

Here It Comes:

Defined Contribution Health Care

by **Kenneth L. Sperling and Oren M. Shapira**

The Patient Protection and Affordable Care Act includes provisions to make the individual health insurance marketplace one where all Americans, including those with preexisting health conditions, can obtain affordable coverage. At the same time, the act has failed to address, in any significant way, many of the underlying flaws in the current U.S. health care system that have caused costs to spiral out of control. The combination of persistent U.S. health care cost increases and a viable individual health insurance marketplace will cause a sea change in employer-sponsored health care offerings that is similar to that seen among employer-sponsored retirement benefit plans: movement away from defined benefit approaches and toward defined contribution designs. Although the authors show parallels between the evolution of employers' health care and retirement offerings, they explain why certain key developments will need to occur before defined contribution approaches become as prevalent in employer-sponsored health care plans as they are in today's employer-sponsored retirement plans.

INTRODUCTION

The concept has been talked about for years: Why not move from today's defined benefit (DB) form of employer-sponsored health care, where instead of the company providing a unilaterally designed plan (or set of plans) to eligible employees, there exists a defined contribution (DC) structure where the employer's responsibility is denominated in dollar terms?

Employers don't provide homeowner or auto insurance; the employer provides compensation so employees can purchase these necessary (or mandatory) coverages themselves. Why should health insurance be different? Certainly the movement toward DC retirement plans has resulted in more predictable cost for employers and more choice and control by employees. Can't this be applied to health care?

Until now, the answer has been simple. Unlike the retirement arena, where access to available investment choices is virtually limitless for everyone, or other insurance where a competitive retail market exists, there is no viable health care marketplace for an individual with

prior medical history. Preexisting condition limitations and medical underwriting requirements would exclude a fair segment of an employer's workforce, making the entire DC argument meaningless. Some employees just wouldn't be able to secure coverage—at any price.

But soon that all will change and, with it, the very underpinnings of the employer-sponsored health care system.

The Patient Protection and Affordable Care Act (PPACA) (or, as the president refers to it, health insurance reform) will prohibit medical underwriting and preexisting conditions completely by 2014. Health insurance will be widely available through state-based “exchanges,” with regulatory oversight over benefits and rates.

Health insurance reform, however, is not *health care reform*. Although there are many positive elements in the health reform legislation that seek to rationalize the health care delivery system, many of the underlying flaws in the current U.S. health care system that have caused costs to spiral out of control have not

been addressed in any significant way. Only a small minority of employers (6%) believe their company will be better off as a result of health reform legislation.¹

These two factors—the viability of the individual health insurance marketplace and an unrelenting increase in cost—will cause a sea change in employer-sponsored health care very much like the movement from DB to DC retirement plans that began in the early 1990s. Employers will soon come to the inevitable conclusion that the only way to control their health care expense is to redefine their commitment and treat health care subsidies as another form of compensation—at compensationlike rates of growth.

This movement, like any new concept, will not happen overnight. It will begin to take shape in hybrid models starting in 2012. By 2014, when many of the insurance reforms take effect, it will be an emerging trend. And by 2020, unless the health care delivery system itself is reformed, it will become the way in which most workers access health insurance coverage in the United States.

RETIREE HEALTH CARE AS HISTORICAL PRECEDENT

Perhaps the clearest example of how access and cost can combine to drive change in the employer market can be seen in the changes that have occurred in employer-sponsored retiree health care.

