United States

Reshaping Health Care

Best Performers Leading the Way

2013

18th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care

National Business Group on Health

TOWERS WATSON

United States

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Employer Survey on Purchasing Value in Health Care

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Executive Summary

"While U.S. employers remain committed to health care benefits for active employees over the next five years, they are redefining their financial commitment in the short run and are more reluctant to commit to coverage for employees over a longer period."

The 2012 presidential election and the Supreme Court decision on the Patient Protection and Affordable Care Act (PPACA) are solidly behind us, and U.S. employers will move aggressively this year and next to comply with the requirements of the health care reform law. Their actions are driven in large measure by a need to manage rising costs and to avoid triggering the 2018 excise tax on high-cost plans. That is one of the key findings of the 18th annual Towers Watson/National Business Group on Health (TW/NBGH) Employer Survey on Purchasing Value in Health Care.

Best Performers Spearhead Change

Many respondents continue to employ strategies that manage costs, respond to health care reform, improve health care quality, and increase employee engagement in their personal health and use of health care services. But in this report, we've focused specifically on the actions taken by a group we call "best performers" — those in the top tier of respondents whose costs have increased over four years at a much lower rate than the TW/NBGH median. More than other respondents, these organizations are using emerging strategies to improve delivery and cost management. They are focusing on supply-side strategies, including vendor performance targets, cost transparency, value-based benefit designs and holding providers accountable. As a result, their employees' share of health care costs are also lower, their total rewards packages more competitive and their employee value proposition more successful.

A Continuing Commitment to Providing Benefits — at Least for Now

While U.S. employers remain committed to health care benefits for active employees over the next five years, they are redefining their financial commitment in the short run and are more reluctant to commit to coverage for employees over a longer period. Only 26% of respondents say they are very confident that health care benefits will be offered by their organization 10 years from now. This is not surprising given the breadth of changes that have occurred and will continue to occur in the health care landscape. For example, employers may be waiting to see whether the public exchanges (due to launch in 2014) will provide reliable alternative coverage for certain segments of their workforce, or even their entire workforce. They may want to understand how their

plans will fare under the 2018 excise tax provision. And they may want to wait and see what their competitors will do before they make major changes to their health benefit plans.

One thing is sure: Transformative changes to health care delivery and financing in the U.S. — discussed for decades and passed into law in 2010 — have begun in earnest. And employers, which collectively are among the biggest payers in the health care financing system, are bound to make major changes, both to stay competitive and to remain influential stakeholders.

Changes Ahead for Employees and, Especially, Retirees

Active employees and their dependents, as well as retirees, will be affected by coming changes. Employers — which by and large do not expect health care reform to lower their costs — will continue to redefine their financial commitment to employee health care. They will likely continue to seek more financial participation on the part of employees, either through greater across-the-board cost sharing or through other strategies such as reduced dependent subsidies.

Imminent change in employer strategy is also afoot for part-time employees who work 30 or more hours a week. For them, under the PPACA, employers may pay a penalty if affordable, qualified coverage is not made available.

For retirees, change is coming even sooner than for active employees. More employers are reducing or eliminating their commitment to post-65 retiree health care, with an eye to exploring opportunities that the public exchanges may create for pre-65 workers. Beginning next year, pre-Medicare retirees will be eligible for guaranteed coverage, potentially with a subsidy, depending on income through a completely new marketplace. Survey respondents have expressed a willingness to help with the cost, transition and communication related to alternative coverage for those interested in retiring before they qualify for Medicare.

Our survey report provides aggregate responses from 583 organizations with a collective $103 billion in total 2012 health care expenditures. Last year, we reported that the significant changes in the U.S. health care system and continually rising costs drove some employers to revisit their total rewards program (that is, the combination of basic rewards such as salary and benefits, performance-based pay, and nonfinancial rewards such as training and education). They aimed to recalibrate their reward portfolio to balance cost concerns with their employees' needs for competitive salary, access to affordable health care and a secure retirement. This year, the potential effect of the PPACA excise tax in 2018 on high-cost health care plans threatens that balance over the long term. The survey results show that many more employers — including those that sat on the sidelines waiting for political and judicial clarity — will seek strategies to lower costs, improve health and avoid the tax. The actions of our best performers may well provide a playbook that others can follow to achieve their goals. This is especially true for those whose strategies and tactics have led to less-than-desirable financial and health results.

"Transformative changes to health care delivery and financing in the U.S. — discussed for decades and passed into law in 2010 — have begun in earnest."

Key Themes

"More respondents say they will work with their health plan vendors to rethink plan design, and improve the quality and efficiency of member care."

Employers take aggressive action
After plan changes, average employer health care costs are expected to reach $9,248 in 2013, up 5.1% from $8,799 in 2012. This is the lowest increase in 15 years and down slightly from a 5.2% increase in 2012. Since the mid-2000s, trend has moderated in the single digits, largely due to an increasing number of employers that manage costs by emphasizing employee accountability (including increased employee costs), and investment in programs and emerging technologies that support and cultivate a healthy and productive workforce. Now, with the PPACA taking effect, the excise tax looming in 2018 and medical trend still double the rate of inflation, we expect to see even more profound change — recalibrated strategy and aggressive action — among larger numbers of employers. More respondents say they will rethink plan design, and improve the quality and efficiency of member care. Strategies include greater vendor transparency, value-based pricing and new reimbursement models.

Best performers set up for long-term success
Our best performers (those whose costs have grown over four years at or below the TW/NBGH median) had an average trend of 2.2%, less than half the mean and roughly in line with general inflation. Their strategies focused on efforts to contain both their costs and their employees' costs so they have a greater share of their budget to devote to other aspects of their rewards, including salary increases and retirement, with an emphasis on value and effectiveness in achieving their attraction and retention goals.

Marketplace changes gaining momentum
Nearly all respondents (92%) anticipate at least modest changes in the health care marketplace over the next five years, and nearly half expect significant changes (44%) or a complete transformation (3%). Many believe the adoption of emerging technologies such as telemedicine, mobile applications, e-visits and data-enabled kiosks will create new access points for health care delivery. Respondents also expect provider reimbursements to be more closely tied to performance — including quality of care, efficiency and health outcomes — than they are today. While 49% of respondents are optimistic about price transparency emerging to support point-of-care decisions, very few (7%) expect health care cost increases to approach the rate of inflation in the next five years.

Rising employee costs impact affordability
Employees' share of premiums increased 8.7% between 2012 and 2013, with the dollar burden rising from $2,658 to $2,888. In fact, employees contribute 42% more for health care than they did five years ago, compared to a 32% increase for employers. Likewise, out-of-pocket expenses at the point of care continue to rise — up by 15% over the last two years, from 15.9% to 18.4%. The total employee cost share, including premiums and out-of-pocket costs, has climbed from about 34% in 2011 to 37% in 2013. Meanwhile, annual salary increases have averaged only 1.6% over the last three years. From a total rewards perspective, rising health care contributions are taking their toll on employee take-home pay. Employees are also paying more through out-of-pocket costs at the point of care. Continued increases in the cost of health care may motivate employees to use employer programs designed to contain and lower costs for both employers and employees by supporting healthier choices, greater accountability and acceptance of value-based plans.

Redefining contribution strategy
The increase in employee contributions includes a rise in the share of premiums paid by employees — from 22.5% in 2008 to 23.8% today. That increase is due partly to subsidy shifts for dependents: Over the last three years, more than 70% of companies increased employee share or premium contributions, and dependent coverage costs increased at a higher rate than single coverage.

Over the next three years, more than 80% of respondents plan to continue to raise the share of premiums paid by employees, and they anticipate

"Companies are increasingly embracing health plan strategies that use financial incentives to hold providers accountable."

increases in all coverage tiers. The use of surcharges for spouses is also growing. Twenty percent of respondents use them now, and an additional 13% plan to next year. Best performers lead all other employers in raising dependents' share of premium contributions as a percentage of total premiums.

As ABHPs evolve, their growth escalates

Account-based health plans (ABHPs) can be an important strategy for reining in costs in advance of the 2018 excise tax and facilitating the shift toward greater accountability from employees and more consumer-like behavior in their purchase of health care. Today, 66% of companies have an ABHP in place, and another 13% expect to add one by 2014. Total-replacement ABHPs are also on the rise. Nearly 15% of respondents with an ABHP use a total-replacement ABHP, up from 7.6% in 2010. Over the same period, median enrollment in ABHPs has nearly doubled, surging from 15% in 2010 to nearly 30% in 2013. This increase has been helped significantly by employers choosing complete replacement of their plans with an ABHP. Nearly one-quarter of all respondents may offer an ABHP as their only plan option in 2014 if they follow through with their current plans to make that change. ABHPs have also become more prevalent as they've been restructured to embed incentive strategies and align with postretirement strategies.

Employers still strongly committed to subsidizing health care benefits

Eighty-five percent of companies say their strategy for employee cost sharing for health care coverage will be an important component of their overall value proposition over the next five years — virtually unchanged from today (90%). However, confidence that they will continue to offer health care benefits 10 years from now remains low (26%), suggesting that employers are uncertain about the direction of the marketplace in the coming years. They may want to see how successful the exchanges turn out to be or how many leaders in their industry eventually choose to pay penalties to direct employees to an exchange rather than continue to offer health care.

Eroding coverage for retiree medical benefits

Employer subsidies for retiree medical coverage have sharply declined over the last two decades, with only 15% of companies offering them to newly hired employees today. Those that continue to provide some level of financial commitment are increasingly shifting to account-based designs. Some are facilitating retiree access to individual and group Medicare plans through a Medicare coordinator to ease this transition and lower subsidies for Medicare-eligible retirees.

Employers embrace incentives and emerging payment approaches to improve the quality of care delivered

Companies are increasingly embracing health plan strategies that use financial incentives to hold providers accountable. Although the percentage of respondents choosing these strategies remains under 25%, many more employers say they expect more provider accountability on these measures next year (33%). We expect this trend to grow now that Medicare, Medicaid and many insurance companies have started using value-based purchasing.

Raising the bar on engagement strategies

Nearly two-thirds of respondents offer employees and their spouses financial rewards to encourage participation in health management programs. All signs point toward tougher requirements for earning financial rewards in the coming years. This year, 6% more employers than last year, for a total of 16%, limited these rewards to participants who showed measurable improvement. Another 31% say they are considering this approach for 2014. But it's not all about financial incentives. Companies recognize they need to develop a supportive workplace culture to engage employees in their own well-being. They are designing creative approaches, leveraging new ideas from behavioral economics, using social media to personalize health messages, placing greater emphasis on the physical work environment and using senior leaders to champion workforce health goals.

About the Survey

The 18th annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care tracks employers' strategies and practices, and the results of their efforts to provide and manage health benefits for their workforce. This report identifies the actions of best-performing companies as well as current trends in the health care benefit programs of U.S. employers with at least 1,000 employees *(Figure 1)*. Respondents were also asked about the specific implications of the PPACA for their health care benefit programs.

The survey was completed by 583 employers, between November 2012 and January 2013. It reflects respondents' 2012 and 2013 health program decisions and strategies, and in some cases, their 2014 plans. Respondents collectively employ 11.3 million full-time employees, have 8.5 million employees enrolled in their health care programs and operate in all major industry sectors (*Figures 2* and *3*). In 2013, respondents expect to spend, on average, $12,136 per employee on health care, which equates to a collective $103 billion in total health care expenditures.

