Employers' private healthcare schemes

Executive summary

1. Nearly three times as many people enjoy access to private medical care as part of the compensation and benefits scheme provided by their employer as pay for PMI themselves and the majority of these are members of large corporate (rather than SME) schemes.

2. Larger companies provide access to private healthcare principally to attract and retain staff and to minimize disruption arising from sickness-related absences. They seek to balance the cost of providing access to private healthcare with the benefits that they derive from it.

3. Companies differ in the importance they attach to containing the costs of providing access to private healthcare. Some (we believe a minority) have maintained benefits while funding the increased costs themselves. Some have maintained the level of benefits but shifted part of the funding burden to staff. Some have sought and more are planning to reduce the costs of their schemes, including by adopting 'open'[1] referral processes and restricted hospital networks.

4. While there is thus variation between employers as to the degree of flexibility that employees are permitted when making healthcare decisions, the 'direction of travel' appears to be towards seeking ways of containing the cost burden on the employer of providing access to private healthcare including by adopting a more guided approach.

Introduction

5. Our first theory of harm postulates that some hospital groups may have market power in particular geographic areas. This might arise from the absence of comparable or suitable facilities in the area concerned and hence the lack of an alternative for patients. To assess whether or not this is the case, we will need to understand the requirements of hospital users and in particular the extent to which they regard different hospital facilities as substitutes. We are conducting survey research to understand what the requirements of individual patients/consumers are. However, for the majority of consumers with access to private medical care, their employer is the purchaser of their hospital services and will thus be in a position to decide which hospital facilities to make available to employees. We therefore wished to understand what the purchasing requirements of employers are. We also wished to consider whether large employers, in particular, may be able to exert buyer power.

6. This paper looks at private healthcare schemes provided by larger employers for their staff. It begins by providing some background information on the company-paid sector and how it compares with the individual-paid sector. It identifies segments within the company-paid market that may be relevant to our analysis, noting trends in numbers of subscribers[2] covered and premiums paid. It goes on to describe the requirements of large employers as regards the features and benefits of their

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[1] Open referrals are referrals made without specifying a particular clinician. This is typically accompanied by a process whereby the PMI will recommend suitable specialists to the patient.

[2] 'Subscribers' are used to denote the individual policyholders. The number of lives covered may exceed the number of subscribers as a subscriber's dependants may also be covered.

schemes, including the degree of flexibility that they permit their staff when making healthcare choices.

The company sector: industry background

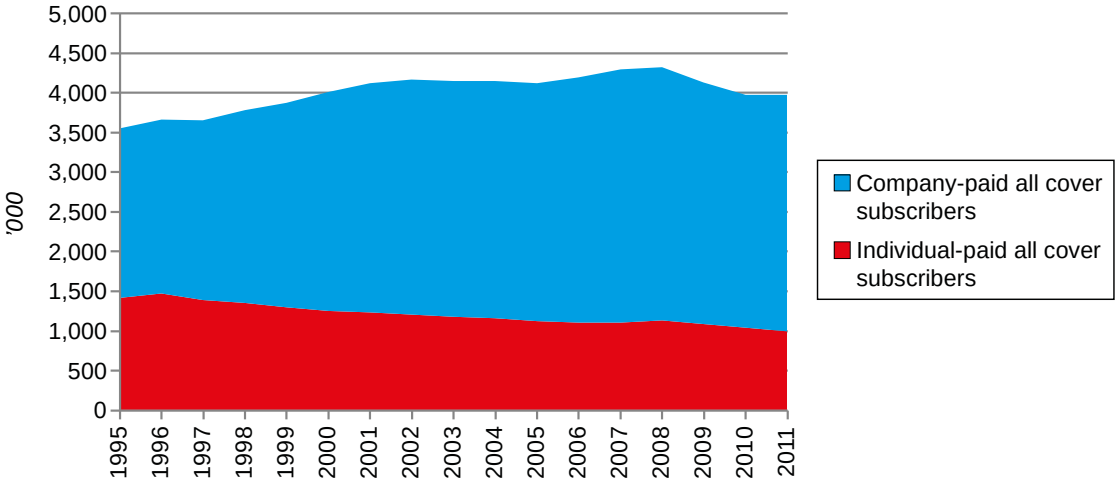
The company-paid vs individual-paid sectors

Subscriber numbers

7. Almost three times as many subscribers are part of company-paid schemes as pay for their own PMI and the majority of these are part of large corporate schemes. In 2011, the number of individual subscribers fell to below 1 million for the first time in recent decades (down from almost 1.5 million in 1995) while the number of subscribers to company schemes remained at about the same level, having been falling since 2008. Laing and Buisson estimate that, as of December 2011, large corporates[3] accounted for 64 per cent of company-paid subscribers, amounting to 1.9 million subscribers, and that SMEs accounted for 36 per cent or 1.074 million subscribers.

