TABLE OF CONTENTS

1 Objective
2 Introduction
3 Healthcare Cost Shifting
4 Employee Tax Exclusion
6 Health Savings Accounts
7 Innovations in the US Health System
8 Conclusion
9 Contacts
OBJECTIVE

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

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

---

3. US Bureau of Economic Analysis reports employer contributions for group health insurance were $668 billion in 2015. Table 6.11D. Employer contributions for employee pension and insurance funds, revised Aug. 3, 2016, [https://www.bea.gov/iTable/iTable.cfm?ReqID=9&step=1&freqid=9&step=3&isuri=1&903=219](https://www.bea.gov/iTable/iTable.cfm?ReqID=9&step=1&freqid=9&step=3&isuri=1&903=219)
Employers have long been providing the tools employees need to become smart, fiscally responsible insurance consumers, and employers are a trusted source of health information and resources.

Health-benefit costs outpace inflation – often by three times or more – and rising benefit costs can act as a drag on business results (Figure 1). In addition, American businesses help fund care for Medicare and Medicaid beneficiaries, as providers often charge private payers higher rates to help cover underpayments for these populations. The American Hospital Association estimates that combined Medicare and Medicaid underpayments totaled $57.8 billion in 2015.6 Our nation’s employers are implicitly subsidizing these programs.

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

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

---

**INTRODUCTION**

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

---

*Projected


---

6 American Hospital Association, Underpayment by Medicare and Medicaid Fact Sheet, December 2016, [http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf](http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf)
Congress should maintain Medicaid expansion and funding levels. Block granting Medicaid and rolling back the expansion would likely result in an increase in uninsured and lower payments to Medicaid providers. Both of these scenarios may lead providers to hike rates for private payers, thereby shifting more costs to employers.

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

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

Implicit cost-shifting could result from several of the ACA reform plans under consideration. Some propose rolling back the ACA’s Medicaid expansion and allowing states to choose between block grant and enrollment-based financing. Moving to block grants would reduce federal involvement in Medicaid and offer states added flexibility to administer their programs. However, it likely would also mean a reduction in total federal funding. A 2013 analysis by the Bipartisan Policy Center estimated that a proposal to block grant Medicaid would reduce federal funding for the program by $160 billion in 2022.10

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

**Recommendation**

Avoid policies that merely shift costs to private payers and adopt policies that address the underlying causes of healthcare cost growth.
Under current law, nearly all premiums for employer-based insurance are excluded from federal income and payroll taxes. The Congressional Budget Office (CBO) estimates this tax exclusion cost the federal government $250 billion in fiscal year 2016. But it also helped to lower the average American worker’s health insurance costs by about 30 percent.11

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

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

Like the ACA’s excise tax on high-cost plans, limiting the tax exclusion will have a substantial, negative financial impact on workers. As employers scale back health plan benefits to minimize adverse tax impacts of coverage costs, employees take on more risk for out-of-pocket expenses. Those that use the most healthcare – generally, people with chronic conditions and families with young children – will be hit the hardest.
In fact, Mercer has evaluated the impact of the proposed caps on the federal income tax exclusion set forth in the Empowering Patients First Act ($8,000 individual/$20,000 family). By 2020, more than 30 percent of households will exceed the cap, with that number increasing to 85 percent of households by 2030 (Figure 3).

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

American businesses are highly motivated to control health costs while maintaining a healthy, engaged workforce. Placing arbitrary limits on the tax exclusion hinders their ability to offer a sustainable benefit package that meets the needs of their employee population.
Health Savings Accounts (HSAs) put employees in charge of their own health dollars and can lead to more responsible use of health resources. Consumer-directed health plans, where HSAs are coupled with high-deductible health plans, have been shown to have a real impact on consumer behavior, decreasing total healthcare spending about 5 percent in each of the three years after a plan is introduced.\(^\text{12}\)

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

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

Policies that would make HSAs more useful include:

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

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

---

**Figure 5**

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

---

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

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

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

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

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

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

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

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

ABOUT MERCER AND OLIVER WYMAN

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

Oliver Wyman is a global leader in management consulting that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. Oliver Wyman’s Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Oliver Wyman launched the Health Innovation Center (OWHIC) in 2011 dedicated to promoting positive change in healthcare. OWHIC champions innovation by disseminating proven innovations; envisioning market-based solutions to today’s and tomorrow’s challenges; and establishing a cross-industry community of thought-leaders to share and shape ideas. For more information, visit www.oliverwyman.com and follow @OliverWyman. For the latest on the business of transforming healthcare, visit health.oliverwyman.com. Follow Oliver Wyman Health on Twitter @OWHealthEditor.
ABOUT MARSH & McLNNAN COMPANIES
Marsh & McLennan Companies (NYSE: MMC) is a global professional services firm offering clients advice and solutions in the areas of risk, strategy and people. Marsh is a leader in insurance broking and risk management; Guy Carpenter is a leader in providing risk and reinsurance intermediary services; Mercer is a leader in talent, health, retirement and investment consulting; and Oliver Wyman is a leader in management consulting. With annual revenue of more than $13 billion and approximately 60,000 colleagues worldwide, Marsh & McLennan Companies provides analysis, advice and transactional capabilities to clients in more than 130 countries. The Company is committed to being a responsible corporate citizen and making a positive impact in the communities in which it operates. Visit [www.mmc.com](http://www.mmc.com) for more information and follow us on LinkedIn and Twitter @MMC_Global.