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The Defined Contribution Approach To Health Care Purchasing. Implications For Managed Care Organizations And Health Insurance Companies

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The Defined Contribution Approach to Health Care Purchasing
Implications for Managed Care Organizations and Health Insurance
Companies

Submitted to the
Center for Public Service
Master of Health Care Administration Program
Seton Hall University

By

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A Research Project Submitted in Partial Fulfillment
of the Requirement for the Degree of
Master of Health Care Administration

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I. Introduction

Since passage of the Taft-Hartley Act and Labor-Management Relations Act in the 1940s, health insurance has been subject to collective bargaining agreements along with cash wages and working conditions. The price freeze instituted during World War II also locked wages in place at current levels for non-bargaining organizations, further raising the level of importance health insurance and other fringe benefits played in the ability of firms to attract needed labor. Since workers value tax-favored health coverage, they are willing to accept compensation that includes health insurance and accept somewhat lower cash wages than if they received wages alone.

The purchasing model that developed from this system of "insurance in lieu of cash compensation" is commonly known as "defined benefit" purchasing, whereby the employer determines the scope of health coverage, plan design, and delivery system, and purchases a program from one or more available insurance carriers or HMOs in their respective market. Though the defined benefit approach survived as the major purchasing model for 50 years, certain conditions have caused employers to reconsider this method:

- Health plan premiums and medical care costs continue their long-term rise despite the number of citizens enrolled in managed care programs. Recent trends including a resurgence in PPO popularity and a loosening of HMO utilization controls has the potential to further increase costs;
- Defined benefit purchasing imposes substantial administrative costs on employers who must maintain or contract resources to design, evaluate, and administer health benefit programs, which is not the core competency of most businesses;

- The recent erosion of protections afforded by the Employee Retirement Income Security Act of 1974 (ERISA), which generally shielded employers from liability arising from medical care and coverage decisions, has caused employers to consider distancing themselves from the benefit decision process;
- Shielding employees from the cost of health care decisions has accelerated the demand for medical services with minimal cost accountability, while forcing all individuals into a plan that may not best meet their needs;
- Employees have embraced the defined contribution model for retirement savings, commonly called 401k plans, which has displaced many traditional defined benefit pension programs.

There is currently substantive discussion within the employee benefits industry of shifting health care purchasing to a "defined contribution" model, also known as "defined care," whereby the employer provides a fixed dollar amount for health care spending and allows employees to select from a range of plans and options, either within an environment controlled by the employer, through a consultant or other third party facilitator, or on the open market with a voucher. In the extreme, benefits purchasing would be separated from the employment relationship.

Despite the heightened discussion, employer interest, and the development of several commercial ventures to facilitate defined contribution, there are a number of complex considerations:

- Defined contribution does not address fundamental public policy issues with respect to health care coverage such as the uninsured and the voluntary, individual insurance market;
- Depending on how it is structured, many employees view defined contribution as a benefit "takeaway," which may upset workers in a tight labor market;

- If employers do not increase defined contribution levels to keep pace with marketplace costs, employees will bear an ever increasing share of health plan premiums;
- Adequate information for plan cost-coverage comparisons may not be available, leading employees to make inappropriate selections;
- Risk pool and adverse selection issues may arise if healthy employees are permitted to opt out of coverage, leaving those with higher than average medical expenses in the plan;
- Tax code changes and regulatory adjustments may be required to facilitate the model.

Furthermore, wide-scale adoption of the defined contribution model would represent a significant paradigm shift for health insurance companies, the managed care industry and insurance brokers. These organizations will be forced to migrate to a "retail" marketing and distribution approach, create alliances with non-traditional third party facilitators, modify pricing and underwriting assumptions, invest in technology infrastructures to support defined contribution, and differentiate the value of their offerings directly to the consumer. Insurance companies and managed care organizations will compete for consumers based on price, plan design, network access, service, quality and overall value.

Though not a new concept, interest in defined contribution by employers has grown dramatically in the last 18 months. Several consulting firms, including KPMG and PriceWaterhouseCoopers have conducted systematic research to gauge interest levels and reactions by large employers to defined contribution. Media and educational organizations serving the employee benefits community have also compiled survey and polling data, though less rigorous in terms of methodology and sampling.

The primary purpose of this Capstone research project is to determine whether employee benefit managers expect their firms to adopt defined contribution as the primary health coverage-purchasing model, anticipated time frames for implementation, perceived issues and obstacles, and expected levels of employee acceptance, and considerations for program design and operation.

The research methodology uses a written survey mailed to employee benefit and human resource executives responsible for health benefit strategy from a purposive sample of private sector employers. A survey instrument incorporating closed-ended questions with opportunities for open-ended comments was utilized.

The results of the research and its implications will be of great interest to executives of managed care organizations, health insurance carriers, and administrative entities who must ultimately devote a significant amount of managerial planning efforts to prepare their firms policy, infrastructure and operations to compete in this environment.

II. Literature Review

A comprehensive literature search was conducted to identify and classify information pertaining to the defined contribution approach to health care purchasing. Since extensive discussion of the subject matter has occurred only in the last 18 months, there are few published, refereed academic studies available. Several large consulting firms with employee benefit practices have conducted and published research primarily relating to employer and employee attitudes towards defined contribution. The majority of published literature identified has been produced by media and educational organizations serving the employee benefits industry, and is less rigorous in terms of methodology and sampling. This information is valuable nonetheless since it draws from interviews with industry experts and leading consultants to identify trends and issues that are highly relevant to the defined contribution approach and are positively correlated with employer interest in the model.

The literature review and discussion is organized as follows:

1) **Growing Interest in Defined Contribution**

An examination of the trade, educational and general media literature, which chronicled events and issues that spurred broad-based interest in the defined contribution approach, will provide background as to the development and concept of defined contribution.

2) **Environmental Factors Affecting Employer-Sponsored Health Plans**

A review and discussion of background literature related to environmental factors and issues which pertain to employer interest in defined contribution and which may precipitate a shift towards the model will serve as a foundation for the ensuing research and analysis.

3) Individual Vs. Employer-Based Coverage

A review of the philosophical and practical aspects of the fundamental question of whether employers should be involved in the direct provision of health benefits examines the issue of defined contribution taken to its logical extreme.

4) Review of Defined Contribution Trends and Issues

Using reviews of qualitative information, essays and journalistic literature predicated on the experiences of industry experts, specific issues related to the defined contribution model alternatives, policy and regulatory matters, and infrastructure requirements will be discussed.

5) Employer and Employee Attitudes Toward Defined Contribution

Specific surveys identified in the published literature concerning attitudes and expectations of employers and employees related to health care coverage and the defined contribution approach, as well as expected levels and time frames for implementation will be reviewed.

Taken together, the five sections will provide a thorough review of significant employer and employee surveys conducted to date, as well as a discussion of major issues identified through literature published by industry leaders and organizations which will affect the provision of employer-sponsored health care purchasing.

Growing Interest in Defined Contribution

Since the advent of employer-sponsored health care benefits during World War II, discussions and debates have periodically ensued concerning the practice of linking health insurance to employment. The rhetoric tends to be exacerbated during periods of significant health care cost inflation, economic slowdowns and recessions, or when the estimate of uninsured citizens shows a marked increase. Questions abound as to whether health care should continue to be provided primarily as a benefit of employment, through a government-controlled plan or infrastructure, or by allowing individuals to purchase coverage in the open-market much like property coverages and financial services. It was not until health care inflationary pressures during the 1980s led employers to managed care plans as the answer to cost and quality concerns that attention turned towards the strategies used by employers to provide health benefits.

The slowing of health insurance premium growth in the 1990s, an expanding economy, the failure of the Clinton administration to pass a comprehensive health reform bill, and the retirement concerns of the baby-boomers temporarily shifted attention away from health care. However, the late 1990s brought accelerating increases in health insurance premiums along with growing dissatisfaction with managed care and a definite "consumerist" voice to the legislative arena. Employer frustration with premium increases, administrative burdens, potential increased liability, and a media-driven backlash against managed care once again ignited the arena of ideas to reign costs while improving satisfaction levels and providing more control over health benefits for the independent-minded workforce of the new millennium.

The catalyst which sparked the defined contribution debate came when Patricia Nazemetz, vice president of human resources at Connecticut-based Xerox Corporation presented a model for

delivering health care benefits at a health policy conference in Washington D.C. whereby Xerox would provide a fixed dollar contribution and permit employees to select their own health coverage (Healthcare Business, March/April 2000). The coverage would no longer be tied to the employees continued employment at Xerox, forcing health insurers to compete for the consumer based on cost, access, service and quality. The model would theoretically mitigate corporate liability for medical malpractice lawsuits and reduce benefit administration costs, while providing broad coverage choices for employees.

After receiving substantial publicity from the presentation, Xerox issued statements that the model was a theoretical approach to providing health care benefits based on recent trends, but had no intention of actually implementing such a program now or in the near future (Human Resource Executive, May 2, 2000). Despite the clarification from Xerox, major employee benefit consulting firms acknowledged that many employers were having such discussions internally, though no significant movement was expected within the next five to ten years. The employee benefit and health care trade journals, as well as the broader business media, began to initiate coverage on the defined contribution concept.

Citing a Xerox plan with a defined contribution component already in place, as well as a similar strategy used by Ingersoll-Rand Co., Winslow and Gentry (Wall Street Journal, February 8, 2000) recognized this fundamental change in health care benefits strategy driven by a number of trends influencing the industry, including the dissatisfaction with managed care, a growing number of popular websites which facilitate consumer decisions, the popularity of 401(k) and other defined contribution retirement plans, and accelerating increases in health insurance premiums. They concur that such a change will be gradual as employers are reluctant to exit the market completely and

employees become accustomed to the idea of comparing health plans.

The provider community was initiated into the discussion of defined contribution as well. Jacob (American Medical News, May 1, 2000) reported on the concept, quoting representatives from consulting firms, purchasing groups and policy organizations that believe interest in the model exists. While Jacob notes that no major employer has adopted a true defined contribution program, the environment could change rapidly if the economy turns recessionary.

Citing a Deloitte & Touche survey of Certified Employee Benefit Specialists that ranked rising medical costs as their primary concern, Caudron (Workforce, April 2000) emphasized that workforce issues such as employee attraction and retention are driving employers to offer and even expand comprehensive benefit packages. She notes, however, that one reason medical costs continue to rise is the disconnection between the consumer and the purchasing decision, and further discusses the financial inefficiency of the health care system due to the inability of demand to influence supply and the administrative costs resulting from the growing complexity of plans. Rowen (Health Care Gold n' Rules, www.definedcare.com) argues that opposing forces within the health care system create an environment of friction in which employers want low premiums, the health insurance and managed care industries want high profits, and the consumer wants every demand met at no cost. The defined contribution structure would allow employees to control the purchasing decision and create competition between plans that would benefit the plan participant and the employer alike.

Quinn (Employee Benefit News, March 2000) also explored the philosophical realm of the issue in asking the fundamental question as to whether or not employers should remain involved in the provision of benefits. One side of the argument is that benefits are merely an indirect way of providing compensation and that employers do not mandate how employees spend their direct

compensation in a specific manner. Conversely, employers can add substantial value in the provision of benefits through purchasing leverage and expertise, the ability to drive quality measurement and health plan accreditation, and in simply ensuring that each employee is protected from the financial burden of a serious health problem, resulting in a social responsibility role for the employer.

Keeping in mind that "employee benefits" is a business unto itself, a report from Solomon Smith Barney (1999) provides evidence of the inefficiencies of current administrative practices. The practice of purchasing health benefits by employers requires seven distinct steps and needs forty five to ninety days to complete. Of the 170 million health insurance transactions completed in 1999, 90 percent were handled by phone, fax or on paper. A defined contribution system based on electronic transactions has the potential to reduce the administrative costs inherent in the entrenched model.

Finally, new organizations have arisen to facilitate the defined contribution model, a necessary pre-cursor to any broad-based adoption of the approach by employers. Significant media attention has been given to Minneapolis-based HealtheCare, which is designed specifically to allow employees to create personal care accounts, select from multiple plan options, and even carry unutilized contributions to future years (Business Insurance, May 22, 2000). Questions as to the position of the Internal Revenue Service in carrying forward pre-tax contributions to future years have not been completely clarified. Another model developed by Vivius, Inc. would allow employers to establish a fixed dollar obligation, but permit employees to select a custom network of health care providers who compete for consumers by listing their fees and services (Business Insurance, May 22, 2000). Amounts remaining in the account could be used for non-covered services, but unlike HealtheCare, unused contributions would be forfeited at the end of the year.

It is likely that the adoption of a defined contribution program by any major employer will

receive significant attention in the employee benefit trade journals and the general business media, much as the implementation of a nationwide managed care program developed for Allied Signal by CIGNA in the late 1980s. This movement by a major national employer dramatically fueled the migration to managed care, as other employers followed suit.

Environmental Factors Affecting Employer-Sponsored Health Plans

Health plans are part of an overall benefit strategy used by employers for purposes of employee attraction and retention, to insulate employees from certain financial risks associated with illness and disability, and to provide vehicles for the accumulation of retirement assets. Benefits also act to sustain or boost productivity levels by providing for paid time away from work, wellness coverage, and programs designed to help sick or injured employees return to work. The benefits concept is being further extended towards the "total rewards" approach, which may include child and elder care benefits, personal financial planning, flexible work schedules, and concierge services.

The health plan holds a prominent place with the benefits package. A survey asking workers in private firms or local governments with more than 20 employees to rate the importance of 23 benefits ranging from health coverage to retirement plans to on-site day care resulted in a score of 4.24 on a 5 point scale for the medical plan, ranking it first among all benefits (AON Consulting, 1998). This ranking represented no change from the previous survey conducted in 1995, also placing the medical plan first, and the degree of importance was nearly the same across all marital and dependent status groupings. Clearly, a major change in the funding or provision of health benefits will receive a significant reaction from employees.

On the employer side, health coverage receives significant attention from benefit managers. Over 70 percent of Certified Employee Benefit Specialists ranked controlling health care costs as

the top benefits priority for 2000, up from number two in 1999 (Deloitte & Touche - ISCEBS, 2000). The response was consistent across all regions of the U.S., except in the West where health plan cost ranked 2 percentage points behind implementing and expanding Internet use in benefits. Though the concern over rising costs will likely cause employers to reexamine health benefits strategy, the survey indicated that the key objective driving benefit policy in 2000 is employee attraction and retention, making wholesale changes to health plan design difficult.

While employee benefit and human resource managers consider employee satisfaction, claims service and quality of care meaningful, cost was cited as the most important single criterion in selecting a health plan (Business & Health-Milliman & Robertson, 2000). Only one in five formally surveyed their employees as to their satisfaction with health benefits, but over 55 percent indicated they educate workers to become better health care consumers and the majority have intensified these efforts in the last three years. When asked about their response to hypothetical rate increases of varying degrees, employers were most likely to shop for a new health plan, then pass the cost of the increase on to employees. They were least likely to reduce benefit levels or eliminate a non-health care related benefit.

For the first time ever, the average medical plan cost for active workers in employer-sponsored health plans topped \$4,000 in 1999 after rising 7.3 percent from the previous year, with substantially higher increases for small businesses and individuals (William M. Mercer-Foster Higgins, 1999). For large employers, the combined average cost for employee and retiree health care benefits is predicted to increase by 12 percent in 2000 (Towers Perrin, 2000) with little variation by plan type, and is the largest increase recorded in the survey since the 1991-1993 period. The government's Consumer Price Index (CPI) rose 2.5 percent in 1999, while the medical care

component of CPI rose 3.5 percent in the same period.