FIGURE 1

Company and individual subscribers



Source: Laing and Buisson, *Healthcare Market Review 2011–2012*.

Spend on medical cover

8. Total spending on private medical cover by companies in the UK was estimated by Laing and Buisson at £2,560 million in 2011, large corporates accounting for 56 per cent of this and SMEs 44 per cent.

9. In total, companies spend significantly more than individuals: £2,560 million by companies and £1,692 million by individuals in 2011. However, individuals (and SMEs) pay higher premiums per individual than do large corporates. Because of this, large corporate spending on health cover in total (including the claims costs met by self-insured companies) is less than individuals spend and not very significantly more than SMEs spend in total.

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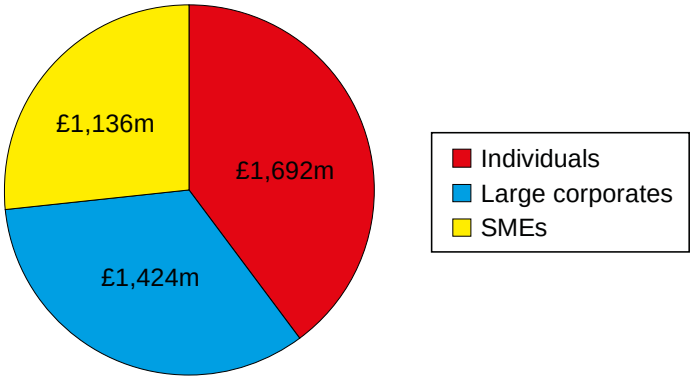
[3] Large corporates are defined by Laing and Buisson as companies with 250+ employees.

FIGURE 2

Health cover spending, 2011



Source: Laing and Buisson, *Healthcare Market Review 2011–2012.*

Types of company schemes—fully insured and self-insured

10. Company schemes may be 'fully insured' or they may be 'self-insured'. In the former case the insurer bears the risk of claims[4] and in the latter all or some of it is borne by the employer.

11. If fully insured, a PMI will be selected by the employer to provide a specified level of healthcare cover in exchange for an annual premium. Typically, this will reflect the company's claims history, being higher or lower according to the size and number of claims being made against the policy.

12. If the employer decides to self-insure, it will, probably with the assistance of specialist compensation and benefit consultants, design its own scheme and create and fund a trust to meet claims from its employees. Typically, an employer will appoint a PMI to administer the scheme, assessing claims and managing the payment process on the trust's behalf.[5] In circumstances where the employer appoints a PMI to administer the scheme, the company will benefit from the rates that the PMI has agreed with private hospital groups and consultants and also with third parties which provide managed healthcare solutions.

13. The benefits of self-insurance to an employer include the avoidance of Insurance Premium Tax, which is currently levied at 6 per cent. However, only larger firms are likely to self-insure since only with a fairly large group of members is the claim rate reliably predictable.[6] Even so, the employer may choose to hedge, taking out 'stop loss' insurance with the PMI, for example in respect of individual claims or the aggregate value of claims.[7]

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[4] Unlike some forms of insurance, PMI is not bought to mitigate the impact of a single, unlikely but catastrophic event. Sickness occurs inevitably on a greater or lesser scale and may be predicted reasonably well based on the nature of the population concerned. The 'risk' here might perhaps be better characterized as the possibility that the cost of meeting claims significantly exceeds that predicted.

[5] As we contacted corporate customers of the major PMIs, all the companies we spoke to use a PMI to administer their trust. Our understanding is that most third party administrators (TPAs) of trusts are PMIs but we found one non-PMI company, Healix, which provided TPA services to large employers: www.healix.com/employers/healthcare-trusts/claims-administration/.

[6] Laing and Buisson estimate that only 1 per cent of SMEs self-insure, whereas 37 per cent of subscribers to large corporate schemes are self-insured. Most, but not all, of the companies we contacted were self-insured, though one [✂] with 20,000 employees told us that it had saved money by becoming fully insured.

[7] Alternatively a company may arrange cover with a captive insurance underwriter.