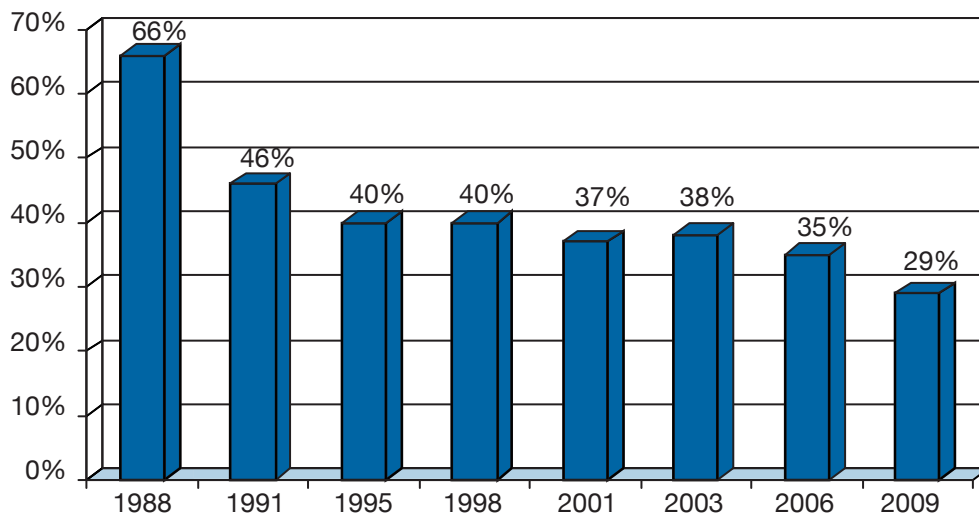
In December 1990, the Financial Accounting Standards Board (FASB) issued a statement, known as Financial Accounting Standard 106 (FAS 106), that changed the way employers were required to account for postemployment health care benefits on their financial statements. In essence, this ruling required employers to treat the cost of retiree health care similar to the way they treated pension plans—by accruing the cost of the benefit over an employee’s working lifetime rather than on a pay-as-you-go basis after retirement. However, unlike pensions, which are assumed to grow at the rate of wage increases, health care costs have historically grown as much as three to four times that amount. The long-term liabilities that FAS 106 created were astounding—and could have buried the balance sheets of many Fortune 500 companies.

In the face of these liabilities, many companies decided to stop sponsoring retiree health care benefits entirely, as can be seen in Figure 1. This trend continued into the effective date of FAS 106 in 1993, then stabilized thereafter.

Some companies, however, decided to maintain their retiree health care plans and just take health care inflation out of the liability calculation. They accomplished this by instituting caps on their retiree health care costs. A common strategy was to cap the employer liability at two times current cost. When the employer’s retiree health care cost reached the capped level, the employer contribution presumably

FIGURE 1

PERCENTAGE OF LARGE FIRMS OFFERING RETIREE BENEFITS TO ACTIVE WORKERS, 1988-2009



Sources: Kaiser/HRET, KPMG, HIAA.

would be frozen and all future increases would be borne by retirees.² At the time, employers solely intended for this strategy to limit accounting liability. Starting in the mid-2000s, however, continued increases in medical cost triggered these caps, and companies were faced with two choices: book an additional balance sheet liability by raising the cap, or pass the full increase in cost to the retiree by maintaining the cap. Most employers chose the latter route, and—presto!—they created the first DC health care plans.

The next iteration was close at hand. With the employer contribution fixed, retiree contributions quickly escalated, and some retirees were no longer able to afford to purchase the relatively rich employer-based benefit. Companies began to realize that their time and money spent administering, managing and communicating these benefits no longer had any impact on the bottom line—their efforts to control cost would only accrue to the retiree in the form of lower contributions, not company expense. In short, there was no good business reason to stay in the game. With employers seeking an exit strategy, the market responded by offering “exchanges” for Medicare-eligible retirees, which created a win-win for both employers and retirees: The company was now out of the benefits design and delivery business, as well as the administrative requirements of sponsoring an Employee Retirement Income Security Act (ERISA) plan, and retirees could deploy their limited subsidies more effectively, having a variety of coverage choices and price points that were the best value for them.

The individual health insurance market for Medicare-eligible retirees was well-suited for this purpose, as there were multiple players in the market, strong competition to keep premiums in check and no medical underwriting. Today, retirees in these exchanges have Web- and phone-based support to assist with choosing a plan, as well as an assortment of Medicare Advantage, Medicare Supplement and Medicare Part D plans where their employer subsidy can be applied.

Once the medical underwriting barrier is removed for non-Medicare-eligible individuals in 2014, this exchange concept will, for the first time, be a viable alternative for pre-aged-65 retirees as well as actives. The question then will be whether employers will be interested in moving to this model of delivery. To answer this question, it is instructive to look at the DB to DC movement in the retirement area, and the factors that drove this evolution.

THE DB TO DC MOVEMENT IN RETIREMENT PLANS

The movement from DB to DC forms of retirement benefits can be summarized by three overarching goals:

- The desire to reduce cost
- The desire to reduce risk and volatility
- The desire to provide more transparent, tangible and shared responsibility with the employee.

