
Written Statement
On behalf of Hewitt Associates LLC

By

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Global Health Management Leader

For

Senate Finance Committee

Roundtable Discussion

On

Expanding Coverage in Self-Insured and Fully Insured Markets
May 5, 2009

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Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt consults with companies to design and implement a wide range of human resources, retirement, investment management, health management, compensation, and talent management strategies. As a leading outsourcing provider, Hewitt administers health care, retirement, payroll, and other HR programs to millions of employees, their families, and retirees. With a history of exceptional client service since 1940, Hewitt has offices in 33 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

Executive Summary

Chairman Baucus, Ranking Member Grassley, and Members of the Committee: Thank you for the opportunity to submit our thoughts for this important roundtable discussion on reforming America's health care system and on expanding health care coverage. I am Ken Sperling, Hewitt Associates' Global Health Management Leader. Hewitt Associates is a global human resources outsourcing and consulting company, providing services to major employers in more than 30 countries and employing 23,000 associates worldwide. Headquartered in Lincolnshire, Illinois, we serve more than 2,000 U.S. employers from offices in 30 states, including many of the states represented by the members of this distinguished Committee.

As the nation pursues a path leading to universal coverage, we believe the most important consideration is how to accomplish this worthy goal in a way that preserves, strengthens, and stabilizes existing employer-based coverage. Employers are the single largest source of coverage for working Americans and their families, and the system is highly valued by both employers and employees. As we look to expand coverage and improve the health of all Americans, we can learn a great deal from the experience of large employers.

Our statement today summarizes some of these insights based on our extensive experience advising large employers on their health care plans. But our statement will also show that reforms to the U.S. health care system are imperative to reduce future cost increases and improve the quality of care. Although nearly all large employers offer health care benefits to their employees, the rapidly escalating cost of this care places an ever-increasing burden on employers and their employees that puts the entire health care system at risk. And smaller employers increasingly cannot overcome the cost barriers that keep them from providing health care coverage for their employees.

As the Committee pursues ways to expand coverage, the question of what level of health benefits should be provided will be a key decision. Our statement provides information on what larger employers currently offer their employees. Large employers tailor their health benefits to fit the needs of their specific employee population by balancing cost, affordability to employees, and the desire to encourage appropriate choices and healthy lifestyles. Hewitt's various data sources show that large employers provide employees with quite comprehensive benefits. Many large employers also provide an unlimited lifetime maximum benefit. Employers want their employees to be protected and they often use auto-enrollment and default plan options to ensure that employees who need coverage are enrolled.

While health care costs for employers are largely driven by the underlying price and utilization of health care services, costs can vary widely based on several factors, including demographics, dependent enrollment, employee contributions, plan design, geography, and health risk. Large, multistate employers prefer to provide uniform benefits to their employees and family members across the U.S. and this allows them to realize the economies of large-scale purchasing. Taking advantage of preemption under ERISA also means that employers' health plans are not burdened by expensive state mandates. Large employers often use self-insurance techniques that eliminate or reduce premium tax and insurer risk margins. These factors alone can lower employer costs by 8–10 percent; nevertheless, employers large and small continue to pay more for health care because of cost-shifting from uncompensated care and public payers.

In response to the rapid escalation in health care costs, employers have used many cost-containment strategies. Among the most promising are a variety of efforts to promote informed health care decision-making and improve employee health. The prevalence of programs to manage chronic illness and promote healthy lifestyles is widespread. In this regard, the large-employer marketplace is an innovation laboratory for new ideas that can be applied to the small-employer and individual health insurance markets. Mechanisms that work well for large, self-insured employers can also be used as a model for reforming insurance markets to enhance opportunities for those who currently struggle to obtain comprehensive health care coverage for themselves and their families.

There is no one-size-fits-all solution for health benefits. When expanding coverage, it is important not to disrupt a coverage system that is tailored to the needs of both the employer and the employee. To illustrate the point, if the Federal Employees Health Benefits Program (FEHBP) were used as a standard benefit model for all employers, most employers would have to *increase* benefits under at least one of the options. And to use the FEHBP's most popular plan design as the model for a new public plan would undermine the current system if it were priced below what private employers are able to provide to their own employees.

While a recent Hewitt survey of large employers showed that 9 out of 10 support health care reform, they have not yet reached consensus on a preferred approach. Most large employers do not currently support an employer mandate based on the limited information currently available, in part, because the details really matter. The specifics of such a mandate, of which some of the most important are outlined in our statement, will greatly influence the impact and the reactions of large employers and their employees.

Hewitt Associates is pleased to make its rich data sources and extensive knowledge of the large-employer marketplace, coverage, and drivers of cost available to the Committee as the Committee pursues the goal of expanding access to high-quality, affordable health care for all Americans. While reform is clearly needed, and is welcomed by large employers, we must accomplish this in a way that builds on what is already working efficiently for the majority of Americans and encourages employers to stay in the game.