14. Subject to the trust's compliance with HMRC rules, the value of claims paid on behalf of individual employees will not be considered as a taxable benefit to the employee concerned. The tax burden on the employee will be calculated on the basis of the cost per employee to the employer in a similar way that the benefit of a fully-insured scheme would be calculated: on the value of the premium per employee.

15. It should be noted that even if 'fully insured', the employer is not insulated from the costs of providing medical care as premiums are likely to rise in subsequent years if the cost of meeting claims increases.

Health cover requirements of large corporate customers

16. Our first theory of harm postulates that private hospital groups may exert market power in local areas where they own a large proportion of local healthcare facilities. This, as envisaged by our third theory of harm, might be exploited by hospital groups in conducting national negotiations with PMIs. High fees negotiated by hospital groups with the major insurers will in turn affect the policy premium paid by fully-insured corporate customers or, in the case of self-insured companies, the fees paid to hospitals as negotiated with the relevant PMI.

17. We wanted to understand whether corporate customers were able to reduce their healthcare costs by either requiring their staff to be more flexible as regards the hospitals where they could be seen and treated or by negotiating directly with hospitals. If companies were willing to ask their staff to travel further to attend a private hospital or to use a restricted set of consultants, they might be able to reduce their overall healthcare costs, either by avoiding the use of particularly expensive providers or by securing preferential rates with a particular hospital group. For example, we thought that a large company (rather than an SME) which does/could represent a significant share of a particular hospital's revenue might be able to exert a degree of local buyer power over that hospital if it sought to negotiate directly. We therefore asked large firms operating health cover schemes how important it was to them to have access to particular hospitals and the extent to which they were able to exert buyer power.

18. We contacted the 30 largest corporate customers of the five largest PMIs and asked them why they provided health cover for their employees, the benefits that they required the scheme to provide (particularly in terms of hospital access), how much their scheme cost and whether and if so in what way they had sought to contain the costs of providing private medical cover. Just over 50 companies responded to our questionnaire and we followed this up with telephone interviews with 12 of these. The remainder of this paper is based on what they told us.

Reasons for providing health cover

19. The two most common reasons firms gave for providing health cover to employees were:

    (a) to attract and retain staff; and

    (b) to reduce absences/disruption arising from sickness.

Attracting and retaining staff

20. This was the reason given most often by companies across all industry sectors. In the financial and professional services sector in particular the benefit was seen as a

standard part of the remuneration package which employees would expect to be offered by an employer. Indeed, several firms in the sector [✂] told us that they regularly monitored the healthcare benefits provided by their competitors to employees, subscribing to various surveys and taking advice from their compensation and benefits consultants to as to how their healthcare benefits compared with competitors'. The most commonly mentioned sources of advice on employee benefits, including healthcare, were Towers Watson and Aon Hewitt.

21. The positioning that employers sought, relative to competitors, varied. One financial services company [✂] wanted to be slightly ahead of the average in respect of benefits, if less so on salaries. Another [✂] recognized that its benefit package was less generous than competitors' but took the view that its staff preferred cash to benefits. A major bank, encompassing retail and investment banking activities [✂], told us that for the latter it was an expected part of the remuneration package and was therefore necessary to attract and retain staff, but for the retail side of the business it was over and above the industry benchmark. However, health cover was seen as an essential part of the occupational health and well-being support that the business provided to its staff. Private healthcare shortened the time frame between health problems arising and effective intervention talking place and resulted in a quicker return to work by the employee.

22. Outside of this sector, an oil company [✂] said that it had tried to match competitors' benefits when it introduced the scheme but had also wanted to differentiate its package and so had enhanced a particular aspect of its cancer care. A logistics company [✂] told us that it liked to go beyond what its competitors offered, making health benefits available to first-line managers, for example.

Reducing absences/disruption

23. Because private treatment could generally be accessed more quickly than through the NHS and could be arranged at a time convenient to the patient, disruption as a result of sickness and sickness-related[8] absence could be minimized. Rapid access to diagnostic services was seen as beneficial in that early diagnosis might result in more effective treatment and that treatment could be scheduled so as to minimize the disruption to an employee's work. Additionally, diagnostic facilities (including GP practices and testing/scanning services) close to the workplace reduced the time an employee would need to be away from their desk for a consultation/examination. Having diagnostic, examination and testing facilities close to the workplace was seen by one bank [✂] as being more important than having treatment available close by since employees would probably prefer to be treated at a hospital close to their home rather than to their workplace.