Figure 1. Number of full-time workers employed by respondents

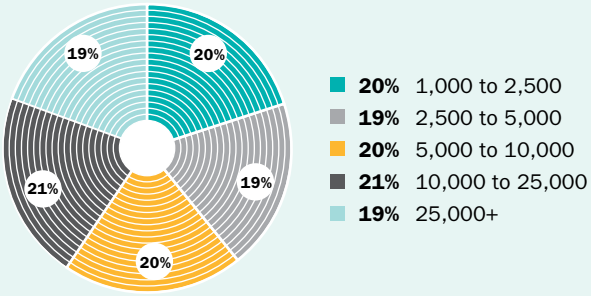


Figure 2. Region where the majority of benefit-eligible workforce is located

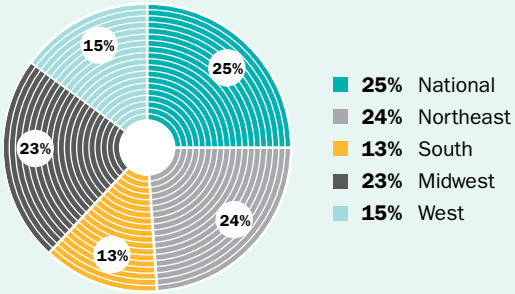
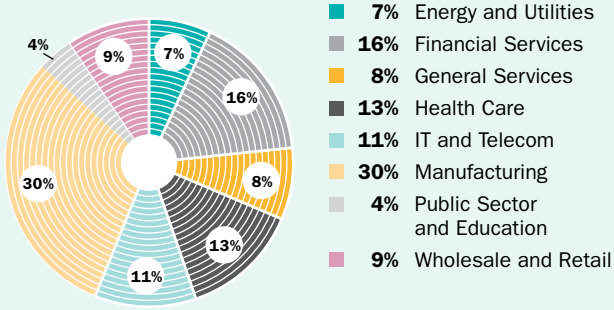


Figure 3. Industry groups



A Note About Health Care Costs

Health care costs and rates of increase throughout the report are based on aggregated company values, combining all plans — insured and self-insured — for all plan types and coverage tiers for actively enrolled employees. Health care cost measures include medical and pharmacy benefit expenses, company contributions to medical accounts — flexible spending accounts/health reimbursement arrangements/health savings accounts (FSAs/HRAs/HSAs) — and costs of administration, including any health management program costs and program participation incentives paid by the plan.*

Health Care Costs per Employee

The following terms are used to define health care costs throughout the report, which include the combination of employer and employee portions of health care expenses:

- **Employer costs** — Costs per employee, excluding employee contributions (from their paycheck) and point-of-care costs
- **Employee contributions** — Employee portion of total plan costs paid per paycheck
- **Out-of-pocket costs at point of care** — Employee spend on deductibles, copays and coinsurance; also called point-of-care costs
- **Total plan costs** — Total costs paid by the plan, including both employer costs and employee contributions
- **Total health care expenses** — Total costs considered for payment, including employer costs and employee contributions and point-of-care costs

Health Care Cost Trends

The rates of increase shown throughout the report are based on the change in the various health care cost measures (noted above) per actively enrolled employee. Trends are shown after changes to plan designs and employee contributions. Rates of increase are also provided if the responding companies made no changes to the medical or pharmacy plan designs, or employee contributions.

*Administration costs include claim-processing fees, network access fees, utilization review fees, stop loss premiums, and any health management program costs and program participation incentives paid by the plan.

Strategy and Planning

What's on the Horizon?

With the PPACA's main directives taking effect in January 2014, most employers foresee big changes ahead for employer-provided health care plans, but they are still not sure exactly what the changes will look like. When asked the degree to which they thought plans would change by 2018 — the year that the excise tax on high-cost plans takes effect — 92% of employers said the plans would be different, with 47% saying they anticipated significant or transformative change *(Figure 4)*. However, when asked which changes they thought were most likely, less than 50% pointed to the likelihood of any specific change in the next five years *(Figure 5)*. This could indicate that the details of these changes are still making their way into the employer mainstream. In fact, many respondents were neutral on the value of specific changes, perhaps because the landscape is rapidly evolving. This is true for both the emerging pay-for-performance strategies and the health care exchanges. The one exception is our best-performer group. Some best performers chose new strategies for 2013, and more plan to do so in 2014 (see Strategies Planned by Best Performers, page 32).

Companies were most confident they'd see advances in vendor price transparency by 2018, with 49% choosing it as an option. They may be hoping the investments they've made or plan to make in transparency tools will pay off. These tools are designed to help employees gain information about health care prices charged by different vendors and their health care results. Emerging technologies used to create new access points for health care, including e-visits, telemedicine and data-enabled kiosks, placed second, with 45% of employers saying they would have an impact on the marketplace in the next five years.

Figure 4. Anticipated change in employer-sponsored health care by 2018

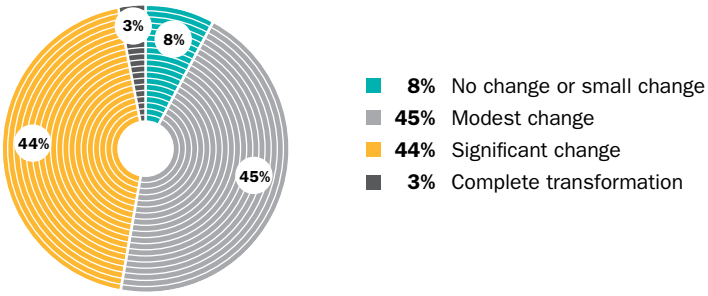


Figure 5. Likelihood of the following changes in the health care marketplace over the next five years

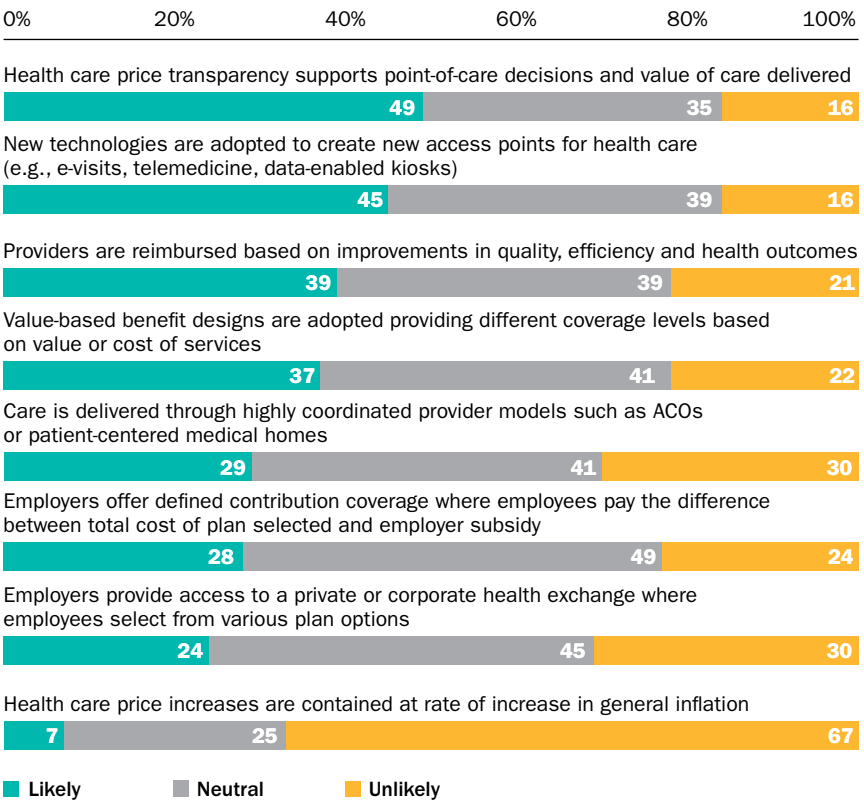
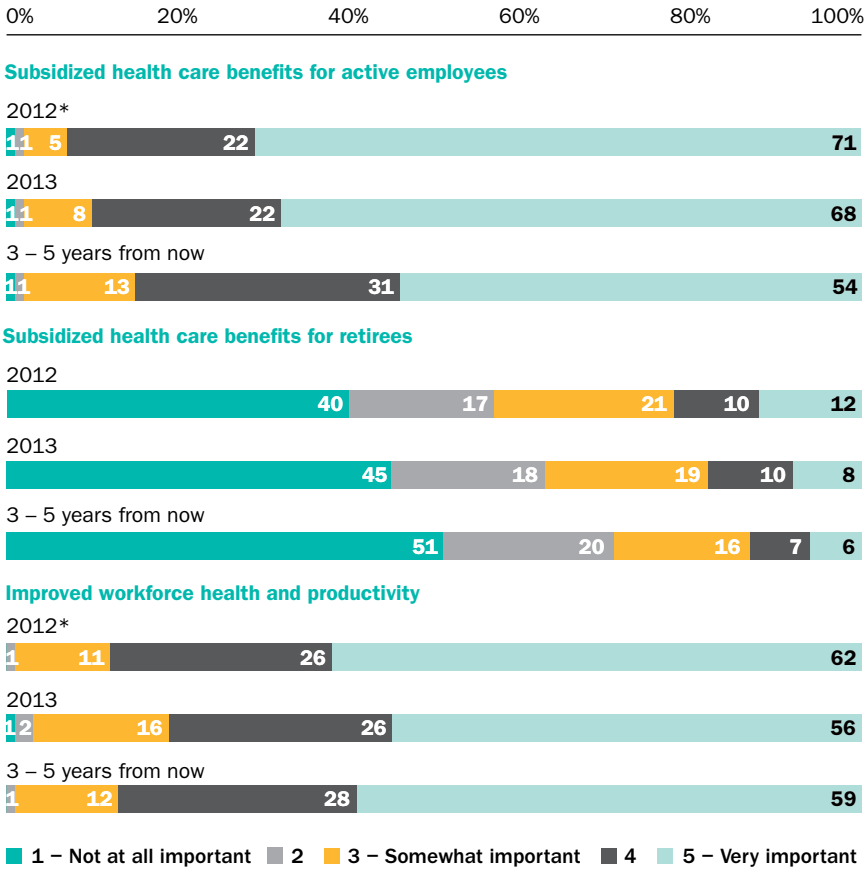
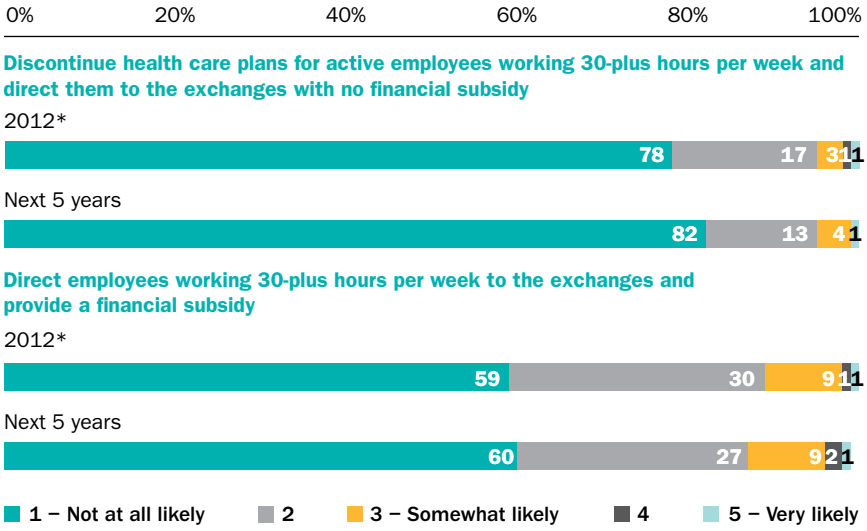


Figure 6. Importance of employer subsidies, and health and productivity to company's employee value proposition in 2012 and beyond



*17th annual TW/NBGH Survey

Figure 7. Likelihood organizations will take the following action in the next five years with their full-time, active health care programs



*2012 Health Care Changes Ahead Survey

While not ranked as highly as other marketplace changes and largely still in development, the use of private exchanges where employees would select from options was selected by one in four employers as likely to be a new channel for coverage over the next five years.

With the exact future of the health care marketplace still unclear, one thing is certain: Employers, under across-the-board cost pressure, do not anticipate any change in the steady rise of the cost of health care over the next five years. A full 67% said that it was unlikely that annual increases would slow down to the rate of inflation anytime soon, and another 25% took a neutral position probably because they are not sure how the PPACA might affect costs.

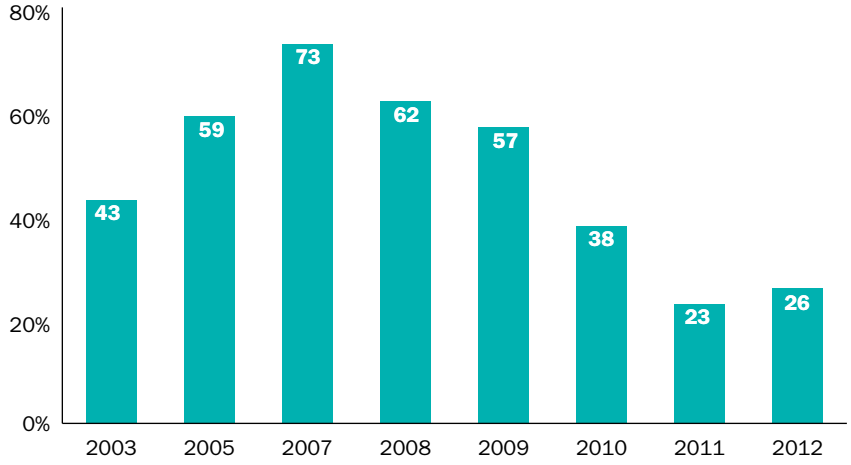
Commitment to Employer-Sponsored Health Care

Most respondents (71%) said subsidized health care benefits for retirees will not be important to their employee value proposition (EVP) in three to five years *(Figure 6)*. However, employers believe their subsidies for health care, and improved health and productivity for active employees, will remain a key component of their EVP in the next five years, although somewhat less important than today. Further, 82% of respondents said it is not at all likely that their organization will direct active employees to a public exchange without a subsidy in the next five years. Even with a subsidy, most organizations haven't changed their minds about directing actives to an exchange: 59% said it was unlikely in 2012, and 60% say it is unlikely by 2018 *(Figure 7)*.

