Managing Medical Plan Costs Around the World in the 21st Century

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During the summer months many European benefits managers can be found, along with the rest of Europe, soaking up the sun on Mediterranean shores. Meanwhile, their counterparts in the United States are exposed to a different form of heat.

For the past three decades, US benefits managers have been engaging in a different, less pleasant, annual ritual as they tackle high medical trend rates year after year. Their summer months have been consumed in an intense exercise of medical plan redesign and carrier negotiations. Executive management demands of “no stones unturned” efforts to mitigate escalating medical costs have become permanent annual fixtures.

The almost obsessive intensity of this annual planning process is understandable. The results are scrutinized by the executive levels of every organization that sponsors a medical plan, especially those with over 1,000 participants. Basically, most of these medical plans are self-insured, and thus these companies are, fundamentally, part-time financial intermediaries of health care services, in that they assume the attendant cost and liability risks implicit in their medical programs.

The occupational medical plan market in the USA is unique in comparison with other countries in the following ways:

- The USA is the only large economy in the world that does not offer its citizens universal access to medical care. Cost shifting from the uninsured and the indigent, who only get partial subsidies from the government, is a heavy burden being carried by private medical plans.

- Medical benefit service pricing has not been subject to legal ceilings or regulated pricing controls.

- There is a significant layer of cost caused by inordinate malpractice insurance premiums.

- Labor law is flexible relative to that of most other countries. The employer is generally able to unilaterally adjust plan provisions in order to reduce benefits or require employees to share a higher proportion of the annual cost.

- There are very few restrictions and/or deterrents in terms of funding vehicle choices available for employer medical plans.

As it is such a fluid and sophisticated market, there are many valuable lessons that can be learned from the employers’ experience over time in trying to manage what seems to be an insidious and irreversible escalation of medical plan costs.

In this article, I aim to present:

- some important lessons that can be learned from the US experience;

- the problems faced by multinational companies in managing their medical plan costs and liability exposure around the world;

- the limitations of the typical solutions that have been, and are being, applied;

- a brief summary of the trends and fundamental factors that will shape the 21st century landscape of medical plans; and

- suggestions for multinational companies in facing the challenges ahead.

All these areas should be considered when managing medical plan costs globally.

THE GLOBAL MEDICAL COST CONTROL CHALLENGE

Despite the existence of robust social health care programs in many countries, multinational employers sponsor supplementary medical plans in most locations where they operate. The cost of these programs has been subject to alarmingly high medical unit cost increases over the last decade in virtually all countries, averaging more than five percentage points per annum in excess of retail domestic inflation levels.

My firm’s 2013/14 medical trend rate survey discloses a continuation, if not an acceleration, of unit cost increases, as can be seen in TABLE 1 overleaf. Some small and mid-size US multinationals find that medical costs outside the
USA are still low relative to the alarming levels within the USA, and thus have so far elected not to devote valuable management time to an activity likely to yield low short-term financial gain. However, enlightened multinational companies have recognized that the issue of employee health affects not just medical premiums, but disability and accident related costs as well as productivity costs driven by turnover, absence and disengagement.

Recognizing the broader challenge, the majority of mature multinationals have worked hard navigating through a number of approaches targeting control of rising health benefit costs. In a way, multinational employers are undergoing the same experiences in regard to the financial strategies that have been adopted in the USA in that they have failed to produce long-term success in a consistent manner when measured on a global scale.

Some of the most popular measures that have been adopted outside the USA include the following:

1. **Tight local procurement of insurance.** This avenue is generally the first recourse to most companies for halting high premium increases. In some soft markets (caused by carrier saturation, or due to many new carriers entering the market) such a technique has rendered some success. This approach eventually becomes relatively ineffective as markets stabilize and recurring adverse loss ratios mount.

2. **Local self-insurance.** This option has limited applicability in practice due to the lack of economies of scale (as most multinationals only maintain a handful of international locations with over 1,000 employees). Even when a company has the size and willingness to adopt this funding approach, actual execution is impaired due to an often inadequate medical service delivery infrastructure at local level, or on account of regulatory restrictions (except for a handful of countries that have a mature medical carrier market and enabling legislation supporting self-insurance). Furthermore, many companies that have actually tried self-insurance have in fact exacerbated the financial performance of their plans due to poor plan administration, especially lax claim adjudication practices that emerge as the local subsidiary management has more leeway for ad hoc special cases.