Importance of particular hospitals

24. We asked firms in which parts of the country they employed large numbers of staff and, in those areas, whether there were particular hospitals that it was important were available to their employees. We asked them, if there were such hospitals, whether they had sought to negotiate special terms with the hospital operator and, if so, what the outcome had been.

25. Because of the size and nature of the firms we were approaching, we reasoned that many of them would employ staff in central London and the City. As it had been put

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[8] For example, care of a dependant.

to us that HCA had a strong position in London, we asked companies with a significant number of employees in London specifically how important it was to them to have access to particular HCA hospitals.[9]

Companies with staff concentrations outside London

26. Companies generally took the view that staff outside London would prefer to be treated close to where they lived and worked, though acknowledged that for more serious or unusual conditions it might be appropriate for them to have access to hospitals further afield. They therefore cited hospitals situated in areas where they had a significant concentration of employees as important in access terms.

27. One transport business [✂] said that it adopted a network arrangement in 2010 to help cut the costs of its scheme but that it added a non-network [✂] hospital in one of its locations specifically to ensure that its staff could be treated there. Similarly, a pharmaceutical company [✂], with operations in the North-West, the South and the South-East, told us that it was very important for its staff to have access to two particular [✂] hospitals in the North-West (Spire Liverpool and Spire Cheshire) and another one in the South [✂]. A retailer [✂] cited a particular hospital located close to its Manchester HQ that it said was important for its staff to have access to. A financial services company with several thousand employees on the south coast [✂] told us that a hospital in the area was second only to London Bridge in terms of its usage. A TMT company [✂] said that it employed a large number of people in the Edinburgh area and the hospital that it used most in the UK was the Spire Murrayfield.

28. Generally, companies told us that they thought their PMI would be able to negotiate better terms with the hospital group concerned than they would.[10] It was very rare for companies to have successfully negotiated special terms with such hospitals, though we did find this in one case outside London. This was a volume-related discount scheme which a financial services company [✂] had, through its PMI [✂], negotiated with Murrayfield Hospital in Edinburgh where it had around 5,000 staff based. This arrangement was made prior to the hospital's acquisition by its current owner, Spire, but was still in force. The TMT company referred to above [✂] with 5,600 staff in the area told us, on the other hand, that it used the facilities of the Spire hospital in Edinburgh more heavily than any other hospital in the UK but had been unable to negotiate preferential terms.

Companies with staff distributed nationally

29. None of the companies we contacted had sought to negotiate special terms on a national basis with a major hospital group. One major bank, with staff distributed across the UK [✂], told us that it thought the bulk purchasing power of its scheme administrator [✂] would outweigh any leverage it could apply direct.

Companies with large numbers of staff in London

30. We asked companies with large numbers of staff based in London how important it was for their employees to have access to named HCA hospitals. Their responses

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[9] We listed HCA's hospitals and asked companies how important it was that their scheme provided their employees with access to them and whether some were more important than others.

[10] The PMI concerned had, in some circumstances, negotiated special terms with a hospital into whose catchment area a concentration of the employer's workforce fell. A PMI told us that it had come to such an arrangement on behalf of an employer in the West Country, for example.

varied. All three of the professional services firms that we heard from [✂], said that access to the HCA hospitals was either 'very important' or 'essential'.

31. Within the financial services sector, investment banks tended to have the same view, one [✂] telling us that the cost saving likely to arise from restricting access would not compensate for the likely negative reaction from senior executives that would ensue. Another [✂] said that it had considered continuing to permit consultations and diagnostic tests at the London Bridge Hospital whilst insisting that treatment took place elsewhere, but said that this would lead to a 'significant backlash' and had not pursued this.

32. Even so, not all investment banks took this view. One [✂] told us that as the costs of its healthcare cover rose by 12 per cent in 2012, it was considering and was likely to adopt an open referral scheme which would allow its employees access to two hospital chains only [✂], excluding HCA hospitals, unless treatment at another hospital could be medically justified. Its PMI [✂] would determine whether claims met this test on a case-by-case basis.

33. The attitudes of the major high street banks which responded differed as regards restricting access to particular hospitals and consultants.

34. One [✂] permitted staff to attend whichever consultant at whichever hospital they wanted but made them pay more for this than if they accepted a more directional pathway. It offered three levels of cover. Its default scheme for managers was the middle level, at a monthly cost to the employee of £40 but it funded this through an equivalent salary enhancement if the employee joined the scheme. Middle level healthcare did not, however, provide employees with access to HCA hospitals: this would require the top tier. If bank executives wished to avail themselves of this level of cover, they could subscribe at a cost of £140 per month, though this would not be funded by the employer.