Hewitt Statement

As the Committee discusses expanding coverage, it is critical that health care reform efforts further strengthen and stabilize employer-based coverage. New legislation must not disrupt existing coverage or inadvertently add incremental costs that are becoming increasingly difficult for both employers and employees to shoulder.

As reported by the Kaiser Family Foundation, 99 percent of employers with more than 200 employees offer health care benefits to their employees.¹ In contrast, only 62 percent of employers with less than 200 employees offer health care benefits to their employees. The overwhelming reason cited by these employers for not offering benefits is cost.

According to a recent Hewitt survey of more than 500 human resources executives, 85 percent were in favor of achieving universal coverage for all Americans. There was no clear consensus, however, in the preferred method to meet this goal, and employers are eagerly awaiting the detailed recommendations of this Committee.

Our statement addresses seven important questions about the employer-based health care system:

- I. Why Do Employers Voluntarily Provide Coverage?
- II. What Do Employers (and Employees) Pay for Health Coverage?
- III. What Are the Cost Drivers in the Employer-Sponsored System?
- IV. What Benefit Designs Do Large Employers Adopt?
- V. How Does the Actuarial Value of Large-Employer Benefits Compare to FEHBP?
- VI. What Efforts Are Large Employers Taking to Manage Cost and Improve Health?
- VII. What Are the Implications for Large Employers of a “Pay or Play” Requirement or an Employer Mandate to Provide Coverage?

The data and observations used to answer these questions (except where otherwise noted) are derived from several proprietary Hewitt databases, including:

- The Hewitt Health Value Initiative™, containing detailed census, cost, and plan design data for 325 large U.S. employers representing 13.1 million participants and \$50.5 billion in 2009 health care spending.
- SpecBook™, Hewitt’s database of plan design prevalence information on 706 large U.S. companies offering benefits to their employees.
- Enrollment data from 200 employers that use Hewitt for benefits administration services, representing over 6.5 million eligible participants.

This statement also draws heavily upon the experience of Hewitt’s consultants and actuaries who have extensive knowledge of—and direct experience with—the employer-sponsored health care system, the health insurance marketplace, and the emerging market trends and strategies aimed at broadening access, controlling cost, and improving the health and productivity of the U.S. workforce.

¹2008 Kaiser/HRET Employer Health Benefits Survey

Controlling spiraling health care costs will benefit every American seeking access to quality, affordable care. It will also make it possible for employers to continue their role as voluntary sponsors of health plans for their employees while remaining competitive in a global marketplace. The Committee's work to develop policy options to reduce cost and improve quality in the health care delivery system will be a critical part of the necessary reforms that must happen to ensure the continuity of the employer-based system.

I. Why Do Employers Voluntarily Provide Coverage?

Employers believe it is good business practice to provide health care benefits for several reasons:

- People are an organization's most important asset, and there is a direct link between employee wellness and workforce absenteeism and productivity.
- Employers believe it is their responsibility to protect employees from the risk of catastrophic loss arising from the expense of serious illness.
- Under current tax laws, providing coverage under an employer-sponsored program is the most efficient way to provide these benefits.
- Providing health care benefits allows employers to attract and retain key talent in a competitive marketplace.

As important as it is for employers to design and offer programs that provide comprehensive protection and encourage employee wellness, it is equally important that eligible employees elect and maintain health insurance coverage. Accordingly, companies use several strategies to ensure that employees take advantage of the health insurance provided. The Committee may wish to consider adoption of these strategies as part of health reform.

- **Automatic Enrollment:** Hewitt administers annual enrollment for over 200 large-employer clients, each with an average of 32,000 participants. All Hewitt health and welfare administration clients use automatic enrollment, commonly referred to as default coverage, because it is the industry best practice for both annual enrollments and new hire enrollments. Employers define the plans in which employees will be "automatically enrolled" if they do not make an enrollment choice.

- For new hires, approximately 50 percent of Hewitt health and welfare administration clients "automatically enroll" employees into single coverage in the lowest-cost medical plan.

- For annual enrollment, or so-called "open season," approximately 87 percent of employers "automatically enroll" employees in the same coverage they had the prior year.

- With respect to employees, in 2008, eighty-three percent of employees were not required by their employers to make an active election. If they did not elect, they would be assigned their current coverage option. The remaining 17 percent were required by their employers to make an active election. If they did not do so, they would be assigned either the low-cost medical plan option or no coverage.