3. **Multinational pooling.** According to my firm’s brokering experience data, pooling medical plans has not resulted in the up-front premium reductions that would be expected from lower risk premium charges (which carriers assess in order to protect themselves from adverse claim volatility). Furthermore, medical plans are systematically being phased out of multinational pools, as nine out of every 10 medical plans pooled in recent years have actually produced negative contributions to international dividends.

4. **Captive reinsurance.** Some companies elect to fund medical benefits through a corporate captive. Most of these companies have other than pure cost control goals (tighter benefit governance, flexibility in plan implementation, corporate tax incentives on property and casualty reserves, etc.). Out of the companies that fund benefits through a captive, most are very selective in terms of including medical plans due to a number of challenges. First, there are few global carriers to front the risk locally with a robust medical service delivery infrastructure that competes with leading local players. Second, low potential for favorable underwriting experience has to be tackled. Third, there can be excessive transactional costs, as medical plans tend to exhibit frequent claims and insufficiently attractive financial upside from cash-flow improvements. Fourth, there are employee contribution considerations, including the respective fiduciary controls, and employee consent requirements. Thus, using a captive in and of itself has not proven to be a viable long-term solution for medical cost control.

5. **Bulk purchasing across countries.** This procurement technique for medical plans is often intrinsically discouraged by local labor, tax and insurance laws that require locally-admitted policies and adherence to local pricing norms, especially in light of employee cost-sharing features. Further barriers are a dearth of global providers with geographically widespread medical plan offerings, and the multiplicity of plan designs across countries which make pooled group pricing technically challenging or altogether impracticable.

It is instructive to note that none of the above measures addresses the demand challenge relating to health claims costs, nor the effectiveness of the care delivery system and instead companies try to minimize the frictional costs caused by administration, insurance risk transfers, solvency and insurer profit.

Aside from the structural factors that are driving medical costs, there are exogenous factors that detract from an

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**TABLE 1**

<table>
<thead>
<tr>
<th>Region and country</th>
<th>2013 Annual General Inflation Rate</th>
<th>2013 Annual Medical Trend Rates</th>
<th>2014 Annual General Inflation Rate</th>
<th>2014 Annual Medical Trend Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Global</td>
<td>4.34</td>
<td>10.14</td>
<td>5.80</td>
<td>4.23</td>
</tr>
<tr>
<td>North America</td>
<td>1.66</td>
<td>7.10</td>
<td>5.44</td>
<td>1.76</td>
</tr>
<tr>
<td>Europe</td>
<td>2.05</td>
<td>6.23</td>
<td>4.18</td>
<td>2.04</td>
</tr>
<tr>
<td>Asia</td>
<td>3.87</td>
<td>10.20</td>
<td>6.33</td>
<td>4.21</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean</td>
<td>5.95</td>
<td>12.85</td>
<td>6.91</td>
<td>5.85</td>
</tr>
<tr>
<td>Middle East &amp; Africa</td>
<td>6.85</td>
<td>13.14</td>
<td>6.29</td>
<td>5.93</td>
</tr>
</tbody>
</table>

employer’s ability to manage medical costs downward, as follows:

1. Acquired rights. Acquired rights labor laws exist in most international locations where multinationals operate. Essentially, these laws make it difficult or impossible for a plan sponsor to amend existing plans in order to introduce or harden cost-containment features, since these measures are seen as taking away benefits already earned by the employees. This effectively reduces the employer’s ability to fight the annual medical trend through plan design changes.

2. Mounting regulatory requirements. Regulations to explicitly or implicitly mandate employer sponsored plans or to enhance medical plan coverage are rapidly emerging. An example worth noting is Brazil, where regulation has led to the following requirements. First, employers that offer medical plans must provide them to the entire workforce. Second, there is a “minimum plan” that has been dramatically expanded of late which bans lifetime benefit maxima and eliminates exclusions for dreaded diseases (such as HIV). Third, certain specific expensive medical procedures are mandated to be covered under the plan. Fourth, coverage is mandatory for same sex couples and domestic partners. Fifth, post-retirement benefit coverage is mandatory (albeit at the employee’s full cost) for plans where the participant is required to share a portion of the premium.

