EMPLOYEE BENEFITS

Willis

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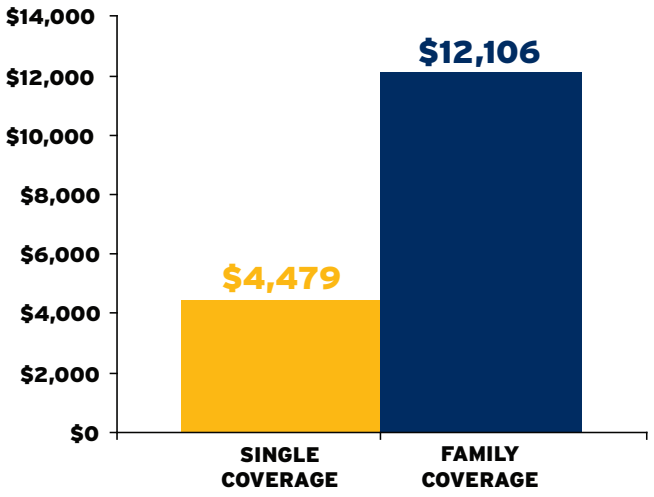
WILLIS OUTLOOK ON U.S. HEALTHCARE BENEFITS

The cost of providing healthcare benefits continues to outpace the general inflation rate. How should employers respond? This special edition of *Executive Signal* examines the current state of healthcare costs in the U.S. From regulatory and market-driven issues to new cost control strategies, such as consumerism and wellness incentives, we present readers with a comprehensive look at healthcare trends, highlighting proven strategies that employers sponsoring group and retiree health programs may wish to consider.

HEALTHCARE TRENDS

Willis closely monitors an array of academic and industry studies of healthcare-related employee benefit trends. Some of the most interesting revelations of 2007 include:

- According to the Kaiser Family Foundation, last year the average annual total insurance premium in employer plans was $4,479 for single coverage and $12,106 for family coverage.



- The Kaiser Family Foundation reports that between spring 2006 and spring 2007, premiums increased an average of 6.1% for employer-sponsored health insurance plans, greatly outpacing the growth in workers' earnings (3.7%) and more than doubling the underlying inflation rate (2.6%).

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ARE YOU PREPARED FOR HEALTHCARE IN 2008 AND BEYOND?

Willis has evaluated a number of initiatives employed by clients to drive success in their healthcare benefits programs. Each client is unique and must evaluate what is most effective for its specific situation. Even so, the following checklist summarizing some of the most critical opportunities and key questions that should be addressed may be helpful in determining your own preparedness for the future.

1. HEALTHCARE BENEFITS STRATEGY

- What are the business requirements (cost structure, staffing requirements, etc.) of your organization?
- How does your culture and mission impact benefits?
- What are the baseline costs of medical, pharmacy, disability and related benefits programs?