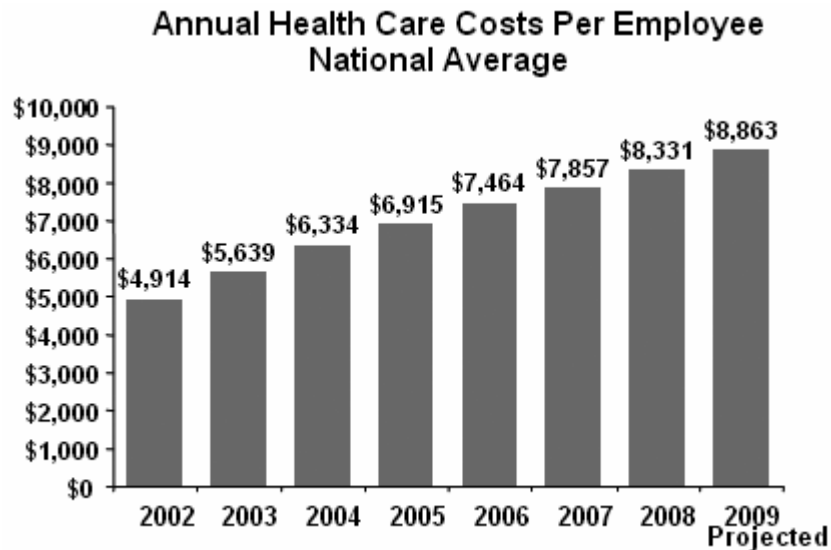
- **Internet Enrollment:** In 2008, Internet enrollment accounted for 86 percent of large-employer plan enrollments, with the balance enrolling with help from a customer service associate.

- Within this group, 87 percent of actively employed participants used electronic enrollment, compared to 41 percent of retirees.

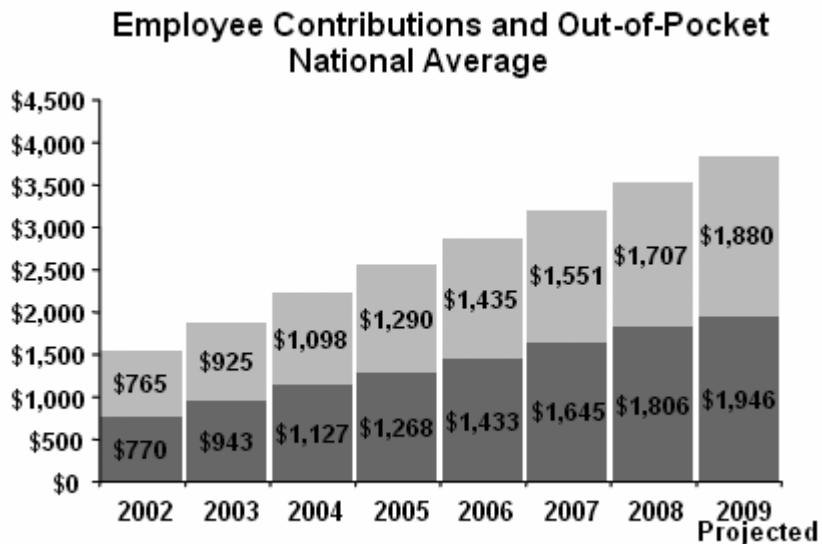
II. What Do Employers (and Employees) Pay for Health Coverage?

According to Hewitt data shown in Exhibit 1, annual large-employer health care costs (i.e., total costs for all health plan participants divided by the number of enrolled employees) have more than doubled since 2001 and are projected to reach \$8,863 in 2009. Over the same period, annual employee contributions and out-of-pocket costs are expected to increase by 190 percent to \$3,826.

Exhibit 1:



Source: Hewitt Health Value Initiative™



Source: Hewitt Health Value Initiative™

- Average Employee Contribution
- Average Employee Out-of-Pocket Costs

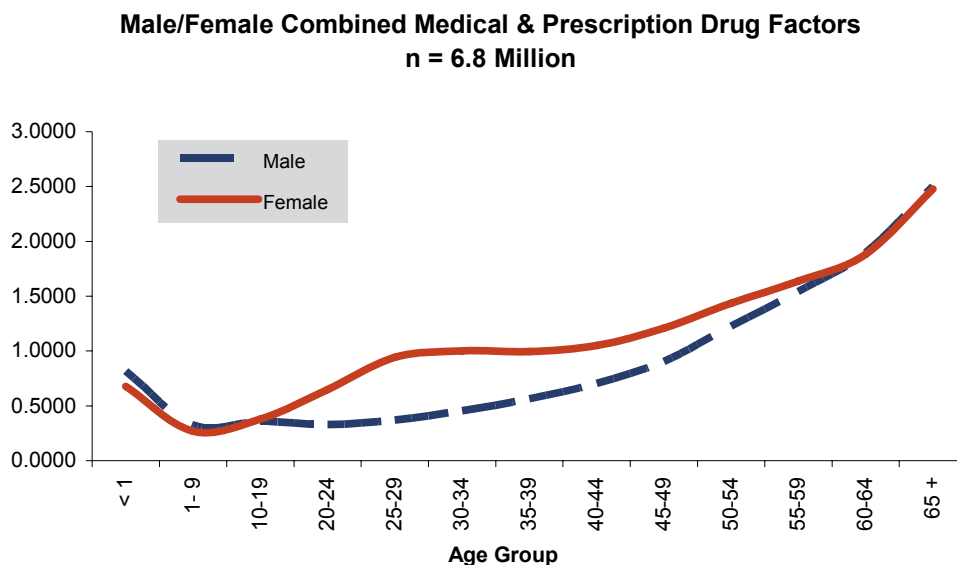
III. What Are the Cost Drivers in the Employer-Sponsored System?