The long-term trend has been to shift more responsibility for health care costs to employees. In 1988, employees paid 20 percent of monthly premium costs. Ten years later in 1998, the employee share of the monthly premium was 27 percent (Gabel, 1999). Despite substantial increase in health premiums, employees did not contribute more for coverage in 2000 than in 1999, and single workers actually contributed less in terms of dollars and as a percentage of total premium costs (Kaiser Family Foundation, 2000). This clearly reflects the tight labor market and the difficulty in attracting and retaining qualified workers faced by employers. The overall number of plan options offered by employers has changed little in recent years, with 65 percent of workers having multiple choices. However, only 6 percent of small employers (3 to 199 workers) offer a selection of plans, while 67 percent of companies with over 5,000 employees provide a choice.

Miller (2000) indicates that the traditional forces which raise health insurance premiums include new medical technology, overutilization of health services, an excess supply of hospital beds, high administrative costs, and cost shifting between payers. However, a number of emerging factors which are economic and demographic in nature are increasing the upward pressure on premiums. These new drivers include a longer underwriting cycle in which insurers attempt to recoup shortfalls from previous years in which prices were not adequate to cover claims, pressure from the investors in for-profit plans, rapidly increasing prescription drug costs and utilization levels, consumer demands for broader access to care, the aging population, and providers who are renegotiating for higher reimbursement levels.

In addition to the reasons for health cost increases cited by Miller, several legislative proposals, some of which have been adopted in individual states, have the potential to further raise

the cost of health insurance, providing further incentive for employers to reconsider strategies. The four major proposals include increasing exposure of health plans to medical malpractice liability, deeming utilization review conducted by insurers to be the practice of medicine, prohibiting health plans from playing any role in making determinations of medical necessity, and requiring plans to admit any willing provider to their network (Barents, 1998). Of primary concern to employers would be increasing the health plan's exposure to malpractice liability, particularly if the employer could also be deemed liable if it exercised discretion with respect to coverage and claim determinations. Barent's estimates such a law would increase the cost of managed care plans between 2.7 and 8.6 percent. Passage of the other three laws, along with regulations imposed by at the state level would increase costs even further. A 1 percent increase in managed care costs at the national level is estimated to result in a \$12.3 billion wage loss to private-sector employees. If the cost increase is shared by employers and employees, a 1 percent increase may increase cost to private firms by \$11.7 billion over 5 years, and raise costs to households covered by managed care programs by \$2.8 billion over 5 years.

To mitigate cost increases, employers are currently implementing a number of management strategies. More than half have adopted changes in the plan design and cost-sharing arrangements, and over one third have changed their network delivery model and their employee contribution strategy (Towers Perrin, 2000). Prospectively, 48 percent of employers expect to change plan design and cost-sharing features, while 37 percent intend to develop or modify the employee contribution strategy. Employers also project greater use of Internet-based administration for their health plans.

Continued cost increases and activist legislation that complicates plan administration and exposes employers to new risks will likely cause employers to seek more aggressive cost and risk

management strategies, the most extreme of which is the reduction or elimination of health benefits.

Individual Vs. Employer-Based Coverage

Taken to its logical end, defined contribution could dramatically change the employers role in providing health from one in which benefits are structured, purchased, funded, and administered, to one where employers provide compensation in the form of vouchers and facilitate the purchasing process by the employee. The position of the employer as primary provider of health coverage was last challenged in 1993 during the public policy debate surrounding the Clinton administration's health care reform proposal. Its defeat quelled the discussion somewhat, though incremental legislation at the state and federal level moved forward.

While health benefits remain a key part of the total employment compensation package, growing health care expenditures by employers coupled with employee disaffection with managed care and the resources required to administer health benefits may prompt employers to take notice of policy and strategies which would separate health care coverage from employment. Certain providers may also view a move to individual-based coverage as a means to weaken the influence of managed care. Insurers and managed care companies would be faced with new challenges in terms of structuring adequate risk pools, adverse selection, and in marketing directly to consumers (Langan, 1999).

Employment-based health insurance affords certain advantages, including the ability to negotiate more favorable premiums due to bargaining leverage and the reduced risk of adverse selection. Administrative and selling costs tend to be lower for group coverage. However, workers who change jobs may also have to change doctors under a new plan, and some are reluctant to change jobs for fear of losing coverage. Most proposals for separating health coverage from

employment do so through the federal tax code, which currently treats employer-sponsored coverage favorably. (Blakely, 1999).

Others have examined both sides of the issues relating to the link between health care coverage and employment (Reinhardt, 1999; Pauly, Percy, Herring, 1999). Reinhardt credits the employer-based system at the practical level with being the most efficient mechanism thus far for the pooling of risk whereby younger, healthier workers effectively cross-subsidize older or sicker employees within the same company. The decentralized nature of the system offers greater opportunity for innovation, and one could argue that employers have been successful in reflecting consumer preferences in their coverage choices. However, employer-based coverage frequently provides no or limited choice of plans, and there is the potential access to personal medical information by the employer, though privacy laws have been strengthened. The tax preference given to employer-sponsored plans also results in those with higher incomes realizing a proportionately greater benefit than do those with lower incomes. There is also an issue of equity since the tax preference has never completely been extended to the self-employed or to those without employer-based coverage.

Using data from the 1987 National Medical Expenditure Survey (NMES), Pauly, Percy and Herring simulated an individual-based insurance market assuming that workers shift from group coverage due to a change in the tax treatment of individual coverage and that large numbers of workers with small employers move to the non-group market. While it is uncertain as to whether an individual market would be more efficient, they conclude that certain net advantages exist if coupled with reasonable tax and regulatory policy. Certain social gains accrue from eliminating employment-related lock-in and loss of coverage due to unemployment. The simulations also suggest that

significantly higher administrative costs are unlikely to accompany an individual-market.

The role played by employers in terms of efforts to control the cost and improve the quality of health care remains an invaluable part of employer-based coverage (Custer, Kahn, Wildsmith, 1999). Citing that as many as 40 percent of individual policies are held for one year or less, the authors argue that the net number of citizens with coverage would decline. State regulatory reforms such as benefit mandates and risk-rating restrictions designed to improve availability would actually increase the cost of coverage, putting it further out of reach for lower income workers. They conclude that the employment-based system provides access for a broad range of individuals, and that targeted subsidies should be used for specific segments of the population who cannot access or afford coverage.

The 1999 Health Insurance Preference Survey (EBRI) examined the level of public satisfaction with the employer-based system and preference for an individual-based structure. Sixty-eight percent of respondents with employer-based health coverage were satisfied with the current mix of wages and benefits, while only 8 percent preferred to exchange higher wages for lower health benefits, indicating high levels of satisfaction with the health insurance provided through the employment relationship.

Focus-group participants at five large employers in select metropolitan areas indicated their preference for choice in health plan selection, but preferred not to act as their own agents (Lave, Peele, Black, Evans, and Amersbach, 1999). They especially did not want to be given a voucher to purchase coverage in the private insurance market, citing a lack of individual bargaining power, the key advocacy role played by the employer, and the complexity of the health coverage. The majority of participants believed plans offered by their employers were lower in price and broader in scope

than policies that could be purchased individually. Those who experienced serious illness cited that employers were often helpful in ensuring the full range of covered services was received, and frequently used the human resources representative to intervene in claim payment determinations. They also appreciate the skill possessed by benefit managers in making informed coverage decisions. However, the participants are not necessarily representative of all workers, nor all workers in large organizations. Each had access to reasonably generous benefits, and all but one company offered a choice of plans.

Irrespective of employee preferences, Styring and Jonas (1999) predict that the aging baby boom generation will dramatically exacerbate demand on social entitlement programs, resulting in benefit reductions and increases in the eligibility age. The cost of continuing to provide health care coverage for an older work force will make it financially unfeasible for employer-based programs to function. Instead, coverage will be provided through medical savings accounts purchased by workers, who will receive a universal tax credit for the purchase of health insurance.

Review of Defined Contribution Trends and Issues

There are specific issues surrounding employer interest in defined contribution which act as drivers in terms of strategic benefit changes, as well as enablers which support the environment and infrastructure needed for implementation of the model. Certain critical factors necessary for broad-based adoption, however, may not be in place.

Vitberg (1999) cites that many leaders in the employee benefit industry believe defined contribution will be reasonably commonplace within 3 to 5 years, and nearly universal within a decade. Once a major employer implements defined contribution, others are likely to quickly follow suit. He further examines trends and events that are indicators that the environment may be in place

to support a health care purchasing strategy change.

First, there is general dissatisfaction with the current system, evidenced by the surge in recent legislative activity and the federal and state level, the loosening of HMO cost control mechanisms due to the consumer backlash, the fact that health care inflation is once again accelerating, and the number of liability suits being filed against managed care organizations. A number of surveys from the major benefit-consulting firms (discussed in the following section) conclude that high levels of interest exist in the employer community. All of the large consultants are providing advice to clients concerning defined contribution, and several have formed strategic alliances, joint ventures, or separate business units to provide defined contribution administrative services. Of the \$18 billion spent annually on health benefits administration, employers incur \$10 billion for internal costs related to plan management, providing an attractive target area for cost reduction by shifting responsibility to employees. Congress may also extend the legislation allowing for limited adoption of medical savings accounts (MSA's) to lift the current enrollment maximums, make all contributions tax deductible, and extend opportunities to large employers. Self-funded health plans, which bypass state regulation and provide certain cash flow advantages to employers, may also lose their attractiveness if legislation or a judicial precedent is established permitting such plans to be sued for economic and non-economic damages instead of only the total amount of a denied claim.

There is also precedent for the defined contribution approach to employee benefits for retirement plans. Though defined contribution funding for retirement plans is not new, widespread employer implementation did not occur until the late 1980s and early 1990s. Defined contribution retirements plans, commonly called 401(k)'s after the section of the Internal Revenue Code permitting their creation, initially supplemented defined benefit pension plans. Most new companies

offer only 401(k) plans, and some established companies even terminated their traditional pension plans in favor of defined contribution.

Several trends, which precipitated the popularity of 401(k)'s, are also emerging in health benefits (Lathrop and Carlbach, 1998). Funded pension plans became a substantial liability for employers in a global, competitive business environment as life expectancies increased, contribution requirements fluctuated from year to year with investment returns, and administrative complexity grew. The defined contribution approach offered a way for corporations to effectively cap financial exposure, while shifting the risk of investment shortfalls to employees. Employers also came to view the retirement plan as a vehicle for employees to accumulate assets on a favorable basis, if they decided to do so. The increasingly mobile workforce also appreciated the portability of the 401(k), which can be rolled to an Individual Retirement Account (IRA) or to the plan of another employer. Finally, the mutual fund industry made performance data widely available and provided a multitude of comparative tools to assist employees with investment selection. Employers were able to leave asset management to fund administrators and employees, while technology created an efficient environment for plan management.

A number of parallels exist in the health care environment that will drive strategic benefit decisions. Health care cost growth is once again starting to grow considerably faster than other costs of doing business. Global competition, deregulation, the inability to maintain profit margins by raising prices, and increasingly assertive shareholders make the continued absorption of health premium costs difficult (Battistella and Burchfield, 1999). The financial, administrative, and compliance aspects of health plans are becoming increasingly burdensome for employers, while the goodwill created by offering a health plan is often eliminated when a claim is denied or a copayment

is increased. In terms of potential administrative savings and budgetary predictability, the defined contribution model becomes increasingly attractive.

Despite employee acceptance of defined contribution retirement plans, Lathrop, Alquist and Knott (2000) argue that certain elements unique to health care may hinder the popularity of defined contribution. There are few reliable, consistent and broadly accepted performance measures to guide consumers in the selection of health plans, unlike the more standard comparative risk-return presentations of asset classes within the mutual fund industry. Furthermore, retirement planning contemplates a longer time horizon, which allows for recovery from investment losses and period asset rebalancing to regain course. Health care decisions are far more immediate and may not be easily revocable in the short term, particularly after incurral of a catastrophic level claim. The risk-averse individual is likely to seek the broadest health care coverage, even if the same person might select a highly volatile investment portfolio to achieve greater long-term returns.

Turning once again to Vitberg, there are certain environmental obstacles that must change or be overcome to transform theoretical interest in defined contribution into a new philosophical and strategic approach to the provision of health coverage. The tight labor market limits the strategic alternatives available to employers concerned primarily with attraction and retention. Insurance companies, managed care organizations and service administrators must also be able to simplify the complex, better enabling employees to understand plan attributes, compare and select health plans, and make critical allocation decisions with their contribution. The inability to inform, educate, and motivate the workforce to effectively navigate and realize value in defined contribution will substantially slow its growth or perhaps recreate the backlash experienced by HMOs. Also, success of the defined contribution model is substantially reliant on the effective use of technology for

education, communication, and administration. Employees must then have adequate access to computers, the ability to navigate Internet-based applications, and the comfort of transmitting potentially sensitive health and financial data over external networks. Finally, significant obstacles exist with respect to the federal tax code and plan portability. Though employers could establish a trust to accept contributions directed for health care coverage, the tax status of vouchers for use in the open market is uncertain. If the defined contribution model links coverage to employers much like the current system, the issue of portability continues unresolved.

Battistella and Burchfield (1999) examined the public interest ramifications of changing the manner in which health care insurance is purchased. The natural risk pool offered by the employment relationship becomes fragmented, and the number of uninsured may increase if employees can opt for cash payments in lieu of coverage, or if contributions fail to keep pace with rising costs. Unions and consumer interest groups are also concerned for individuals who make inappropriate choices and may be exposed to the financial consequences of a large, unexpected claim. The collective loss of managerial talent and employer resources, which have been reasonably effective in slowing the rate of cost increases and in pursuing quality improvements, may have deleterious long-term effect.

Citing that health care accounts for one of every seven dollars in the national economy, Battistella and Burchfield argue that unrestrained cost growth could trigger a jump in overall inflation levels and damage the entire U.S. economy. To the extent that health care is viewed as a free good, rising expectations and demands without creating an awareness of the actual cost by consumers is likely to exacerbate the problem. Direct involvement in health care purchasing by employees increases individual awareness of the trade-off between health spending and other demands. From a social and philosophical perspective, the broad overriding issue is one of

promoting autonomy and personal responsibility for individual welfare. Finally, legislative proposals, which further increase the cost of health care, will result in employers reducing coverage levels or discontinuing insurance. The proposed Patient Access to Responsible Care Act (PARCA) introduces more than 300 new federal requirements and 200 new mandates for self-insured plans and subject employers to lawsuits, while 300 new regulations would apply to insured plans. Defined contribution programs, which issue vouchers specifically earmarked to purchase health insurance, provide even lower income workers with insulation from major medical expenses.

Major structural changes to any benefit program are not always readily accepted. A new form of retirement program known as a "cash balance plan" was met with significant employer resistance when rolled out by several companies. This approach called for conversion of the traditional defined benefit pension plan in which the accrued vested benefits were recast as a cash balance that younger, mobile employees could more easily value. The most significant change was the funding approach in which benefits would accrue more evenly over the working life of the employee as opposed to accruing at a faster rate as the employee nears retirement age. In addition to a public backlash by the employees of several well-known corporations, the Internal Revenue Service received nearly 200 comments from concerned workers, and the Equal Employment Opportunity Commission is considering whether or not the plans violate age discrimination rules (Reese, March 2000). It is not inconceivable for defined contribution programs to face similar challenges, particularly if contributions are risk-adjusted and include a factor for age.

For defined contribution to actually be implemented, several enablers are required, some of which will be outside of the employer's control (PriceWaterhouseCoopers, 2000). Employers must further redefine their culture away from paternalistic tendencies and accept that employees can be

self-reliant, informed health care consumers. They must further relinquish the role of policy-maker, while providing self-education tools to employees to facilitate informed purchasing decisions. From an external perspective, the health insurance market must adequately develop into an open, efficient, consumer-oriented system that supports individual choice at the "retail" level. Technology must further provide a vehicle for simplified information access, choice and administration. Washington D.C. and the states also need to create a tax and regulatory environment favorable to health savings accounts and other structures that may be utilized to deliver defined contribution, as well as clarify certain issues related to the ability to carry-over unused contributions to future years. Finally, the provider community will need to significantly step up efforts to provide cost and quality information, and to establish consumer-oriented approaches to health care service and delivery.