The achievement of these goals occurred in three distinct stages. Within each of these stages were numerous key elements that furthered the evolution of DC plans. While the events within the retirement and health care markets undoubtedly will occur on a different time line, there is good reason to believe that health benefits will continue undergoing some of the same trends that occurred among retirement benefits.

Stage 1: Design Changes Within the DB Model

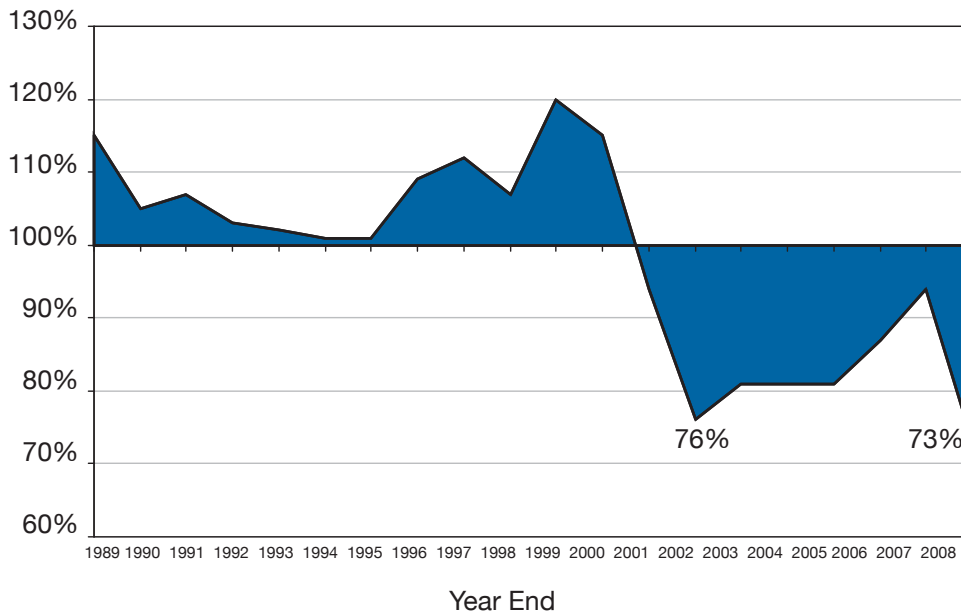
Americans working in post-World War II America were taught there was a three-legged stool defining financial security in retirement: Social Security, private pensions and personal savings. Each leg was equally important in building a secure future. While DC arrangements such as profit-sharing plans, money purchase plans and tax-deferred annuities were prevalent, DB pensions were still the predominant form of employer-sponsored retirement plans for much of the 20th century. However, in the early 21st century, significant swings in interest rates, coupled with a challenging equity environment, created volatility in the funded status of U.S. pension plans that was too large for sponsoring employers to ignore (Figure 2).

This was further exacerbated by the increasing longevity of retirees brought about by increases in medical technology and treatment. In response to increased cost and risk associated with pension benefits, many employers began to alter their designs. One of the more popular changes was to move the definition of *pension-eligible wages* from an average final pay to a career average pay formula, in order to use less of an employee’s later (higher salary) years of service.

Stage 2: The Hybrid Plan

Workforce changes in the 1980s and 1990s also contributed to a restructuring of the retirement marketplace. More women entered the workforce, and working spouses became the rule rather than the exception. Length of service became shorter as employees were more willing to change jobs for better career and compensation opportunities. The DB pension, which rewarded long-service employment, was not going to attract and retain a more mobile workforce. The *cash balance plan* was an attempt to create more transparent value within the structure of a DB pension. In this hybrid arrangement, employees were able to see employer contribution “credits” to a hypothetical account that would lead to full funding of a pension-type formula in retirement. Workers

FIGURE 2
VOLATILITY IN PENSION-FUNDED STATUS



Source: Hewitt Associates, “Study Findings: Benefit Plan Disclosure Under FASB Statements No. 87 and 106,” 2009.

could now see the benefit to staying with (or the loss by leaving) their current employer. In a recent Government Accountability Office survey, 58% of employers with nonbargaining employees reported converting their traditional plans to hybrid plans.³

The move to cash balance was kick-started in the late 1990s by several prominent employers announcing they were replacing their traditional DB pension plan with this model, including AT&T, Aetna, Eastman Kodak, CBS and IBM.⁴ With several major U.S. companies setting the precedent, other companies followed. Simultaneously, 401(k)s were gaining steady popularity. Cash balance hybrids had increased workforce awareness of the advantages of DC plans. DC plans were easy to understand, portable and employee-directed. Many workers participated in 401(k) plans in addition to their cash balance plans.