While the cost of health coverage to employers is largely driven by the underlying price and utilization of health care services, this cost can vary widely based on several factors, including demographics, dependent enrollment, employee contributions, plan design, geography, and health risk. While there may be a number of initiatives that the Committee might recommend to help employers manage their costs, it is important to remember that not only is all health care local, it is also population-specific for the employer.

Meaningful change will require a thorough understanding of the underlying drivers of employer health care cost.

- **Demographics** is the age and gender mix of the population. An older workforce will have higher health care costs than a younger workforce. Exhibit 2 provides the relative cost of medical and prescription drug coverage based on age and gender. In this graph, 1.00 equals the average health care cost of a 40-year-old female.

Exhibit 2: Demographic Risk Factors by Age and Gender



- **Dependent Enrollment**, or the number of spouses and dependents covered under the employer's plan, can significantly drive overall cost. On average, 47 percent of employer health care spending is attributable to the cost of covering spouses and dependents. Large employers tend to absorb a larger proportion of these costs either because the spouse's employer does not offer coverage or the large-employers' plans are more generous.
- **Employee Contributions** for health coverage vary widely. Each company makes this determination based on what is considered competitive in their industry and by balancing what the company can afford with what employees can afford. Each year, Human Resources executives wrestle with the appropriate amount to charge employees through payroll contributions, how much exposure employees will share in the cost of health care services, and what share of the cost the company can absorb. As noted above, in 2009, large employers will spend \$8,863 per employee²³ on health care coverage. Of this amount, employees will contribute 22 percent of the cost of coverage, or \$1,946.
- **Plan Design** is another important driver of overall health care cost, and is very employer-specific. Companies select plan design provisions such as deductibles and copayments, taking into consideration the affordability of employee payroll contributions. Plan designs are also tailored to drive certain behaviors, such as lower copayments to encourage the use of generic drugs, 100 percent coverage for preventive screenings to incent wellness, or higher copayments to discourage over-utilization of

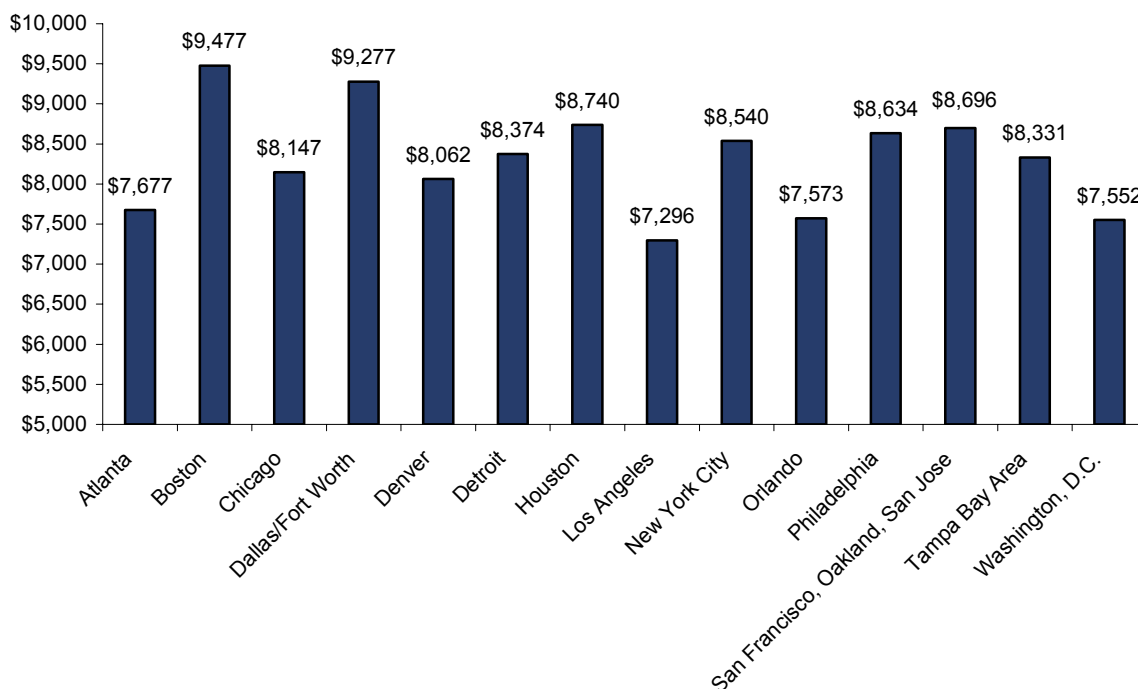
² The "per employee cost" is an average of the total cost for all health care participants divided by the number of enrollment employees.

emergency room visits for non-emergency care. More detail about plan design prevalence is included later in this statement. In 2009, the average employee covered by a large company's health care plan will pay a projected \$1,880 in health care expenses through plan design cost sharing.

