Produced for The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program

Shifting Responsibilities

Models of Defined Contribution

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Foreword

In the current health care marketplace – which is dominated by employer-sponsored insurance – striking a balance between what employees want and what employers can give them is difficult. The managed care backlash has spurred an increasing demand for choice from consumers, while employers, faced with rising health care costs each year, try to balance the satisfaction of workers with their own bottom line. Although not a new concept, the defined contribution approach – in which employers pay a fixed amount for their workers' health care benefits, but share or relinquish the management of such benefits – is being discussed as a possible solution.

Many workers say they want more decision-making power in their health care and would like to enroll in plans tailored to their personal needs. Most also say they do not want to contribute more toward their premiums. Many also say, however, that they value the benefits that employer-based insurance affords them, such as lower rates.

The employers' view is similarly multi-sided. A study of business attitudes about the future of employment-based health coverage revealed that most employers feel that they are better equipped than employees to manage coverage and can make better health plan choices.[1] Still, managing benefits can be administratively burdensome. Large companies with hundreds or thousands of employees must offer multiple health plans, while small companies must patch together the staff to manage the health benefit function.

Given this environment, what is the likelihood that defined contribution will replace the current system? Opinions vary considerably, in part because the dramatic changes over the past decade have proven how inaccurate such predictions are. But another reason for this lack of agreement is that policy leaders, practitioners, and researchers use the term "defined contribution" loosely and with varying meanings.

In March 2001, The Robert Wood Johnson Foundation's *Changes in Health Care Financing and Organization* (HCFO) program held a meeting to discuss the research and policy implications of a move to defined contribution. For example, some health policy experts believe that one of the major advantages of employer-sponsored insurance is risk pooling and risk sharing among employees. If this market shifts to defined contribution, will risk selection become more of an issue? And would the same risk adjustment techniques work?

The HCFO meeting participants included researchers, health plan representatives, risk adjustment experts, and public policymakers. From the beginning, participants recognized the need for a typology of possible defined contribution models and worked to develop this framework. They then turned to the implications of each model.

This report does not attempt to assert whether employers are indeed moving to defined contribution, but rather seeks to identify the advantages and drawbacks of implementing various forms of such a mechanism. It also outlines product options, contracting requirements, and responsibilities of both employers and employees in four defined-contribution models. We hope that, through this report, our readers will understand better the issues raised by the prospect of a defined contribution system and will begin to formulate future research and policy questions as this debate moves forward.

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Introduction

A number of factors have converged in recent years to make "defined contribution" one of the most frequently used terms in health policy discussions. There is seemingly endless speculation and debate about whether employers are moving away from defined health benefits to a defined contribution system – one in which employers provide a set amount of money toward an employee's health coverage – and what the implications of such a move might be. What has been missing from these discussions is a common understanding of what defined contribution means. It is not a single health insurance arrangement but rather a general approach that can take a variety of specific forms. This report provides a detailed framework of four models of defined contribution and identifies some of the implications of each of them.

The concept of defined contribution was first introduced in the context of retirement benefits as employers switched from traditional pension plans, which guaranteed a level of payment upon an employee's retirement, to defined contribution plans (such as 401(k) and 403(b) plans), in which the employer guarantees only the amount of the contribution to the plan over time. Some assert that employers' willingness to consider defined contribution health benefits stems from their familiarity with defined contribution retirement plans. While the two are conceptually linked, there are key differences that need to be considered when evaluating the potential of defined contribution health benefits. For example, risk pooling is an important component of the employer-based health insurance system that is not as integral to retirement benefits. Nevertheless, employers' experience with defined contribution in the retirement arena is one of several motivating factors leading employers to contemplate a similar shift in health benefits.

There is general consensus among informed policy and business leaders about the goals of defined contribution and factors that have pushed this movement forward. However, while pundits easily list circumstances that would increase or decrease the likelihood of a shift to defined contribution, there is less agreement on how likely employers are to make this change in a significant way. Some call the movement inevitable, while others believe that the status quo will continue with little change. There is, however, considerable interest among employers and policymakers about what defined contribution is and what effects it might have.

The defined contribution concept can manifest in numerous ways. The ideologically purest model is one in which employers remove themselves completely from administering health benefits by either giving the employees cash (as a separate payment or increased wages) or a voucher that they can use in the market to purchase coverage. At the other end of the spectrum is a defined-choice model in which employers continue to offer a range of health-benefit options at varying price levels. The employer provides a specified premium dollar contribution (perhaps tied to the lowest-cost plan), and the employee pays for any premium difference above the contribution level.

Between the two end points, there are numerous permutations. Some of these "in between" models rely on a combination of an employee personal health care account with contributions from employers, employees, or both (which can roll over annually), and major medical coverage with a deductible above the cap of the personal account.

This report begins with a brief review of the existing literature on defined contribution. It then presents a typology of various defined contribution models, focusing on the commonalities and differences among them and how they affect the decisions that employers, consumers, and health plans must make. It also considers the implications of defined contribution models on tax policy, risk segmentation, and risk adjustment.