New structural models and operational protocols developed by the Medicare program are frequently adopted by the private sector given its size and prevalence as a payer. There have been recent proposals to replace Medicare's defined benefit model with a voucher system that would permit beneficiaries to purchase private health insurance coverage, perhaps within the "managed competition" model presented during the health care reform debate of 1993 (Sheils and Fishman, 1998). Despite concern that lower income beneficiaries may not be able to supplement the voucher with personal funds if it is not adequate to purchase comprehensive coverage, similar proposals remain alive due to the expected future funding shortfalls in the Medicare system.

Sheils and Fishman also discuss the Federal Employees Health Benefits Program (FEHBP), which is frequently cited as a limited, working model of the defined contribution approach. Under the FEHBP, beneficiaries select from a menu of health plans that provide the minimum benefit package and meet certain standards. Premiums are "community rated," providing the same premium

for all participants regardless of demographic characteristics. The contribution is equal to a percentage of the average premium charge by the six largest plans, with the beneficiary paying the incremental cost of selecting a more higher priced program. Although there is evidence of disproportionate selection of high-acuity individuals into certain plans, the program has been reasonably successful at controlling costs due to competition and beneficiary price sensitivity.

Any movement toward defined contribution is expected to be evolutionary rather than a rapid shock to the benefits environment, and will certainly be influenced by the availability of third party facilitators and service businesses to manage the process for employers. Over \$160 million in venture capital has flowed to start-up organizations who will develop and service the market, and far more is expected as interest accelerates (Vitberg, 1999). The investment community, which closely monitors such developments, predicts the move to defined contribution will occur in three "waves" (Marhula and Shannon, 2000). In the first wave, employees will be given a defined amount of money to purchase from a select group of health plans approved by the employer, who will probably remain actively involved in plan management and administration. Leading edge employers may then extend their vouchers to purchases outside of the approved array of plans, and may engage a third party facilitator to provide information, decision-support, carrier selection and certain administrative functions. In this wave, health plans will offer semi-customized products to employees based on price points, health needs, and risk tolerance. The final wave will bring a shift to a totally self-directed environment where employee's shop from service providers offering adaptive benefits, or even in a "reverse auction" market designed for affinity groups.

In terms of contribution models, Marhula and Shannon predict two distinct approaches will emerge. The "voucher model", which is reasonably common in cafeteria-type plans currently in

effect, provides the employee with a fixed contribution. The primary difference is that contribution levels may vary based on the risk-adjusted demographics of the individual, and possibly even acuity, better allowing health plans to customize programs for certain population segments. An outside facilitator will provide information and plan selection services. Employees may contribute additional amounts for a plan priced greater than the contribution level, but could also be permitted to retain the difference or upgrade another benefit with excess contribution dollars. The most frequently promoted structure is the "asset model" predicated on the medical savings account approach which combines an interest-bearing vehicle to pay directly for preventive and routine care, and a major medical or catastrophic policy to cover extensive medical, hospital and surgical services. Remaining funds are either transferred into the following year, or may be accumulate. At age 65, penalties for non-medical withdrawals are waived and the funds may be used to supplement retirement income.

The ability to predict the type of models that will evolve in a defined contribution setting is somewhat perilous. Health care coverage is subject to federal and state regulation by multiple agencies including the Internal Revenue Service. There is strong precedent for major changes in benefit strategy to be quickly followed by legislation and regulation promulgated by labor, consumer interest groups, and the regulators themselves, all of which will determine the permissibility of certain arrangements and the rate of adoption by employers.

Employer and Employee Attitudes Toward Defined Contribution

Though certain trends seem to suggest the environment is becoming increasingly favorable for defined contribution arrangements, it is ultimately the attitudes of the employers and the professionals who drive organizational benefit strategy that will determine the rate of adoption. Furthermore, it will be employees who will determine whether or not there is a net benefit to taking

responsibility for their allocating health care dollars and making coverage decisions based with limited involvement by their employer and the benefit professionals on whom most have relied during their working lives.

Technology has accelerated the amount of information available for consumers to comparison shop based on price, quality and value for virtually any product or service. Individuals can now bid for certain items, and so-called "reverse auctions" even reduce prices as the volume of purchase's increase. Despite the complexity of medical care and the agency relationship between doctors and patients, it is difficult to believe that the health care and insurance industries will remain shielded from the empowered consumer. Indeed, personal health care sites are some of the most popular destinations on the Internet, and pharmaceutical companies now market to consumers almost as aggressively as they market to physicians.

KPMG and Northwestern University's Institute for Health Research and Policy Studies (1998) surveyed and interviewed 321 key executives at 70 health care organizations throughout the U.S., as well as over 1,800 heads-of-households. The study hypothesized that the individual consumer's new predominance in the health care market is increasingly influencing policy, strategy, operations and the investment strategies of organizations within all segments of the health care industry. On a 5-point scale, the survey resulted in a 4.26 mean agreement score across all market segments that health care organizations will provide education and accessible data to encourage and empower consumers to purchase health care directly. In terms of supporting examples, over 32 percent indicated that consumers are asking more questions, are demanding more choice, and are more likely to complain. Though a positive indicator for defined contribution implementation, it is most telling that while 40 percent of organizations believed consumers want to be more informed,

only 17 percent of payers were convinced. The survey also produced a 4.69 mean score tightly grouped among all segments agreeing that health care organizations will develop new products, offer more choice, and provide service enhancements to respond directly to consumer preferences.

The consumer sample of the same survey, normalized to reflect the education level and insurance coverage of the U.S. population, found that respondents who self-reported good health are more satisfied with the administration of their health plans than those who reported being in fair or poor health. While a substantial number of consumers directly seek information on health care, 75 percent indicate they have researched considerably more information on the price, quality or options of a car or television than they have on any health care issue.

Americans that have employment-based health insurance are very satisfied with the current blend of wages and benefits and are not anxious to change to individual-based coverage (EBRI, 1999). While 68 percent are satisfied with the current arrangement, only 20 percent would prefer higher health benefits and lower wages, and just 8 percent preferred to trade increased wages for reduced benefits. Men are significantly more likely than women to prefer individual health insurance. An individual's current experience with their health plan also influences their preference. Those dissatisfied with their plan, least confident in their employers plan selection, find their current plan difficult to understand, or are in plans with managed care features are all more likely to opt-out of the employment-based system of coverage.

Another study produced similar results in terms of preference for employment-based coverage, but also found the employers as the leading choice in the future even among those currently uninsured (Commonwealth Fund, 1999). Only 23 percent of those with coverage through an employer believed it would be better to allow individuals to purchase health insurance directly,

concluding that employees find substantial value in the role of employer as plan sponsor, which has significance for the defined contribution model. Workers with a choice of plans were more likely to indicate their employer did a "good job" of selecting quality health plans than those without choice. The survey further cited that employers pay the full cost of health coverage for only 25 percent of workers, and 22 percent indicated they pay more than \$1,500 per year to participate in the plan offered by their employer. From the defined contribution perspective, the vast majority of employees are already directly contributing pre-tax wages for health insurance.

The Commonwealth study also found that only 15 percent of adults changed health insurance coverage for another plan. The most frequent reason was due to a change in job, which left 5 percent of those currently insured without coverage for some period during the year, affecting those with incomes below \$35,000 most often.

An Internet-based survey of individuals visiting a web-site providing information and articles concerning defined contribution believe that the model will be adopted far faster than predicted by industry experts, with 64 percent estimating that the time frame would be less than 5 years (Managed Care On-Line, 2000). Those identifying themselves as employers were significantly more optimistic than consumers, administrators, or insurance organizations. One should proceed with caution before extrapolating the results of this survey to the population of employers. The sample is in effect "self-selected" since it included only those who happen to visit the web-site, who are likely to have a greater interest in defined contribution by virtue of reaching out for the information.

Interviews with 50 health care leaders and a polling of 380 health industry executives found that more than 60 percent believe employers will move to some sort of defined contribution system by 2010, while a slightly lower percentage think employers will offer medical savings accounts as

an option and that Medicare will become a defined contribution system (PriceWaterhouseCoopers, 2000). Several industry leaders felt strongly that Medicare will adopt a voucher system, and that while employers will remain involved in health care purchasing, their role will be dramatically reduced. The study also found that over 30 percent of those surveyed believe consumers will have the most impact on the health care system by 2010, second only to medical technology. Interestingly enough, insurers, who will have far more direct interaction with consumers under defined contribution, are viewed as not prepared for the empowered consumer. One of the key conclusions reached by the research is that health care organizations that are consumer-oriented are most likely to succeed in such an environment.

Booz-Allen Hamilton (1999) surveyed employers drawn from the list of the 100 best companies to work for cited by Fortune magazine. The sample included firms from 31 employees to over 200,000 representing most major industry sectors as well as non-profit organizations. The fact that nearly all firms surveyed did not want their names publicized provides some insight into the economic and political dynamics at play with this volatile issue. With respect to knowledge of the concept, attitudes and readiness, the respondents fell into three distinct groups. Using military jargon, the "DefCon III" group consists of several large companies with an awareness of defined contribution, but have no intention at all to move to such an arrangement. These employers tended to be paternalistic from a benefit perspective, and believed that health care purchasing was too important and complex to be turned over to employees. The vast majority of employers fell into "DefCon II," believing that the defined contribution approach will take hold, but completely unwilling to be a first mover due to the risk of alienating a mobile workforce. Finally, "DefCon I" employers are ready and willing to shift to defined contribution, but concede that there are

significant risks in being the first to do so unless something happens to change the labor environment. The study concluded that defined contribution is likely to emerge rapidly, but only after a major shock to the economic system. Resistance from those in the existing employee benefits infrastructure may slow progress.

In terms of external drivers of the defined contribution concept, the majority of large employees indicated they would shift health plan purchasing decisions to employees if legislation were to pass exposing health plans, and subsequently employers, to malpractice liability (Watson Wyatt Worldwide, 2000). The 503 employers surveyed collectively offer health care coverage for over 18 million employees, with an average firm size of 17,000. Slightly more employers would consider shifting responsibility to employees if costs continue to rise, or if legislation were to pass, giving tax credits to individuals to purchase health insurance outside of the employment arrangement. Only 20 percent believe that the country will move to a system in which employees are fully responsible for their own health care coverage. Those that did believe such a system would evolve did not think it would occur for at least a decade. In the interim, most employers do have a strategy to prepare employees to be better health care consumers and to share more responsibility for their health benefits. In what could be a "silent driver" for defined contribution, 44 percent of employers indicate they are taking no special steps to prepare for the aging baby boom population. While this demographic shift will result in only small cost impacts in a given year, cost implications will be substantial over time.

In a similar study of 600 executives and staff administrators for large employers, 40 percent would support federal legislative proposals that replace the current employee tax exclusion for employer-sponsored care with an individual tax credit for the purchase of any health coverage, citing

this as a way to move employers out of the business of directly providing health insurance (Hewitt, 1999). Over one-third said they would be likely to eliminate coverage if employers were subject to medical malpractice lawsuits. In looking at current benefit structures, most employers are using a constant percentage subsidy as an employee contribution strategy, paying the same percentage of premium for any plan selected. However, many are also using a constant dollar subsidy (paying the same dollar amount for each option) or value pricing to provide a greater contribution for higher quality plans. Already in place, these structures may ease the transition to a defined contribution approach simply due to employee familiarity. Employers have also backed away from using a single delivery system of choice, citing the need to provide the right plan choice for each person in an increasingly diverse workforce. Only 17 percent offer a single, national plan in all markets, further facilitating defined contribution, which is likely to incorporate a similar approach.

Perhaps an understated driver of defined contribution is the issue of retiree health coverage, whereby employers provide supplemental Medicare coverage to post-65 retirees. For this segment of the insured population, employer costs are increasing at a rate of 12 to 16 percent per year, and the Financial Accounting Standards Board Statement 106 (FAS 106) now requires employers to recognize the accrued liability for retiree health coverage on their balance sheets. Prior to FAS 106, employers were permitted to recognize only expenses incurred within a given year on a "pay as you go" basis. A majority of employers providing retiree health benefits surveyed in the Hewitt study believe that retiree coverage will possibly be provided on a defined contribution basis within the next 3 to 5 years.

The most comprehensive study to date was performed by KPMG in consultation with Professor Regina Herzlinger of the Harvard Business School (1999). Incorporating a telephone survey of 103 Fortune 500 and Fortune 1000 companies, as well as over 14,000 employees from 117 Fortune 1000 companies, its objectives were to assess the current level of satisfaction with employer-based plans among employers and employees, and to determine the reaction to the defined contribution concept.

Consistent with other surveys, employers view health coverage primarily as an employee recruitment and retention tool, but employers are more apt to change health plans to achieve better cost control than for any other single reason. Though 93 percent of employers indicated satisfaction with their current health plan options, 46 percent were receptive to the defined contribution concept. Thirty-four percent cited greater choice of health plans as being the greatest advantage to defined contribution, while only 18 percent found cost control as the primary advantage. Thirty-one percent of employers were unreceptive to defined contribution, and 11 percent were either neutral or undecided.

Of those who indicated receptivity to the defined contribution concept, 80 percent would be likely to implement the model if there was no negative tax impact on either the company or its employees. Within this group, 58 percent indicated they would implement defined contribution within one year, and 21 percent cited 2 years. This is far faster than predicted by most industry experts.

In terms of obstacles, receptive employers believe that the government and existing labor agreements will present the greatest barriers to implementation, while unreceptive employers cite employee acceptance of the concept and the education they will require to understand the change as

being the primary obstacles to adoption. While 45 percent of employers predicted employees would not be interested in defined contribution, 73 percent of the surveyed employees said they would be interested. The interest level was primarily driven by the ability to choose the plan providing the greatest value, one in which their own doctors participate, and one that would be portable if they changed employers. The uninterested employees cited convenience, satisfaction with the current plan, and trusted their employers to make the most informed decisions about their health care coverage.

Despite the optimistic results for defined contribution expressed in this study, the sample's demographic profile of employees makes extrapolation to the general population of employed adults questionable. The vast majority of those sampled (74 percent) had completed a college or higher level of education, while 49 percent were managers or executives with a median household income of \$67,400. Furthermore, the survey was conducted via the Internet with responses returned either electronically or on paper. This is suggestive of a highly educated and compensated segment of the workforce who has access to technology and is comfortable with its use. Results of employee interest levels were markedly different in the Commonwealth survey cited previously, which over-sampled adults living in low and moderate income telephone areas to yield a disproportionately larger number of low and moderate-income households.

Since employers and employees alike are aware of defined contribution only at the conceptual level at this juncture, acceptance levels could change one way or the other once a specific plan is proposed and the details of the plan designs, selection options, funding, and administration are presented to stakeholders.

III. Methodology

Identification of Research Participants

The primary purpose of this research project is to determine whether employee benefit managers expect their firms to adopt defined contribution as the primary health coverage-purchasing model, anticipated time frames for implementation, perceived issues and obstacles, expected levels of employee acceptance, and considerations for program design and operation.

In terms of employee benefits, it is common for organizations within the same industry or labor market to have similar strategies for providing health coverage. It is also common for employers competing for labor to modify their benefit strategy after one or more organizations with a large employee-base publicly announce a change in the provision or design of a given benefit. Therefore, a purposive sample was drawn from the 100 largest private-sector organizations in the state of New Jersey in terms of total employees. This technique is intended to provide a research base reasonably predictive of significant health care market trends and influential with respect to benefit strategy adoption by other local and national employers.