- **Geography** can be a cost driver because health care costs vary based on the cost of doing business in that community, local practice patterns, and the degree of competition among health plans and providers. Exhibit 3 illustrates the average health care cost per employee in 2008 for 15 major metropolitan areas.

Exhibit 3:

2008 Health Care Costs Per Employee in Major Metropolitan Areas



Source: Hewitt Health Value Initiative™

- **Health Risk**, or the burden of illness in an employer population, is an emerging focus of employers' health care strategies. The body of evidence proving that investment in health and wellness can both lower health care cost and improve productivity has become a central tenet of employers' buying criteria, and by extension, health plan product development. The traditional focus on acute and chronic care is being replaced with a more intense concentration on preventing the onset and progression of disease in the at-risk population.

In our Hewitt Health Value Initiative database of 325 major U.S. companies, the variation of 2009 health care cost per employee ranges from a low of \$5,323 per employee to a high of \$13,553 per employee. Exhibit 4 attributes this variation to differences in the underlying cost drivers.

Exhibit 4: Explanation of Variation in Employer Cost

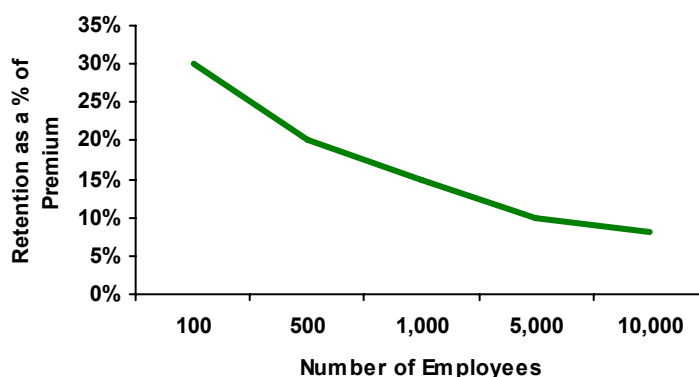
Factor	Relative Importance in Explaining Variation
Dependent Enrollment	27.5%
Demographics	21.1%
Health Risk	20.3%
Employee Contributions	13.1%
Plan Design	11.1%
Geography	6.8%
Total	100.0%

Economies of Scale are another factor that influences the price of the employer health plan. Health plan expenses are made up of both fixed and variable costs.

- Fixed costs include expenses for the setup and administration of any insurance contract, regardless of size. Systems costs such as eligibility file protocols, claims administration parameters, summary plan descriptions, billing arrangements, and account service are other examples of fixed costs.
- Variable costs, which are sensitive to employer size, include claims processing and customer service staffing levels.
- Small employers' fixed costs are a larger percentage of the total, so the percentage of total cost dedicated to expenses is high. As employer size increases, these fixed costs are spread over a larger employee base, reducing the overall percentage expenses and allowing the employer to fund more actual health care services. Approximate retention percentages (defined as all non-medical claims expenses) by size of employer are illustrated in Exhibit 5.

Exhibit 5:

Retention Percentage by Size of Employer



As the Committee looks for ways to expand access to affordable coverage for employees of small firms, it is especially important to consider programs that enable small employers to band together. Larger groups can then take advantage of these economies of scale when purchasing plans, which will significantly lower their overall costs.

Self-Insurance is commonly used by large employers to maximize purchasing efficiency. Currently, 55 percent of employees participating in employer-sponsored programs are covered under self-insured arrangements. Employers large enough to absorb the risk involved in health benefits—both the risk of individual large claims and the aggregate risk of higher-than-expected claims volume—can save costs. These savings accrue from three sources:

- Under ERISA, self-insured programs are not required to comply with state-mandated benefit requirements. While the estimated cost impact of compliance with state mandates varies, the Congressional Budget Office estimates that, in general, state-mandated benefits increase premiums by about 5 percent.⁴
- Self-insured plans do not pay a premium tax, which varies from a low of approximately 1.7 percent to a high of approximately 4.5 percent, with an average of close to 2 percent of premium.
- Because the self-insured plan absorbs the risk of claims fluctuation, it does not pay risk charges to the insurance company. These risk charges can range from 3–10 percent of premium, and they are also sensitive to employer size. As the risk pool gets larger, variability in claims decreases, and risk charges correspondingly decrease.

These three items alone can easily add 8–10 percent or more to the total cost of purchasing health care. This again underscores the obstacles that small employers face in providing affordable health care benefits to their employees. This also makes a strong case for the need to preserve the current ERISA preemption of state law for large, multistate employers. Indeed, weakening ERISA preemption would pose probably the greatest single danger to the current employer-based system.