Confidence About the Long Term

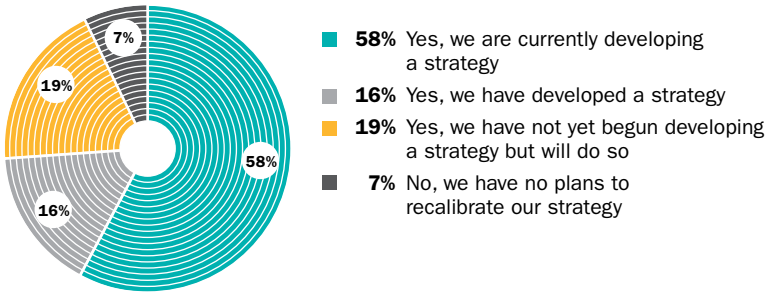
Despite the deceleration in health care cost increases in recent years (e.g., a median of 8% in 2006, to 5.9% last year and 5.1% this year), respondents' confidence that their organization would provide health care benefits a decade from now has declined since the passage of the PPACA in 2010 *(Figure 8)*. A full 93% of respondents say they have updated or will be updating their health benefit strategy *(Figure 9)*. Not surprisingly, 57% say they are changing their strategy due to the impact of provisions in the PPACA. These employers would do well to study the actions of our best performers for strategies that engage employees, health care providers and vendors in thinking about the cost and value of health care (see page 30).

Figure 8. Employers' confidence that health care benefits will be offered at their organization a decade from now remains low



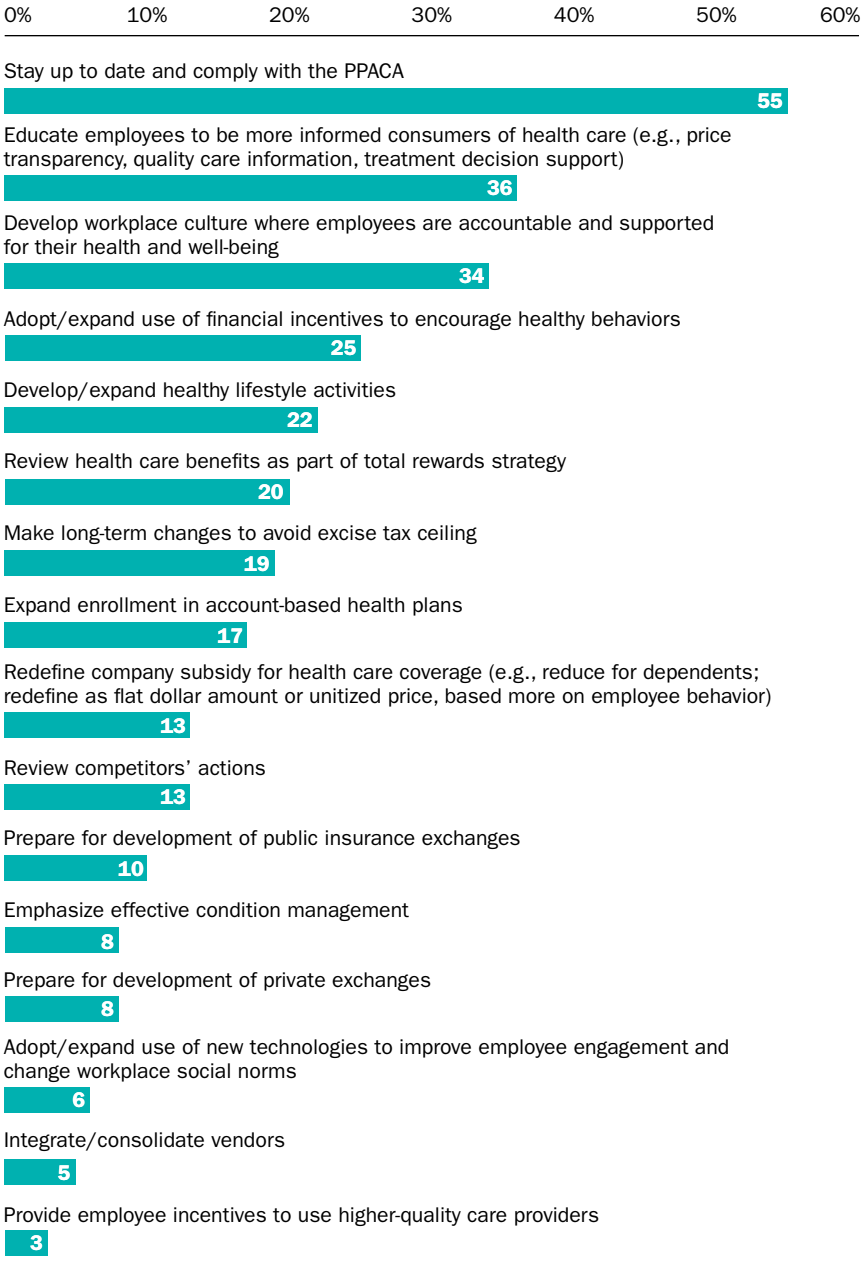
Note: Indicates responses of "very confident"

Figure 9. Many companies are focused on recalibrating their health care strategy for 2014 and beyond



"These employers would do well to study the actions of our best performers for strategies that engage employees, health care providers and vendors in thinking about the cost and value of health care."

Figure 10. Top focus areas of employer's health care strategy in 2013



Top Focus Areas

With the exchanges looming and other regulations being implemented, staying up to date with the PPACA returns as the top priority of employers in 2013, just as in 2011. Last year, it fell to second place behind building a supportive workplace culture — including physical environment, leadership support, and education and information to support more informed decisions, which rate in the second and third positions of overall top priorities in 2013 *(Figure 10)*. All indications are that employers will continue to focus on the most effective ways to control rising costs and improve employee health and well-being.

Cost Trends

In a recent Bank of America/Merrill Lynch survey of CFOs, 60% cited health care costs as their top concern for 2012. That's a new trend for corporate finance leaders, who traditionally have left health care benefits in the hands of HR. What's more, in a recent Towers Watson survey of CFOs and CHROs, Finance respondents anticipated a growing role for themselves in benefit strategy. At the moment, the HR/Benefits function still manages employee health care at 58% of companies.

It should be no surprise that health care is on CFOs' radar screen in a bigger way than ever before. The PPACA's major provisions and attendant penalties that could affect the bottom line, coupled with the continued increase in health care costs, have brought the issue front and center to the C-suite and the board.

Although medical cost trends have stabilized at between 5% and 7% over the last five years as a result of plan design and contribution changes, these benefit costs are still growing at twice the rate of inflation and have outpaced wage growth for more than a decade *(Figure 11)*. In fact, wages have been rising between 2.0% and 3.5% annually for much of the last decade, dipping to 1.6% over

HR/Benefits still in charge (at most companies)

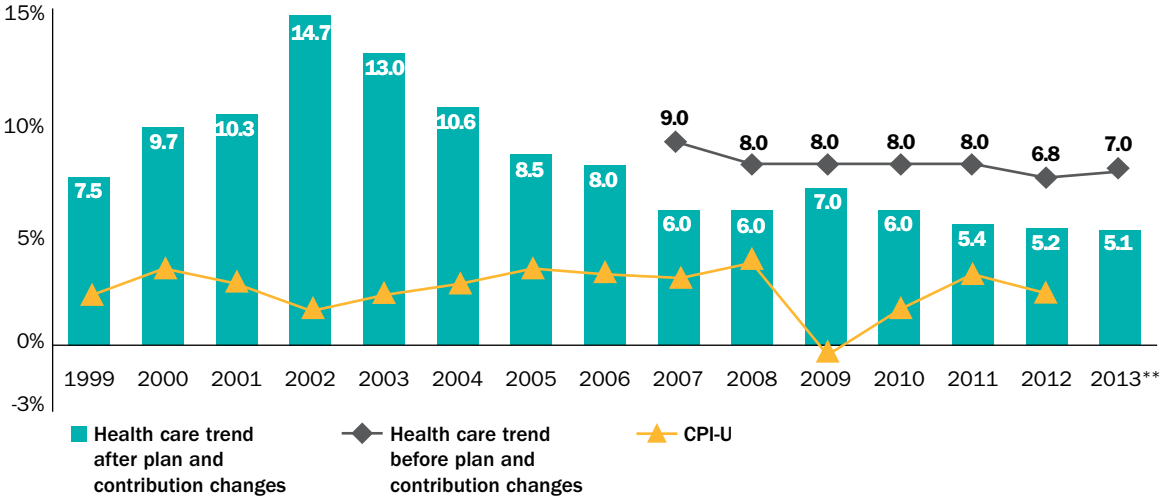
58% **of companies govern their health care plan(s) exclusively through their Benefits department, whereas**

11% **of companies use only a separate non-board level committee.**

Many companies (24%) use several committees, with the majority using a combination of the Benefits department and a separate non-board committee to oversee the health care plan (12%).

Statoid

Figure 11. Health care cost increases have leveled off*



Note: Median trends in employer costs for actively enrolled employees; CPI-U extracted from the Department of Labor, Bureau of Labor Statistics

*A company's medical benefit expenses for insured plans include the premium paid by the company. For a self-insured plan, these expenses include all medical and drug claims paid by the plan, company contributions to medical accounts (FSAs/HRAs/HSAs), and costs of administration minus employee premium contributions. The annual change in costs is based on costs for active employees after plan and contribution changes. Respondents are asked to report trends directly in the survey.

**Expected

"For some employees, the question of affordability becomes even more evident as their paycheck deductions for health care premiums rise while their wage increases shrink."

the last three years. The slower pace of health care cost trends, then, does not diminish the growing affordability challenge for active employees, who see an increasing share of their total rewards going to health care benefits. Unquestionably, organizations where HR and Finance are aligned on a total rewards strategy will be best positioned to assess both the cost and talent implications of decisions in the future.

In 2012, medical costs after plan and contribution changes rose 5.2%, compared to 5.4% in 2011, and are expected to increase by 5.1% in 2013. To put this stabilization in context, it is important to realize that without changes in plan design and increases in employee contributions, average cost trends would have been 6.8% in 2012 and would be anticipated to be slightly higher (7.0%) next year. Pharmacy costs after plan changes rose 4.5% in 2011, 5% in 2012 and are also expected to grow at 5% in 2013. Again, without plan changes, the rates would have grown 6% in 2011 and 2012, and would be 7% next year. It is clear that changes in plan strategy can help hold the line on costs, but the most successful companies embrace a more holistic strategy (see Strategies for Long-Term Success, page 33).

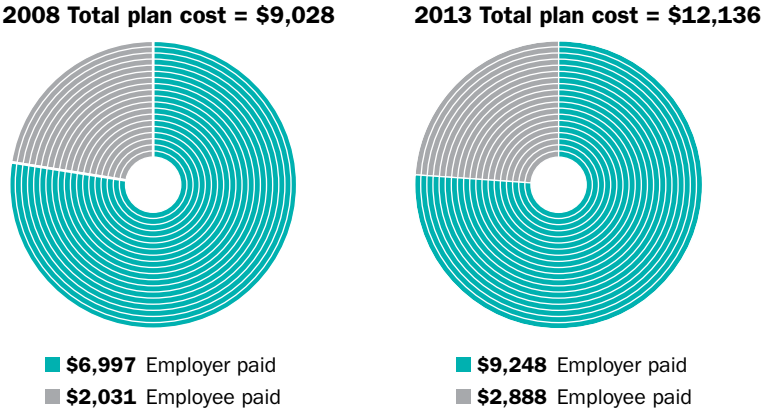
Figure 12. PEPY medical and drug costs

	Total plan costs		Employer costs	
Percentile	**2012**	**2013***	**2012**	**2013***
Mean	**$11,457**	**$12,136**	**$8,799**	**$9,248**
25th	**$9,507**	**$9,867**	**$7,236**	**$7,593**
50th	**$10,909**	**$11,461**	**$8,595**	**$8,900**
75th	**$12,672**	**$13,592**	**$10,158**	**$10,700**

Note: Costs include medical and drug claims for actively enrolled employees. Total per-employee per-year (PEPY) costs include both employer and employee shares. Employer costs are less employee contributions.