Shifting Responsibilities: Models of Defined Contribution

Health benefits are a double-edged sword for many employers. On the one hand, they are a valuable part of a compensation package that employers use to attract and retain employees. On the other, they represent a growing, unpredictable, and arguably uncontrollable cost center. Employers are intrigued by defined contribution because it enables them to provide health benefits while limiting their responsibility for health benefits management. At the same time, a defined contribution system offers employees more choice in their health care decisions. Further, a defined contribution system might make an employer's health care costs more predictable, and could even decrease the amount spent on health benefits.

Proponents suggest that defined contribution plans also improve an employer's ability to meet the diverse needs of its workers.[2] Booz-Allen and Hamilton have suggested that a movement in this direction could lead to increased innovation and customization of health benefits, improved customer service, and consumers' limiting their demand for care.[3] Others point out that certain models of defined contribution would create benefits that are more portable and would increase accountability within the system.[4]

Health care inflation, the managed care backlash, and comfort with the Internet are all factors that encourage an employer movement to defined contribution. The recent return of health care inflation to a pace higher than overall inflation has put employers under financial pressure, which they have felt even more strongly during the economic downturn in 2001. Employers also have experienced a managed care backlash characterized by increasing employee dissatisfaction with their health care options. As a result, employers fear the risk of new regulation, legislation, and potential liability that might arise from consumer outcries against managed care (e.g., the ability for employees to sue their employers). These events have converged at a time of particularly high employee and employer frustration with the health care system as a whole.

The ability of the Internet to provide consumers with direct access to health care information enables a consumer-driven system, thus increasing interest in defined contribution. Among the studies that have been done to date, there is consensus that the capacity provided by Internet start-ups to provide consumers with direct access to health care information is affecting employer interest in this new way of providing health benefits.[5-8] Opinions differ, however, about how important a factor it is. Some have argued that the Internet is integral to the success of defined contributions,[9] although most view it as only one factor among many that enables employers to seriously consider defined contribution. In any case, PricewaterhouseCoopers has cautioned that Internet intermediaries need to establish a successful history before they are widely used, because employers are hesitant to invest in something untested.[10]

Barriers to Widespread Adoption of Defined Contribution

Even though the factors described above have arisen simultaneously, there has not been a mass movement away from the traditional provision of health benefits. While high costs, complaints about managed care, and the Internet may be pushing employers toward defined contribution, there are a number of other factors pushing them away from it. As discussed earlier, health benefits are one of the tools that employers use to recruit and retain employees. A new system with less employer involvement and more employee control could be perceived as a reduction in benefits, even if they are equivalent to those furnished through traditional employer-sponsored insurance.[11,12] Also, to the extent that a defined contribution model is not adjusted for health care inflation, the benefits people receive for the money they pay will decrease over time.

Employers' willingness to pass on health care costs to their employees is inversely related to the strength of the economy.[13] When the economy is strong and the demand for quality workers high, employers have been hesitant to change employee benefits too dramatically. As the economy weakens, employers are more likely to transfer the cost to employees. A report from the Center for Studying Health System Change suggests that employers are making slight changes in their benefit structure, but are not altering their contribution strategies.[14] PricewaterhouseCoopers reports that 75 percent of the employers they surveyed thought they would be at a competitive disadvantage if they implemented defined contribution in a high employment market.[15]

This appears to be the case at General Motors. Bruce Bradley, director of Managed Care Plans at GM, said, "[T]o compete in a labor market…we cannot get out of the defined benefit business."[16] A study recently conducted by the Economic and Social Research Institute found that view was pervasive among the employers they interviewed. Most acknowledged that health benefits are a necessary cost of doing business and many employers felt a moral obligation to provide coverage for their employees.[17]

In addition, while transferring more control of health care decisions from employers to employees through defined contribution scenarios has some appeal, that transfer inherently requires employees to sift through dramatically more, and more complex, information. At a minimum, increased and improved employer communication with their employees is required to describe and explain a new defined contribution system. This communication element is part of the function for which Internet start-up companies market their services.

The ability of employers to pool people with varying health risks is another strength of the employer-based system. The ability of younger, healthier employees to subsidize the costs of older, less healthy employees is a crucial component of the social contract of insurance. If defined contribution breaks the link between the employer and insurance, that contract may be jeopardized.[18] Depending on the model implemented, defined contribution health benefits may lead to increased risk segmentation. An employer's risk pool is almost certain to disperse if employees go into the individual

Employer-Based Coverage Implementation Decisions

One of the characteristics of the defined contribution models is a shift in responsibility for the implementation decisions associated with employer health care coverage. Below is an explanation of each significant decision set and some questions to further demonstrate the meaning.

Benefit Package – This includes the essentials of a benefit structure, including covered services and cost sharing. In the market today, there are a range of packages from catastrophic to comprehensive coverage. Who decides which benefits and services are covered? Who decides what the structure of the formulary will be (e.g., open or closed, three-tiered, etc.) and which drugs will be included? Who sets the level of cost sharing?

