coverage is far from clear. Just 78% of large employers that currently offer a retiree plan to new hires believe they will still do so five years from now. In 2006, 7% of retiree medical plan sponsors offer an HSA to help employees save for post-retirement medical expenses; 20% say they are considering adding an HSA for this purpose.

Employers favor tax credits as a solution for the uninsured

When asked for an opinion on various approaches to solving the problem of the uninsured, the greatest portion of employers approved or strongly approved of tax credits for health insurance for individuals (67% approved, 21% strongly approved). Employers also favored additional tax incentives to promote greater adoption of HSAs (54% approved, 17% strongly approved). More than two-fifths said they approved of a federally financed system, like Medicare, for all Americans (32% approve, 11% strongly approve).

Employers were most strongly opposed to requiring employers to offer a plan or pay into a fund to provide coverage for the uninsured, the “pay-or-play” approach recently adopted in several states (42% disapproved, 14% strongly disapproved), and to requiring individuals to purchase insurance (41% disapproved, 11% strongly disapproved).

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

Very small employers (10–49 employees), those most at risk for dropping coverage, were more likely to favor the “pay-or-play” approach (32% approve or strongly approve) than jumbo employers (15%). They were also more likely to favor a federally financed approach (44%, compared to 20% of jumbo employers).

Survey methodology

The Mercer *National Survey of Employer-Sponsored Health Plans* is conducted using a national probability sample and, with nearly 3,000 employer participants in 2006, is the largest and most authoritative annual survey on the topic. All employers, public and private, with at least 10 employees were sampled. 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 600,000 employers and more than 90 million full- and part-time employees, and have an error range of +/-3%.

The full report on the survey results, including a separate appendix of tables of responses broken out by employer size, region and industry, will be published in late March 2007. The report costs \$500 and the report and tables cost \$1,000. Copies of the report and tables may be pre-ordered online at MercerHR.com/ushealthplanssurvey or by calling Tara Lewis at 212-345-2451.

Notes for editors:

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

Point of service (POS) plans utilize a network of providers and require participants to get a referral from a primary care physician (gatekeeper) before using specialists or hospital services; a lower level of coverage is provided for care received outside the network.

Preferred provider organizations (PPOs) utilize a network of providers that members may access freely; there may be incentives to use network providers, but participants are covered for care received outside the network.

A **consumer-directed health plans (CDHP)** is a medical benefit design in which employees use spending accounts—**health reimbursement accounts (HRAs)** or **health savings accounts (HSAs)**—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 HRA, an employer contribution is required and employers can decide whether money left in the account at the end of the year may roll over. With an HSA, an employer contribution is optional, and employees have full control over all money in the account.

Health benefit cost increases level off at 6.1% in 2006, after three years in which employers reduced the rate of growth

EMBARGOED from release before November 20, 2006

About Mercer Health & Benefits

Mercer Health & Benefits is a business of Mercer Human Resource Consulting, a global leader for trusted HR and related financial advice and services, which has more than 15,000 employees serving clients in over 180 cities and 40 countries and territories worldwide. The company is a wholly owned subsidiary of Marsh & McLennan Companies, Inc., which lists its stock (ticker symbol: MMC) on the New York, Chicago, Pacific and London stock exchanges.

###