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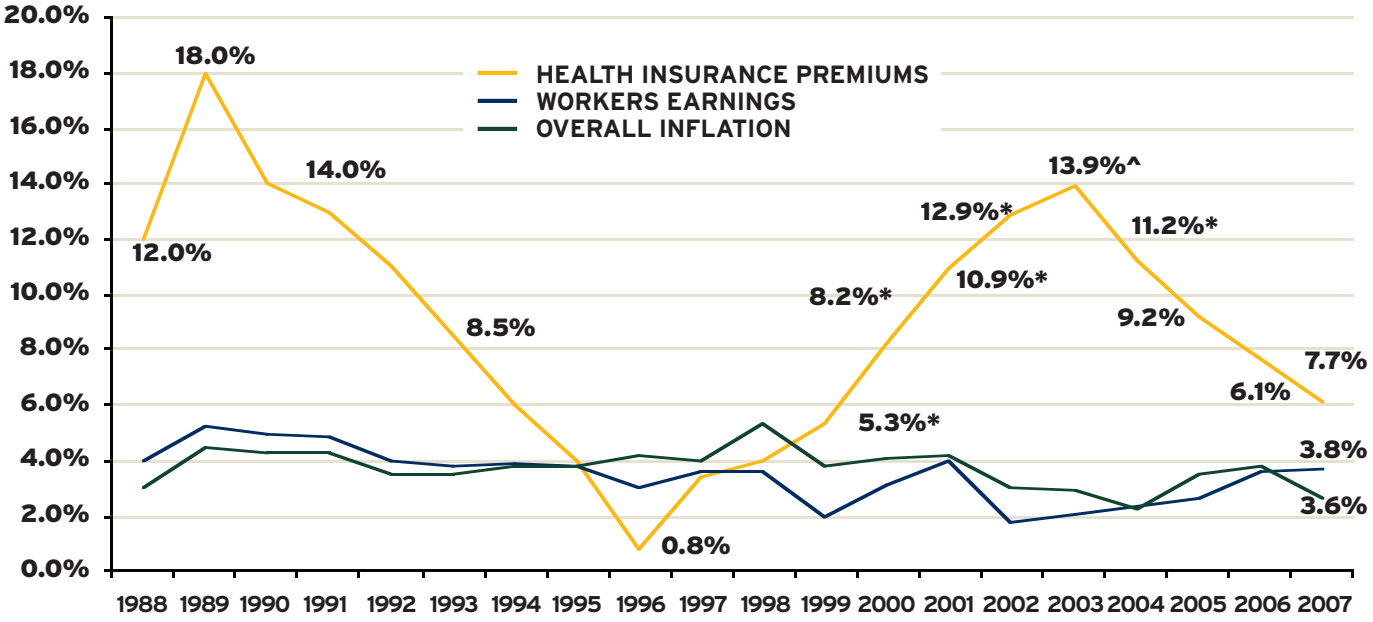
Increases in Health Insurance Premiums Compared to Other Indicators

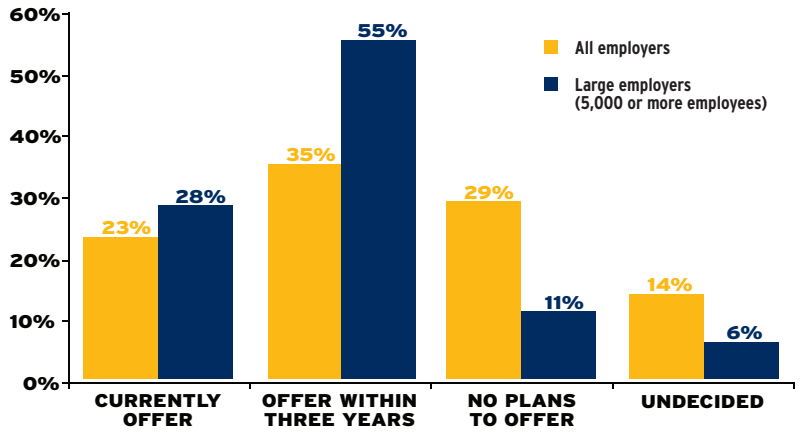


- Employers are beginning to gravitate to consumer-based strategies, where employees take on more responsibility for costs, lifestyle choices and treatment decisions. (Some consumerism critics decry consumer-directed health plans (CDHP) as just a reflexive cost shift; however, when properly structured, a CDHP is more accurately characterized as a means of shifting consumer responsibility and mindset to one where individuals more attentively scrutinizie their personal healthcare expenses.) Many employers have adopted this approach by establishing health reimbursement arrangements (HRAs) and health savings accounts (HSAs). (Movement to consumerism is consistent with a general trend away from employer paternalism, similar to the now widely accepted switch from defined benefit pension plans to 401(k) plans on the retirement side.) This shift was accompanied by a jump in employer expectation that consumers would assume more risk and responsibility for their health and healthcare. Some employers expressed high expectations for immediate financial relief, but the move to the consumer-directed approach will, in reality, be most effective over the long haul.

- Public awareness of consumerism appears to be growing, evidenced by the surge in the demand for consumer-support tools ranging from information on provider prices and quality to resources about medical treatment. In response, many more such tools are being developed and made available by insurers and others. As awareness grows, consumers appear to be getting more comfortable taking an active role maintaining their health and in healthcare.

- There has been significant growth in employer-based prevention and wellness strategies to reduce healthcare costs, lost productivity and absenteeism. Statistical evidence demonstrating tangible returns on investment for these efforts is also becoming more widely available.