As most multinationals know, the cornucopia of regulations is by no means confined to Brazil. In fact, according to my firm’s 2012 global governance survey, health care and pension cost control and regulatory compliance are top priorities for most multinational employers.

OCCUPATIONAL PLAN EXPERIENCE IN THE USA

The average annual employer cost of healthcare in 2012 was approximately US$8,000 per employee – a 40% total increase in the last six years.

The corresponding annual average employee total financial contribution to healthcare (out-of-pocket costs and payroll costs) was US$5,000 – a staggering 82% increase – over the same six-year period. The combined cost has increased by a total of 52% and this is despite a myriad of strategies that have been implemented for the sake of cost-containment.

In order to appreciate these figures from the employee’s perspective, consider that the typical annual pay increase has averaged around 3%, compared with the 10.5% annual average medical cost increase to the employee over the past 10 years.

The increase in cost to employees has nearly erased their average income gains over the same time period, which many consider a significant contributor to the wage stagnation over the past 10 years. In order to obtain a better understanding of this unfortunate experience, a brief history of the evolution of occupational medical plans in the USA is presented below.

Occupational medical plans in the USA began to emerge as a result of a 1942 law that limited wage increases but allowed employers to adopt employee benefit insurance plans. These medical plans worked rather well until the introduction in 1965 of the Medicare program for retired individuals. The Medicare program introduced:

- a fee-for-service reward structure for providers that generated incentives for unnecessary volumes of medical procedures;
- adoption of “usual, customary and reasonable” rates, which essentially engendered uncontrolled wholesale price increases by providers; and
- a third-party payment system (the State) which essentially removed the consumer’s ability to “bargain for best value.”

The above factors led to an explosive demand and cost acceleration. Every decade since has brought about some form of health care transformation, as shown in BOX 1 above.

Many opinions exist as to the reasons for the failure of the wide ranging delivery and financial strategies that have been adopted for the purpose of controlling costs. However, the significant and powerful imbalance between supply and demand relating to health care services can not be underestimated – with supply limited and demand almost endless, this market will not sit comfortably with normal economic models for the foreseeable future. Looking ahead, it is not clear that the PPACA will result in control of unit cost increases. The only point of agreement is that from the plan sponsors’ and plan participants’ perspectives the system has failed to deliver cost stability. This realization has led employers to address the core factor that must incontrovertibly bring about a permanent solution: the increase in demand driven by the declining health of the covered population.

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**BOX 1:** Health Care Developments in the USA by Decade

- **1970s.** Scheduled benefits (split between basic and major medical benefits) – targeting employer financial resources to best use by employee.
- **1980s.** Comprehensive indemnity benefits – consolidation of basic and major medical benefits in search of economies of scale.
- **1990s.** Managed Care (Health Maintenance Organizations or HMOs and Point of Service plans or POS) – attempt to control provider costs through the use of capitation pricing and to discourage user overutilization by placing restrictions on access to services through gate keepers (e.g., primary care physicians).
- **2000s.** Introduction of consumerism (high deductible plans, Health Savings Accounts, Health Reimbursement Accounts, etc.) – continuing to allow freedom of provider choice while providing employees with incentives to manage utilization.
- **2010+.** Patient Protection and Affordable Care Act (PPACA) popularly known as “Obamacare” revolutionizes how the playing field operates by introducing universal care through a complicated system of employer and individual mandates for prescribed insurance coverage. The reform also encourages consumerism in the purchase of insurance.
According to my firm’s 2012 health care survey and data from a 2010 World Economic Forum (WEF) study, the USA as a nation is becoming less healthy, but living longer on the back of the advances in curative medicine. The main drivers of worsening health are eight health risks and behaviors (see FIGURE 1 above), including:

- poor diet,
- physical inactivity,
- smoking,
- alcohol use, and
- lack of health screening.

These risks drive the incidence and impact of the 15 most common chronic conditions, which in turn account for 80% of the total cost for all chronic illness worldwide. The impact of these 15 conditions on an employer’s medical spend typically exceeds 65% of total cost. By reducing the frequency and severity of the most costly medical conditions, employers can begin to control health care costs, and improve employee health and performance (see FIGURE 2 opposite). Employers who can target and impact just three of the eight health risks can save as much as US$700 per employee per year.