External Factors driving cost to employers have been well documented. Most notably, costs are shifted to the private health care system because of uncompensated care and below-market reimbursements by public payers. Estimates vary regarding the precise impact of this cost-shift, but it is clear that a reduction in the number of uninsured Americans as well as full and fair reimbursement by the Medicare and Medicaid systems would certainly relieve the upward pressure on employer health care spending. If it is not fiscally feasible to close this gap in public/private reimbursement rates to providers, at a minimum, health reform should ensure that the payment differential does not worsen further. Increased cost-shifting pressure on private payers would very likely create a two-tier system where employers offering their own plans are at a significant cost disadvantage.

IV. What Benefit Designs Do Large Employers Adopt?

Large employers tailor their health benefits to fit the needs of their specific employee population, balancing cost, affordability to employees, and the desire to encourage appropriate choices and healthy lifestyles. When designing a benefit package for health reform, it is important not to disrupt existing benefit designs or add to the cost of existing coverage. To aid the Committee in understanding current benefit design, Exhibit 6 provides a summary of the prevalent design provisions of the companies in Hewitt's SpecBook database that offer Preferred Provider Organization (PPO) network benefits to their employees.

⁴ *Increasing Small-Firm Health Insurance Coverage Through Association Health Plan and HealthMarts*, Congressional Budget Office, January 2000.

Exhibit 6:

Design Provision	Typical Large Employer Benefit
Annual individual deductible	<ul style="list-style-type: none"> ■ Average: \$496 ■ Median: \$350
Plan coinsurance (typically the amount paid by the plan after the deductible has been met)	<ul style="list-style-type: none"> ■ 80%: 44% of companies ■ 90%: 33% of companies ■ 100%: 9% of companies ■ Other: 14% of companies
Out-of-pocket maximum (typically the individual's maximum exposure in a calendar year)	<ul style="list-style-type: none"> ■ Average: \$1,786 ■ Median: \$1,900
Lifetime maximum	<ul style="list-style-type: none"> ■ \$1 million (M) or less: 8% of companies ■ >\$1M to \$2M: 37% of companies ■ > \$2M to \$5M: 15% of companies ■ >\$5M: 1% of companies ■ Unlimited maximum: 39% of companies
Physician office visit copayment	<ul style="list-style-type: none"> ■ Average: \$21 ■ Median: \$20
Retail prescription drugs: Generic	<ul style="list-style-type: none"> ■ \$5 copayment or less: 25% of companies ■ \$6–\$10 copayment: 39% of companies ■ 80%–100% coinsurance: 25% of companies ■ 50%–79% coinsurance: 4% of companies ■ Other: 7% of companies
Retail prescription drugs: Brand (formulary)	<ul style="list-style-type: none"> ■ \$11–\$20 copayment: 24% of companies ■ \$21–\$30 copayment: 21% of companies ■ 70%–89% coinsurance: 31% of companies ■ 50%–69% coinsurance: 9% of companies ■ Other: 15%

V. How Does the Actuarial Value of Large-Employer Benefits Compare to FEHBP?

It should be noted that many large employers currently offer a choice of plans to their employees, in order to respond to the needs of a diverse workforce and to provide options that allow employees to trade-off cost-sharing in plan design with employee contributions toward the cost of the plan. There has been considerable discussion about a creating a new government-run plan as a part of health care reform and establishing a standard or minimum benefit level for other private plans to follow. In these discussions, the Federal Employees Health Benefits Program (FEHBP) has been suggested as the standard of what might be provided to all Americans. For that reason, we compared the actuarial value of the FEHBP Blue Cross/Blue Shield Standard Option (hereafter referred to as the Standard option) with the average actuarial value of large employer plans. The actuarial value of the Standard option is relatively high (i.e., on average, the benefits are richer than the generous benefits that many large employers provide today). If that popular FEHBP option were to become the minimum standard for employer-sponsored coverage, most employers (83.7 percent) would have to increase benefits for at least one of the options currently offered to employees. In other words, despite most large employers providing comprehensive benefits to their employees, using the FEHBP Standard option would set the bar at even a higher level than what employers and employees are currently struggling to afford.

Further, if a new public plan were to be created using the FEHBP Standard benefits as a model and with below-market provider reimbursements, its pricing would most likely drive large numbers of employees currently in employer plans to the public plan. This migration would seriously undermine the current employer-sponsored system in the self-insured and insured marketplace and likely lead to its eventual demise. Among other serious concerns, such a shift would break the link that employers have established between workforce health and productivity that is so critical to keeping America's businesses competitive globally.