Accountability – Accountability for care is comprised of grievance mechanisms and processes, medical necessity decisions, and other customer service issues. Who is ultimately responsible if the consumer has a problem? Who is held responsible for mistakes? Who establishes and implements a grievance process? Who determines which procedures are medically necessary?

Choice of Health Plans/Intermediaries – Traditionally, employers have decided how many plans they will offer their employees. This would not necessarily be the case in some defined contribution models. Who decides how many plans to offer? Who chooses which plans to offer? Who is the contact person for various carriers? Within which entity is that person located? For simplicity, we assume that an employer can choose any plan or intermediary and that the plan/intermediary will accept the employer. We do not deal with the possibility that plans/intermediaries are not required to offer coverage.

Choice of Providers – Health plans have historically contracted with providers and, in turn, offered those providers (e.g., physicians, hospitals, etc.) to their enrollees. Employers have had some influence over which providers are available to employees through their choice of plan. Under defined contribution, who decides which providers consumers can see?

Employer Cost – Who determines the total outlay for health coverage? Who sets the employer's budget for health care? What is the rationale for that amount? Is it based on budget constraints or on a specified level of care?

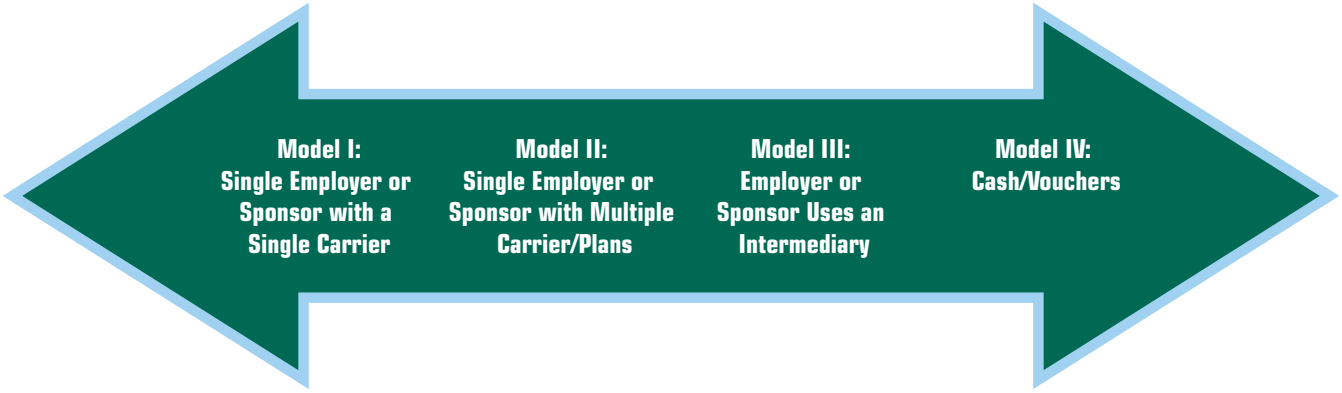
Financial Risk – Someone is held financially responsible for the cost of care. In some models, the risk is borne by multiple entities, and in others, by one alone. Who assumes the cost of medical care? Who pays for care utilization?

Risk Pooling – One of the most highly touted benefits of the employer-based health care system is pooling diverse risks into one source. Within some defined contribution models, that pool would be maintained. In others, a new pool is created. In still others, risks would not be pooled in a systematic way. At what level will pooling occur, if at all? Who will be responsible for pooling risks?

Information Dissemination – To make decisions, consumers need information. Sometimes they need basic information, such as a physician's office hours, specialty, degree or certification, etc. Other times the information is more complex – discerning which services are covered, understanding quality of care information. Employers and health plans generally provide this information in the current system. With defined contribution models, who collects this information? Who is responsible for getting information to the consumer?

Administrative Functions – There are a host of administrative tasks that go into providing health care coverage. For example, contracting with providers, processing claims, managing utilization, coordinating benefits, reimbursing providers, etc., are all important components of administering health benefits. In defined contribution models, who is responsible for maintaining these functions?

Figure 1: The Continuum of Defined Contribution Models



market, where premiums for healthier and/or younger people are markedly lower than those for sicker and/or older people, who, in some cases, are unable to get coverage at all.[19] Even if employees remain in an employer group, there is increased danger of risk segmentation if the range of choices expands. Concerns about the individual insurance market and dismantling employer risk pools lead decision makers to approach a defined contribution system with caution.

Additionally, one of the major advantages of the traditional employer-based system is the way the employer's premium contribution is treated. Employers are wary of losing the favorable tax treatment of their contribution, both for themselves and their employees. Depending on the model of defined contribution implemented, this tax treatment may be threatened. There are additional concerns about whether certain models can legally operate under the current tax law. These issues will be explored in more detail later in the report.