FACTORS SHAPING THE MEDICAL PLAN LANDSCAPE

In my view, the following three factors will have a major impact on the cost structure of multinational companies as related to medical plan expenditure and the opportunity cost of absenteeism on account of illness:

- transformation of the world economy with a power shift to emerging markets,
- aging of the world population, and
- growth of lifestyle risk factors around the world.

I will comment on each of these in turn.

Transformation of World Economy

Many studies have been published and much information is available in the media regarding the economic development of China and India as well as Brazil and Russia. One of the most popular studies has been produced by Goldman Sachs, which first coined the term “BRIC” countries*. A later version of this study introduced 11 other countries† which are projected to dominate the world economy (see TABLE 2, also opposite). Multinational companies are investing heavily in most of these countries in order to penetrate their domestic markets – as opposed to merely exploiting cheap labor arbitraging opportunities.

Local talent pools of the type being sought by multinationals are very shallow. Consider that 30% of India’s population and 10% of Brazil’s are illiterate. The problem of finding, and then retaining, the type of qualified staff fit to work in multinational companies is at the top of business challenges for companies seeking to expand in emerging markets.

Aside from technical skills, English language capabilities and on-the-job experience, roles that require analysis, independent thinking and taking control of situations

are often culturally foreign to individuals in collectivist, risk averse societies such as China. As a case in point, India, Brazil, China, Mexico, South Africa and Turkey are all rated by the World Economic Forum as having “severe” employability challenges.

What makes matters worse, anecdotal evidence abounds that indigenous employers, especially in BRIC countries, are making a sport of poaching staff from multinational companies with inducements such as higher economic upside, rapid career advancement opportunities, and better cultural fit.

At the same time, social systems have failed to keep pace with the increasing demands of an expanding middle class. Inadequate facilities, waiting lines, red tape, and poor

FIGURE 2

Annual Total Costs per Covered Employee of Typical Medical Plans

NOTE: Representative costs in US dollars (as at 31 December 2012) of Aon Hewitt progressive multinational clients

TABLE 2

The Next 11 and the BRIC Countries vs. the USA and the EU

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<tbody>
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<td>1,340</td>
<td>780.0</td>
<td>8,227</td>
<td>70,710</td>
<td>9.6</td>
<td>7.50</td>
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<td>1,825</td>
<td>37,668</td>
<td>3.3</td>
<td>5.00</td>
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<td>Indonesia</td>
<td>238</td>
<td>116.5</td>
<td>878</td>
<td>7,010</td>
<td>1.9</td>
<td>5.10</td>
</tr>
<tr>
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<td>191</td>
<td>103.6</td>
<td>2,396</td>
<td>11,366</td>
<td>8.5</td>
<td>2.00</td>
</tr>
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<td>Pakistan</td>
<td>171</td>
<td>55.8</td>
<td>232</td>
<td>2,085</td>
<td>0.8</td>
<td>6.10</td>
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<td>Bangladesh</td>
<td>159</td>
<td>73.9</td>
<td>123</td>
<td>1,466</td>
<td>0.1</td>
<td>6.10</td>
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<td>Nigeria</td>
<td>155</td>
<td>48.3</td>
<td>269</td>
<td>4,640</td>
<td>0.9</td>
<td>6.30</td>
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<td>Russia</td>
<td>143</td>
<td>75.6</td>
<td>2,022</td>
<td>8,580</td>
<td>17.1</td>
<td>2.20</td>
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<td>112</td>
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<td>1,177</td>
<td>9,340</td>
<td>2.0</td>
<td>1.70</td>
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<td>Philippines</td>
<td>94</td>
<td>38.9</td>
<td>250</td>
<td>3,010</td>
<td>0.3</td>
<td>7.00</td>
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<td>Vietnam</td>
<td>91</td>
<td>46.2</td>
<td>138</td>
<td>3,607</td>
<td>0.3</td>
<td>5.20</td>
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<td>Egypt</td>
<td>80</td>
<td>26.1</td>
<td>257</td>
<td>2,602</td>
<td>1.0</td>
<td>2.20</td>
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<td>Iran</td>
<td>75</td>
<td>25.7</td>
<td>549</td>
<td>2,663</td>
<td>1.6</td>
<td>-1.90</td>
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<tr>
<td>Turkey</td>
<td>74</td>
<td>24.7</td>
<td>795</td>
<td>3,943</td>
<td>0.8</td>
<td>3.20</td>
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<tr>
<td>Rep. of Korea</td>
<td>49</td>
<td>24.6</td>
<td>1,156</td>
<td>4,083</td>
<td>0.1</td>
<td>2.80</td>
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<tr>
<td>Total BRIC + N11</td>
<td>4,181</td>
<td>1,965</td>
<td>20,293</td>
<td>172,773</td>
<td>48.0</td>
<td>4.84</td>
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<tr>
<td>USA</td>
<td>309</td>
<td>155</td>
<td>15,680</td>
<td>38,514</td>
<td>9.8</td>
<td>1.60</td>
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<td>EU</td>
<td>492</td>
<td>228</td>
<td>16,360</td>
<td>33,084</td>
<td>4.3</td>
<td>-0.50</td>
</tr>
</tbody>
</table>