*Expected

Figure 13. Total employee/employer health care costs



Active Employees

Employers anticipate total costs paid by the plan will reach $12,136 per active employee in 2013 — up from $11,457 in 2012 — a 5.9% increase in total costs *(Figure 12).* The average employer share of total plan costs continues to climb at a rate greater than the CPI and wages — $9,248 in 2013, compared to $8,799 in 2012, up 5.1%. They pay 32% more than they did five years ago, while employees contribute over 42% more *(Figure 13).*

Employees paid, on average, 23.2% of total premium costs in 2012 and are expected to pay 23.8% in 2013 as companies take steps to control their costs. In paycheck deductions, this translates into an average employee contribution of $2,658 to premiums in 2012, which is expected to rise to $2,888 in 2013 — an 8.7% increase in one year.

In addition to premium increases, companies anticipate that employees' out-of-pocket expenses at the point of care will rise to 18.4% of total allowed charges in 2013, compared with 17.8% in 2012 and 15.9% in 2011.

For some employees, the question of affordability becomes even more evident as their paycheck deductions for health care premiums rise in order to fund higher health care costs while their wage increases shrink. Altogether, the share of total health care expenses, including premium and out-of-pocket costs paid by employees, is expected to be 36.9% in 2013, up from 35.9% in 2012 and 34.4% in 2011.* This means that for every $1,000 in health care expenses in 2013, employees pay $369 for premiums and out-of-pocket costs, and employers pay the remaining $631.

Over the last year, companies have stepped up actions to position their programs for long-term success, especially with the PPACA's excise tax scheduled to take effect in 2018. Evidence of this trend to try to control costs can be seen in the rise of ABHPs and increased employee enrollment in them (see Account-Based Health Plans, page 24).

As employers begin to change their strategies to comply with the PPACA and avoid the excise tax, it's important to note the dramatic difference between the average company's costs and those of companies that have employed strategies that

*Total health expenses include employer and employee portions of the premiums and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance).

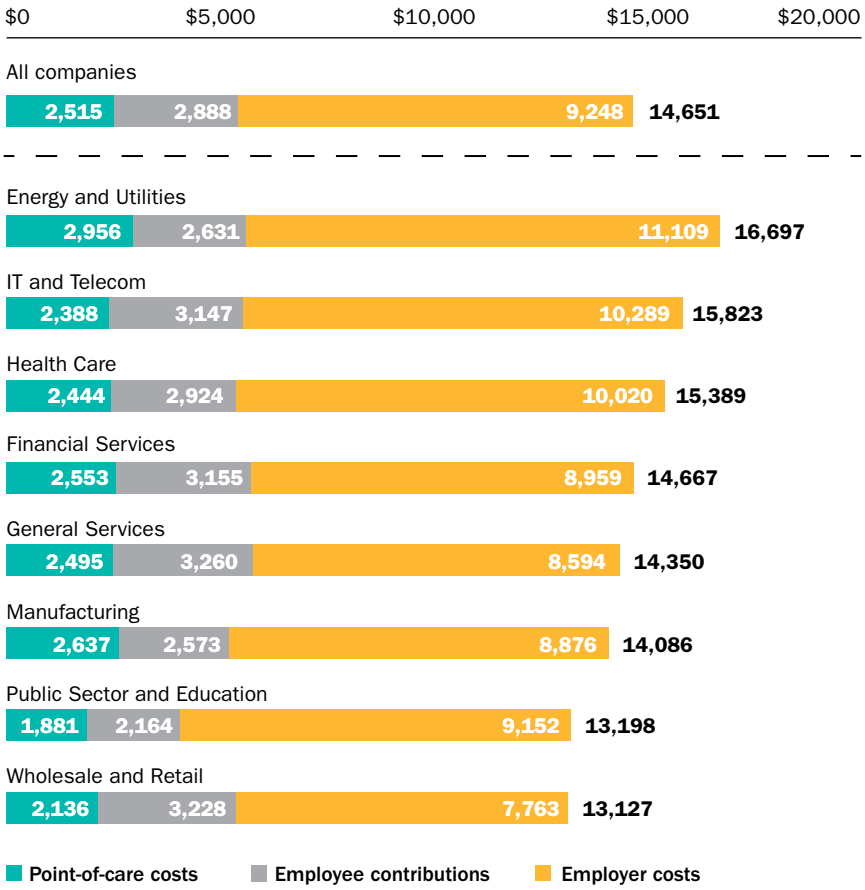
put them in the lowest quartile of costs. These companies' costs are nearly 20% lower than average. At current rates, those performing at the average are four years ahead of the trend curve. In other words, those companies with costs in the lowest quartile in Figure 12 won't reach the cost levels of the average company today until 2017.

A Look at Industry Differences

There is nearly a 30% difference between low- and high-cost industries in our survey *(Figure 14)*. While this represents, in part, differences in demographics and family size, as well as overall plan values, this variation in costs suggests that health care has a larger role in the total rewards design in some industries. It's particularly interesting that total employee costs (the dollar amount of out-of-pocket expenses at the point of care plus employee contributions) are relatively similar across all industries except the public sector. This means that employer costs for health care benefits range even more broadly. For instance, the energy industry, on average, spends 43% more than the retail industry for employee health care. This disparity telegraphs that some industries will need to be more aggressive than others to bring their costs under the excise tax limits.

"It's particularly interesting that total employee costs (the dollar amount of out-of-pocket expenses at the point of care plus employee share of premiums) are relatively similar across all industries except the public sector."

Figure 14. Total health care expense per employee per year by industry, 2013



Note: Total health expenses include employer and employee portions of the premiums and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance).

Pre-65 and Post-65 Retirees

Retirees, especially pre-Medicare eligible, face even greater affordability challenges than active employees and pay a considerably larger share of coverage costs. Once retirees reach age 65 and become eligible for Medicare benefits, affordability improves: They pay, on average, $2,086 per year for single-only coverage and $5,377 for family coverage.

However, retirees under age 65 pay more than twice that — nearly $4,701 per year in premiums for single-only coverage and over $11,363 per year for family coverage. Without some form of subsidy such as an employer plan, many of these employees may find it difficult to retire and secure affordable coverage. Even with an employer subsidy, some may still find it too costly.

The realization that their subsidy is too little for retirees to afford coverage (especially those pre-65) is leading some companies to reassess the value of their retiree medical benefit as well as the role retiree health benefits play in their total benefit mix. The opening of the health care insurance exchanges in 2014, which could provide access to comparable health care at lower rates, may prove a more cost-effective alternative for some companies and their retirees (see Retiree Medical Plans, page 16).

Figure 15. Annual premiums and rates of increase for retiree-only and family coverage for 2013

	Annual total premiums		Retiree premium share		Rates of increase	
	Retiree only	Family	Retiree only	Family	2012	2013*
Retirees under age 65	**$9,064**	**$21,126**	**51.9%**	**53.8%**	**6.1%**	**6.5%**
Retirees age 65 and older	**$4,584**	**$11,283**	**45.5%**	**47.7%**	**4.8%**	**4.1%**

*Expected

Best Performers Deliver Sustained Results

Organizations continue to show dramatic differences in their ability to manage their health care cost trends. A group of organizations we refer to as "best performers" has been successful in maintaining health care cost trends at or below the TW/NBGH norm for each of the last four years (see Active Employees, page 12).

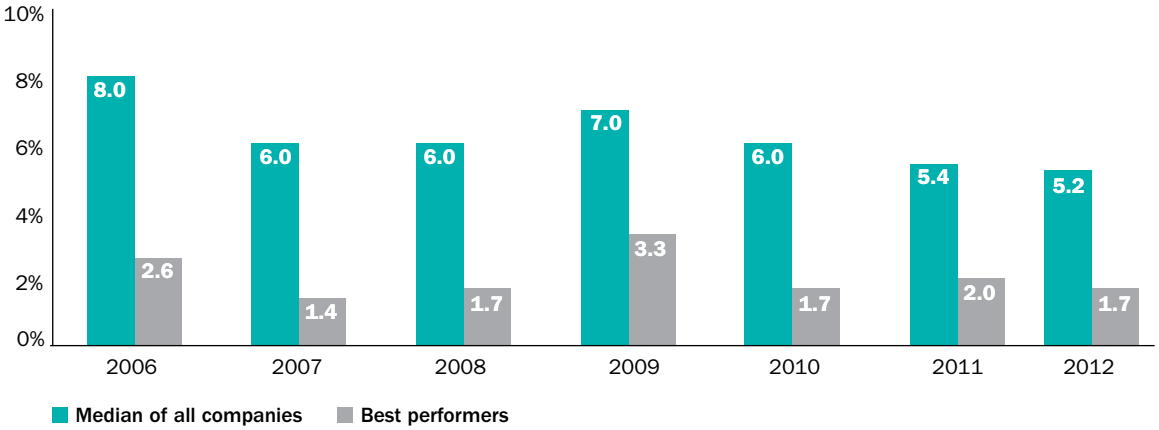
Our research this year identified 45 companies that qualify as best performers.* *Figure 16* shows that the ability to keep cost increases low over an extended period of time distinguishes these companies from other organizations. In fact, the median trend across the last four years was 5.9%, versus 2.2% for best performers.

By contrast, some companies have experienced

*A company had to complete this year's survey and the 2011 or the 2012 TW/NBGH survey to be eligible to be a best performer. The number of best performers is based on 246 eligible companies, which translates to 18% of companies reporting an annual trend at or below the all-company median for each year from 2009 to 2012.

The company profile of the best performers looks very similar to other companies that responded to the survey. For example, every major industry is represented by the best performers, with a similar average age, male/female ratio and similar percentage of employees electing dependent coverage as the overall sample. However, best performers are larger than the average company in the overall sample — averaging 51,000 versus 28,000 employees.

Figure 16. Best performers versus median annual cost trends (after plan and contribution changes) 2006 – 2012

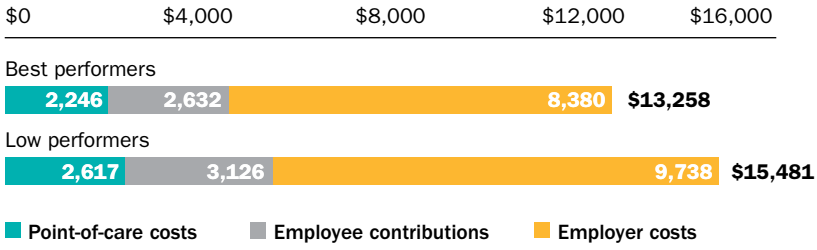


Note: Median trends are for employer costs for actively enrolled employees, after plan and contribution changes. Best performers are based on cost trends between 2009 and 2012.

greater challenges in managing their cost increases. Low-performing companies — whose two-year average cost increases are in the top 25% — have a median 10.3% cost trend.

As shown in *Figure 17,* best performers are noticeably ahead in terms of total cost management. In 2013, the cost difference between best performers and low performers is $2,225 per employee. For the average best performer with 10,000 employees, this equates to a cost advantage of over $22 million per year. Likewise, employees working for a best performer also fare much better than their counterparts at low-performing companies, paying nearly $500 less per year in premiums and nearly $400 less per year in point-of-care charges. In addition to the obvious advantage of reducing health care costs for themselves and their employees alike, affordable health care is key to a company's ability to provide a competitive reward package and to succeed long term in supporting their employee value proposition, and meeting attraction and retention goals.