Prevalence of Wellness Programs



**Estimate is statistically different from the previous year shown at p<0.05.*

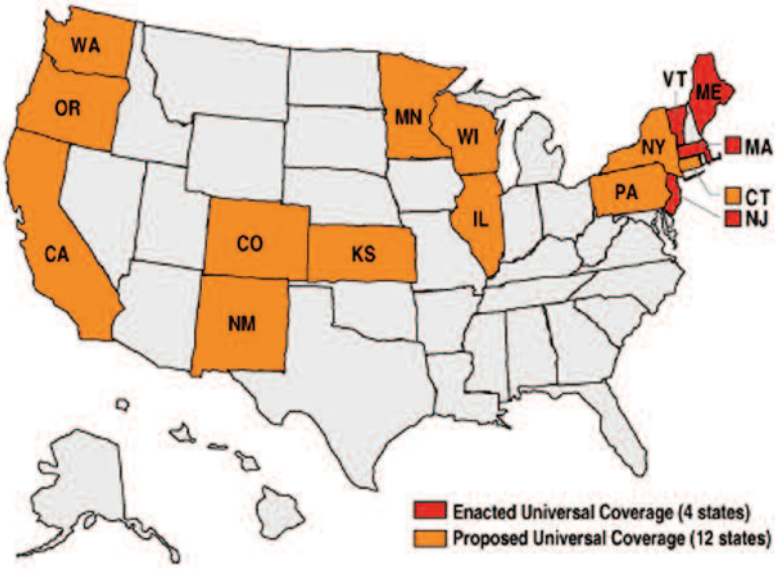
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999-2006; KPMG Survey of Employer- Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2006 (April to April).

- Insurance plans are employing more care management techniques, such as prior authorizations for specific services (magnetic resonance imaging, specialty pharmaceuticals and many surgical procedures).

- The plight of the uninsured and underinsured is gaining prominence in political discourse.

LEGISLATIVE DEVELOPMENTS



Healthcare, along with war and national security, continues to dominate the national legislative agenda. The healthcare debate and the current structure of employment-based healthcare benefits in particular make employee benefits a hot legislative topic. Many key employee benefits issues – Medicare, executive compensation, minimum wage, paid family leave, mental health parity – remain alive and kicking, as does the most problematic issue of all: providing health coverage for the uninsured.

Although the issue has been a political hot button for many years, interest spiked in 2007. This may be due, in part, to actions at the state level. Governors in California, Pennsylvania and Illinois, to name a few key states, have proposed sweeping healthcare reform legislation. The push to do something about delivering health coverage at the state level has been fueled by the increasing drain on limited state resources by the uninsured, the successful passage of similar legislation in Massachusetts and Vermont, and the lack of progress by the federal government in finding a solution. Some proposals even include mandates on employers to provide Internal Revenue Code Section 125 programs (often referred to as cafeteria plans) for all workers, so that an employee can find his or her own insurance coverage but pay for it on a pre-tax basis as part of an overall strategy to make benefit coverages more affordable.

In addition to state legislative activity, several national proposals have been set forth by various coalition groups, federal legislators and 2008 presidential candidates. Many ideas are similar to earlier initiatives introduced in recent years, ranging from building on the current healthcare coverage system to completely overhauling it. Sample proposals include:

- ## TAX-BASED SOLUTIONS

  This concept centers on providing tax incentives (both federal and payroll taxes) for all individuals with health coverage. Individuals would receive a standard deduction of $7,500 for single coverage and $15,000 for family coverage, regardless of the actual cost of coverage. Employers could continue to take a full deduction for health insurance expenses, including for any additional payroll tax expense resulting from the payment of the employer share of FICA tax on the cost of health insurance above the standard deduction limits. Employees would no longer be permitted to pay for health insurance coverage on a pre-tax basis under Section 125 cafeteria plans. Projected to increase coverage by three to five million individuals, this proposal would benefit those who do not currently receive a tax deduction on the cost of their health coverage.