35. Another bank [✂] told us that it provided access to all hospitals in London. It said that this was because while retail banking staff would not be likely to insist on a particular hospital, staff on the investment banking side of the business would. This bank told us that it would not be practicable to offer two different schemes through the same trust.

36. A third [✂] introduced open referral in January 2011. It told us that it offered two levels of cover: standard and enhanced. Under the former, staff were limited to the recommendations of the scheme's administrator [✂] but under the enhanced scheme, to which employees had to contribute, they were not. It said that a majority of its staff had opted for standard cover but, of those that joined the enhanced scheme, 33 per cent receiving treatment opted to stay within the guided pathway.

37. Still within the financial services sector, the two insurance brokers which responded [✂] told us that they did not consider it important to provide access to HCA hospitals. One [✂] said that it did not aim to provide a 'Rolls Royce' scheme, though some form of health cover was a standard element of remuneration packages in the sector generally.

38. Outside the financial services sector, some other firms with large numbers of staff in London operated relatively unrestricted schemes. These included TMT [✂], logistics [✂] and FMCG [✂] businesses. That said, other large companies operated more restrictive schemes. Some very large corporations [✂] told us that it was not important to provide their staff access to the HCA hospitals, for example.

39. It was not clear why these differences existed. Where such firms explained the reasons for considering staff access to the HCA hospitals important, they tended to cite the convenient location of the HCA facilities more than other factors. The location of the London Bridge Hospital, in particular, made it possible for employees of City firms to minimize their absence from the office when attending medical appointments.

40. Some of these companies cited the reputation of these hospitals for high-quality healthcare as being the reason for including them in their schemes. Others [✂], however, told us that since no appropriate quality measures were available it was impossible to draw value-for-money conclusions.

41. In this context, we also note that four financial services firms [✂] expressed some concern at the ownership of private GP and occupational health facilities by the hospital group HCA in that these might be more likely to refer patients to consultants at HCA hospitals on grounds other than medical necessity. One [✂] said that it might be difficult to detect if this was happening since referrals could be driven by the perceived quality of the healthcare available at HCA hospitals or their convenient location. Another [✂] noted that the Roodlane practice did frequently refer patients to London Bridge and contrasted their referral practice with that of two other clinics used by the firm. None of these firms was able to offer any evidence of a systematic bias towards HCA referrals or of particular instances where they believed a referral had been made on non-medical grounds.

Measures to contain costs

42. The amount that companies spend on the provision of health cover is significant, averaging £865 per employee covered.[11] Based on what the large companies that we contacted told us, expenditure per head appears to vary considerably, from less than £400 to over £1,000.

43. The priority that companies attached to containing the costs of private healthcare for their employees and maintaining the benefits of their scheme also varied. Some companies had considered but refrained from adopting cost-cutting measures in the past. One professional services firm [✂] told us that it had investigated introducing an excess and reducing the number of staff covered by the scheme but had not done so as this 'would be seen as degrading the benefit level'. Another [✂] said that it had considered introducing excesses and caps but had decided not to since there was not a great deal of pressure ('noise') to reduce the costs of the scheme, and to downgrade the benefits would be seen as counter to the firm's culture of treating people very well. A bank [✂] said that it had not seriously considered changes for several years but the rise in costs in 2012 had made reducing the costs of the scheme a higher priority. A public sector services company [✂] had rejected a number of cost-cutting initiatives as these would not generate sufficient savings 'to offset likely adverse reaction from staff'. One TMT company [✂] said that it had explored the introduction of open referrals in 2008 and had decided not to adopt it but was currently reconsidering this option.

44. Some said that they had made changes at the margin ('tweaks') such as discontinuing providing the benefit to retirees [✂] or raising the cost to employees of adding dependants to the policy [✂].

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[11] Laing and Buisson, *Health Cover, 2011–2012*, p21.

45. The most common measure adopted was the introduction of or an increase in a policy excess which, we were told, was effective in reducing claims.[12] Other measures included 'shared responsibility' (whereby the employee would pay, say, 25 per cent of the cost of treatment up to a limit of, say, £150), removal of free cover for dependants and, less commonly, open referrals.