Figure 17. Total health care expense by performance group in 2013

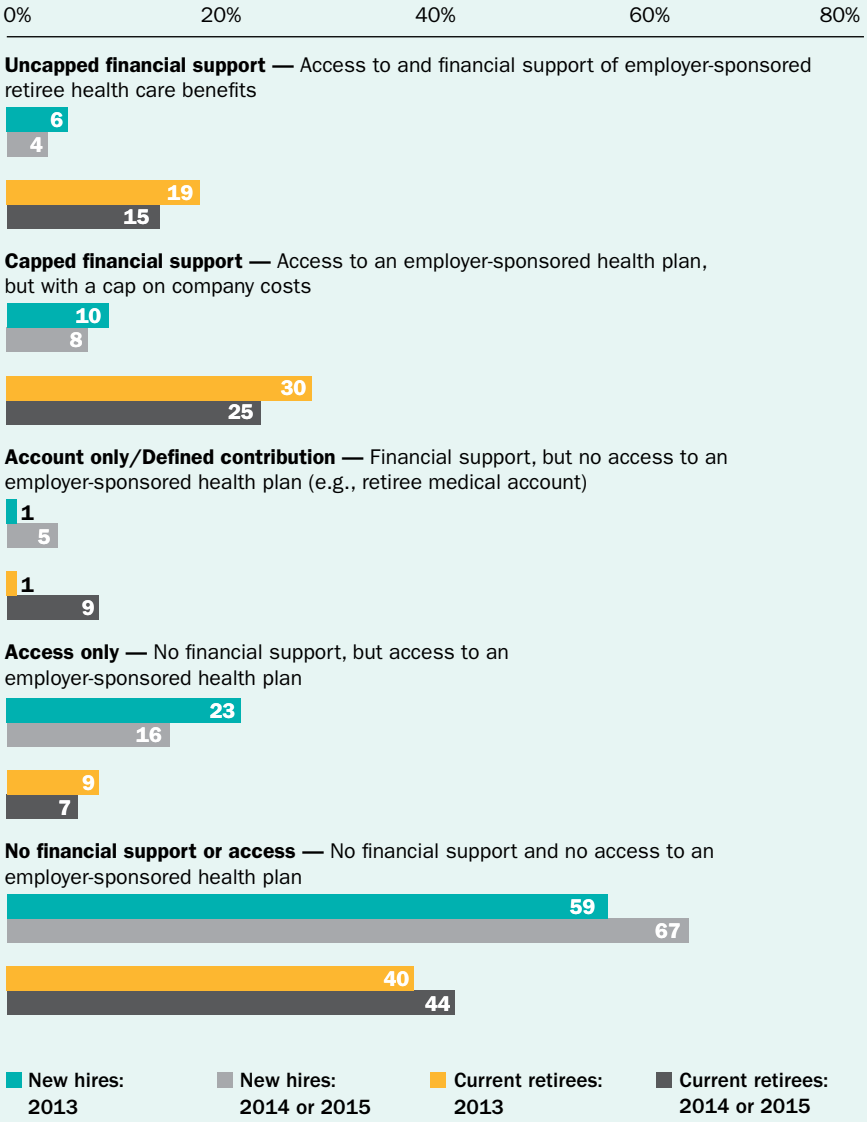


Note: Total health expenses include employer and employee portions of the premiums, and employee out-of-pocket costs at the point of care (including deductibles, copays and coinsurance). Best performers comprise 45 companies that have maintained trends at or below the TW/NBGH median trend for each of the last four years. Low performers are based on the highest quartile of two-year average trend.

Retiree Medical Plans

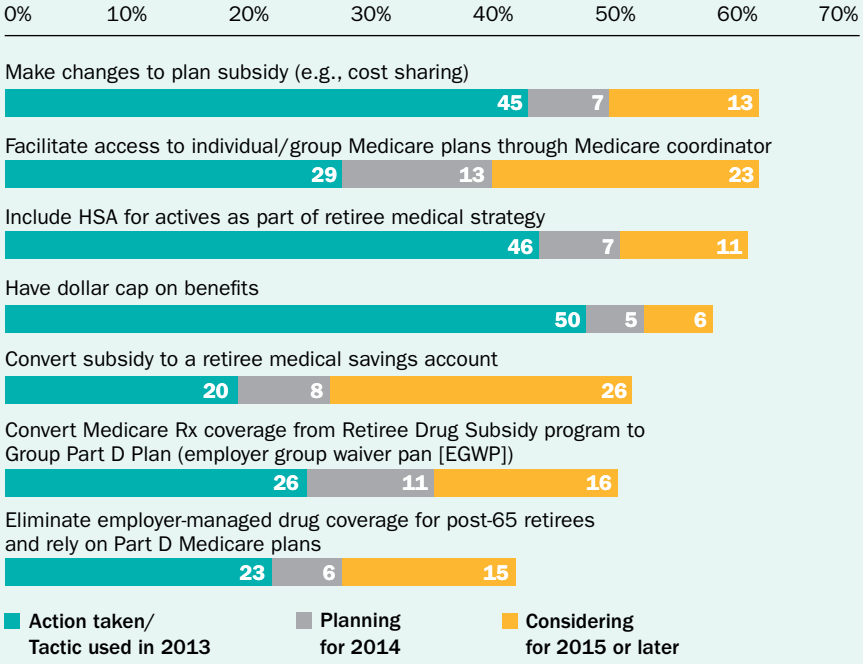
About 60% of all companies offer some form of retiree medical support — either subsidies or access to coverage through a Medicare coordinator. For several decades, employer subsidies have been steadily eroding as employers have reassessed their commitment to these programs. In fact, the cost challenges have reached a point where, for many pre-65 retirees, retiree medical coverage is largely unaffordable even when subsidized by their employer. Public exchanges have the potential to expand affordable coverage for many current and future retirees for whom health care coverage is unattainable today, especially for those ineligible for Medicare. Likewise, 13% of employers expect to facilitate access to individual/group Medicare plans for their post-65 population in 2013, and 23% are considering it for 2015 or later.

Figure 18. Pre-65 retiree medical support for various subgroups of the workforce for 2013, and expected for 2014 or 2015



As they redefine their subsidies under these programs, some employers are considering account-based solutions to help retirees transition to the public exchanges when they open. In particular, one-third of best performers with a retiree medical program today are planning to convert their employer subsidy to a retiree medical savings account by 2015. In addition, HSAs for active employees are increasingly being positioned as part of the overall retiree medical strategy. Ten percent of best performers have adopted this strategy for 2013, and a similar number are planning to do so by 2014.

Figure 19. Declining subsidies for retirees with health accounts becoming more prevalent



Note: Based on respondents that provide financial support or access to coverage in 2013 and excludes responses of "not applicable"

Emerging Trends

Changes in Contribution Strategies

Tying employee contributions to successful completion of specific tasks such as health assessments and screenings remains the most popular change in contribution strategies as employers continue to redefine their financial commitment to employee health care. However, other strategies are just emerging *(Figure 20)*. Nearly 40% of companies in the financial sector structure their contributions based on employee compensation, a significantly higher percentage than the IT/telecom sector (14%) or the energy sector (19%). It's a strategy other industries might consider emulating to make health care more affordable for lower-paid employees, and one that about 30% of all respondents have taken or plan to take this year.

Twenty-nine percent of best performers today (compared to 21% of low performers) structure contributions so that employees pay the difference between the total cost of the plan selected and a flat dollar employer subsidy. An additional 11% of the best performers plan to adopt this structure for 2014. They are also ahead of low performers in requiring employees to take steps to enroll in their health plan (18% versus 13%), as opposed to automatic enrollment.

Best performers are also likely to have integrated their health care benefits into a broader total rewards framework, which allows them to view health benefit costs in relation to pay and other benefits, and reallocate resources to establish an employee value proposition that attracts, retains and motivates employees *(Figure 21).* They are even more likely than low performers to make this a priority in 2014. In fact, 43% of best performers are expected to manage their subsidies as part of a total rewards budget rather than a health plan budget process by 2014, compared to only 27% of low performers.

Most respondents (71%) say they have raised dependents' share of premium contributions (as a percentage of total premiums) over the last three years. Over the next three years, 83% plan to raise the percentage of premiums paid for coverage tiers with dependents, and more than half of those plan medium to large increases.

Figure 20. Changes in contribution structure

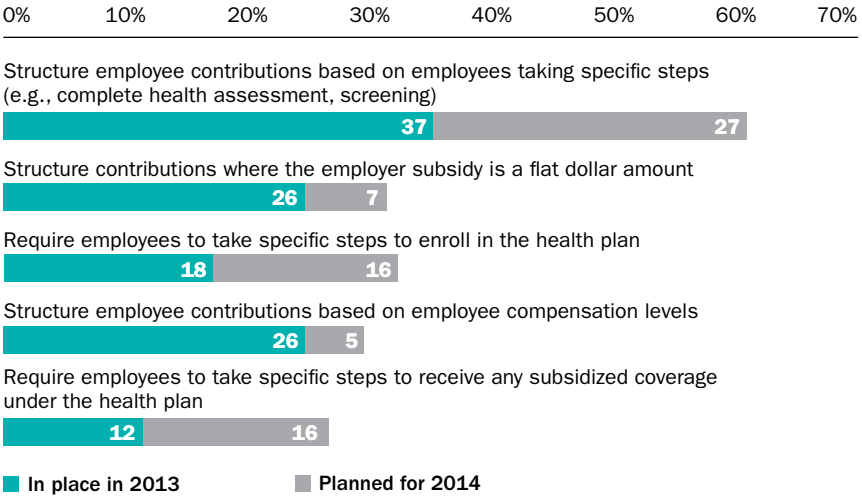
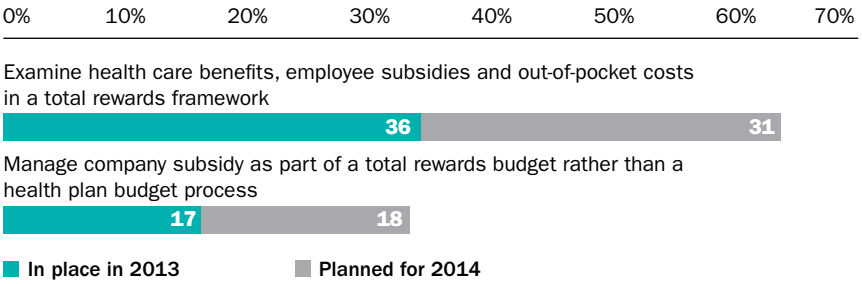


Figure 21. Health care in a total rewards framework



Over the last year, best performers are leading the way by increasing employee contributions in tiers with dependents at higher rates than single coverage (47%, compared to 33% of low performers). And this strategy continues to grow among best performers: 71% expect to use it in 2014. The most successful companies are also more likely to have increased employee contributions per each dependent covered (13%, versus low performers at 6%) and to have expanded the number of coverage tiers (20% versus 11%). These two tactics are expected to rise to 27% and 31%, respectively, among best performers by 2014.

New Delivery Models

Not surprisingly, the IT/telecom industry is leading the way in the use of telemedicine, and 26% offer it to their employees today. But it's rapidly catching on in other sectors. Beginning in 2014, one-third of energy and retail companies plan to adopt telemedicine. Best performers across the industry spectrum have embraced onsite health services, and 41% already have a clinic in at least one location, with another 11% planning to adopt an onsite center by 2014.