BUILDING ON THE EMPLOYER-BASED SYSTEM

Employers not providing health insurance coverage or contributing to the cost for coverage would be taxed (6% in Democratic presidential candidate John Edwards' campaign proposal). Of course, this "pay or play" scheme has been a centerpiece in several state so-called "reform" proposals. Massachusetts' law includes that requirement as did Maryland's "Wal-Mart law" (so-called because only Wal-Mart would have been affected). Even city (San Francisco) and county (Suffolk on New York's Long Island) government proposals have included such provisions.

So far, the federal courts have determined (when the laws are actually challenged) that such state and local laws are preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Although the Massachusetts law has not yet been challenged, federal courts have already overturned Maryland's and Suffolk County's laws. The San Francisco ordinance went into effect on January 9, 2008, but the ERISA preemption issue will be reviewed by a federal court later this spring. ERISA preemption remains an important barrier to the states, keeping them from enacting legislation that would force employers to comply with 50 different state laws (not to mention the thousands of county and municipal laws that could be enacted). Willis is working diligently as a member of a national coalition to strengthen the preemption concept and defeat any attempts to wear that legal concept down piecemeal.

In addition to imposing a tax on employers, those needing to purchase coverage would be given access to regional health markets, which are pooled arrangements run by the government that would offer a choice of different insurance plans. Insurance carriers could not deny coverage, nor could they charge more, to insure an unhealthy individual. Medicaid and the State Children's Health Insurance Program (SCHIP) would also be expanded. Financing for the program would come from raising taxes on upper income individuals and reducing the tax gap (the difference between what the federal government is owed and what it collects).

UNIVERSAL COVERAGE MANDATE

Individuals would purchase coverage directly from insurers rather than obtaining coverage through employers. Employers currently providing coverage would initially be required to pay their workers the amount they had been spending on their health insurance, and eventually all employers would be making "Employer Shared Responsibility Payments" to help employees buy their own insurance. The health coverage that would be available is said to be similar to what members of Congress currently receive and would feature special wellness and disease prevention incentives. The program would be financed through a new tax on employers.

SUMMARY

Healthcare reform and coverage for the uninsured have been debated for many years (even before Hillary Clinton's failed attempt during President Bill Clinton's first term). Without bipartisan support, broad Congressional changes are unlikely.

Although there has been a significant increase in state legislative activity to tackle the problem, and several proposals have been made on the national level, the outcome remains uncertain. Moreover, without significant federal financial support, state efforts to enact broad reforms will be hindered by numerous obstacles – particularly in terms of financing. Some healthcare experts are concerned that with all the attention centered on health coverage access, presidential candidates and legislators may miss another fundamental issue – healthcare cost. Although millions do not have health insurance, a majority of voters do, and numerous surveys reveal that voters with health insurance are most concerned about curbing skyrocketing medical costs.

Prepared for Healthcare? continued from page 1

- What is the value of the benefits programs to the organization?
- How does this vary by business unit and employee class?
- What timely, actionable management information is needed?
- How do results compare to industry benchmarks?
- If you don't make any changes, what are the projected results?
- What are the alternative strategies, goals and action plans?

- If changes are made, what is the impact on the employer and the employee?
- How will changes in the regulatory arena and Congress affect you?
- How does the size of your organization impact your ability to take risk, use multiple vendors, structure the program?

2. WELLNESS

- What is the Return on Investment?
- How can members be identified as early as possible as having – or at risk for getting – cancer, diabetes, cardiac and other high cost diseases?
- How can this information be used to mitigate risk and address prevention?
- What legal, cultural, behavioral and other issues must be addressed?
- What barriers are in place? Are there silos that need to be integrated to promote sharing of information and collaboration?
- What motivation and incentives are needed to drive changes in lifestyle and behavior?
- What can be done internally; what should be outsourced?
- What vendors should be considered as partners?
- Should one wellness program apply to all locations and health plans?
- What are the key success factors, and how will these be monitored?