* according to ‘Economic and financial indicators’, The Economist, 2013

overall service quality are common features of emerging market social health care systems.

Individuals in the employable elite being keenly aware of their value do not hesitate to exercise their power to demand working conditions that best suit them, almost invariably including supplementary medical benefits for themselves and their dependents as part of their hiring packages.

Population Aging
It is commonly known that the populations of the USA and Europe are aging rapidly as a result of the baby boom generation having been followed by decades of low fertility. Even the rapid projected aging of China directly linked to the one-child policy has been abundantly covered in the press.

What is less commonly known is that population aging is a worldwide phenomenon with very few exceptions.

Two of the key impact areas for multinational employers are as follows:

- Despite retirement ages increasing, net declines in working-age population and shrinking labor supply are expected.
- There is increasing demand from employees for employer sponsored medical and pension plans as social plans undergo severe financial stress and curtail their benefits.

In short, big projected increases in healthcare and long-term care can be expected.

Growth of Lifestyle Risk Factors Around the World
Lifestyle risk factors – sedentary lifestyle, poor diets, and higher unmanaged stress levels – are growing globally. Alcohol and tobacco consumption are mature issues that, as people age, are becoming more of a problem and continue to be a challenge in many countries. These risk factors lead to non-communicable diseases (cancer, and cardiovascular and respiratory conditions) or NCDs which now account for most deaths in the world. In short, the global burden of non-communicable diseases is already significantly greater than that of communicable diseases, and growing.

According to the WEF’s Annual Executive Opinion Survey, almost one half of all business leaders worry that at least one non-communicable disease will hurt their company’s bottom line in the next five years. The largest concerns caused by NCDs are with cardiovascular disease and cancer. NCDs account for 63% of all deaths globally; and thus these diseases are currently the world’s main killers.

The levels of concern are greatest among business leaders in low-income countries, in countries with poor quality healthcare and in those that offer low access to healthcare.

The problem goes far beyond the financials of medical plans. The fact is that absenteeism and productivity losses on account of mortality and morbidity from NCDs are expected to result in an estimated US$47 trillion in lost output in the next 20 years. This is equivalent to 5% of the world’s GDP (in 2010 US dollars). Mental health and cardiovascular diseases account for over two-thirds of the projected lost output.

The silver lining is that the magnitude of this expected loss can be significantly reduced through lifestyle modifications in the population in order to minimize exposure to the above-mentioned risk factors. This silver lining extends to health-related benefits – reducing the health complications created by lifestyle risk is one option that does seem to address the fundamental issue of exploding growth in demand for medical services.

CONCLUSIONS
In a world with a dwindling labor supply, lost production from NCDs is not only an HR and Finance challenge but a serious strategic business issue.

Clearly, it will be crucial for employers to ensure that effective health care benefits and health care education are available for all employees and their families, aimed at:

- preventing/reducing the future sickness experience,
- providing high quality health care treatment when needed;
- facilitating the management of chronic health conditions;
- educating the global workforce on the benefits of healthcare and good health; and
- encouraging healthy behaviors.

As learned from the US experience, standard cost-management approaches will be insufficient to addressing anticipated future spiraling medical costs. The playing field will become even more challenging and employers will have to learn how to face projected lost production from ill health and premature mortality resulting from preventable conditions.

In conclusion, maintaining a healthy workforce will not only be the way to solve the medical cost increase conundrum, but, moreover, it will be a business imperative for corporate success and survival.

References