The businesses selected for the study were identified through the use of the 2000 American Directory of Group Insurance Plans (published by Judy Diamond), a commercially available database of approximately 147,000 health and welfare reports filed with the federal government under the Employee Retirement Income Security Act (ERISA). The act requires all organizations offering health and welfare benefits which have 100 or more plan participants to file a Form 5500 with the Department of Labor and the Internal Revenue Service on an annual basis. The database comprises 85,000 individual plan sponsors. For purposes of this survey, the database was filtered to identify New Jersey-based employers by total number of employees. In addition to the total

number of employees, number of participants in each benefit program, and high-level plan information, the contact person for benefits, human resources, risk management, and finance is included.

Instrumentation and Data Collection

A questionnaire using a combination of nominal, ordinal and interval-level forced choice responses, as well as a provision for open-ended commentary was used for primary source data collection. The questions were compiled from several surveys of employee benefit managers previously conducted by major consulting firms. However, certain questions concerning implementation, operations and administration of the defined contribution approach were originally developed for this study, as no previous surveys incorporating this aspect were identified. The study and subsequently, the instrument, collects psychographic information, but certain demographic data are also requested for correlational purposes.

The questionnaire has three objectives:

- 1) Establish a baseline of the responding organization's current benefit strategy, overall satisfaction, and perceived level of effectiveness;
- 2) Measure attitudes towards defined contribution, the intent of the organization to implement the model, and the perception of certain related issues;
- 3) Determine how employers conceptualize implementation and operational issues in a defined contribution environment.

The questionnaire incorporates a specific structure in terms of question categorization and ordering:

- I. Current Health Benefit Strategy and Issues
- II. Defined Contribution Concept & Assumptions Introduced

- III. **Defined Contribution Questions:**
 - A. **Philosophical and Perceptual Issues:**
 - 1) **Awareness of Concept**
 - 2) **Support for Concept**
 - 3) **Primary Drivers for Concept**
 - 4) **Perceived Advantages, Disadvantages & Barriers**
 - B. **Conceptual Implementation Issues:**
 - 1) **Employee Issues**
 - 2) **Health Plan-Market Issues**
 - C. **Operational & Practical Issues:**
 - 1) **Level of Employer Involvement**
 - 2) **Structural Issues**
 - 3) **Administrative Issues**
- IV. **Employer Demographics**
 - A. **General Benefit-Related Demographics**
 - B. **Overall Benefit Administrative Structure**

The questionnaire was mailed with a cover letter to employers derived from the purposive sample via first class mail to the attention of the person identified in the database as the employee benefit manager. Where no employee benefit manager was provided, the hierarchy of contact was the human resources manager, the risk manager, and the financial officer. The cover letter and survey instructions indicate that the respondent should have direct input as to the organization's overall health benefit strategy. A follow-up letter was mailed to those organizations not responding within

15 days after the initial survey mailing.

Given the sensitive nature of health benefit strategy changes, there is no disclosure of the specific responding organizations. Response analysis is reported in aggregate only. The cover letters and questionnaire are reproduced in the Exhibits section.

Data Analysis and Measurement

Analysis of the survey responses will primarily utilize descriptive statistics and qualitative discussion of the results. The study uses an exploratory approach to collect psychographic data identifying perceptions and attitudes based on certain hypothetical assumptions from a purposive sample. Nonetheless, the results will be useful to health plan executives and administrative organizations in determining investment levels, strategies, structures and products for the defined contribution model.

In addition to identifying perceptions and attitudes, the response analysis attempts to correlate certain variables related to the current health benefits strategy and employer demographic information with a propensity towards implementing a defined contribution model.

The study participants are representative of very large businesses that have a national or global presence, are highly capitalized, have the resources to employ sophisticated employee benefit and human resource executives to manage health care programs, and likely utilize the services of one or more benefit consulting firms. As such, the results of this study may not necessarily be representative of all employers, especially not small businesses which employ less than 500 workers. Such organizations do not have the resources to be first movers in terms of benefits, nor the scale to influence major employers. Mid-sized businesses which employ between 500 and 1,000 workers could more closely resemble the benefit purchasing characteristics of the large organizations used

in this study, but typically do not have the same level of market influence.

The research may be generalized to other regions of the United States since the participants tend to have employees in multiple states. However, the adoption rate of benefit innovations is considerably different between regions as evidenced by the rate of managed care market penetration in the West as opposed to the Northeast. The actual rate of defined contribution implementation could differ substantively by location even if attitudes were the same across all regions.

Federal and state legislation or regulation passed and adopted subsequent to this study could change expected adoption rates and implementation strategies if it either provided specific incentives or substantial barriers to defined contribution. Product or technological innovations may also result in outcomes that deviate significantly from those predicted in this study.

IV. Results

Description of the Study Respondents

The survey achieved a 26 percent response rate after two first class mailings of a cover letter and questionnaire to the firm's employee benefit manager or human resources manager as identified in the database. The cover letter and survey instructions specified that the respondent should have direct input as to the organization's overall health benefit strategy, which may have implications for the findings since this group of respondents derives their employment from the administration of health and welfare benefit plans.

The respondents represent a wide range of business sectors, including technology development and services, manufacturing, pharmaceuticals, entertainment, business services, real estate, food products, and telecommunications. Due to the prevalence of large pharmaceutical firms based in New Jersey that fit the targeted demographic profile of the study, this sector is slightly over-represented in the results. However, the pharmaceutical industry as a group did not submit responses that were significantly different from the other industries represented in the study.

With respect to the number of employees based in New Jersey, over 76 percent of all respondents had between 300 and 5,000 employees, though the range extended to 20,000. Looking at the total U.S. employment of these firms, including New Jersey, the respondents were reasonably dispersed between 2,001 and 50,000 workers, with one respondent having more than 50,000 employees. Collectively, the responding organizations represent over 676,000 workers throughout the U.S. Given that this segment of large employers tend to be leading indicators in terms of employee benefit trends, the universe of respondents is a good group from which to derive and extrapolate trends such as defined contribution.

Nearly 70 percent of respondents indicated the presence of employee segments represented by labor unions within their organization (see Table 1). Of those with bargaining units, over 61 percent indicated that between 25 and 50 percent of their workforce was represented by labor unions, and approximately one-third had a total union presence of less than 10 percent of their workforce (see Table 2). Given recent labor statistics that less than 10 percent of the total U.S. workforce is unionized, collective bargaining units are disproportionately represented with the group of respondents.

Table 1. Responding Organizations with Collective Bargaining Units

	Percentage (n = 26)
Yes	69%
No	31%

Table 2. Percentage of Workers under Collective Bargaining Agreements

	Percentage (n = 26)
Less than 10%	33%
10% to 24%	6%
25% to 50%	61%
More than 50%	0%

Health benefit costs represent significant expenditures for the responding organizations when measured as a percentage of total employee cash compensation (see Table 3). Including administration, 75 percent of respondents spend between 5 and 14 percent of payroll for health care

benefits, with over 12 percent indicating expenditures of over 25 percent of payroll. As a percentage of total benefit spending, including retirement plans and legally required benefit programs (e.g., state disability and unemployment insurance), health care benefits represent between 20 and 29 percent of benefit costs for one-third of respondents, and 30 to 40 percent for approximately 29 percent of respondents (see Table 4). The range was tightly clustered between 10 and 40 percent of total benefit spending.

Table 3. Estimated Percentage of Payroll Expended for Health Benefits, Including Administration

	Percentage (n = 26)
Less than 5%	4%
5% to 9%	29%
10% to 14%	46%
15% to 20%	8%
21% to 25%	0%
More than 25%	13%

Table 4. Estimated Percentage of Payroll Attributable to all Health, Welfare, Retirement and Legally Required Benefits

	Percentage (n = 26)
Less than 10%	8%
10% to 19%	21%
20% to 29%	34%
30% to 40%	29%
More than 40%	8%

In terms of internal staffing for benefits management, the vast majority of respondents indicated that fewer than 5 persons were deployed for either health benefits administration or total

benefits administration, though 4 firms indicated staffing levels of more than 25 employees were dedicated to managing all benefit programs. While there are no well-established benchmarks for benefit department staffing levels, the size of the responding organizations in terms of employees relative to internal benefits staff suggests significant outsourcing of certain administrative functions.

Asked to estimate the number of employees with Internet access either at home or at the work site, the responding firms were nearly equally dispersed between 40 and 70 percent of workers. Slightly less indicated that more than 70 percent of workers had Internet access, while 12 percent estimated between 20 and 29 percent. Since many defined contribution models are predicated on Internet-based communication and administration, a high level of technology access by the workforce is considered an enabler for such programs.

To reiterate, the questionnaire used in this exploratory study of the defined contribution approach to health benefits has three objectives:

- 1) Establish a baseline of the responding organization's current benefit strategy, overall satisfaction, and perceived level of effectiveness;
- 2) Measure attitudes towards defined contribution, the intent of the organization to implement the model, and the perception of certain related issues;
- 3) Determine how employers conceptualize implementation and operational issues in a defined contribution environment.

The key survey findings for each section are presented independently.

Current Health Benefit Strategies and Issues

In terms of analyzing and interpreting the implications for defined contribution health benefit programs, it is helpful to understand the respondent's current benefit strategy, structure, factors for evaluating health plan performance, satisfaction levels and future expectations. Since changes in benefit strategy tend to be evolutionary, it is likely that such current elements of the strategy will significantly influence any transition towards defined contribution and even remain intact if such a transition does occur.

Current Strategy

Employee benefits are generally developed with consideration as to the environment, whether geographic or demographic, in which a given employer competes for human resources. As such, employers competing for the same labor pool are conscious of the total compensation offered by competitors in terms of cash wages and benefit programs. As confirmation of this phenomenon, 68 percent of respondents indicated that their overall health benefit strategy is to offer coverage levels equal to labor market competitors. Only 4 percent maintain a strategy of offering market-leading health benefit coverage levels, while no respondents indicated a strategy of providing coverage levels below their labor market competitors. Thus, it is likely that any change in benefit strategy by one major firm will be closely monitored and perhaps adopted by others in the same labor market.

Though it is frequently cited that the primary expected outcome for providing health benefits to employees is to attract and retain employees, over 60 percent of the respondents indicated that their organizations offered such benefits to provide affordable health care to employees, or to protect employees against catastrophic financial loss. This is not surprising since the presence of a substantial benefit package is likely to be a given in such large organizations, and may play less of

a primary role in recruitment and retention than with smaller firms. Respondents who were human resource managers were more likely than benefit managers to cite employee recruitment, retention and productivity as the primary expected outcome of the health benefit program.

Current Structure

The ability of employees to choose the appropriate health plan option is often cited as one of the key benefits of defined contribution. Within the current health benefit structure, over 92 percent of the responding organizations offered more than one health plan option (see Table 5). Forty-six percent offered three plans, while 27 percent offered two and over 11 percent offered more than four plans, indicating that employees of large firms already have at least a modicum of health plan choice.

Table 5. Number of Health Plan Options Offered

	Percentage (n = 26)
One	8%
Two	27%
Three	46%
Four	8%
More than four	11%

All but one responding organization required employees to contribute to a portion of the health plan premium (see Table 6). Of those requiring contributions, 77 percent utilize either a constant dollar subsidy in which employees contribute the same fixed dollar amount for each option, or a constant percentage subsidy that requires contribution of a specified percentage of each plan offering's total premium (see Table 7). These "pricing" structures are quite similar to those suggested in most defined contribution models.

Table 6. Percentage of Employers Requiring Employees to Share Premium Cost

	Percentage (n = 26)
Yes	96%
No	4%

Table 7. Strategy Used for Employee Sharing of Premium Costs

	Percentage (n = 26)
Constant dollar subsidy (pay the same dollar amount for each option)	34%
Constant percent subsidy (pay an equal percentage of each option)	42%
Demographic adjusted pricing (subsidies adjusted for employee mix)	4%
Value pricing (greater subsidies for higher quality plans)	8%
Geographic pricing (prices that reflect local cost levels)	4%
Other	8%

Performance Factors

When asked to rank the top factors considered in selecting a health plan, the top two factors cited almost equally were provider network access and employer cost, followed by the scope of benefits provided by the plan. Provider network access was ranked number one or two slightly more often than cost, probably reflecting the shift to network-based programs and concerns raised in the last three years by employees as to physician and hospital access (see Table 8).

In terms of factors for measuring the health plan performance, employee satisfaction was ranked number one nearly twice as often as the other elements, followed by financial efficiency and administrative quality. Consistent with this result is the ranking of success factors in terms of overall health benefit strategy, with employee surveys or feedback receiving the top ranking, followed by

a comparison of financial results to projected annual costs and comparisons with industry or labor market competition (see Table 9). Since provider network access, which ranked highly as a selection factor, has a dramatic influence on satisfaction levels, it is likely that benefit managers will heavily weight the role of employee satisfaction on future benefit strategy considerations.

Table 8. Top Factors Considered in the Selection of Health Plans

	Percentage (n = 26)
Plan accreditation (e.g., NCQA)	8%
Employee out-of-pocket costs	8%
Cost to employer	26%
Provider network access	27%
Quality assurance programs	10%
Scope of benefits provided	18%
Other	3%

Table 9. Top Factors in Measuring the Success of the Health Benefits Strategy

	Percentage (n = 26)
Comparison with industry or labor market competition	23%
Employee surveys or feedback	29%
Comparison of results to estimated annual cost	23%
Measure against plan performance guarantees	13%
Comparison to market or national averages	12%
Other	0%

Current Satisfaction Levels

In addition to the legal requirements for health plan communications under ERISA, federal labor regulations and state insurance law, such communications often have the objective of improving employee satisfaction by increasing the levels of understanding as to plan objectives, cost,

use and design. When asked to estimate employee understanding of four factors, the respondents believed that employees best understand the plan enrollment process, while the vast majority believe employees do not understand the true cost of their health coverage. This is significant in that the insulation of employees from the true cost of health care is often blamed as one of the primary reasons for continued inflation.

In terms of current satisfaction levels, two thirds of respondents indicate they are moderately satisfied their current health benefits strategy, and estimate that two thirds of employees within their organizations are moderately satisfied with their health plans (see Table 10). One third are very satisfied with their current strategy and estimate the same level of satisfaction of their employees (see Table 11). This suggests that there are not high levels of dissatisfaction within either the population of benefit managers or employees of large firms to act as a catalyst for wholesale strategy changes.

In terms of shortcomings of the current health benefit program, an equal number of respondents (38 percent respectively) cited employer cost and administration as the most significant issues (see Table 12).

Table 10. Respondent's Satisfaction with Current Health Benefit Strategy

	Percentage (n = 26)
Very satisfied	35%
Moderately satisfied	65%
Less than satisfied	0%

Table 11. Respondent's Estimate of Employee Satisfaction with Current Health Benefits

	Percentage (n = 26)
Very satisfied	31%
Moderately satisfied	65%
Less than satisfied	4%

Table 12. Most Significant Shortcoming of Current Health Benefit Program

	Percentage (n = 26)
Employee satisfaction	8%
Quality of care	0%
Cost (employer)	38%
Administration	38%
Accessibility of providers	8%
Other	8%

Future Expectations

Employee benefit managers were also asked to provide expectations for the future with respect to health care benefits. In terms of plan offerings, 58 percent expect to offer the same number of plans in three years, while 35 percent expect to offer fewer plans (see Table 13). Only two respondents expect to offer more plans. Though the questionnaire did not ask for a reason as to why employers might reduce the number of offerings, one possible cause is that industry consolidation has resulted in dramatic reductions in the number of health plan underwriters, particularly in the market serving large national employers. Administrative complexity and increasing regulatory requirements may also be factor.

In terms of cost sharing levels, 50 percent of respondents believe employees will contribute

to health plans at the same rate over the next three years as they do today, and 38 percent citing that employees will pay more of the cost (see Table 14). Three employers indicated that employees would contribute less for health benefits over the next three years.

Finally, nearly 70 percent of firms believe employee satisfaction levels will be stable over the next three years, while 19 percent expect improvements and 11 percent anticipate a decline in satisfaction.