The federal government did not stand in the way of the increasing popularity of DC plans—quite the opposite. The allowance of automatic enrollment and increased contribution limits throughout the last decade helped fuel the eventual dominance of DC retirement models.

Stage 3: The Freezing of Pension Plans

With the combination of hybrid cash balance plans and the growth in 401(k) participation, companies

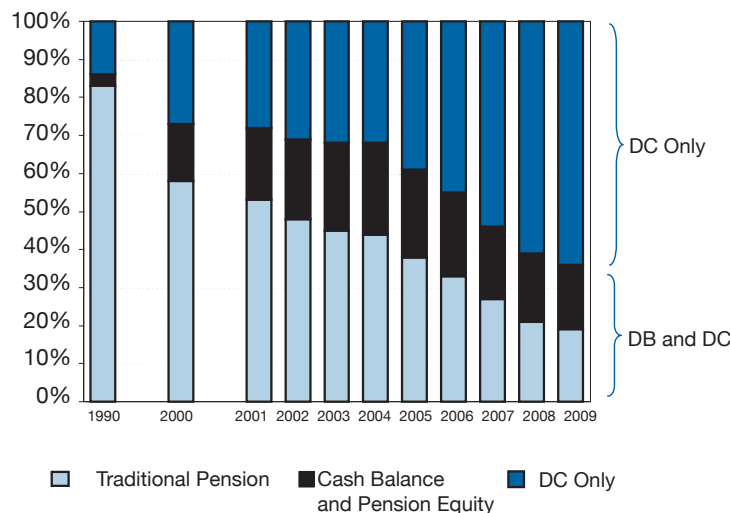
began to question whether the DB pension model had any place in their total rewards framework. DC plans offered less risk and volatility to the employer and were both more efficient to administer and more highly valued by employees as a “shared responsibility” between employer funding and employee contributions. Employers began to freeze future accrued benefits into their DB plans, and over the last decade the DC plan has become the dominant form of retirement benefit in the employer-sponsored market (Figure 3). Again, movement by key employers such as IBM and Verizon accelerated this movement.

OVERLAPPING TRENDS ACROSS HEALTH AND RETIREMENT

Health care benefits are undergoing a chain of events similar to the evolutionary trends in retirement benefits. In the midst of political reform and new employer benefit design strategies, the health care market is undergoing a transformation that ultimately will lead to a DC benefits structure. The goals of cost control, risk transfer and shared responsibility—which have been largely elusive in health care to date—will drive employers to a similar outcome. Along this path, health benefits will continue to be shaped by legislation, financial necessity and market trends.

FIGURE 3

**CHANGES IN PREVALENCE OF RETIREMENT PLAN TYPES
AMONG LARGE U.S. EMPLOYERS**



Source: Hewitt Associates, SpecSummary™ database, 2009.

Trends in Traditional Health Care Benefit Cost and Risk

The continued rate of health care costs has been extensively documented and discussed. A 2009 Hewitt Associates' report to Business Roundtable, during the framing of the health reform legislation, showed that current trends left unchecked will lead to an unsustainable cost burden that will severely hinder U.S. companies' ability to compete in a global marketplace (Figure 4).

In addition to the increased cost associated with employer-sponsored benefits, increasing availability and use of sophisticated, life-saving medical treatments has exposed plan sponsors to individual claims that can easily exceed \$1 million. Health reform legislation prohibiting most forms of annual or lifetime benefit maximums will expose companies to an increasing level of volatility and risk.

Growth of Consumer-Driven Health Plans (CDHP)

In an effort to inject rational cost sharing as well as a sense of shared responsibility for health spending, more employers have moved toward offering CDHPs either alongside or in place of traditional benefit plans. According to Hewitt's 2010 survey of over 1,200

large U.S. employers, 19% offer a CDHP with a health reimbursement arrangement (HRA) and 29% offer a CDHP with a health savings account (HSA) component. CDHPs are essentially a hybrid of DB and DC arrangements, as they combine a traditional preset plan design with a tax-efficient vehicle to hold fixed employer and/or employee contributions.