Actors in Health Coverage and the Roles They Play

It is important to consider the critical decisions underlying the provision of health coverage and the entities responsible for each of them. Employers, employees, health plans, and intermediaries are responsible for a wide range of activities related to health coverage. In most cases, these entities share responsibility, albeit not always equally. As employers move from traditional health benefits to a defined contribution system, responsibility for these functions may shift from one entity to another, affecting such things as choice of benefit packages, accountability for dissatisfaction with the choices, choice of plans and providers, absolute spending level, financial risk, pooling of health risk, information dissemination, and administrative functions. (See box on page 4 for a further description of the implementation decisions.) These decisions and where responsibility lies for making them build this typology and create the distinctions among defined contribution models.

Defined Contribution Typology

The following typology features four models that capture the range of options available under a defined contribution system. Under Model I, one employer or sponsor offers a single carrier within which employees have a choice of benefit packages and providers. Next is Model II, in which a single employer or sponsor offers multiple carriers' plans. In Model III, employers use an intermediary (usually based on Internet technology) through which they provide coverage. Finally, in Model IV, employers turn over control of purchasing coverage to employees. This model includes the provision of health care coverage vouchers or cash.

Model I – Single Employer or Sponsor with a Single Carrier

In this model, a single employer or other sponsor, such as an association, has a sole benefit plan providing coverage and uses one carrier to administer the plan and/or bear risk; employers must contract directly with the plan to provide coverage to employees. Within that plan, there could be multiple product options – such as health maintenance organizations (HMOs), point of service plans (POSs), and preferred provider organizations (PPOs) – with differing benefits and cost-sharing levels. Each type of product can have a variety of cost-sharing arrangements. For example, an employee could select an HMO with a co-payment of $5, $10, or $15, or a PPO with a $500, $1,000, or $2,000 deductible. The employer provides a fixed-dollar contribution to employees, likely to be tied to a reference product (ensuring access to a certain level of benefits). The employee is responsible for any additional premium costs.

This model has the fewest shifts in responsibility among the participating entities. The carrier, with the employer, still determines the benefit package for each offering, maintains accountability, assumes some of the financial risk, disseminates information, and bears the responsibility for administering the program. Within this model, the employer determines its absolute level of spending, controls the choice of carrier, and

continues to pool the risk of its employees. While employees ultimately select their providers, the choice of providers is determined by the health plan. In this way, Model I most closely resembles traditional health benefits and, therefore, poses the fewest implementation challenges.

Model II – Single Employer or Sponsor with Multiple Carriers/Health Plans

The primary characteristic that distinguishes this model from the first is increased employee choice. Under this model, employees are able to choose among plans, which, to the extent that plans contract with different providers, gives them more power to choose providers. Employers or sponsors select health plans with fairly standard benefit packages and allow their employees to choose among those plans.* As in Model I, the employer contributes a fixed amount, likely to be tied to a reference plan. Model II also maintains many of the relationships among the entities and is not a significant move away from traditional employer-sponsored coverage.

As with Model I, in Model II there is a formal contract between the employer or sponsor and the plans. Employers control, through their selection of plans, the benefit structure available to their employees. Employers also maintain the risk pool for their employees. Health plans remain accountable to enrollees and share the financial risk with employers and employees. They also collect and disseminate information, although employers are responsible for providing employees with comparison information. The health plan remains primarily responsible for the overall administration of health benefits.

Purchasing groups and cooperatives, while serving as an intermediary between employers and health plans, fit best within the typology in Model II. Employers, who are often members of purchasing cooperatives or alliances for reasons other than purchasing health care, may join together to purchase coverage as a larger group. This permits them to share risk more broadly† and to use their combined market power to negotiate better arrangements with health plans.

Purchasing groups can facilitate the relationship between small employers and health plans but do not necessarily intervene in the contractual relationship. Through this kind of intermediary, employers offer their employees a variety of benefit packages and a broader choice of plans than might be available otherwise. Again, in this model, the employer would provide a fixed contribution. Purchasing groups are involved, at some level, in shaping the benefit structure available to employees. The employers also work with the intermediary to choose the plans from which employees can select.

In this scenario, the purchasing group is the entity responsible for collecting and disseminating information, although they could work with the health plan and employer to do so. There are some cases in which the group would contract directly with care groups or groups of providers. In these cases, the purchasing group assumes many of the health plan's roles, including working with employers to determine the benefit structure, selecting and contracting with participating providers, pooling risk, and disseminating relevant information.

Model III – Intermediaries

The primary difference between Model III and the first two is that this model calls for increase consumer responsibility. In Model III, employees share financial risk with the employer and an intermediary but are at greater risk than in the other models because they must use funds from their personal health savings accounts to access most services. While personal health savings accounts could be part of Models I and II, they are a necessary component of Model III. Consumers, therefore, have greater responsibility for managing the financing of their care. At the same time, the lines of accountability for potential problems are not obvious. Is the employer, the intermediary, or the provider ultimately responsible if problems in accessing or paying for care arise?