Table 13. Number of Health Plan Options Expected in Three Years

	Percentage (n = 26)
More options	8%
Same number of options	57%
Fewer options	35%

Table 14. Employer Expectation of Premium Cost Sharing Levels in the Next Three Years

	Percentage (n = 26)
Employees will likely pay more of the cost	38%
Employees will likely pay the same amount	50%
Employees will likely pay less of the cost	12%

Philosophical and Perceptual Issues in Defined Contribution

Since the pure defined contribution approach has not significantly penetrated the large U.S. employer market, decisions to implement such a strategy by those with responsibility for health benefit decisions will be predicated on perceptions of the model's advantages, disadvantages and ability to resolve shortcomings in current strategy at least as much as on quantitative cost-benefit analyses. This is particularly true of early adopters, who will not have the benefit of monitoring how other employers fare.

In terms of awareness, all but two respondents were aware of the defined contribution concept prior to receiving this questionnaire, with 80 percent learning of the concept through employee benefit trade journals or benefit conferences and seminars. Only two respondents first learned of the approach directly from employee benefit consultants, who are now quite active in developing consulting and administrative service capabilities for defined contribution.

This group of respondents, however, is not optimistic with respect to defined contribution implementation. Fifty percent of respondents indicate that adoption of the defined contribution model by their organization is very unlikely, while 42 percent specify that implementation is somewhat unlikely (see Table 15). Only one benefit manager indicated that his/her firm was very likely to adopt defined contribution.

When asked to estimate a time frame in which defined contribution would become common, 50 percent cited five to ten years, while 15 percent indicated longer than ten years and 15 percent said never (see Table 16). Only 20 percent believe such an approach would be common in three to five years, and none believed it would happen in less than two years.

Table 15. Likelihood of Implementing a Defined Contribution Approach

	Percentage (n = 26)
Very likely	4%
Somewhat likely	4%
Somewhat unlikely	42%
Very unlikely	50%
Not sure	0%

Table 16. Time Frame that Respondents Believe Defined Contribution will Become Common Practice

	Percentage (n = 26)
Less than two years	0%
Three to five years	20%
Five to ten years	50%
Longer than ten years	15%
Never	15%

The benefit managers were also asked about the likelihood of adoption given a specified condition. While the most likely condition predicting the implementation of defined contribution is the passage of legislation exposing health plan and employers to malpractice liability, the vast majority of respondents would only be somewhat likely to adopt defined contribution (see Table 16). The same is true if health costs continue to rise, or if individuals were offered tax credits to purchase their own coverage. When asked if their organizations would eliminate the direct provision of health benefits if individuals could avail themselves of tax credits for the purchase of individual coverage or if malpractice liability were extended to employers, 73 percent and 65 percent respectively indicated their firms would continue to provide health care benefits directly (see Table 18).

Table 17. Likelihood of Eliminating the Direct Provision of Health Benefits if Tax Credits were Available to Individuals for Health Insurance

	Percentage (n = 26)
Yes, we would no longer provide health benefits directly	27%
No, we would continue to provide health benefits directly	73%

Table 18. Likelihood of Eliminating the Direct Provision of Health Benefits if Exposure to Malpractice Liability was Extended to Employers

	Percentage (n = 26)
Yes, we would no longer provide health benefits directly	35%
No, we would continue to provide health benefits directly	65%

In terms of the perceived advantages of a defined contribution strategy, the respondents cited better overall health benefit cost control as the greatest advantage, followed by reduced employer liability for medical malpractice (see Table 19). Lower administrative costs were a distant third. As to the disadvantages, all three responses were directly related to the complexity of health benefit plans. Employee understanding was overwhelmingly cited as the primary disadvantage followed by the complexity of plan selection and comparisons (see Table 20). Health plan market complexity was third. Thus, benefit managers perceive the key advantages to be in mitigating the risk of inflation and liability, but believe health benefits are too complex for employees to select a plan. This is further bolstered by responses as to the greatest obstacles, in which respondents ranked employee education and understanding at the top (see Table 21). Despite the concentration of collective bargaining units in these organizations, the presence of labor union agreements as an obstacle was cited next to last.

Table 19. Primary Advantages of the Defined Contribution Approach

	Percentage (n = 26)
More satisfied employees	10%
Better choice of health plans	10%
Better quality of health plans	0%
Better overall cost control	27%
Lower administrative costs	21%
Reduced employer liability	31%
Other	1%

Table 20. Primary Disadvantages of the Defined Contribution Approach

	Percentage (n = 26)
Complexity of plan selection (comparisons)	26%
Complexity of administration	11%
Complexity of the health plan market	26%
Employee understanding	28%
Cost to employees	7%
Cost to employer	2%
Other	0%

Table 21. Primary Obstacles to the Implementation of Defined Contribution

	Percentage (n = 26)
Cost to employees	9%
Cost to employer	3%
Employee education and understanding	24%
Labor union agreements	8%
Complexity of plan selection (comparisons)	17%
Ability to purchase sufficient coverage	12%
Company philosophy towards benefits	16%
Ability of the health plans to manage it	10%
Other	1%

When asked if the defined contribution approach would resolve the most significant shortcoming of the current health benefits program (previously cited as employer cost and administration), 81 percent said it would not, while 15 percent indicated it would help but not totally resolve the key shortcoming (Table 22). Only one employer believed the approach would likely resolve the most significant shortcoming.

Table 22. Likelihood of Defined Contribution to Resolve the Most Significant Shortcoming of the Current Health Benefit Strategy

	Percentage (n = 26)
Yes, it is likely to resolve the most significant shortcoming	4%
It will help, but not totally resolve the most significant shortcoming	15%
No, it is not likely to resolve the most significant shortcoming	81%

Conceptual Implementation Issues in Defined Contribution

Taking the concept a step further, employee benefit managers were asked to conceptualize the implementation of a defined contribution strategy in consideration of the employees of their organization and the overall health plan marketplace.

Consistent with the respondent's perception, approximately 70 percent believe employees would be somewhat or very unreceptive to the defined contribution approach (see Table 23). Yet, a surprisingly high 30 percent indicated that employees would be somewhat receptive, though none believed employees would be very receptive. Over 73 percent indicated that employees would not be capable of selecting a health plan that is appropriate for them at first, but would be able to do so eventually, while 20 percent believed it is too complicated for employees (see Table 24). Only two respondents thought that employees could do so, but with difficulty.

In terms of employee satisfaction, which was cited as a key factor in determining plan performance and measuring success, nearly 62 percent of respondents believe that satisfaction levels will deteriorate under defined contribution, while 35 percent see no effect on employee satisfaction (see Table 25). Only one employer sees satisfaction improvements under the approach.

Table 23. Respondent's Estimate of Employee Receptivity to Defined Contribution

	Percentage (n = 26)
Very receptive	0%
Somewhat receptive	31%
Somewhat unreceptive	50%
Very unreceptive	19%

Table 24. Respondent's Estimate of Employee's Ability to Select an Appropriate Health Plan

	Percentage (n = 26)
Yes, it would be easy	0%
Yes, but it would be difficult	8%
Not at first, but they would eventually	73%
No, it is too complicated	19%

Table 25. Respondent's Estimate of Change in Employee Satisfaction Under Defined Contribution

	Percentage (n = 26)
Yes, satisfaction would improve	4%
Satisfaction would remain unchanged	34%
No, satisfaction would deteriorate	62%

Considering the health insurance marketplace, employers overwhelmingly believe that most health insurance and managed care companies are not adequately prepared for the defined contribution model, cited by over 92 percent (see Table 26). Over 96 percent of respondents see most health plan comparative information as inadequate (see Table 27). Furthermore, benefit managers do not think health plans or the overall health care marketplace (including physicians and other care providers) will become more responsive to consumers under defined contribution (see Table 28). Seventy-seven percent believe there will be no change in health plan responsiveness, while 85 percent do not see the overall health care market becoming more responsive.

Table 26. Respondent's Perception of the Preparedness of Health Insurance and Managed Care Companies for Defined Contribution

	Percentage (n = 26)
Yes, most are adequately prepared for defined contribution	8%
No, most are not prepared for defined contribution	92%

Table 27. Availability of Adequate Comparative Information for Employees to Select a Health Plan

	Percentage (n = 26)
Yes, there is adequate comparative information	4%
No, most comparative information is inadequate	96%

Table 28. Respondent's Estimate of Change in Consumer Responsiveness by Insurance and Managed Care Companies

	Percentage (n = 26)
Yes, health plans will become more responsive	23%
No, there will be no change in health plan responsiveness	77%

Operational and Practical Issues in Defined Contribution

The questionnaire further asked the employers surveyed to hypothetically consider certain practical and operational issues with respect to defined contribution implementation. Caution is advised with respect to results of this section as responses are likely to be influenced by attitudes and perceptions, as well as the difficulty in considering the implementation of a concept not fully developed within the responding organizations. Actual implementation models may deviate considerably from those derived from this study based on the actual defined contribution model developed and utilized by a given employer.

Health benefits are often categorized in terms of the actual plan covering physician and hospital services, and those covering health-related "ancillary" benefits such as vision and dental plans. Over 62 percent of respondents indicated that the defined contribution approach would be extended to ancillary health benefit programs as well, and two-thirds would provide a single defined contribution amount for the selection of all health-related benefits and not carve out a separate contribution for ancillary coverage.

In terms of employer resources dedicated to health benefit management, nearly 54 percent of respondents see a somewhat limited role for the employer, while 35 percent believe they will remain fully involved. Only three respondents believe involvement will be severely limited and none saw the employer as having no involvement whatsoever (see Table 29).

Table 29. Company Involvement in Health Benefits Management if Defined Contribution were Implemented

	Percentage (n = 26)
Remain fully involved in health benefits management	35%
Have a somewhat limited role in health benefits management	55%
Severely limit involvement in health benefits management	12%
Have no involvement in health benefit management	0%

In a defined contribution environment, the respondents see continued involvement in all of the major aspects of health benefit management, but cited slightly higher levels of involvement in the areas of employee education for plan selection, and in directly selecting the menu of health plans that would be offered. Nearly 70 percent see a combination of internal and outsourced administration, not unlike current management practices.

With respect to health plan administration, previously cited as one of the key shortcomings of current health benefit programs, two-thirds of respondents believe that plan administration would become more complicated under defined contribution, while nearly 20 percent see no significant change from current administrative practices (see Table 30). Furthermore, 46 percent see significant increases in administrative costs under defined contribution and 42 percent see no effect. Only three respondents believe administrative costs will decrease significantly (see Table 31).

Table 30. Expected Effect of Defined Contribution on Health Benefits Administration

	Percentage (n = 26)
Administration would become more complicated	65%
Administration would not change significantly	20%
Administration would become less complicated	15%

Table 31. Expected Effect of Defined Contribution on Health Benefits Administrative Costs

	Percentage (n = 26)
Administrative costs would increase significantly	46%
Administrative costs would not change significantly	42%
Administrative costs would decrease significantly	12%

Comparison of Key Results to Previous Study Data

In terms of attitudes and expectations for defined contribution in health care purchasing, the responses provided by this group of health benefit managers is more positively correlated with the attitudes expressed by consumers in the EBRI (1999) and Commonwealth Fund (1999) studies than those conducted of corporate executives by the major employee benefit consulting firms. Both studies showed that consumers believe the involvement of employers as purchasing conduits provides value that individuals could not achieve on their own. These results are a stark contrast to the PriceWaterhouseCoopers (2000) survey of health care leaders and industry executives, which resulted in a much more optimistic view of the defined contribution approach.

Research of employers conducted by employee benefit consulting firms also indicated much more willingness on the part of these organizations to shift a considerable portion of the health plan purchasing decision to employees if legislation were passed exposing health plans and employers to malpractice liability (Watson Wyatt Worldwide, 2000). Even more employers were willing to shift responsibility if costs continue to rise, or if legislation is passed to facilitate a defined contribution approach. Many employers were actually in support of individual tax credits as a way to reduce their involvement in providing health care (Hewitt, 1999).

The KPMG/Harvard study (1999) of large employers also indicated a substantially higher level of receptiveness to the defined contribution approach with a receptivity level of 46 percent, and an expected implementation time line far faster than predicted by benefit managers in this research. A positive correlation was found with respect to implementation barriers cited by the unreceptive group of employers, where employee understanding of health plan purchasing ranked as the number one obstacle.

V. Discussion

The research results clearly indicate that the vast majority of the large number of New Jersey employers participating in the study are unreceptive to the defined contribution approach, believe that selecting health plans would be difficult for employees, and are unlikely to significantly curtail their involvement in health benefit purchasing and administration, even under specified adverse conditions. Furthermore, the respondents do not believe that insurance companies and managed care organizations are adequately prepared for a defined contribution environment, do not currently produce useful comparative information to assist employees in selecting the appropriate plan, and would not become more responsive to consumers under this approach. Finally, a significant majority predicts that employee satisfaction with health benefits would actually deteriorate under defined contribution, administrative costs would increase, and that it would fail to resolve the most significant shortcomings of their current strategies.

The respondents believe that a great deal of value is created by the involvement of the employer in developing health benefits strategy, evaluating and selecting insurance companies and managed care organizations to provide coverage and administer health plans, managing certain internal administrative processes, and measuring program effectiveness. There are few circumstances under which the benefit managers surveyed would agree that it is beneficial to limit employer involvement and provide significantly more control to employees in selecting and purchasing their own health plan, particularly outside of the employer-structured environment. It is also evident that the respondents do not believe that current health plan carriers or administrators are oriented towards consumers and have not created satisfactory informational and purchasing structures to facilitate appropriate health plan choices by employees.

Discussion of the study results will be framed by the following six major questions of interest raised by the responses, with emphasis as to the implications for health insurance carriers and managed care organizations:

- 1) Does the role and capacity of the respondent as decision-maker influence the level of interest in defined contribution?
- 2) Are the concerns raised about deteriorating employee satisfaction and the complexity of health plan selection sustainable obstacles to the implementation of defined contribution if economic and legislative conditions alter the environment?
- 3) Is the health insurance and managed care industry prepared for a shift to the defined contribution approach in its current state?
- 4) Does the current defined contribution approach to funding retirement benefits provide a viable model for health care?
- 5) What other considerations and implications exist for employers and health plan vendors in a defined contribution landscape?
- 6) What other factors, unique to this study, should be considered in the results?

1) Does the role and capacity of the respondent as decision-maker influence the level of interest and ultimate adoption rate of defined contribution?

This research provides a significant contrast to other recently published studies in which respondents viewed defined contribution much more favorably, or at least were amenable to the approach under circumstances that either facilitate the model or impose undue liability and financial risk to the employer. Confounding a simple explanation is that the vast majority of current plan

strategies and features cited by respondents already incorporate elements of defined contribution in the broadest sense. All but two employers offer multiple health plan options, which presumes that employees must select between at least two options, and only one employer pays the full cost of coverage. The remainder require some level of contribution from the employee and utilize either a constant dollar or constant percentage subsidy for each plan offering, an approach common in many defined contribution models. One-third of employers expects employees to contribute more of their compensation to health plans over the next 3 years.

Certainly, the lack of a well-defined model for the defined contribution approach may be a factor leading to the unfavorable rating. The literature review presented a number of models under which the approach may be implemented ranging from a controlled, employer-structured environment to the use of tax credits to permit employees to purchase coverage in the open market. At this early juncture, it is difficult to evaluate the implications of such a broad conceptual approach without understanding the details to which the strategy would be subjected, especially the operational and regulatory issues. The success or failure of benefit strategies, particularly health strategies, hinge on the details of implementation and the interaction of a multitude of stakeholders with sometimes divergent interests, including health plans, fiscal and administrative intermediaries, providers and hospitals, regulators, consumers and employers. A major change in strategy affecting how coverage is provided will have significant "downstream" affects that must be adequately evaluated.