3. ABSENTEEISM AND PRESENTEEISM?

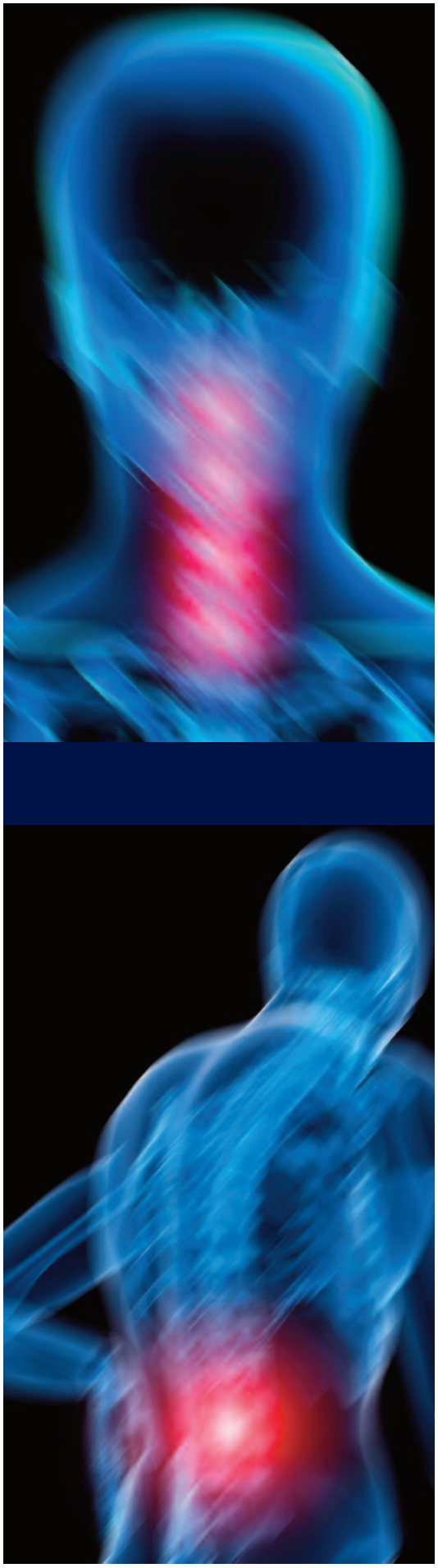
- What is the level and cost?
- How can this be measured?
- What is the correlation between the health of the work force and their absenteeism and "presenteeism" (lack of productivity)?
- Studies show that total costs, including absenteeism and presenteeism, are generally highest for back/neck pain, fatigue and depression. How does this impact your strategies and priorities?