In Model III, employers provide health benefits to their employees through an intermediary, such as an Internet-based company. In general, intermediaries are responsible for some employer and health plan functions in purchasing and providing health coverage. Some have suggested that these intermediaries will succeed by doing a more cost-effective job with the administrative activities from which employers want to remove themselves.[20] For example, intermediaries might select health plans and benefit packages, and coordinate employee enrollment, provider selection, and contracting. The degree to which intermediaries assume these roles depends on their business model and whether they are more similar to purchasing groups or to the current wave of Internet-based companies.

The Internet start-up companies born in the late 1990s are a newer form of intermediary that aim to empower consumers in selecting health insurance coverage. With some of these companies, employers use the intermediary almost as a health plan (e.g., to negotiate and contract with providers and develop benefit packages). In other business models, the Internet provides consumers with direct access to the health care market.

Many new Internet companies focus on establishing a more direct relationship between consumers and providers

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* We realize that many employers offer a self-insured product with fully insured products, which creates a unique set of selection issues. For the purposes of this report and simplicity, we limit our discussion to multiple fully insured products.

† In practice, there are only very few examples of pooled risk within purchasing pools.

by giving employees more choice and responsibility for managing their own costs and care. (See box on page 7.) With this kind of intermediary, employers give their employees a defined amount of money to purchase care through the Internet intermediary, which in turn contracts directly with providers.

Generally, these Internet companies provide an inexpensive, high-deductible, major medical product and deposit the remainder of the employer's contribution into a personal health savings account. These accounts can be used for preventive or urgent care, and the dollars spent on those services are counted toward the employee's deductible for the major medical coverage. Employees can also use the funds for other services, but those dollars would not necessarily count toward the deductible.

Supporters say this model would work best if unspent funds were rolled over into an account for each subsequent year. These companies are working to get these models up and running, but would welcome changes to the tax structure that might make this process easier. The tax policy implications of all of the models are discussed in more detail later.

Most of these organizations furnish an extensive array of health information via the Internet. For example, they might provide consumers online access to their personal health history, physician locations, fees (when available), and references, as well as health news and a health calculator. This type of intermediary rarely represents the sole coverage offered to an employee group, it is usually offered along with more traditional health plans.[21]

Within this context, intermediaries establish benefit structures, and the employer, through its selection of intermediaries, determines which benefit packages will be available to its employees. To the extent these organizations serve as plans, employers maintain control over how many and which intermediaries are available to employees. Employers set their defined contribution and share the responsibility for some financial risk, risk pooling, and information dissemination. The intermediaries, however, are responsible for contracting with and selecting providers. Therefore, they determine which providers employees can see. Several of these Internet-based intermediaries suggest that they give employees a greater choice of providers than traditional health plans.

Internet Companies Supporting Defined Contribution Models

What do they do?

There is no single business model that describes all of the Internet-based intermediaries. These entities do, however, have several common goals. In general, they bring together employers and insurance companies (or other companies with established provider networks). They negotiate with both employers and the other companies and contract with both to provide coverage to employees. The Internet intermediaries usually assume the administrative and marketing functions that health plans were responsible for historically. Through these new organizations, employees could have wider selection and more responsibility in selecting their coverage.

Many of these companies have three components in common. First, employers would contribute to an account, which could be supplemented with employee funds to pay for basic medical and preventive care. These accounts vary in structure and co-payment/deductible arrangement, are generally tax advantaged, and are arranged so that unused funds can be carried over into subsequent years. The second component is a form of catastrophic or major medical insurance coverage. The insurance plan (either owned or purchased by the Internet company) would cover excessive medical expenditures, out-of-network or out-of-area providers, and accumulated regular health care expenditures. This benefit would begin after an employee's deductible and out-of-pocket maximum (gap between account-funded services and covered services) are reached. The third component is the provision of health care information. Specifically, the Internet company would provide online and phone support for health and financial planning information to enhance consumer decision-making ability. They might also provide information about their provider (e.g., specialty, education, etc.).

Strategy for Choice

There are two major business models for these new Internet-enabled intermediaries that differ on the basis of their strategies for consumer choice. In the first, employees choose among insurers or established networks (e.g., HealthSync, Myhealthbank, Destiny Health, Definity Health, Lumenos, HealthMarket). In the other, employees choose providers directly from those participating with a particular company (e.g., Vivius). Generally, the organizations will target their marketing efforts to employers alongside more traditional health plans or through existing managed care companies as another product line on either a national or regional scale.

Who are they?

There are several examples of emerging Internet-based intermediaries. Eight of these organizations have joined together to form the Consumer Driven Health Care Association. The association was formed to promote awareness of these new approaches to health benefit programs.[1] Definity Health, Destiny Health, HealthAllies, Health Market, Lumenos, Myhealthbank, Sageo, and Vivius are all members. Other examples include HealthSync, CaliforniaChoice, and Highmark Blue Cross Blue Shield's BlueChoice.