Figure 22. Redefining the commitment to dependents

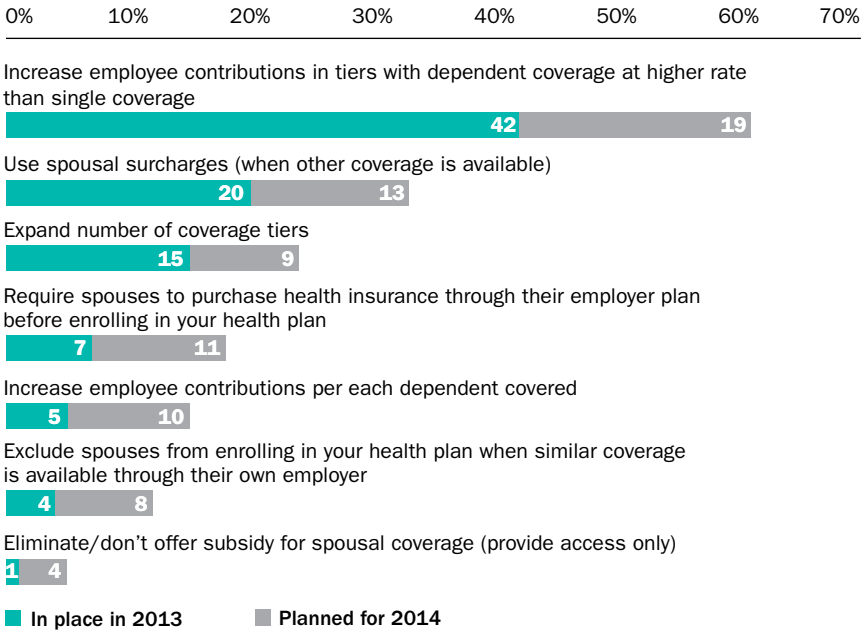


Figure 23. New delivery models

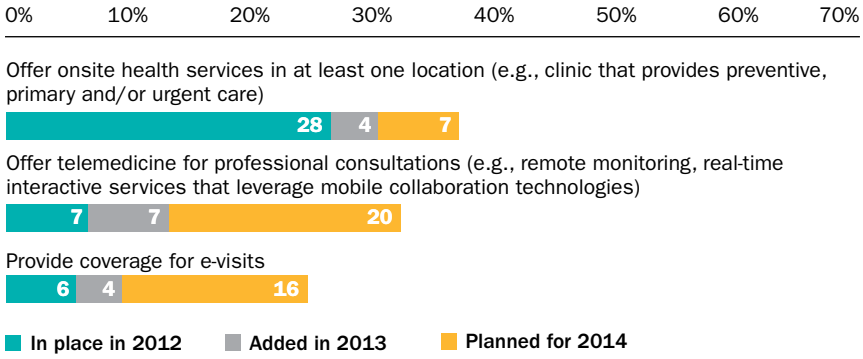
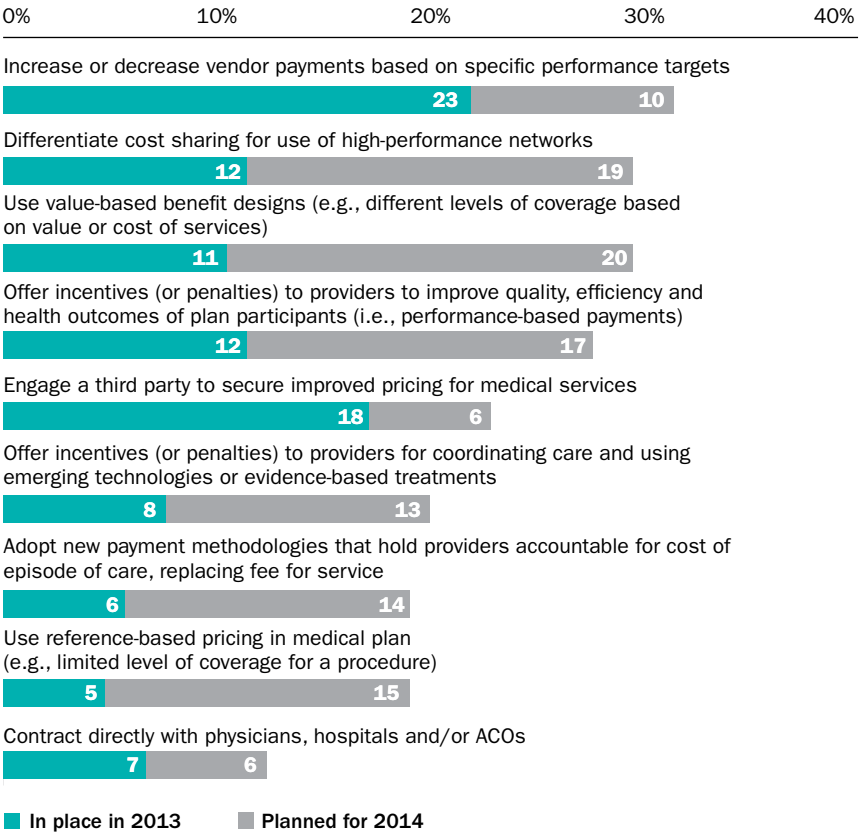


Figure 24. Using incentives and emerging payment approaches to improve the quality of care delivered



Historically, employers have focused on demand-side tactics — managing plan designs, network options and consumerist measures to stimulate employee accountability. Now there is also growing interest in more effectively managing the supply side. Employers are adopting various payment reforms and provider strategies to improve quality of care and stimulate provider accountability.

In addition, the PPACA payment reform provisions — including value-based purchasing, accountable care organizations (ACOs), bundled payments and medical homes — target improvements in quality and efficiency. Several key pay-for-performance programs created by the PPACA have already begun to roll out, including the hospital value-based purchasing (VBP) program and the hospital readmission reduction program. (Value can be broadly considered to be a function of quality, efficiency and cost.) Medicare and Medicaid — the largest health care payers in the country — and some large insurance companies are already using VBP measures under the PPACA, and many employer plans are following suit. We fully expect employer plans to implement these changes with increasing rapidity over the next few years *(Figure 24).*

Best performers are clearly leading the way and are planning to expand the use of these strategies over the coming year *(Figure 25).*

Figure 25. New provider strategies are favored by best performers

	Best performers		Low performers	
	2013	2014*	2013	2014*
Increase or decrease vendor payments based on specific performance targets	36%	44%	20%	30%
Differentiate cost sharing for use of high-performance networks	13%	31%	12%	25%
Use value-based benefit designs (e.g., different levels of coverage based on value or cost of services)	11%	33%	12%	32%
Offer incentives (or penalties) to providers to improve quality, efficiency and health outcomes of plan participants (i.e., performance-based payments)	22%	47%	5%	28%
Engage a third party to secure improved pricing for medical services	18%	24%	19%	30%
Offer incentives (or penalties) to providers for coordinating care and using emerging technologies or evidence-based treatments	16%	38%	4%	21%
Adopt new payment methodologies that hold providers accountable for cost of episode of care, replacing fee for service	16%	38%	2%	13%
Use reference-based pricing in medical plan (e.g., limited level of coverage for a procedure)	9%	27%	5%	21%
Contract directly with physicians, hospitals and/or ACOs	13%	31%	7%	13%

*Includes companies indicating "planned for 2014"

Price Transparency

Health plans are expanding their tools in the area of price transparency, which could be driving greater adoption by employers. Thirty-three percent of respondents report using these tools, and an additional 10% plan to do so in 2013 *(Figure 26)*. Currently, 32% encourage vendors to share online medical information with employees, and another 14% plan to do so over the next two years. In a related strategy, 40% of employers require vendors to provide data for employee outreach and integrated reporting, and an additional 15% plan to do so in 2013 or 2014.

Communication and transparency are core strategies for managing costs, especially as many more employers migrate their workforce into ABHPs. It's essential that employees in these programs be armed with the best available information to make smarter health care decisions so they can reduce their costs without sacrificing quality.

Today, 45% of best performers are putting pressure on plans and providers to offer patients access to online medical information, compared to 29% of low performers.

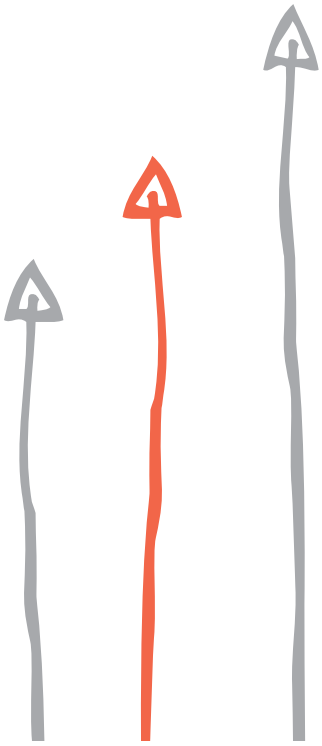
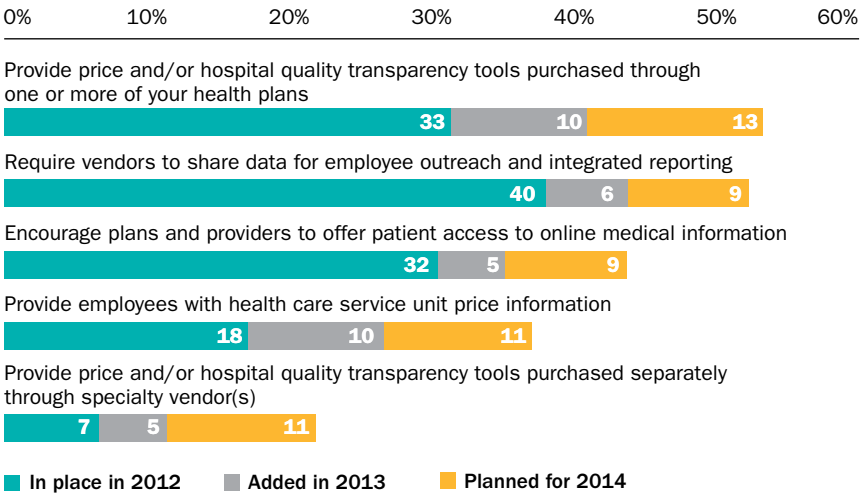


Figure 26. Access to price and quality information on the rise



Private health exchanges

Private health exchanges are among the newest delivery approaches. Only a handful currently exists, although others are in development.

Less than 1% of respondents offer their employees access to a private health exchange, but 15% are considering doing so in 2014.

Statoid

Using Financial Incentives and Requirements to Engage Employees

"More recently, companies have been expanding biometric outcomes to include achievement of specific body mass index levels and target cholesterol levels."

Growth in the use of penalties to engage employees in health program participation has slowed over the last two years in favor of outcome-based incentive designs. This is a continuation of a strategy companies have followed over the last few years to impose tougher requirements to earn financial rewards or avoid penalties. These requirements are increasingly focused on results and on holding employees accountable for achieving specific health standards. Tobacco use has been on companies' radar screens for many years, and the use of tobacco-use surcharges continues to grow, up from 35% in 2012 to 42% in 2013 (See Getting Tough on Tobacco, below). It is expected to reach 62% by 2014. More recently, companies have been expanding biometric outcomes to include achievement of specific body mass index levels and

Getting tough on tobacco

36%
of companies reward employees for participating in a **smoking-cessation program.**

9%
of companies use penalties for **tobacco users** not joining a smoking-cessation program.

42%
of companies use surcharges for **tobacco users,** at roughly **$50/month.**

52%
of companies today **ban smoking** directly *outside buildings* or *on campus.*

8%
of companies plan to *adopt* this **ban policy** in **2014.**

4%
of companies have *adopted* a policy **not to hire smokers** in states where it is legal to do that.

2%
of companies plan to *adopt* this **no-hire policy** in **2014.**

Statoid

target cholesterol levels. Today, 16% of companies align their rewards/penalties to specific biometric targets (other than tobacco use), and another 31% are considering this strategy for 2014 *(Figure 27).*

There is growing interest in expanding financial incentives to include spouses, and 59% of respondents anticipate doing so by 2014, up from 23% that did so in 2012. Expanding financial incentives to spouses can be an effective way to engage employees as well.

Adoption of new technologies — including telemedicine, mobile apps for e-visits and data-enabled kiosks — will help increase employee engagement, facilitate communication, and monitor and support employee decision making.

Best performers have led the way in the use of achievement-based standards. Today, 51% of them use incentives based on tobacco-use status, and 33% are using biometric outcomes. Meanwhile, 44% of low performers use incentives tied to tobacco use cessation, but only 19% use biometric outcomes. Interestingly, best performers are less likely to use penalties to encourage program participation than low-performing companies (16% versus 23%). And best performers have extended their incentives to include spouses and other dependents, recognizing that healthy lifestyles are a family affair. In fact, 40% of best performers apply their incentives to employees and spouses alike, compared to 30% of low performers.

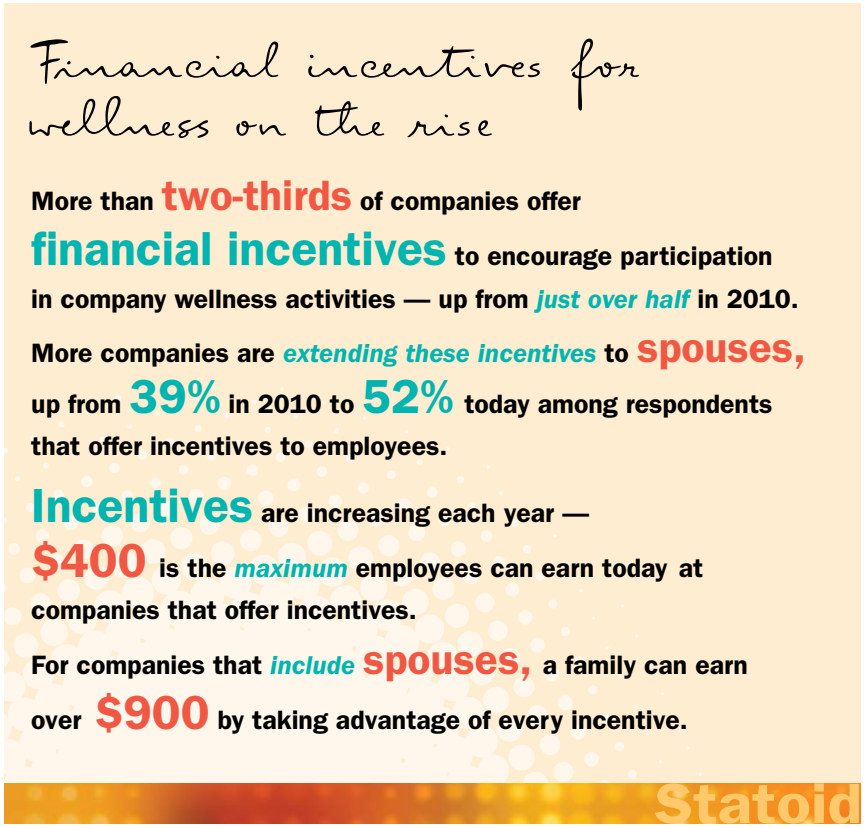


Figure 27. Wellness incentives and tougher requirements expand in use

	2011	2012	2013	2014*
Use financial rewards for individuals who participate in health management programs/ activities (i.e., positive incentives)	54%	61%	62%	81%
Use penalties (e.g., increase premiums and/or deductibles) for individuals not completing requirements of health management programs/activities	19%	20%	18%	36%
Require employees to complete a health risk appraisal and/or biometric screening to be eligible for other financial incentives	35%	42%	54%	75%
Require employees to validate participation in healthy lifestyle activities in order to receive a reward or avoid a penalty (e.g., evidence of fitness center use, engagement with a primary nurse case manager)	–	23%	33%	59%
Reward or penalize based on smoker, tobacco-use status	30%	35%	42%	62%
Reward or penalize based on biometric outcomes other than smoker, tobacco-use status (e.g., achievement of weight control or target cholesterol levels)	12%	10%	16%	47%
Apply rewards or penalties and/or requirements under your health management programs/activities to employees and spouses alike	19%	23%	31%	59%

*Includes companies indicating "planned for 2014"; Data from 2011 and 2012 are based on the 17th annual TW/NBGH Survey.