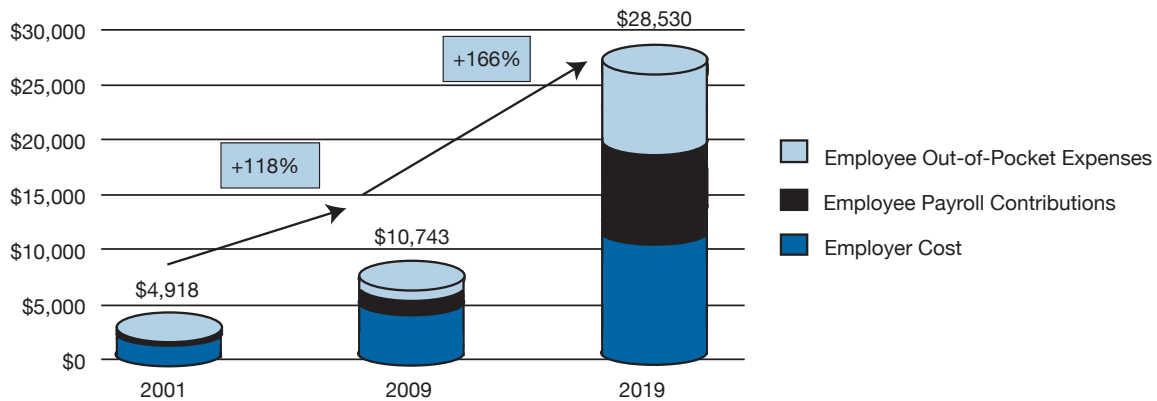
The growing trend of CDHPs closely mimics the emergence of (hybrid) cash balance plans in the 1990s. Much like today, cash balance plans were popular at a time when employers were hesitant to drop their traditional benefit plans, yet had a desire to introduce a vehicle that reduced cost and began to denominate the employer commitment in dollar terms. Similar to the way CDHPs increase awareness of health costs, many were also fond of the way cash balance plans allowed employees to see the employer-provided value of their retirement savings in a theoretical account. It is striking how similar these vehicles are as transition models from DB to DC.

Encouraging Legislation

Both the retirement and health care markets experienced regulatory reforms that cleared a path toward shifting from a DB approach. Of particular similarity is the recent health reform mandate requir-

FIGURE 4

TOTAL HEALTH CARE COST PER EMPLOYEE FOR LARGE COMPANIES, 2001-2019



Source: Hewitt Associates Report to Business Roundtable, September 2009.

ing employers to offer autoenrollment for their health care plans, effective in 2014.⁵ And while the state-based health insurance exchanges will go live in 2014, states may allow large employers to participate beginning in 2017. The combination of exchange vehicles to purchase individual or group health insurance in a competitive and accessible market, as well as tax-efficient funding vehicles such as HRAs and HSAs, may prove too attractive for employers to resist.

WHAT STILL NEEDS TO HAPPEN

As can be seen, there are several existing trends in health care that mirror what has been observed in the retirement benefits and the retiree medical markets over the last decade. To continue this analogy, one can argue that health benefits are currently stuck in a hybrid state of DB and DC plan designs. In order to push through this stage and fully adopt a DC approach, there are still several key things that must occur.

Evolution Precedes Revolution

The decision to no longer provide employer-sponsored health care benefits will not be made lightly by any employer. Health care is the most highly valued of all employee benefits by a wide margin, and the cost associated with severe illness can bankrupt all but the most affluent Americans. In advance of a pure DC approach, transition models will need to emerge that offer a bridge between current employer coverage and a new model of delivery. For example, a private, employer-only exchange may offer coverage options that

mirror the state exchanges, with a mix of group and individual coverage to ease the transition over time. Robust decision support and consumer advocacy will be necessary to help employees decide which option provides the best balance of cost and risk protection.

► THE AUTHORS

Kenneth L. Sperling is Aon Hewitt’s global health care practice leader responsible for business strategy, thought leadership and service innovation for Aon Hewitt’s health and benefits business. During his 18-year tenure with Aon Hewitt (formerly Hewitt Associates), Sperling has advised Fortune 500 companies, worked with the Wall Street community and testified before the U.S. Senate Finance Committee and House Ways and Means Committee. He served on the advisory board of the University of Connecticut’s health management program and has guest lectured at the Harvard School of Business and the Yale School of Management. Sperling is a graduate of Duke University and earned a master’s degree in business administration from New York University. He is based in Norwalk, Connecticut.