1 Consumer Driven Health Care Association web site: www.cdhca.org.

Model IV – Vouchers or Cash Payment

Model IV comes closest to accomplishing one of the major goals of defined contribution – a smaller role for employers and more choice and responsibility for employees. It represents the ideologically purest form of defined contribution – one in which employees are given a defined payment to purchase the health coverage that best suits their needs. The payment might be a voucher, a refundable tax credit, higher wages, or any other transfer of funds. With this subsidy, employees purchase their coverage independently in another non-employer group, or in the individual insurance market (either through traditional insurers or an Internet intermediary). In the case of cash transfers (e.g., higher wages), employees do not have to purchase coverage at all. Under this model, it is possible that the employer's only role is its financial contribution.

In Models I, II, and III, the employer works with either the health plan or intermediary to develop a benefit structure. By providing cash or a voucher, the employer allows employees to determine their benefit package, possibly by working with those same entities or by choosing a plan in the individual insurance market. In Model IV, intermediaries and health plans compete with each other for employees' business. Employees have control over which plans they will use, which providers they will see, and how much financial risk they will bear. Employers continue to determine the amount they will spend on the contribution, but that is the extent of their role. They could help employees by providing information on health plans, but are not obligated to do so.

Under this model of defined contribution, it is unclear which entity is ultimately held accountable. The intermediary or health plan an employee selects has to respond to consumer issues, and presumably, employees are held accountable for their decisions. Although employers do not have a formal accountability role in Model IV, most employees are accustomed to seeking help from their employers when something goes wrong with their health coverage. Over time this may diminish, but there would be a period of adjustment.

Perhaps the most important characteristic that distinguishes this model is the lack of an employer-based risk pool. There is no obvious way to systematically pool high and low risks. Thus, the danger of risk selection problems is dramatically higher than it is with the present provision of health care benefits or with the other models of defined contribution. Segmentation problems are even greater if employees are given higher wages and allowed to decline coverage. In addition, employers face a major conundrum when setting the amount of the contributions: should they pay more for higher-risk employees and their families? And, if so, how much more?

Implications of Each Model

Consumer choice and responsibility both increase as one progresses along the continuum of defined contribution models, and there is a dramatic change in employee responsibility between Models III and IV. Also, as the models become more consumer-driven, the complexity of information that employees must navigate increases. Figure 2 illustrates how responsibility changes from Model I to Model IV.

While employees may prefer making more of their own decisions, employers have indicated that it will be important to support employees during the transition period to defined contribution. Employees may need more assistance and support as they experience a new world with new rules, more decisions, and more information.

The models become more dramatically different from the current employer-based health insurance system as Model IV is approached. Currently, there is an infrastructure in place to implement Models I and II. How the Internet-based companies in Model III, voucher, and cash methods of defined contribution fit within the existing structure remains a question. The most significant implications of these models are in tax policy and risk segmentation and adjustment.

Tax Policy

The primary tax policy concern related to defined contribution is the favorable tax treatment of an employer's health care contribution to both the employer and employee. Under current law, employers are allowed to deduct their contribution as a business expense. At the same time, employees do not include the contribution as taxable income on their personal income or "employment" taxes (e.g., Social Security, Medicare, and unemployment taxes).[22] This is one of the most valued features of the employer-based system. With most of the defined contribution models, the favorable tax treatment of the employer contribution will remain intact. The tax exclusion and deduction are jeopardized, however, when the payment from employer to employee can be used for something other than the purchase of health insurance, as is possible in Model IV.

Defined Contribution Models I and II rely on the existing structure of the employer-sponsored insurance system: Employers provide a payment directly to a health plan on behalf of their employees, and the payment can be used only for health coverage. Therefore, the employer can continue to deduct the amount of the payment, and the employee does not claim it on his/her personal income taxes. Because the contribution is dedicated to the purchase of health insurance, employers and employees can treat it, for tax purposes, the same as contributions with defined benefit coverage.

The extent to which the Internet-based intermediaries in Model III fit within current tax law depends on the business model they use. Generally with these approaches the employer contribution is linked directly to health coverage, so employers and employees retain the favorable tax treatment. The companies whose models include a personal care account of some kind should consider how these accounts fit best within the tax code. Do they fall under the rubric of flexible