Account-Based Health Plans (ABHPs)

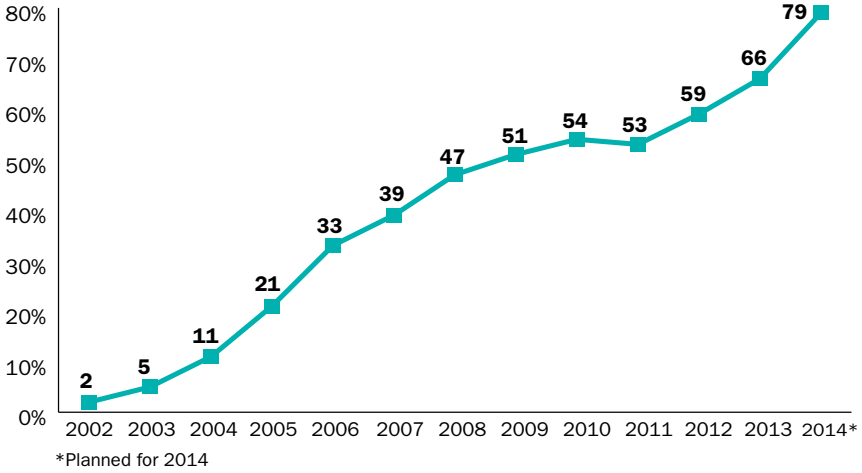
Tax-advantaged ABHPs are widespread across all industries except the public sector, where only 40% of organizations have an ABHP in place.

We define an ABHP as a plan with a deductible offered together with a personal account (i.e., an HSA or an HRA) that can be used to pay a portion of the medical expense not paid by the plan. ABHPs typically include decision support tools that help consumers better manage their health, health care and medical spending.

Not all ABHPs are created equal. Their effectiveness depends on a number of factors, including whether the ABHP is full replacement for other plans, the size of the deductible, the degree to which employees enroll in an HSA or HRA, and whether wellness initiatives are included to encourage employee engagement in their health and well-being. Employer adoption of ABHPs had been marked by significant increases in deductibles, which negatively affected enrollment. But ABHPs continue to evolve, embedding incentive strategies and aligning with retirement strategies. Employers have now moved to reduce the dollar burden on employees, contributing funds to an HSA and subsidizing premiums of ABHPs at a higher level than other options. More companies are helping ease the transition to ABHPs through a year-round communication strategy. And companies with an ABHP are much more likely to provide price and/or hospital-quality transparency tools than others (54% versus 30%), and more likely to offer decision support tools for preference-sensitive care (33% versus 17%).

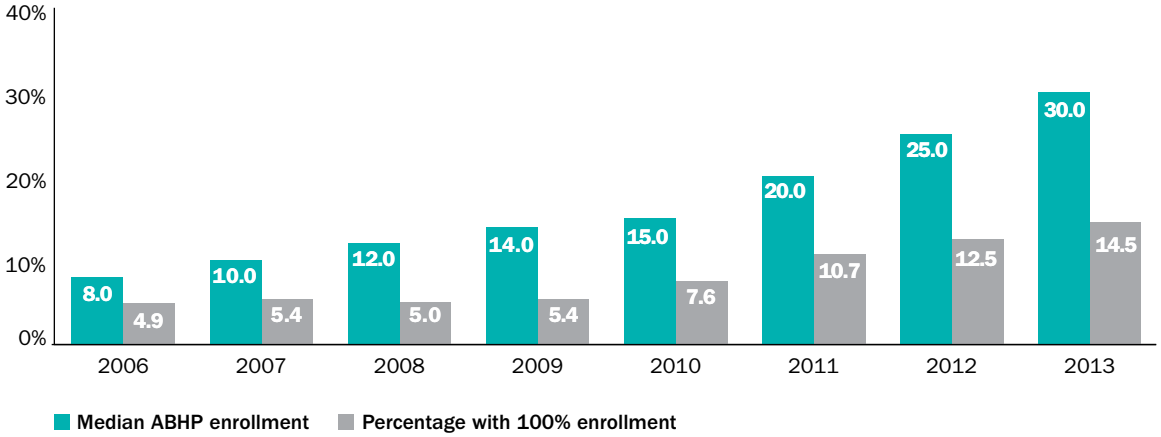
More and more employers are tying their contributions to positive employee actions to improve health. By aligning their ABHP strategy with their health management strategy, companies have been able to move to a full-replacement ABHP more quickly. And full replacement has resulted in a substantial increase in employee enrollment in these plans, which has risen significantly over the last three years, from 15% to 30% *(Figure 29)*. We've seen a steady increase in enrollment in both account types, with HSA enrollment rising from 13% in 2011 to 20% today, and HRA enrollment rising from 28% to nearly 40% in 2013.*

Figure 28. Take-up in ABHPs on the rise



*Planned for 2014

Figure 29. ABHP enrollment rates rising at a rapid pace



Note: Estimates are based on companies that offer an ABHP in various years: 2006 is based on the 12th annual National Business Group on Health/Towers Watson survey; 2007 is based on the 13th annual survey; 2008 is based on the 14th annual survey; 2009 is based on the 15th annual survey; 2010 is based on the 16th annual survey; 2011 is based on the 17th annual survey, and 2012 and 2013 are based on the 18th annual survey (current).

*Based on companies offering an HSA and HRA, respectively; Enrollment rates for 2011 are based on the 17th annual TW/NBGH Survey.

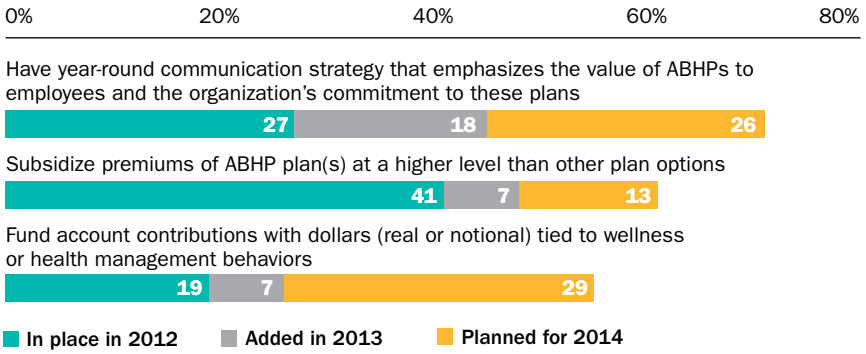
"By aligning their ABHP strategy with their health management strategy, companies have been able to move to a full-replacement ABHP more quickly."

Figure 30. ABHPs as the only plan option is on the rise

	2007	2010	2012	2013	2014*
ABHP with HRA	20%	20%	23%	26%	32%
ABHP with HSA	25%	38%	48%	53%	67%
Contribute funds to an HSA	15%	30%	39%	42%	57%
Offer an ABHP as our default plan option	–	11%	17%	22%	40%
Offer an ABHP as our only plan option among our self-insured plan options	–	–	9%	12%	23%
Offer an ABHP to collectively bargained employees	–	–	17%	21%	27%

Note: Based on all companies with or without an ABHP; 2007, 2010 and 2012 are based on prior years of the TW/NBGH Survey.
*Includes companies indicating "planned for 2014"

Figure 31. Linking health management incentives to ABHPs is on the rise



Note: Based on companies with an ABHP or planning to adopt an ABHP in 2014

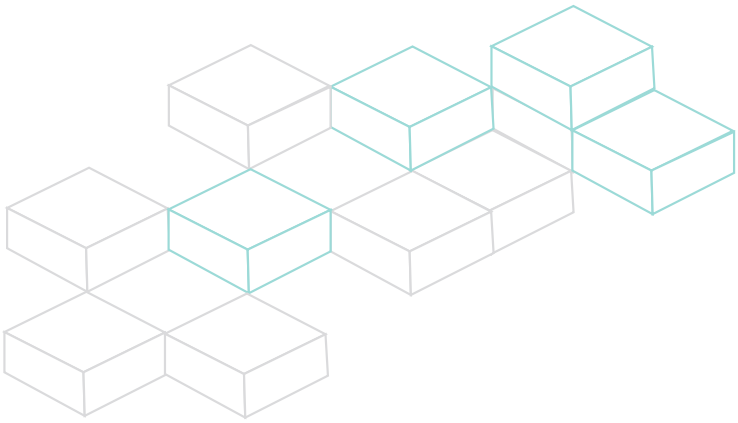
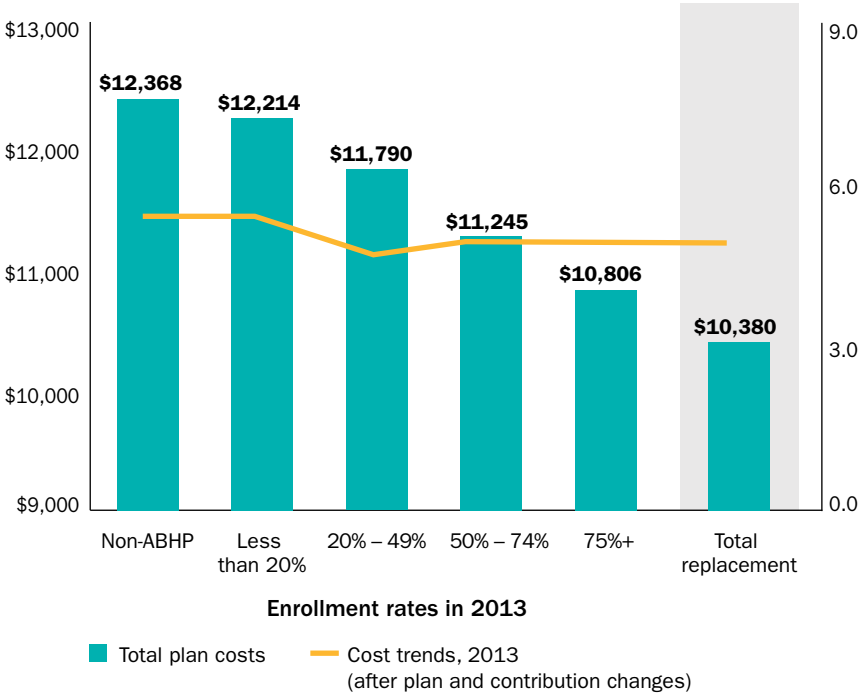


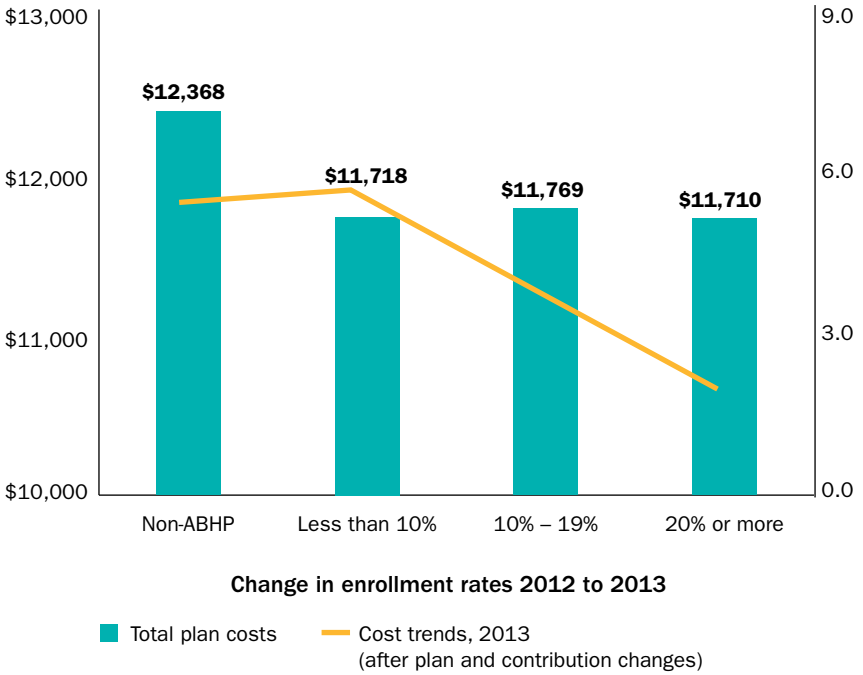
Figure 32. ABHP enrollment linked to lower health care costs



Companies able to successfully migrate employees into an ABHP stand to reap significant savings. Our research shows again this year that companies with at least 50% of employees in an ABHP report total costs per employee that are more than $1,000 lower than companies without an ABHP *(Figure 32)*. However, an ABHP alone, even with high employee enrollment, does not guarantee long-term success. Companies with more than half of their employees enrolled in an ABHP report an average cost trend nearly identical to the TW/NBGH norm. Where we do see a cost trend advantage is among companies transitioning their workforce into an ABHP. In fact, companies increasing enrollment by 20% or more to their ABHP over the last year report average cost trends of only 2% over the period *(Figure 33)*.