Another consideration for this variation is the role and capacity of the respondents. Though certain studies were directed towards benefit or human resource executives, many included financial executives and other senior officers. While these executives certainly have high level input with

respect to health benefits strategy, they have minimal involvement in the administrative details, excepting certain financial aspects. However, the defined contribution approach can be viewed as far more of a philosophical shift in the employer's relationship to its employees and in the nature of compensation itself, than simply a strategic or operational change in the structure of the health benefit program. Should the employer provide a "self-directed" program of compensation and a favorable structure for employees to contribute to a program of benefits, or should it adopt a "paternalistic" position of consistently directing a portion of employee compensation to a predetermined array of health, welfare and retirement benefits? Is it better to provide a "structured" defined contribution approach such as the 401(k) retirement program, or should the employer eliminate all involvement and simply provide cash compensation and let employees purchase coverage outside of the employment relationship? The answer portends a philosophical decision predicated on the employer's business environment and its labor market, which is then operationalized through a benefit purchasing and delivery structure. Human resource and benefit executives are undoubtedly involved in the decision process, but such philosophical shifts are more likely to be precipitated by chief executives and financial officers when faced with adverse economic conditions, or when presented with business reasons for considering such alternative approaches.

This study was specifically directed to benefit or human resource managers, who were further instructed that the ultimate respondent should have direct responsibility for health benefit strategy. The population of respondents derives their employment from the management and administration of the health benefit function, which could be significant in two respects. From a purely self-interested perspective, strategies that ultimately limit the involvement of a centralized benefit staff, especially one in which the health benefit function is specialized, necessarily has

implications for the employment of such individuals. While there is no evidence that benefit managers would not be required unless health benefits are completely severed from the employment relationship, it is possible that firms marketing their services for defined contribution are doing so partially by emphasizing cost savings resulting not only from fixing the premium contribution levels, but also through administrative efficiencies. Simply put, the employer may require fewer benefit staff positions if outsourcing such arrangements is effective.

The daily involvement in health benefit management and the interface with employees and health plans experienced by benefit managers also provides an appreciation for the complexity of plan selection and the irrevocability of such coverage decisions. It is not uncommon for a benefit manager to become an "ombudsman" for an employee faced with a claim denial or difficulty in obtaining the necessary preauthorizations to receive certain treatments, despite the potential greater liability faced by the employer in exercising discretion with respect to coverage decisions. Benefit managers are well aware of the complexities of health policy exclusions, limitations, and administrative procedures, which are not always easily communicated and can be misunderstood or overlooked by even highly education employees. They also realize the financial implications for younger employees who may underinsure or forgo coverage in favor of current compensation. Thus, the capacity of the decision-maker will likely have a tremendous effect on the adoption rate of defined contribution, as well as the type of model implemented. Benefit managers may be much more cautious about adopting such an approach than their executive counterparts in other areas of the organization, who may prefer to eliminate or reduce direct participation in functions not deemed a "core competency."

Insurance companies and managed care organizations considering strategies for the defined contribution market must then be cognizant of the decision-making process and the "gatekeepers" with respect to shifts in health benefits philosophy and shifts. Companies serving small to medium size business segments are likely to find the benefits decision-maker is also a key business operating officer or perhaps even chief executive considering high level effects on the business rather than just health care strategy. Even in large companies, where benefit and human resource executives make key strategy decisions, a directive from the chief executive or financial officer to reduce operating costs by a specified percentage can quickly change the context of the benefits program. Health plan providers should also remain cognizant of the advisement role played by benefit consulting firms, who are currently deploying capital to serve the defined contribution market. Decision drivers are further explored in the next major question.

2) Are the concerns raised about deteriorating employee satisfaction and the complexity of health plan selection sustainable obstacles to the implementation of defined contribution if economic and legislative conditions alter the environment?

Managed care is often criticized in the popular media and by the medical profession, which frequently translates to opinion polls citing public dissatisfaction. Yet, studies asking individuals about their own health coverage, which is most often some type of managed care arrangement, consistently show reasonably high levels of satisfaction. Likewise, the findings of this study show that few benefit managers are dissatisfied with their organization's current approach, and believe the same is true of their employees. A great deal of weight was placed on maintaining high levels of employee satisfaction, consistently ranking it as the number one factor in rating health plan

performance, followed by financial efficiency and administrative quality. In terms of plan selection, provider network access, a key driver of employee satisfaction, ranked nearly as important as plan cost. With any significant change in benefits, even selecting a new carrier, comes a reasonable amount of employee disruption. New rules, procedures and decisions create a certain level of anxiety likely to cause at least a short-term deterioration in satisfaction, which could be extended indefinitely if the implementation and transition period is problematic. Is the emphasis placed on employee satisfaction as a performance indicator sufficient to limit the growth potential of defined contribution?

Within the framework of considering satisfaction, it is important to understand that the defined contribution approach is not the same as selecting a health plan. The health benefit offerings currently provided by the employer could most likely continue to be offered under defined contribution. It is the philosophical context of employee compensation and the constructs necessary to operationalize the strategy that is the essence of defined contribution. The result is to empower the employee as an individual consumer and allow him or her to determine the appropriate levels of insurance protection and asset accumulation specific to their circumstances and risk tolerance. This is influenced by the perceived role of health and retirement benefits within the organization, and its perceived or measured contribution to recruitment, retention and productivity.

While high levels of satisfaction with the health benefits program unquestionably contribute to good labor relations and act to bolster employee recruitment and retention efforts, the timing and geographic concentration of this study places its context in that of a tight labor market and a strong, albeit slowing economy. During this long period of sustained economic expansion, it is common to see employers enhancing benefit programs and offering new arrays of services to attract and retain

skilled employees. However, one only needs to look back at the period during which employers moved away from nonrestrictive indemnity health plans to managed care programs due to a sustained period of rapid health cost inflation that threatened not only profitability, but the global competitiveness and very survival of U.S. firms. The combination of workforce reductions in the blue and white-collar ranks and the inability to build increasing health costs into prices precipitated swift action by employers to engage managed care plans, irrespective of a skeptical workforce facing new restrictions on access to physicians and hospitals, as well as referral and precertification requirements. The same period also saw the growth of defined contribution retirement plans. The decisions were directives from the organization's senior management rather than the human resources or benefits staff. This does not suggest that human resource or benefit executives are not sensitized to overall business issues. Rather, their unique first-hand knowledge of health benefit issues from the perspective of the workforce may be subordinated to that of the need for decisive action to quell shareholder concerns and regain competitive footing in a cost-driven market.

Insurance companies and managed care organizations must therefore be watchful of the convergence of economic events such as period of lower corporate profitability, rising health care cost inflation, workforce reductions, and certainly adverse legislation to predict the adoption rate of defined contribution. Unlike the period of managed care expansion, today's workforce views the employment relationship in a different light, and has experienced a solid 20 years of defined contribution retirement programs. Given a weakened labor market, employers may find an opening to step back from the direct provision of health benefits. Indeed, corporations with retiree populations covered by health plans have implemented a defined contribution approach, effectively limiting post-retirement health care benefits. This shift was precipitated by Financial Accounting

Standard No. 106 (FAS 106), which required corporations to recognize accrued post-retirement health benefit liabilities on the balance sheet rather than as current expenditures. A single change in accounting convention was sufficient to shift health benefit strategy.

3) Is the health insurance and managed care industry currently prepared for a shift to the defined contribution approach?

The results have significant implications for insurance companies, managed care organizations, and especially administrative intermediaries that are expected to "package" and facilitate defined contribution programs. Benefit managers believe the industry is collectively unprepared to operate in a consumer-driven environment, and that existing educational materials and comparative literature is inadequate to enable employees to comfortably make health plan purchasing decisions. Citing employee education and understanding as one of the primary obstacles to defined contribution is indicative that this is one of the key details that must be in place for acceptance levels to increase considerably. It is also one of the areas on which benefit managers expect to spend the most time under defined contribution. Coupled with the expectation that administration would become more complicated in a defined contribution world and that the shortcomings of current strategies would not be addressed is an indication that those promoting the model do not have the necessary infrastructures or have not adequately considered the impact of such a culture change on employees and presented a program of information and education deemed adequate by benefit managers.

Two-thirds of the respondents believe that current satisfaction levels would deteriorate under defined contribution. If the health plans currently serving these employers were to remain available

as options under defined contribution, and similar employer contribution strategies such as constant dollar subsidies continued to be utilized, then one has to conclude that the deterioration in satisfaction would occur by virtue of the defined contribution "process." Are employer contribution levels adequate? Will health plan cost increases accelerate, and who should absorb such increases? Are the plans understandable and is comparative information adequate to make an appropriate plan selection?

Further systematic study is required to determine the causes of these perceptions, particularly since most carriers do not work in such an environment except those with extensive experience in individual markets or with group health purchasing coalitions. However, there are certain competencies that carriers will need to gain for the defined contribution approach. Carriers may be well served by reviewing the paths taken by the financial services industry in meeting the retail-level demands and expectations in defined contribution.

First, the creation of a product portfolio that mirrors the risk-return characteristics of an investment portfolio is warranted. Offering or arranging to offer plans ranging from non-restrictive indemnity programs to more restrictive preferred provider options and HMOs, as well as financial and coverage attributes ranging from high deductible catastrophic coverage and medical savings accounts to comprehensive-low coinsurance programs will be critical in recognizing the different needs of income and demographic cohorts within the employed population. Unlike investment products, adverse selection must be considered if employees with higher than average health care costs gravitate toward a certain program or carrier.

Second, marketing and sales efforts must occur on two levels. Employers, purchasing coalitions, and health plan facilitators must first agree to offer the products of a given carrier, then

the employee must recognize the value of the carriers brand and attractiveness of its products. Thus, a retail plan of action must be integrated with the traditional group sales approach.

Third, plan design presentation must be comprehensive and provide all of the material facts necessary to select an appropriate program, yet be simple so as to facilitate the decision process. Educational tools and comparative information such as the risk tolerance profiles and asset allocators, which enable individuals to assess their own situations and make reasonable choices, need to be incorporated by health plans. Computer-based questionnaires could help an employee determine their comfort levels with choosing from a selectively contracted network of doctors and hospitals, potential levels of out of pocket payments, and the consequent cost of choosing open access plans. This could be combined with the establishment of a personal health care account for each employee, which tracks contributions, plan selections, eligibility, accumulated funds (if permitted), and benefit information, as well as provide general and condition-specific health information.

Fourth, information system strategies need to consider the accessibility of encoded data by the consumer. Older mainframe computer applications tend to use codes that would be indecipherable to the employee and as such, must be modified or translated in common language. Of course, privacy and confidentiality of individually identifiable patient information is a key consideration. The use of unique passwords and appropriate levels of data encryption will be required. Especially important is that all information must be specific to the plan selected by the employee. General information about the carrier or their products will lead to confusion, misunderstandings and dissatisfied employees and benefit managers.

Finally, plan information must be equally accessible to doctors, hospitals and other provider organizations who are authorized and have a need to know such information for purposes of

coordinating care and establishing financial arrangements. A significant proportion of employee satisfaction with a given program can be directly attributable to the activity that occurs in a hospital or physician's office when accessing care. A plan's relationship with its participating providers will have an enormous influence on whether or not an employee remains loyal to a given carrier. Carriers that facilitate the back-office administrative processes with providers will have a decided edge in employee satisfaction and in controlling administrative expenses.

4) Does the current defined contribution approach to funding retirement benefits provide a viable model for health care?

On the basis of these survey results, the current defined contribution approach for retirement plans appears to provide a good foundation from which to consider the health model. As discussed in the literature review, many parallels exist between the health care financing environment of today and the trends and issues which precipitated the dramatic growth in defined contribution, or 401(k) type retirement programs. Even when considering the more immediate implications of health plan selection versus the generally longer time horizon for retirement planning, the basic structures that allowed the 401(k) approach to achieve high market penetration levels can be adopted for health coverage. It is also a familiar model that preserves the value added by the employment relationship while allowing employees to make selections appropriate for their circumstances. There are, however, significant differences in levels of standardization and regulatory structures that provide retirement plans with certain advantages over a similar model for health plans.

First, current defined contribution retirement plans, while portable in terms of the ability to transfer assets to another qualified plan maintained by the individual (e.g., an IRA), are delivered

within the employment structure. A plan provider, which may be a mutual fund company, bank, brokerage, or other financial institution, is evaluated and selected by benefit managers on the basis of criteria such as cost, fund selection, long term performance record, communication materials, technology and service capabilities. Other administrative entities to service the plan may also be reviewed and selected as necessary. Employees may elect whether or not to participate in the plan. Those electing to participate select one or more limited investment options from an array of alternatives with different risk-return characteristics and within certain IRS restrictions, contribute a percentage of their pay to the plan on a pre-tax basis. Employers frequently match the amount contributed up to a specified limit. Contributions are deducted from payroll and periodically transmitted to the investment manager, who establishes a specific account for each employee and allocates the contribution in accordance with the employee's directive. Periodic statements are provided to employees, but daily valuation of assets in each employee's account may be available through an Internet site. Employees may also reallocate assets or change investment options electronically, depending on the plan and the investment manager.

A similar approach could be implemented for health care plans. Indeed, the vast majority of those surveyed have elements of a controlled defined contribution model already in place. Section 125 of the Internal Revenue Code currently permits employers to provide a fixed contribution to be used by employees to customize their overall health benefit package by selecting from a menu of options, and also establish tax-advantaged accounts for health care and other benefits. The primary limitation of Section 125's application to true defined contribution are the requirements that funds earmarked for premiums and non-covered expenses must be used in the current year or forfeited by the employee. Accruals for future expenditures or to accumulate assets

for the payment of future health expenses, or premiums during retirement or periods of unemployment are not permitted.

Employers could certainly select a defined contribution "health manager," much like the investment managers and administrative intermediaries for retirement plans. The health manager provides an array of health plan options akin to the investment risk-return spectrum, maintains individual employee health accounts, produces statements, and facilitates reporting and back-office administration.

One problem is that there are few reliable, consistent and broadly accepted performance measures to guide consumers in the selection of health plans, unlike the more standard comparative risk-return presentations of asset classes within the mutual fund industry. Organizations such as the National Committee for Quality Assurance (NCQA), a non-profit organization that accredits health plans, have created standard reporting formats for plan comparisons such as HEDIS. However, such indicators are more useful to consultants and benefit managers with health care knowledge, than to consumers. Yet, the Federal Employees Health Benefits Program (FEHBP) and other purchasing entities have been quite successful in presenting multiple plan comparisons and even in creating competition between plans to moderate cost increases. Either an industry-developed standard or a regulation that prescribes standards for a health plan "prospectus" and for the consistent presentation of plan attributes and performance indicators that are meaningful to consumers would further facilitate a health care model predicated on the 401(k) approach.

In considering this model, insurance companies and managed care organizations should consider not only the questions of tax law and comparative literature, but that, by no means is the facilitation of this model exclusively in the purview of the health care industry. Aside from firms

dedicated to defined contribution administration, the financial services industry could use its existing infrastructure and client base to move aggressively into the market. Mutual fund "supermarkets" could easily add health plans to their array of offerings, which could be an effective distribution channel, but could also act to commoditize the plan providers.

5) What other considerations and implications exist for employers and health plan vendors in a defined contribution landscape?

The acceleration of defined contribution will undoubtedly call the attention of health policy experts, legislators and regulators who will examine its public policy implications. With the level of uninsured Americans growing during a period of economic expansion, policymakers will assess the potential effect on the number of uninsured. While some will argue that permitting employees to divert compensation away from health coverage or to reduce coverage levels in favor of asset accumulation or current spending, some approaches may decrease the number of working uninsured by joining a market aggregator and offering an employer subsidized lower priced plan or at least catastrophic coverage. It is reasonable to expect federal and/or state legislation requiring employers who offer health benefits to mandate a certain minimal level of coverage.