Figure 2: Changing Responsibility Among the Four Models

Decisions	Model I	Model II	Model III	Model IV
Benefit Package	The plan and employer work together to determine what benefit package is available to employees.	Same as Model I, except the employer selects the "standard" package and purchasing groups can be involved. To the extent there is variation in benefit packages, employees can choose among them.	The employer works with the intermediary to determine the benefit package available to employees. The available packages are more variable in this model.	The employee, through choice of insurer or intermediary, determines the benefit package.
Accountability	Employer and health plan are accountable to employees.	Employer and health plan are accountable to employees.	There are not clear lines of accountability. Presumably, the employer and intermediary would share accountability.	No formal lines of accountability. Employees are held accountable for their choices with whichever entity they choose.
Choice of Health Plans/Intermediary	The employer alone chooses the health plan.	Same as Model I.	Same as Model I except that employers are choosing intermediaries.	The employee alone chooses their coverage.
Choice of Providers* *In each of the models, consumers have the option of paying more for an out-of-network provider. For the purposes of this report, we are referring to providers available through a network or contract.	The health plan selects the providers with which they will contract. The employer chooses a health plan, which determines the providers available to employees. Ultimately, the employee chooses a provider from those available.	Same as Model I except that purchasing groups can also choose health plans and more than one plan is available.	Same as Model I except that an intermediary contracts with providers, not health plans.	The plans or intermediaries select the providers with which they will contract. The employee chooses a provider from those available.
Employer Spending Level – Control of Employer Costs	The employer alone decides what the defined contribution will be.	Same as Model I.	Same as Model I.	Same as Model I, but faces different and bigger choices in setting the amount.
Financial Risk	Spread across the employer, employee, health plan, and, at times, providers.	Same as Model I.	Sometimes the intermediary shares financial risk with the employer, employees, and providers.	Employee is at higher financial risk, but shares that risk with the intermediary/health plan and providers.
Risk Pooling	The employer pools the risk of their employees.	Same as Model I.	Same as Model I.	No entity is responsible for pooling health risk.
Information Dissemination	Shared by the employer and health plan.	Same as Model I. Purchasing groups can also share some responsibility.	Shared by the employer and intermediary.	Either the intermediary or health plan.
Administrative Functions	The health plan assumes most of the responsibility. Employers conduct some of the administrative functions.	Same as Model I. Purchasing groups may have some responsibility in this area.	Intermediary and employer share responsibility.	Either the intermediary or health plan assumes responsibility with minimal administrative involvement by the employer.

spending accounts, medical savings accounts, or cafeteria plans? Most companies' accounts are set up to fit into one of these categories, which means the constraints under which they operate are well established.

One issue of particular concern with these accounts is whether the money can carry over from one year to the next. According to PricewaterhouseCoopers, employer contributions to an account designated for health care only may be eligible to roll over from year to year as long as the account does not contain employee dollars. Employers could set up accounts into which their employees would contribute tax-free dollars, but under current law the money would not carry over to the next year.[23]

This is just one example of how Internet-based intermediaries with personal health care accounts are able to operate within the existing tax code. The structures are in place and changes are not necessary for implementation of this defined contribution model. Furthermore, they are organized in such a way that Model III intermediaries are able to maintain the tax benefits of employer-sponsored insurance for employers and employees.

Model IV, in which employees receive a health insurance voucher or cash to purchase insurance, has the greatest potential to lose the favorable tax treatment. Because a voucher can be used only to purchase health insurance, the amount of an employee's voucher is excluded from his/her gross income, and employers deduct the sum of their employees' vouchers from their taxable income. Any payment that can be used for something other than health insurance, or other expenses outlined in the tax code (e.g., medical savings accounts, flexible spending accounts, and cafeteria plans), is considered income to the employee. Once the link between an employer's contribution and the purchase of health coverage is broken, the tax treatment of the contribution is called into question. Likewise, employers cannot deduct the expense of providing the contribution.

Some suggest that the favorable tax treatment of employers' contributions under the current employer-based system is so valued that any defined contribution model that fails to use it is politically infeasible.[24] Among those who favor a move away from the current dependence on employer-sponsored insurance, the cash version of Model IV represents an opportunity to make a clean break from the predominantly employer-reliant system. Widespread adoption of this model, however, may hinge on changes in tax law.

Risk Segmentation

One of the advantages of the employer-based system is that it brings together groups of people with varied health experience and risk for reasons other than purchasing health care coverage. Employers' ability to pool people with both high and low health risks means that they pay the same amount for coverage of both groups despite differences in anticipated utilization and cost.[25] Younger, healthier employees, therefore, subsidize the costs of coverage for older, less-healthy employees.

If defined contribution becomes an increasingly popular option, important questions arise about how it would affect risk segmentation. Risk segmentation is of concern because of its effects on consumer costs and ability to obtain coverage; if segmentation becomes extreme, insurers may lose money and go out of business. Largely because the number of products available to employees increases when moving from Model I to Model IV, the potential for risk segmentation increases as healthier people choose the lowest-cost product. Adjustments to contributions based on risk may be necessary.

Employers with arrangements similar to Model I, with a single carrier but multiple products, have some risk segmentation among their products, but because the employer maintains responsibility for pooling the risk, the balance remains in check. Since the employer's contribution is tied to a reference product, the benefit package may be relatively comparable across products, which helps alleviate segmentation. In Model II, because multiple plans are offering multiple products (and, therefore, more choices), the stage is set for increased segmentation.

While segmentation is a danger to individual consumers, it is also a concern among firms. Smaller organizations, in particular, are susceptible to the experiences and health risks of their employees because they have fewer people to share the risk. Employers join purchasing groups to gain purchasing clout and decrease administrative costs and hope that by doing so, their premiums remain affordable. At the same time, the health risk of employees may be spread among more people. To the extent that groups offer multiple products, risk segmentation is possible.