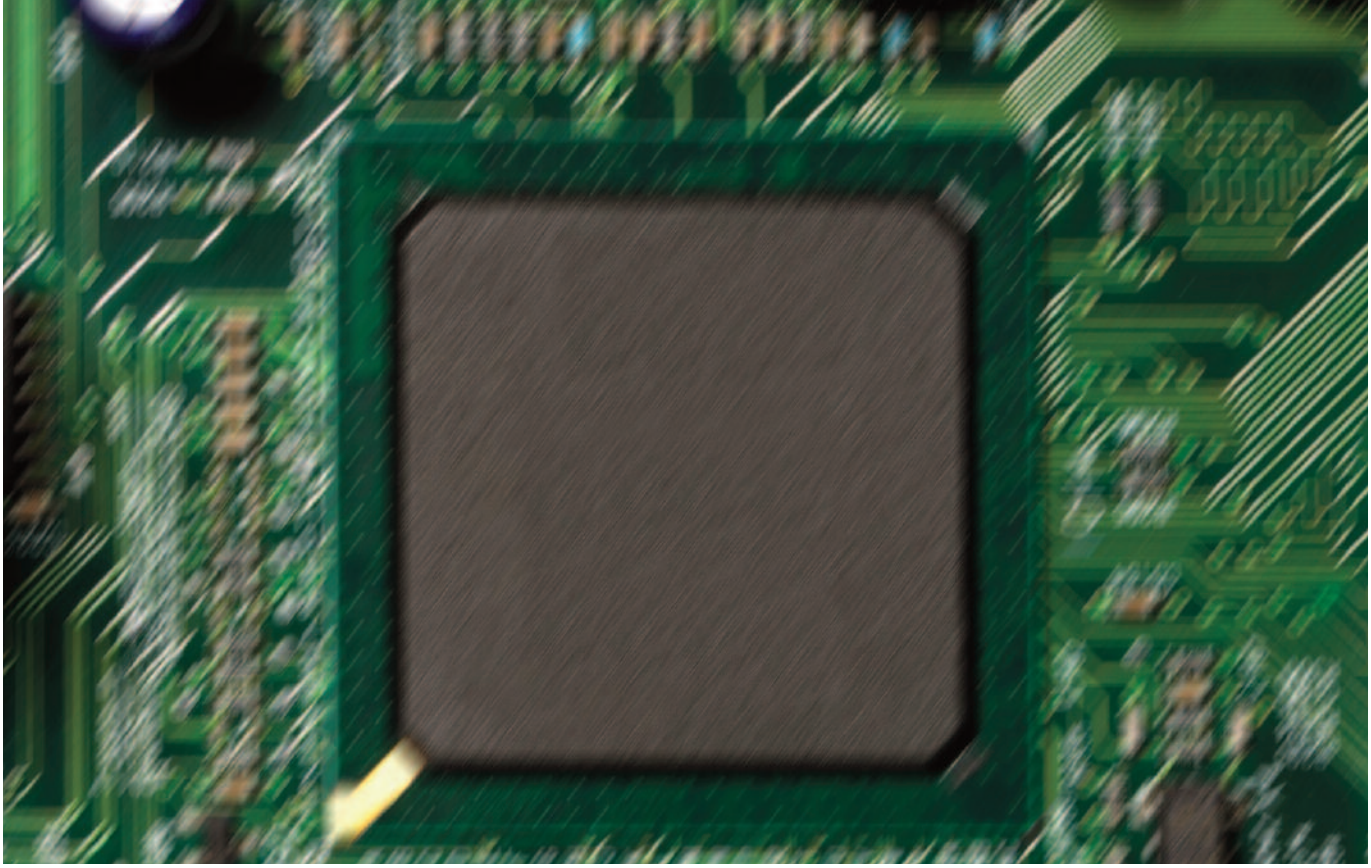
4. COMMUNICATION STRATEGY

- What have you done in the past?
- What has worked well? What should be done differently?
- How do employees feel about the organization?
- What benefits do they value the most?
- What is their perception of the total cost and their share?
- What are the major issues of the C-Suite/HR/employees? Cost? Fairness? Trust?
- How do employees like to get information?
- Do they have internet access?
- How do you drive change? In general? From entitlement to engagement?

5. CONSUMERISM

- Is your work force ready for it?
- Are Health Reimbursement Accounts and Health Savings Accounts effective?
- What design is cost-effective and fair to employees?
- How do you drive high participation?
- What tools and training are needed?





6. PROVIDER NETWORK

- What network has the best access?
- What network has the best cost?
- What network has the best quality? Why is it important?
- How do you measure and balance access, cost and quality?

7. DEPENDENT ELIGIBILITY AUDITS

- What are the issues (including legal issues)?
- How do you make this as palatable as possible?
- How do you make this as simple and unobtrusive as possible?
- What are the savings in dollars and ROI?
- What approaches are available and what works best?

8. CARE MANAGEMENT (DISEASE MANAGEMENT)

- What are you doing now?
- How do you identify gaps in care and close these gaps?
- What are the numbers: eligible?...enrolled?...in clinical compliance?
- What is the ROI?
- Should you reach out to only those who are diagnosed or those at risk?
- Should the program cover only the major diseases or take a broader approach?
- How do the approaches vary by vendor?
- Does it make sense to carve out care management from the carrier?

9. VOLUNTARY BENEFITS

- Is this appropriate for your industry and situation?
- Individual or group policy approach?
- What coverage?
- What type of enrollment: meetings, individual, web-based?
- How does this impact your ability to attract and retain employees?
- Is this a one-time, annual or more regular event?
- Does VB enrollment include core benefits enrollment?

10. TECHNOLOGY AND OUTSOURCING

- How can these be used to increase efficiency and take work off your desk?
- Which services?
- Do you buy, build or rent?
- Should you outsource clinical services to a call center that provides high quality assistance related to claims, identifying the highest quality physicians on complex cases, or other services?