Expect new and stronger legislation to regulate medical underwriting and risk-based rating, particularly in an extreme defined contribution environment where employees may shop the open market for individual coverage. The type of regulation extended to the property and casualty coverage (e.g. automobile insurance, homeowners coverage), as well as existing laws regulating individual and small group health coverage will serve as a baseline for what may be adopted.

With its potential to disrupt the current employment-based risk pooling and internal subsidization that occurs between individuals and families, the young and the old, the healthy and the sick, both health insurance underwriters and those public and private institutions that monitor the fiscal integrity of insurers will need to proceed cautiously. New rating approaches may be required and an entire new set of subsidy dynamics may emerge. Community rating necessarily entails extensive subsidies between demographic groups. Insurers may then find the traditional single-employer line of business subsidizing the defined contribution pool if adverse selection occurs or if administrative and marketing expenses increase markedly.

Health plan providers must become actively involved in the public policy discussions sure to ensue if defined contribution moves forward. Consumer protection legislation, already on the horizon, is likely to become even more stringent if legislators perceive the erosion of the employer's role. Such legislation will be influenced not only by consumer groups, but the medical profession will be given an opening to assert its positions, which could weaken cost control mechanisms and ultimately accelerate premium increases. Furthermore, health plans will need to consider and communicate the impact of defined contribution to stakeholders, including shareholders where applicable and to the financial strength rating agencies, who will look critically at underwriting impacts and could potentially downgrade ratings due to uncertainties.

6) What other factors, unique to this study, should be considered in the results?

Unlike the studies discussed in the literature review, this research was limited to employers based in the state of New Jersey and the respondents indicated levels of collective bargaining in their workforce disproportionately higher than the penetration of labor unions overall.

In terms of the geographic limitation of the study, innovations in health benefit changes vary in penetration throughout different regions of the U.S. The decided shift to managed care programs in the 1980s was late in coming to the Northeast region, and penetration levels are still below many other areas of the country. Studies conducted without regard to geographic limitation may be partially reflective of the willingness of companies located in other regions to be first movers and adopt changes more rapidly than those in New Jersey and the Northeast in general, or to the variation in labor market conditions between regions.

Though not cited as a major obstacle to defined contribution by the respondents, the heavy penetration of collective bargaining units in these organizations may influence the way in which benefit managers view their entire approach to health benefits. Benefit and human resource executives are sensitive to the impact of changes in strategy and delivery on the workforce, even if such changes are agreed upon during labor negotiations. In addition to the somewhat anti-defined contribution position publicly espoused by unions, any human resource executive who has experienced a tense labor negotiation will understand the sensitivity to changes in health and welfare benefit programs by union members and their representatives.

The nature of the industry and the demographics of the average employee could also influence the decision to consider defined contribution. The respondents to this study mostly represent mature industries and likely have stable, long-term employees. They are not start-up companies with a young workforce and high employee turnover rates. As such their benefit philosophies are likely to be staid in the more traditional approaches.

VI. Implications for Additional Research

Though certain non-profit organizations have published research on the defined contribution approach, the majority of studies have been conducted by employee benefit consulting firms, and have focused primarily on the projected rate of adoption by employers, as well as surface considerations of advantages and disadvantages, regulatory, tax, and public policy issues. Academic research to date has been limited, perhaps due to the lack of empirical data on the defined contribution approach. Studies have primarily remained in the exploratory realm since practice of the model is extremely limited. Given the significance of such a strategic shift, particularly if emergence was rapid, there are specific areas that must receive due consideration from employers, health plan providers, and policy makers.

a) Public Policy Issues

Whether in evolution or revolution, defined contribution will receive attention from regulators and policy makers, particularly with respect to its impact on aggregate tax receipts, the level of uninsured citizens, and issues of insurability and underwriting. This is difficult at best since a true defined contribution model has not yet emerged. Not unlike defined contribution retirement plans, its counterpart health model has implications for publicly provided health care programs. For example, will the ability to accumulate assets within a defined contribution health care account facilitate true portability, enable early retirees to maintain health coverage before reaching the age of Medicare eligibility, and even use accumulated funds to purchase supplemental health and long term care policies? Should the tax code be neutralized with respect to health coverage purchased individually or through the employment relationship? Should regulators mandate the purchase of a

policy providing for a minimum array of benefits, or should employees be permitted to accept current compensation in lieu of health coverage? How will hospitals and other providers of care be affected if younger employees waive health coverage? Likewise, will the natural risk pool and intergenerational subsidies occurring within current financing arrangements be disrupted to the point of being ineffective? Should limited risk adjustments for individuals be permitted?

Research on pertinent public policy issues will serve to educate policy makers and regulators as to the potential impact of defined contribution, but will also act to enlighten them as to a market-driven innovation that is the natural extension of the consumer-driven models thriving in other areas of business. As is common in technology, policy significantly lags innovation, particularly as the pace of change accelerates. Thus, an early basis for policy consideration may at least provide a foundation not only to check potential abuses, but also to minimize restrictions in areas where defined contribution will facilitate socially desirable ends.

b) Regulatory Models, the Tax Code, and Benefit Law

Flowing naturally from public policy considerations, the very structure that supports policy decisions requires systematic research for applicability in a defined contribution environment. Depending on the funding status of a given health benefit plan, a plethora of laws and regulations enforced by a multitude of agencies are involved. Insured health benefit plans are regulated primarily by the individual state insurance commissioners and vary widely by jurisdiction, complicating programs for multi-state employers and insurance carriers. Self-funded programs are governed by the Employee Retirement Income Security Act of 1974 (ERISA), with primary enforcement coming from the Internal Revenue Service and the U.S. Department of Labor. Common law and precedent, as well as judicial activism, also influence the operation of health benefit plans. Research as to the

impact, effectiveness and applicability of a fragmented regulatory structure is crucial to fully consider implementation models for defined contribution. Is it beneficial to move towards a more consistent model of regulation with consolidated enforcement, or should local issues continue to prevail? Under defined contribution, is the distinction between insured and self-funded programs valid?

Consideration needs to be given to the tax implications as well. In addition to the potential impact on tax receipts, using the tax code to support public policy positions is important to study as well. Should defined contribution models be differentiated in the tax code? Should tax policy be formed with a revenue neutral approach, or is it desirable to subsidize certain arrangements or decisions? Similarly to defined contribution retirement plans, should plans be penalized for disproportionately providing contributions for highly compensated employees?

c) Financial Implications for Health Plan Providers

Depending on the level of penetration of the defined contribution model and its impact on any individual health insurance carrier or managed care organization, regulators, financial strength rating agencies, shareholders, policyholders, and providers will be interested in understanding the financial impact of such a model. Such an impact is likely to occur in two areas. First, the disruption of the risk pool and the potential for a given carrier to be disproportionately selected by individuals with more health problems due to a particular plan design or pricing attribute can raise medical expense ratios, exacerbate the underwriting cycle and accelerate cost increases. Second, marketing and administrative costs could increase if insurers compete for individuals and lose some of the administrative efficiencies inherent in the group approach. Third, the pool of insured persons in non-defined contribution plans could subsidize the defined contribution pool unless the insurer strictly

allocates all fixed and variable costs to each line of business. Finally, the cost of a plan change is very low for an individual versus an entire employer group. An individual dissatisfied with coverage or service by a given plan can simply change plans during the next enrollment period. A large employer group may be much more reluctant to switch to a new carrier given the time and resources necessary to evaluate, select and implement a new plan, not to mention the disruption to employees. As such, health plan providers could experience higher levels of member turnover, and perhaps even a greater fluctuation in membership from year to year.

All of these issues have the potential to substantially alter the financial landscape for health plans, and could result in lower than expected financial results, market exits, increased capital and surplus requirements, and accelerated merger and acquisition activity. Since defined contribution also portends using insured programs as opposed to self-funding, insurers may also find themselves assuming more risk, albeit margins may be larger depending on the brand and pricing power of a given carrier. Strategic decisions as to the whether the carrier wants to be a leader in defined contribution or disregard the segment altogether will be of interest to stakeholders.

d) Market Branding and Competition

Of particular interest to health plan providers will be the impact of changing from a group-based decision model to an individual-based decision model, where the decided advantage will be with those carriers having strong brand awareness and a credible reputation for coverage, claims-handling and service. Practical research as to brand awareness and favorability ratings at the consumer level is likely to be predictor of success for a given health plan provider in the defined contribution market.

Understanding the type of products and the policy attributes, as well as the financial integrity

of such products and policies will be critical for health plan providers to understand. Adding certain features may attract a disproportionately sick population, or may attract a very broad base of employees if coverage and access restrictions are limited. However, if such policies do not adequately reflect expected claims cost, the financial position of the carrier could deteriorate, placing it in the position of having to raise rates significantly in future years and possibly drive out the healthier population.

VII. Conclusion

The current discussion about defined contribution in health care purchasing continues to remain in an exploratory realm, with interested parties attempting to discern employer and employee attitudes and predict potential adoption rates. Absent a single, dominant driver, the demand side of the market continues to sit idly, forming attitudes and opinions while watching for movement by others. At the same time, the supply side of the market is committing capital to create a defined contribution infrastructure and is preparing to gain the first mover advantage if the door opens even a bit. A key question is whether the supply and demand curve will intersect, or if the supply side can successfully influence the demand side and effectively create a defined contribution market. What is more likely is that elements of an aging workforce, health premium cost increases, a slower economy and weaker labor market, and a significant litigation scare will converge with the technological infrastructure to allow defined contribution to evolve out of natural business necessity.

Those with an interest in defined contribution must also consider the health strategy decision process carefully, particularly the capacity and role of those likely to precipitate such decisions. Not all employers will be interested in this model. Those who feel that the provision of health care benefits and wellness programs are aligned and integrated with their overall business philosophy and workforce strategies are not likely to be candidates for such an approach. However, employers with younger, mobile workforces who believe that their role is to simply provide total compensation for employee services and that workers should have discretion in determining where to direct funds may move first. Any industry facing extensive global cost competition and deteriorating financial results could decide that the cost predictability of a defined contribution approach is desirable.

Insurance companies and managed care organizations interested in defined contribution should study the development and evolution of defined contribution retirement programs. Despite the differences between retirement and health benefits, one is likely to find parallels in the attitudes of benefit managers immersed in defined benefit pension plans and the business drivers behind the dramatic growth in defined contribution. The familiarity of the model as an employer-based program that allows for choice and limits cost could be supported even by those benefit and human resource executives generally opposed to defined contribution in health care.

Finally, even an evolutionary shift to defined contribution could change the market for insurance carriers and managed care organizations. Defined contribution retirement plans did not completely replace defined benefit pension plans, but dramatically slowed their growth. Likewise, traditional types of health coverage will remain intact, but defined contribution could gradually capture an increasing share of the market. Brand awareness, retail marketing, new distribution channels, financial implications, new regulations and even new market entrants have the potential to alter the current familiar landscape, perhaps even more than the rapid migration to managed care. The shift to managed care took major health insurance players out of the market, forced mergers and acquisitions, changed the public policy landscape, and dramatically affected hospitals and providers. Depending on the rate of adoption and extent of the model, defined contribution has similar potential. Insurance carriers and managed care organizations should now begin formulating strategies and approaches for competing in such a market if it becomes a reality, evaluate financial impact, and consider the effect of an active decision to forgo this market segment.

References

A New Direction for Employer-Based Health Benefits: Survey of Fortune 1000 Employers and Employees. KPMG Peat Marwick and The Harvard Business School, 1999.

Alquist, Gary, Knott, David, and Lathrop, Philip (2000). *The Real Consumer Revolution in Healthcare: Defined Contribution Health Plans.* Booz-Allen and Hamilton, http://www.bah.com/viewpoints/insights/health_rev_2.html, March 2000.

America @ Work, A Focus on Benefits and Compensation. AON Consulting, 1998.

Annual Employer Health Benefits Survey 2000. The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, <http://www.kff.org>, 2000.

Battistella, Roger and Burchfield, David (1999). *Employment-Based Health Insurance: The Inevitable Transition from Defined Benefit to Defined Contribution.* Compensation and Benefits Management, Vol. 15, No. 1, Winter 1999.

Benefits Priorities Survey 2000. Deloitte and Touche Human Capital Advisory Services and The International Society of Certified Employee Benefit Specialists, 2000.

Blakely, Stephen (1999). *Severing the Link Between Health Insurance and Employment.* Employee Benefit Research Institute Notes, Vol. 20, No. 8, August 1999.

Case, Mary S. (2000). *Health Cast 2010: What's on the Horizon for Employers.* PriceWaterhouseCoopers HR Advisory, Vol. VIII, No. 2, Spring 2000.

- Caudron, Shari (2000). *Employee, Cover Thyself*. Workforce, April 2000.
- Consumerism in Health Care: New Voices*. KPMG Peat Marwick, LLP and Northwestern University Institute for Health Services Research and Policy Studies, January 1998.
- Custer, William S., Kahn III, Charles N. and Wildsmith IV, Thomas F. (1999). *Why We Should Keep the Employment-Based Health Insurance System*. Health Affairs, Vol. 18, No. 6, November/December 1999.
- Defined Care On-Line Survey*. Managed Care On-Line, <http://www.definedcare.com>, 2000.
- Duchu, Lisa, Schoen, Cathy, Simantov, Elisabeth and Davis, Karen (2000). *Listening to Workers: Findings from the Commonwealth Fund 1999 National Survey of Worker's Health Insurance*. The Commonwealth Fund, January 2000.
- Gaebel, J. (1999). *Health Benefits in 1998 for Small Employers*. A Report from the Henry J. Kaiser Family Foundation, February 1999.
- Geisel, Jerry (2000). *Cutting Complexity*. Business Insurance, May 22, 2000.
- Health Care Cost Survey 2000*. Towers Perrin, January 2000.
- Health Care Expectations: Future Strategy and Direction*. Hewitt Associates, LLC, August/September 1999.
- HealthCast 2010: Smaller World, Bigger Expectations*. PriceWaterhouseCoopers, 2000.
- Health Insurance Preference Survey 1999*. Employee Benefit Research Institute, February-March 1999.

Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003, Prepared for the American Association of Health Plans by Barents Group, LLC Health Economics Practice, April 22, 1998.

Jacob, Julie (2000). *Defined Benefits: Multiple Choice*. American Medical News, May 1, 2000.

Kochaniec, Joanne Wojcik (2000). *Employees Call Shots*. Business Insurance, May 22, 2000.

Lathrop, Philip J., Ahlquist, Gary D., and Knott, David G. (2000). *Health Care's New Electronic Marketplace*. Strategy and Business, Issue 19.

Lathrop, Philip J. and Carlebach, David C. (1998). *HMO's "R" Us. A Prescription for the Future*. Booz-Allen and Hamilton, Strategy and Business, Fourth Quarter 1998.

Langan, Michael J. (1999). *Should Employers Provide Health Benefits: The Next Big Debate?* Benefits Law Journal, Vol. 12, No. 2, Summer 1999.

Lave, Judith R., Peele, Pamela B., Black, Jeanne T., Evans III, John H., and Amersbach, Gabrielle (1999). *Changing the Employer-Sponsored Health Plan System: The Views of Employees in Large Firms*. Health Affairs, Vol. 18, No. 4, July 1999.

Marhula, Daren C. and Shannon, Edward G. (2000). *Defined Contribution Defined: Health Insurance for the Next Century*. U.S. Bancorp Piper Jaffray Equity Research, June 2000.

Mercer/Foster Higgins National Survey of Employer Sponsored Health Plans 1999. William M. Mercer, 1999.