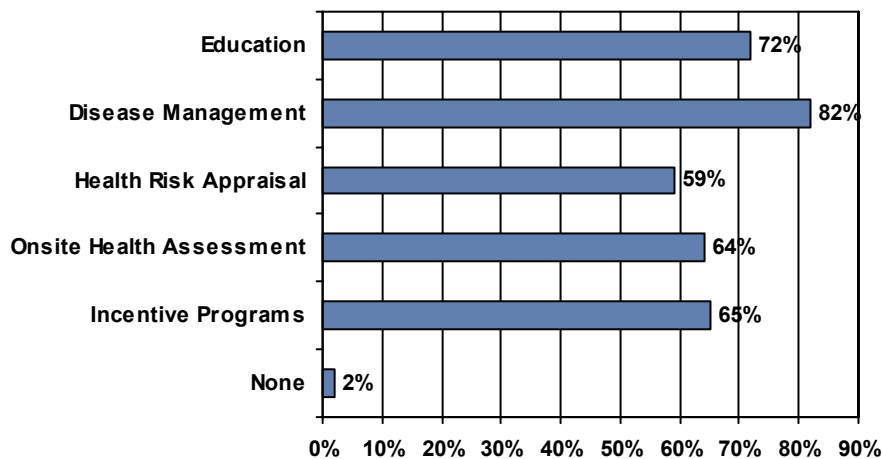
VI. What Efforts Are Large Employers Taking to Manage Cost and Improve Health?

Faced with ever-rising health care expenditures, employers have utilized many strategies to control cost, which offer potential lessons-learned to this Committee.

- Large employers are implementing aggressive vendor management programs, often with the assistance of the procurement arm of their organizations, to ensure that health plans are delivering value.
- They are also conducting frequent bidding exercises, creating an extremely competitive marketplace where the health plans aggressively vie for market share.
- They are also implementing measurement scorecards to encourage a constant state of innovation, discarding programs of questionable return in place of new or improved programs that will deliver improved results.

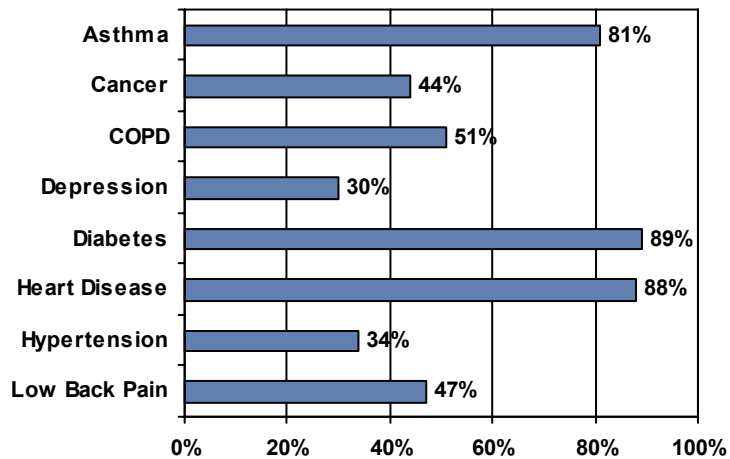
Many employers understand that efforts to improve employees' health has multiple benefits, including improving quality of life, optimizing productivity, lowering the rate of absence and disability, and lowering overall health care spending for both employer and employee. The prevalence of various health promotion programs among large employers is shown in Exhibit 7.

Exhibit 7: Percentage of Employers Offering Various Health Promotion Programs



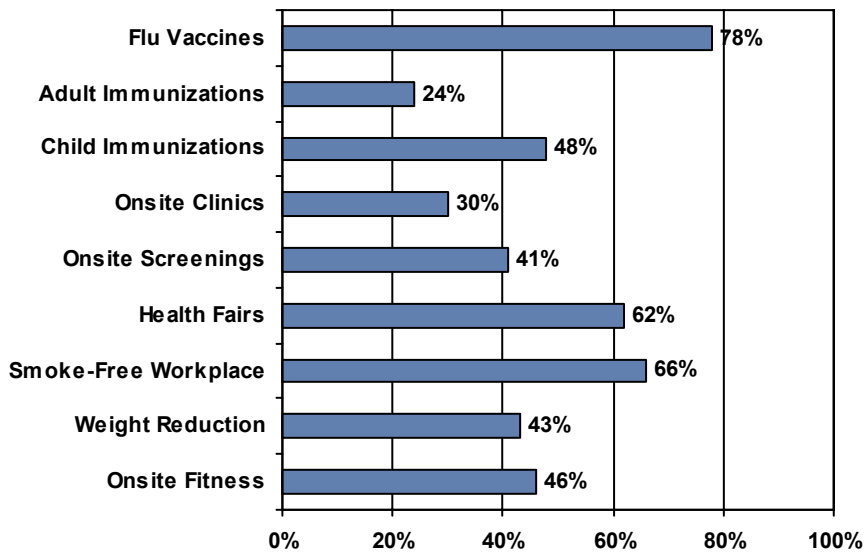
Large employers also offer a range of condition-specific disease management programs to assist employees in managing chronic illness, as shown in Exhibit 8. Both the number, scope, and sophistication of these programs has matured significantly in recent years.

Exhibit 8: Prevalence of Disease Management Programs



Wellness programs have become a mainstream part of most large employers' benefit programs. Employer involvement in promoting these programs, offering on-site access to screenings and immunizations, and developing a "culture of health" has notably increased in the last few years. Exhibit 9 provides examples of the most popular wellness programs sponsored by large employers.