Oren M. Shapira is an analyst at Aon Hewitt’s Norwalk, Connecticut office. He is currently completing his studies at the University of Connecticut’s health management program.

And a competitive marketplace will need to be in place to keep escalating health care premiums in check before an employer will be comfortable moving to a DC model. Otherwise, annual increases in subsidy that follow a compensation-based trend will only result in cost shifting to employees and put additional pressure on employers to return to historical practices.

Legislation That Favors Standalone DC Plans

Health insurance reform legislation will create a viable individual and small group market, delivered through state-based exchanges, in 2014. For large employers, dropping current coverage and allowing employees to access coverage in the exchanges will trigger a penalty of \$2,000 for every full-time employee—even if the employer subsidized this coverage to the same extent that it paid toward traditional coverage. In the current law stipulating employer responsibilities, a standalone HRA or HSA would not escape this penalty. In order for more employers to move toward a full DC approach, there must be additional clarity that allows companies to subsidize health coverage received from any source rather than be mandated to offer specific benefits.

A Market Mover (or Two)

While the shift to DC was already well underway by the early 2000s, the number of companies offering a DC plan exclusively spiked following IBM's announcement to freeze its pension plan in 2005. Looking at health care in parallel, the number of large firms offering health benefits has remained steady at close to 99% for the past decade.⁶ However, if a large, well-known employer were to announce movement to a DC approach, many companies likely would follow suit. A survey performed by the Employee Benefit Research Institute in December 2007 (well before health reform became law) reported that most employers "said that, if other employers dropped coverage, for competitive reasons they would be forced to reconsider their decision to offer benefits."⁷ If one or two or ten large employers move toward DC across multiple industries, offering health benefits no longer will be seen as a competitive necessity. This would create a chain reaction of other large firms moving in this direction. As we have seen in cash balance, in 401(k) and even in managed care with AlliedSignal circa 1987, a market mover will be necessary to finalize the shift in health care from DB to DC.

CONCLUSION

There are four main reasons that employers choose to be the source of health insurance for employees and their families:

1. Competitive practice
2. Tax efficiency
3. A vested interest in the health and well-being of employees
4. The lack of a viable individual market in which all employees can purchase their own coverage.

Health insurance reform will eliminate reason four beginning in 2014. The actions of a few large, market-moving organizations may eliminate reason one. Clarifying regulations regarding standalone HRAs and HSAs may eliminate reason two. And reason three can be accomplished outside of the group insurance marketplace with well-constructed wellness and care management programs, as can be seen in other countries where government-run health care systems are financed through taxes and other revenue streams.

In summary, the employer-sponsored health care market is on the tipping point of revolutionary change, enabled by recent insurance market legislation and fueled by unsustainable cost increases. There is historical precedent, both in the retiree health care and pension market, to prove this change is both possible and inevitable. Whether history views this movement as the final break in employers' responsibility to employees, or a natural movement to shared responsibility and economic reality, is a chapter that has yet to be written. ◀

Endnotes

1. "The Road Ahead—Under Construction With Increasing Tolls," Hewitt Associates, 2010.
2. In 1993, the United States was in the middle of a health care reform debate led by then-First Lady Hillary Clinton. Many employers believed that the caps would never be hit, because a government-controlled health care system would be in place before costs rose to the capped level.
3. U.S. Government Accountability Office, 2008 retirement survey. Available at www.gao.gov/new.items/d08817.pdf.
4. Employee Benefit Research Institute, "An Overview of Cash Balance Plans," *EBRI Notes*, July 1999, Volume 20, #7, www.ebri.org/pdf/notespdf/0799notes.pdf.
5. Kaiser Family Foundation, Health Reform Implementation Timeline. Available at www.kff.org/healthreform/8060.cfm.
6. *Kaiser/HRET Survey of Employer-Sponsored Health Benefits*, 2000-2009. Available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.
7. "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" Employee Benefit Research Institute, *Issue Brief*, December 2007. Available at www.ebri.org/pdf/briefspdf/EBRI_IB_12-20073.pdf.

International Society of Certified Employee Benefit Specialists

Reprinted from the First Quarter 2011 issue of *BENEFITS QUARTERLY*, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.

©2011 International Society of Certified Employee Benefit Specialists