- Miller, Joel E. (2000). *Déjà vu All Over Again: The Soaring Cost of Private Health Insurance and Its Impact on Consumers and Employers*. National Coalition on Health Care, May 2000.
- Pauly, Mark, Percy, Allison and Herring, Bradley (1999). *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*. Health Affairs, Vol. 18, No. 6, November/December 1999.
- Putting Employees in Charge: A Survey of Employers, Health Care Providers and Health Plans*. Watson Wyatt Worldwide, Washington Business Group on Health, Healthcare Financial Management Association, 2000.
- Quinn, Richard (2000). *To Be or Not to Be in the Business of Benefits*, Employee Benefit News, Vol. 14, No. 3, March 2000.
- Reese, Shelley (2000). *Can Employers Rewrite the Rules for Health Care Coverage*. The State of Health Care in America – 2000, Business and Health, Vol. 18, No. 6, Supplement A.
- Reinhardt, Uwe E. (1999). *Employer-Based Health Insurance: A Balance Sheet*. Health Affairs, Vol. 18, No. 6, November/December 1999.
- Rowen, Tom (2000). *Healthcare Gold 'n' Rules*. Managed Care On-Line, <http://www.definedcare.com>, June 2000.
- Selling Insurance Online: An Indefinite Future for Defined Contributions*, Solomon Smith Barney, Westside PR, <http://www.westsidepr.com>.
- Selis, Sara (2000). *Will Defined Contribution Catch On?* Healthcare Business, March/April 2000.
- Strazewski, Len (2000). *Defining Moments*. Human Resource Executive, May 2, 2000.
- Sheils, John F. and Fishman, Andrea (1998). *Comprehensive Medicare Reform: Defined Benefit Vs. Defined Contribution*. National Coalition on Health Care, September 1, 1998.

Styring III, William and Jonas, Donald (2000). *Health Care 2020: The Coming Collapse of Employer Provided Health Care*. The Hudson Institute, June 1999.

Winslow, Ron and Gentry, Carol (2000). *Health Benefits Trend: Give Workers Money and Let Them Buy a Plan*. The Wall Street Journal, February 8, 2000.

Vitberg, Alan K. (2000). *Consumerism in Health Care – An Overview of Defined Care and Its Implications for Managed Care Organizations*. <http://definedcare.com/submissn.htm>, September 2000.

EXHIBITS



SETON HALL UNIVERSITY
1 8 5 6

Naomi Bailin Wish, Ph.D.
Director

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Assistant Director

October 23, 2000

Dear Benefits Manager:

Employee benefit industry leaders are actively discussing a new health benefit purchasing strategy called the "defined contribution" model. Many predict that employers will provide a flat dollar amount for health care spending, allow employees to select from a range of plans and options, and drastically limit their direct involvement in health plan selection and management.

Adoption of the defined contribution model by major employers would represent a paradigm shift in health benefit strategy, dramatically affecting the entire health care market as insurance companies and managed care organizations compete for directly for consumers empowered to make their own health care coverage choices.

As a leading New Jersey employer, we need your opinions and attitudes on this important new development in health benefit strategy by completing and returning the enclosed survey. The respondent should have responsibility for your organization's health plan purchasing strategy. The questionnaire was pre-tested, and requires only ten minutes to complete.

- ◆ **In return for your participation, you will receive a complimentary copy of the findings.**
- ◆ **All information will remain completely confidential.**
- ◆ **Responses will be reported in aggregate, and individual organizations will not be identified.**

The study is being conducted in conjunction with Seton Hall University's Center for Public Service. The research findings and their implications will be of great interest to executives of managed care organizations, health insurance carriers, plan administrators and employee benefit managers who must ultimately devote a significant amount of strategic planning and managerial resources if defined contribution becomes a reality.

Thank you in advance for your contribution to this newly developing area of employee benefit strategy.

Sincerely,

Vincent M. Farinella, CEBS

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The Defined Contribution Approach to Health Care Benefits

This questionnaire has been pre-tested, and requires only fifteen minutes to complete. Directions: For each question, please put an "X" in the box of your choice, or rank responses where appropriate. Space is provided for general comments at the end of the survey. Thank you for your assistance.

Current Health Benefit Strategies and Issues

Thinking about the health care benefits currently offered by your organization...

1. Which statement best describes your organization's overall strategy for providing health benefits?

- Offer health benefit coverage levels better than our labor market competitors
 - Offer health benefit coverage levels equal to our labor market competitors
 - Offer health benefit coverage levels lower than our labor market competitors
 - Offer health benefit coverage levels appropriate for our particular workforce
 - Allow employees to choose health benefit coverage level that best fit their needs
 - Other (please specify)
-

2. What is your organization's overall strategy for selecting health plans?

- The best available plans in each market location
- A single, national plan for all markets
- A combination of the above
- Other (please specify) _____

3. In terms of plan selection, please rank the top three factors considered by your organization (1 being the most important).

- Plan accreditation (e.g., NCQA) _____
 - Employee out-of-pocket costs _____
 - Cost to employer _____
 - Provider network access _____
 - Quality assurance programs _____
 - Scope of benefits provided _____
 - Other (please specify) _____
-

4. What is your primary expected outcome for providing your employees with health care benefits?

- Recruit new employees
 - Retain current employees
 - Maintain or increase employee productivity
 - Provide affordable health care to employees
 - Protect employees against catastrophic financial loss
 - Other (please specify)
-

5. On average, how many health plan options does your organization currently offer per employee?

- One
- Two
- Three
- Four
- More than four

6. Three years from today, how many health plan options do you expect to offer (per employee)?

- More options
- Same number of options
- Fewer options

7. Do employees in your organization contribute a portion of the health plan premiums?

- Yes
- No

8. If yes, what is your organization's current employee cost sharing strategy for health plan premiums?

- Constant dollar subsidy (pay the same dollar amount for each option)
 - Constant percent subsidy (pay an equal percentage of each plan option)
 - Demographic adjusted pricing (subsidies adjusted for employee mix)
 - Value pricing (greater subsidies for higher quality plans)
 - Geographic pricing (prices that reflect local cost levels)
 - Other (please specify)
-

9. What do you expect will happen to employee cost sharing levels for health benefits over the next three years?

- Employees will likely pay more of the cost
- Employees will likely pay the same amount
- Employees will likely pay less of the cost

10. In terms of measuring the performance of your health plans, please rank the top three factors considered by your organization (1 being the most important).

- Administrative quality _____
 - Financial efficiency _____
 - Employee satisfaction _____
 - Clinical quality indicators _____
 - Plan accreditation (e.g. NCQA) _____
 - Other (please specify) _____
-

11. In terms of your organization's health benefit strategy, please rank the top three factors you consider in measuring its success (1 being the most important).

- Comparison with industry or labor market competition _____
 - Employee surveys or feedback _____
 - Comparison of results to estimated annual cost _____
 - Measure against plan performance guarantees _____
 - Comparison to market or national averages _____
 - Other (please specify) _____
-

12. If your organization's health care coverage levels did not match your competition's health care coverage levels, would you change your levels to match theirs?

- Yes
- No

13. If yes, how would you change your organization's health care coverage levels to match your competitors?

- Would increase to match higher competitor levels (but not decrease)
- Would decrease to match lower competitor levels (but not increase)
- Would increase or decrease to match competitor levels

14. How well do you believe your employees understand:

	Very Well	Somewhat Well	Not Well
Your organization's health benefit strategy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your organization's annual enrollment and plan changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan design and coverage limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The true cost of their health coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Generally, how satisfied are you with your organization's health benefit strategy today?

- Very satisfied
- Moderately satisfied
- Less than satisfied

16. Generally, how satisfied do you believe your employees are with their health benefits today?

- Very satisfied
- Moderately satisfied
- Less than satisfied
- Not known

17. What do you expect will happen to your employee satisfaction levels over the next three years?

- Satisfaction will likely improve
- Satisfaction will likely be stable
- Satisfaction will likely decline

18. What do you believe is the most significant shortcoming of your current health benefit program?

- Employee satisfaction
 - Quality of care
 - Cost (employer)
 - Administration
 - Accessibility of providers
 - Other (please specify)
-

The Defined Contribution Approach: Philosophical and Perceptual Issues

There is currently discussion within the employee benefits industry of shifting health care purchasing to a "defined contribution" model whereby the employer provides a fixed dollar amount for health care spending and allows employees to select from a range of plans and options, either within an environment controlled by the employer, through a consultant or other third party facilitator, or on the open market with a voucher.

Thinking about the concept of defined contributions for health benefits...

19. Did you hear about the defined contribution approach to health benefits purchasing before receiving this questionnaire?

- Yes
- No
- Not sure

20. If yes, how did you first hear about it?

- Employee benefit trade journals
 - Employee benefit conference or seminar
 - Information from a benefit consulting firm
 - Advertising from a benefit service organization
 - Discussion with colleagues
 - Other (please specify)
-

21. How likely is it that your organization would implement the defined contribution approach?

- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely
- Not sure

22. In what time frame do you believe the defined contribution approach will become common?

- Less than two years
- Three to five years
- Five to ten years
- Longer than ten years
- Never

23. How likely is it that your organization would implement the defined contribution approach under each of the following conditions?

	Very Likely	Somewhat Likely	Not Likely
Health benefit costs continue to rise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legislation exposing health plans and employers to malpractice liability is passed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legislation offering individual tax credits for purchasing health insurance is passed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer dissatisfaction with managed care and lack of choice continues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The health plan market were to further consolidate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Based on your beliefs, please rank the three primary advantages of the defined contribution approach (1 being the greatest advantage).

- More satisfied employees _____
 - Better choice of health plans _____
 - Better quality of health plans _____
 - Better overall cost control _____
 - Lower administrative costs _____
 - Reduced employer liability _____
 - Other (please specify) _____
-

25. Based on your beliefs, please rank the three primary disadvantages of the defined contribution approach (1 being the greatest disadvantage).

- Complexity of plan selection (comparisons) _____
 - Complexity of administration _____
 - Complexity of the health plan market _____
 - Employee understanding _____
 - Cost to employees _____
 - Cost to employer _____
 - Other (please specify) _____
-

26. Based on your beliefs, please rank the three primary obstacles to implementation of the defined contribution approach (1 being the greatest obstacle).

- Cost to employees _____
 - Cost to employer _____
 - Employee education and understanding _____
 - Labor union agreements _____
 - Complexity of plan selection (comparisons) _____
 - Ability to purchase sufficient coverage _____
 - Company philosophy towards benefits _____
 - Ability of the health plans to manage it _____
 - Other (please specify) _____
-

27. Do you think the defined contribution approach would resolve the most significant shortcoming of your current health benefit program?

- Yes, it is likely to resolve the most significant shortcoming
- It will help, but not totally resolve the most significant shortcoming
- No, it is not likely to resolve the most significant shortcoming

28. Current proposals in Washington D.C. would replace an employee's current tax exclusion for employer-sponsored health benefits with an individual tax credit for the employee's purchase of any health coverage. If this legislation were adopted, would your organization completely eliminate directly providing health care benefits?

- Yes, we would no longer provide health benefits directly
- No, we would continue to provide health benefits directly

29. If federal legislation were adopted which extended malpractice liability to employers, would your organization completely eliminate directly providing health care benefits?

- Yes, we would no longer provide health benefits directly
- No, we would continue to provide health benefits directly

The Defined Contribution Approach: Conceptual Implementation Issues

For purposes of this section, assume your company no longer selected health care insurers for its employees, but instead, provided a fixed dollar contribution to a tax-advantaged account. Each employee could then use these funds in combination with their own contributions to purchase health coverage directly from insurers or through a market broker.

30. How receptive do you believe the employees in your organization would be to the defined contribution approach?

- Very receptive
- Somewhat receptive
- Somewhat unreceptive
- Very unreceptive

31. Under defined contribution, do you think most employees would be capable of selecting a health plan that is right for them?

- Yes, it would be easy
- Yes, but it would be difficult
- Not at first, but they would eventually
- No, it is too complicated

32. Do you think the defined contribution approach would improve overall employee satisfaction with health benefits?

- Yes, satisfaction would improve
- Satisfaction would remain unchanged
- No, satisfaction would deteriorate

33. Do you think most health insurance and managed care companies are adequately prepared for a defined contribution environment?

- Yes, most are adequately prepared for defined contribution
- No, most are not prepared for defined contribution

34. Do you think there is adequate comparative information for employees to select a health plan that is right for them?

- Yes, there is adequate comparative information
- No, most comparative information is inadequate

35. Do you think health plans will become more responsive to consumers in a defined contribution environment?

- Yes, health plans will become more responsive
- No, there will be no change in health plan responsiveness

36. Do you think the overall health care marketplace (including providers) will become more responsive to consumers in a defined contribution environment?

- Yes, the overall health care market will become more responsive
- No, there will be no change in health care market responsiveness

The Defined Contribution Approach: Operational and Practical Issues

Thinking about the operation and administration of a defined contribution program...

37. If your organization implemented a defined contribution program for health benefits, how much involvement do you think you would have in health benefits management?

- Remain fully involved in health benefits management
- Have a somewhat limited role in health benefits management
- Severely limit involvement in health benefits management
- Have no involvement in health benefit management

38. If your organization implemented a defined contribution program for health benefits and you remained as the health benefits manager, how involved would you be in the following?

	Very Involved	Somewhat Involved	Not Involved
Establishing plan design and coverage levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Directly selecting the health plans that would be offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishing plan performance standards and guarantees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing employee education for plan selection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing employee guidance and advice for plan selection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. If your organization implemented a defined contribution program for health benefits, how do you think administration would be managed?

- All administration would be handled internally
- All administration would be outsourced
- A combination of internal and outsourced administration

40. How do you think the defined contribution approach to health benefits would affect plan administration?

- Administration would become more complicated
- Administration would not change significantly
- Administration would become less complicated

41. How do you think the defined contribution approach to health benefits would affect your organization's administrative costs?

- Administrative costs would increase significantly
- Administrative costs would not change significantly
- Administrative costs would decrease significantly

42. Would your organization likely extend the defined contribution approach to all health-related ancillary benefits (e.g., dental, vision, etc.)?

- Yes, all health-related benefits would move to defined contribution
- No, only the medical plan would move to defined contribution

43. If yes, would your organization be likely to provide one overall level contribution for the selection of all health benefits or provide separate defined contributions for ancillary health-related benefits (e.g., dental, vision, etc.)?

- Provide a single contribution for the selection of all health benefits
- Provide a separate contribution specifically for ancillary health-related benefits

Background Information

Please provide the following background information about your organization:

44. How many employees does your organization have in New Jersey?

- Fewer than 500
- 501 to 2,000
- 2,001 to 5,000
- 5,001 to 10,000
- 10,001 to 20,000
- 20,001 to 50,000
- More than 50,000

45. How many employees does your organization have throughout the United States (Including NJ)?

- Fewer than 500
- 501 to 2,000
- 2,001 to 5,000
- 5,001 to 10,000
- 10,001 to 20,000
- 20,001 to 50,000
- More than 50,000

46. Does your organization have collective bargaining units?

- Yes
- No

47. If yes, approximately what percentage of your company's workforce is in a collective bargaining unit?

- Less than 10%
- 10% to 24%
- 25% to 50%
- More than 50%

48. How many internal staff members in your organization manage health benefits?

- Fewer than 5
- 6 to 10
- 11 to 15
- 16 to 20
- More than 25

49. How many internal staff members in your organization manage all benefit programs?

- Fewer than 5
- 6 to 10
- 11 to 15
- 16 to 20
- More than 25

50. What percentage of payroll do you estimate is spent for health care benefits, including administration, in your organization?

- Less than 5%
- 5% to 9%
- 10% to 14%
- 15% to 20%
- 21% to 25%
- More than 25%

51. Of all health, welfare, retirement, and legally required benefits, what percentage of spending is attributable to health care benefits in your organization?

- Less than 10%
- 10% to 19%
- 20% to 29%
- 30% to 40%
- More than 40%

52. What percentage of employees in your organization do you estimate have Internet access, either at work or at home?

- Less than 10%
- 10% to 19%
- 20% to 29%
- 30% to 39%
- 40% to 49%
- 50% to 59%
- 60% to 70%
- More than 70%

53. Please provide any additional comments concerning the defined contribution approach:

**Your input is appreciated.
Thank you for your time.**