Exhibit 9: Prevalence of Wellness Programs



However, employers have found it takes more than just program design to create a culture of health. The following elements are almost always present in organizations who embrace wellness as part of their core beliefs:

- Active support from senior leadership;
- Promotion of health-related activities across the organization;
- Incentives to drive behavior change;
- Metrics to track success; and
- A long-term view of the return on investment.

Another innovation that has emerged in recent years is the use of techniques to encourage the development of better educated employee consumers. Consumer-Driven Health Plans (CDHP), for example, seek to encourage employees to make informed decisions about health care utilization, with financial rewards for health conscious behavior.

The major health plans (Anthem, Aetna, CIGNA, and United Healthcare) have all performed longitudinal studies on the effectiveness of CDHPs. Results and methodologies vary, but the general findings have been:

- Populations enrolled in CDHPs had lower overall rates of cost increase than populations enrolled in traditional PPO plans.
- Reductions in cost were driven by lower utilization of health care services across all risk categories.
- CDHP participants utilized more preventive care services (primarily due to most CDHPs covering preventive care at 100 percent).
- Overall prescription drug utilization and cost decreased, at the same time as medication compliance for chronically ill individuals increased.

VII. What Are the Implications for Large Employers of a “Pay or Play” Requirement or an Employer Mandate to Provide Coverage?

In a recent Hewitt survey of large employers, 9 out of 10 say that health care reform needs to happen, but these employers have not yet reached consensus on a preferred approach. In part, that is because the details really matter. Take, for example, an employer mandate, or “pay or play.” Most large employers do not currently support an employer mandate based on the limited information currently available. Hewitt itself does not endorse a pay or play approach at this time, in part because the critical details required to fairly evaluate such a plan are still not defined. The specifics of such a mandate will greatly influence the impact and the reactions of large employers and their employees.

For example, with respect to an employer mandate, these are just some of the details to be carefully evaluated:

- What would be the form and size of a “meaningful” employer contribution? Would it be a fixed dollar amount or percentage of pay? At what economic level would the requirement be set?
- Would the mandate apply to both part-time and full-time workers? There would be more consensus around full-time employees. Mandating contributions for part-time employees is more controversial. Part-time workers often change jobs frequently, and workers who take these jobs as supplemental family income often have coverage available through other sources.

- Would the mandate apply to covering all family members? And would the contribution amounts for large employers be the same for single employees and married employees? Many large employers now tier the employer and employee contributions to provide equitable treatment for single employees, single parents, and larger households.
- Would a working couple still have a choice between their respective employers' plans? And if so, how would that work in terms of any mandated contribution?
- Could employers satisfy the mandate by substantiating that they provide a plan of equivalent overall value to the standard? Or would they have to comply on a benefit-by-benefit basis?
- If a national health exchange is created, would large employers and their employees be permitted to participate in this program? Or would participation be available only to individuals and small businesses?
- Would employees of large employers be permitted to opt out of the employer's plan and enroll in a national health exchange plan? And if so, what would be the terms and the consequences for opting out of the employer's plan? The group health plan "insurance" concept would face a sure demise if younger and healthier employees could opt out and take the full average employer health care contribution with them.

Conclusion

The majority of Americans currently receive health care coverage through their employer and like it that way. This is a voluntary system where employers choose to participate and cover employees as well as their dependents. Employers subsidize approximately 78 percent of the premium costs despite an expense burden that clearly impacts their ability to compete in a global marketplace.

The employer-sponsored model offers many features that should be emulated as the Nation seeks viable ways to expand health coverage. It allows for large scale purchasing and pooling of risks enabling those who are less healthy to secure affordable coverage for themselves and their families. Employer-based plans typically waive pre-existing conditions and cannot limit coverage based on individual health status. HIPAA regulations ensure that people can move from job to job without concern for being denied coverage due to health status. And employers use auto-enrollment and default plan options to ensure that employees take advantage of the comprehensive health care coverage available to them.

The large employer system is a laboratory where innovative ideas for controlling cost and improving health are created and tested continually. Proven strategies then trickle down to the small employer marketplace and individual plans, as health plans adopt successful programs into their mainstream products. Examples of this process include the development of value-based purchasing, competitive bidding, health risk analysis, consumer-driven health initiatives, disease management programs, and innovative pharmacy management programs.

As good as it is, however, the employer-based health care system is increasingly at great risk. Costs are high due to the underlying cost of care and shifting of cost from other segments. Some employers pay as much as \$13,000 annually for every employee they cover. While it is important not to disrupt the system that provides coverage for so many Americans, changes need to be made both in the payment and delivery system as well as the ways in which small employers and individuals access affordable coverage.

As the Committee develops specific proposals to expand coverage, Hewitt would be pleased to share our extensive data on, and knowledge of, the large employer marketplace to help support the public policy goal of creating positive reforms in the U.S. health care system.