46. Bupa launched open referrals as a pilot in 2011 at the request of one of its corporate customers. Bupa made it an option available to corporates as from January 2012. Bupa told us that open referral was not mandatory on clients but that it was Bupa's recommended position. As a result, all clients coming up for renewal from January 2012 were offered terms on an open referral basis, though also given the option to request continuation of their current service without open referral. Bupa told us that as of July 2012, just under half of the lives it covers or provides administrative services for in the corporate segment (including Health Trusts) were on open referral policies.

47. AXA PPP, announcing an extension of its corporate Pathways open referrals product in October 2012, said that it hoped that this would become the preferred option for its corporate clients in two to three years.[13]

48. Open referrals had been introduced by one major retail bank [✂] specifically as a way of reducing costs and three other companies [✂]. Three further companies said that they were planning to introduce open referrals in 2013 [✂]. One of these companies [✂] told us that it had concluded that open referral would reduce the cost of the scheme but with no reduction in clinical care. It said that a further benefit of open referral was that its employees would not be 'shortfalled'. Another [✂] said that its decision had been prompted by a 12 per cent increase in the cost of the scheme in 2012.

49. Other measures aimed at containing costs mentioned by more than one company included the use of alternative treatment pathways for particular conditions. Most commonly mentioned were referral to physiotherapy services procured by the insurer/trust administrator where staff had musculoskeletal conditions [✂] or potential psychiatric problems [✂].

50. One bank [✂] told us that about one-third of its claims were associated with musculoskeletal problems and that the traditional pathway of visiting the GP, referral to a physiotherapist or surgeon was slow and expensive. It said that the Nuffield service, offering telephone advice and home exercises initially, which was available to its scheme members, was more flexible, quicker and cheaper.

51. None of the companies we contacted indicated that they had considered withdrawing private health cover from its benefit package entirely, though one retailer [✂] said that it had withdrawn cover from a layer of its workforce. However, we were told by one firm of employee benefit consultants (Towers Watson) that a 'tipping point' may be approaching. It told us that, increasingly, its clients found the existing model of healthcare provision unsustainable as a result of rising costs. It told us that a tax burden of £500 had been sufficient to lead some of its clients' lower-paid employees to withdraw from the scheme, thus increasing the companies' risk profile and attracting higher premiums. It said that companies in the UK, including those which were part of US corporations, may adopt different types of schemes such as Healthcare Savings Accounts or Consumer Directed Healthcare Arrangements which had

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[12] For example, one company [✂] told us that its claims fell from £670,000 to £480,000 when it introduced a £100 excess in 2008/09.
[13] www.hi-mag.com/health-insurance/product-area/pmi/article408950.ece.

become much more common in the USA. These schemes provide employees with a 'fund' of healthcare benefits which they may spend or accumulate in a tax-free savings account which may transfer with the employee between employers and into retirement. We were told that such schemes were cheaper for employers to provide and that since employees were spending 'their own' money they may be expected to consider questions of value for money more carefully than they would under insurance-based schemes.

Conclusions

52. Our first theory of harm postulates that some hospital groups may have market power in particular geographic areas where they own a large proportion of local healthcare facilities. We wanted to understand whether, in such circumstances, corporate customers were able to reduce their healthcare costs either by requiring their staff to be more flexible as regards the hospitals where they were seen and treated or by negotiating directly with hospitals.

53. The extent to which companies require flexibility from their staff in selecting hospitals for treatment varies. As we have seen, employers generally aim to strike a balance between the costs of their schemes and the benefits they derive from them in terms of staff satisfaction and absenteeism. Some, including but by no means all, or only, the professional services and investment banking sectors, appear to lay greater stress on the latter than the former and have met the rising costs of their schemes with only minor reductions in benefits. Others have opted for or maintained schemes which permit employees greater choice of hospital or consultant but at a price to them. Still others have adopted or are in the process of introducing open referrals or restricted networks, despite the fact that these measures might be unpopular with some staff.

54. That said, while there are variations, if there is an overall 'direction of travel' it appears to be towards seeking ways of reducing the cost burden on the employer of providing private health cover including by adopting a more guided approach.[14]

55. A more guided approach may enable companies to reduce the cost of private healthcare where alternative, cheaper facilities are available to which employees may be directed but where one hospital operator owns most of the private healthcare facilities in an area neither adopting a more guided approach nor attempting to negotiate preferential terms appear likely to reduce the private healthcare costs of even a large corporation.

[14] It was suggested to us [✂] that Consumer Directed Health Care, which is growing in acceptance in the USA, and whereby employees have access to a fixed sum to spend on healthcare benefits but may do so as they wish, may become more popular with UK employers.