For employers that offer Internet-based intermediaries along with traditional health plans and products, risk segmentation is of particular concern. Because of their structure (i.e., high-deductible, major-medical coverage with personal health care accounts), Internet-based organizations can offer a lower-cost option relative to other health plan products. The less-expensive product that they provide is likely to attract people with the lowest anticipated utilization and cost. Most of these products allow employees to spend a small portion on their premium while saving the remainder of their employer's contribution to spend when needed.

Unlike Models I and II, in which employer payments are tied to a reference plan, Model III provides products through Internet-based intermediaries that are substantially different from those offered by traditional health plans. The sharp distinction between employees' options in terms of costs and benefit packages increases the opportunity for risk segmentation.

The potential for risk segmentation is highest in Model IV. Employers are no longer responsible for pooling the risk of their employees, and employees are allowed to choose

among any products, providers, and plans in the individual market. The voluntary nature of the health care system increases segmentation in the individual market. If employers give employees cash, they give them an additional choice that is critical to market segmentation: not to purchase insurance at all. Further, commercial plans, where not prohibited by regulations, can often choose not to enroll an individual based on underwriting.

Some portion of the healthiest people avoid purchasing insurance until they get sick. Likewise, healthier people who choose to purchase coverage are more likely to select lower-cost plans. Health services researchers and public and private decision makers have been thinking about how to address these risk segmentation issues for some time.

Risk Adjustment

Risk adjustment is one tool used to re-align the incentives within insurance markets such that the negative consequences of enrolling high-risk people are minimized.[26] While there are other ways to control selection, such as limiting employees' choices and limiting transitions among products, these tools affect only the behavior of employees, not the incentives of insurers.[27] By adjusting insurers' payments, they can compete on factors such as efficiency and quality rather than on their ability to attract low-risk enrollees. Payments can be regulated based on factors such as age and sex or based on known health status. Health-based risk adjustment is relatively more accurate in predicting cost than adjustments based on age and sex alone.

To implement health-based risk adjustment under any type of plan, there are several important questions that need to be answered: What data will be collected? Who will collect it? Who will have access to it? Would the adjustment be made retrospectively, prospectively, or concurrently? What does risk-adjusted payment look like to employees (e.g., are they aware of the adjustment)? How willing will insurers and employees be to accept health-based risk adjustment?

Defined Contribution Models I and II have a role for health plans, which can collect the kind of data necessary for risk adjustment. In some cases, that information is collected in a defined-benefit system. To the extent that a health plan is involved, the adjustment can remain invisible to employees. Payments to plans currently are adjusted by age, sex, and family size largely without the employees realizing that any alteration to the payment takes place. Because Models I and II are not dramatically different from the existing system, implementing some type of risk adjuster for these kinds of defined contribution would not be markedly different from what is done now. As is the case currently, questions of acceptance arise as the adjustment becomes more complex. There is no reason to think that this would be different with defined contribution.

Two issues related to risk adjustment are called into question for the intermediaries in Models III and IV. First, it is not clear which entity would be responsible for collecting the relevant information and how it would be shared. Whereas health plans are centralized under Models I and II, and these plans often collect the data, Models III and IV lack an entity that performs a similar function. The second issue is the political implications of health-based risk adjustment. Unlike Models I and II, employees will know the adjustment to the payment since the employees see their employers' contribution and decide how to allocate that amount. What will employees think about different workers getting different payments? How will younger, healthier employees respond to their older, chronically ill colleagues receiving a larger payment? There is the potential for perceptions of inequity among employees that is largely masked currently.

Most risk adjustment experts assert that the challenge is both technical and political; they are confident that the technical piece can be accomplished, but suggest that getting employees and insurers to support health-based risk adjustment is more difficult. Insurers that have successfully selected low-risk enrollees would lose money with health-based risk adjustment. Some experts contend that good risk-adjustment methods reveal inefficiencies among insurers and providers, which may make them reticent to participate. The technical challenges increase slightly from Model I to Model IV, but the politics surrounding risk adjustment become significantly more complex. Those challenges are heightened by the fact that risk segmentation is most likely in Model IV, making risk adjustment more important to avoid adverse consequences for sicker and poorer workers.

Conclusion

It is clear that if the goals of defined contribution – increased choice and control for consumers and more predictable costs and less administrative responsibility for employers – are achieved, there are still important hurdles to overcome. While the hurdles are fewer with the defined contribution models that make more incremental adjustments to the current system, they are less likely to have dramatic impacts that would attract employers to Model IV.

It is difficult to know whether employers will gravitate toward a defined contribution system anytime soon. If there is a movement among employers, it is equally uncertain how significant that movement will be. Clearly, as employers consider these new models, private and public decision makers need to think about the tax and risk implications (both short-term and long-term) that come with them.

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