Long-term success involves more than changing plan design. Where we see a significant difference, year after year, is in the comprehensive approach best performers take to increase employee and provider accountability, help cultivate smarter health care consumers and take advantage of emerging trends in a rapidly changing provider marketplace. These companies prove most successful at holding the line on costs.

Figure 33. Increased ABHP enrollment linked to lower trends



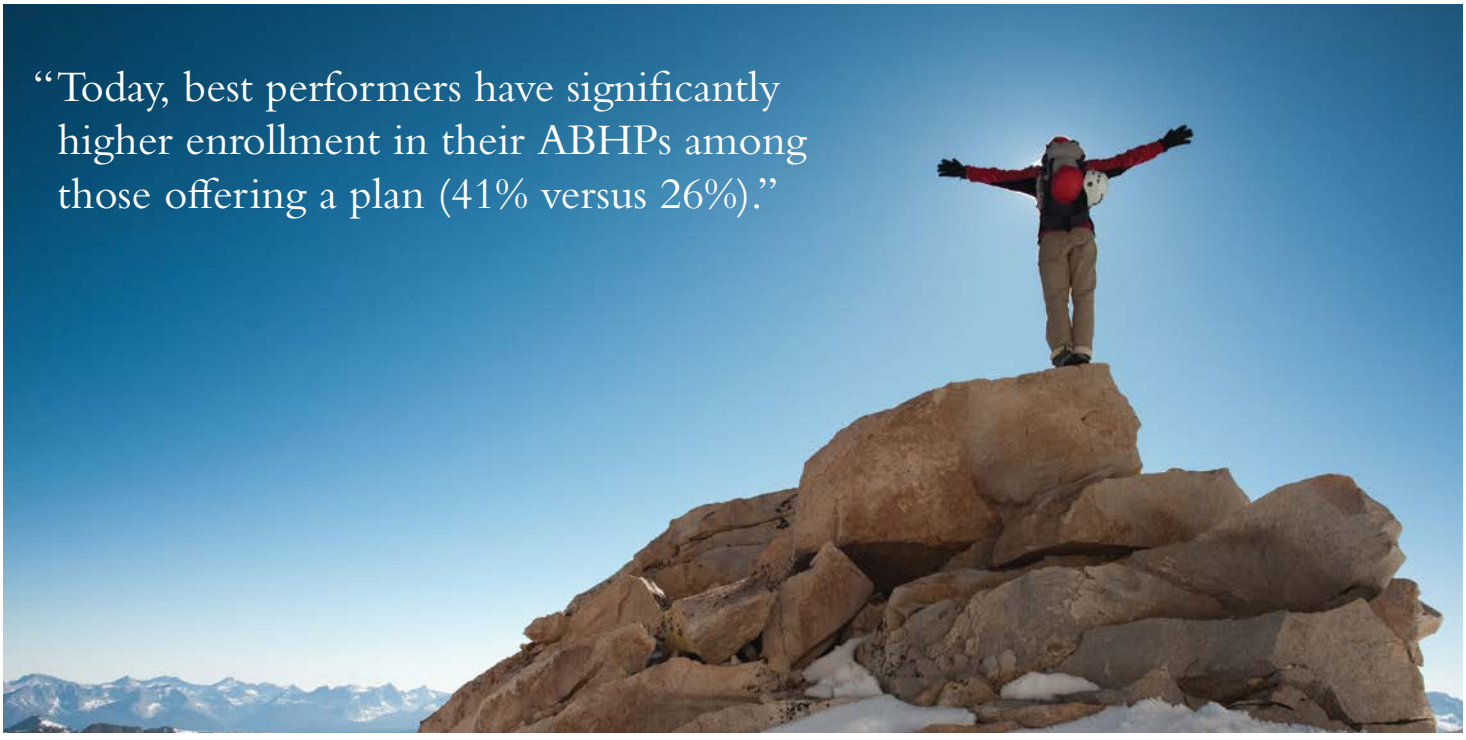
Best Performers Lead the Way on ABHPs

Today, 78% of best performers have an ABHP in place, compared to 64% of low performers. But now, low performers are taking more aggressive steps than best performers to adopt ABHPs and boost enrollment in advance of the 2018 excise tax rules. In fact, 14% of low-performing companies are planning to add an ABHP in 2014, compared to only 2% of best performers. Today, best performers have significantly higher enrollment in their ABHPs among those offering a plan (41% versus 26%). But that imbalance will change quickly, since twice as many low performers as best performers plan to go to total replacement by 2014 (14% versus 7%) *(Figure 34)*. As such, 27% of today's low performers could be total replacement by 2014, compared to 22% of today's best performers. The effect on their performance remains to be seen.

Figure 34. ABHPs and performance groups

	Best performers		Low performers	
	In place in 2013	Planned to add for 2014	In place in 2013	Planned to add for 2014
Offer an ABHP	**78%**	**2%**	**64%**	**14%**
Offer an ABHP with an HSA	**64%**	**11%**	**49%**	**16%**
Contribute funds to an HSA	**53%**	**9%**	**42%**	**17%**
Offer an ABHP with an HRA	**31%**	**0%**	**25%**	**6%**
Offer an ABHP as our only plan (i.e., total replacement) among our self-insured plan options	**16%**	**7%**	**14%**	**14%**

Note: Based on all companies in respective groups



Specialty Pharmacy

Specialty drugs — groundbreaking biologics, injectables and other innovations developed to treat complex illnesses such as cancer and rheumatoid arthritis — are the fastest-growing cost segment of employer-provided pharmacy plans. Despite the high costs of these drugs, it is often challenging for employers to obtain comprehensive and specific cost and utilization information on specialty drug spend, particularly for medications covered through medical plans *(Figure 35)*. When this information is available, however, many employers are exploring financial and clinical management approaches to mitigate drastic cost increases, including prior authorization, step therapy and formulary management *(Figure 37)*.

While 20% of respondents have adopted incremental solutions, managing high cost trends requires more aggressive approaches. This remains a strategic challenge.

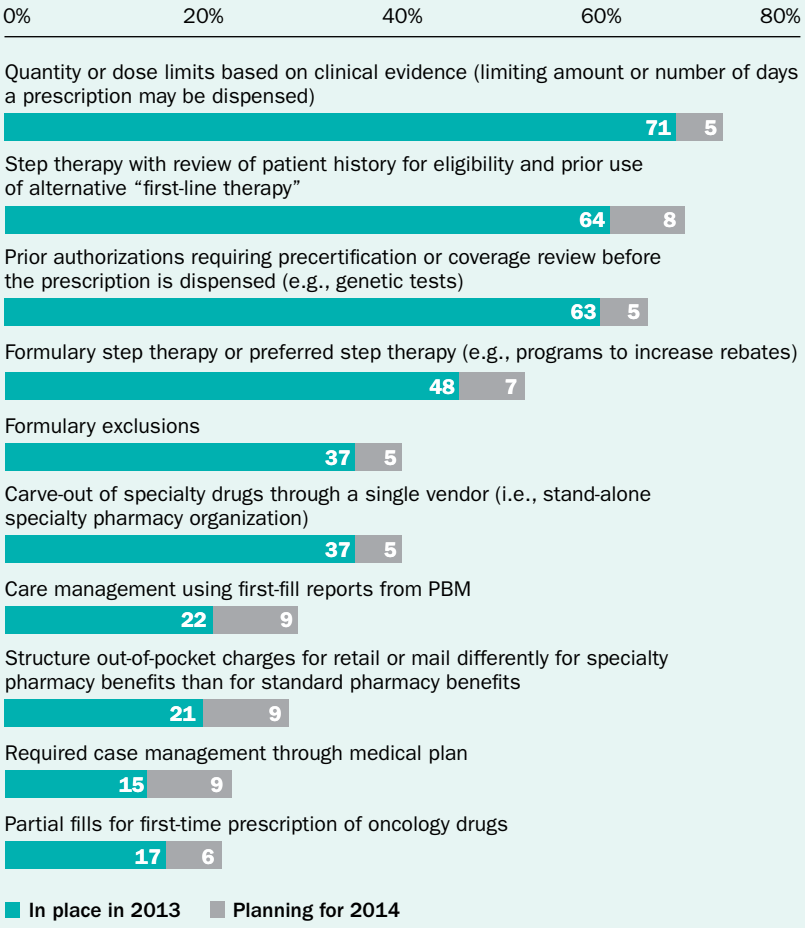
Figure 35. Familiarity with specialty pharmacy costs

	Very familiar	Somewhat familiar	Not at all familiar
Through medical plans	**19%**	**49%**	**32%**
Through pharmacy benefit programs	**43%**	**38%**	**19%**

Figure 36. Percentage of total pharmacy spend through the pharmacy benefit manager (PBM) that specialty pharmacy represented in 2012

Less than 10%	**9%**
10 to 19.9%	**36%**
20% or more	**31%**
We don't track specialty pharmacy spend	**4%**
Don't know	**20%**

Figure 37. Activities to manage specialty pharmacy benefits



Part-Time Employees

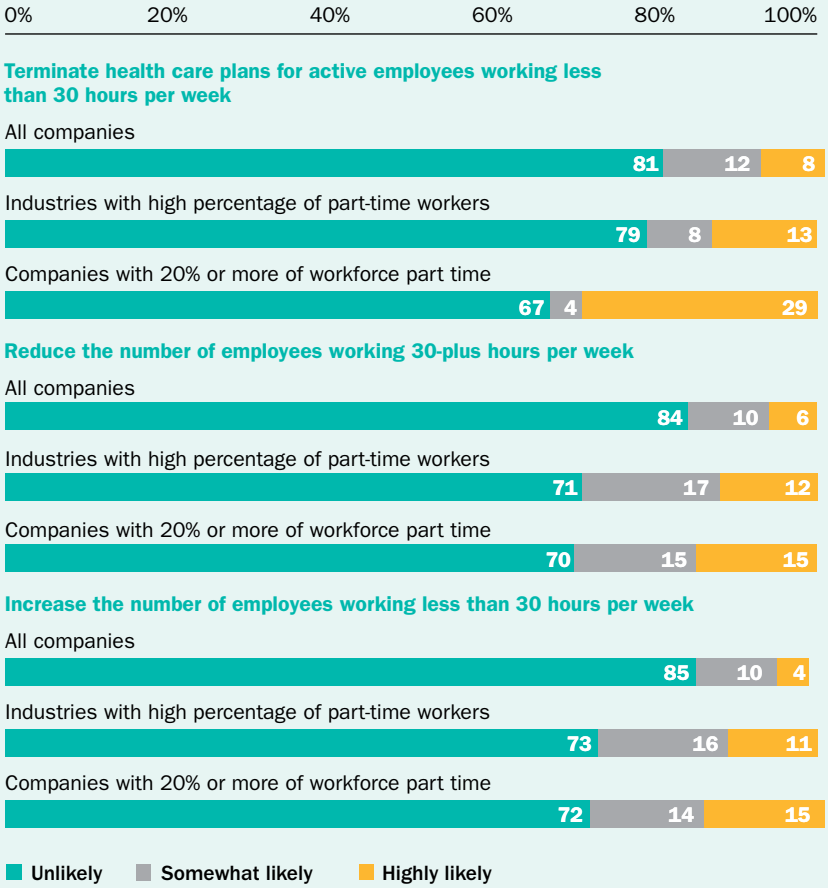
With the public exchanges opening next year, the PPACA rules will require employers that offer health care benefits to cover part-time employees working 30 or more hours a week, or pay penalties. For many employers, this change could significantly increase the number of employees eligible to receive coverage and drive industries that rely on part-timers to manage their costs more aggressively. So far, few seem to be changing their strategy *(Figure 39),* which may reflect their uncertainty regarding exchanges and an interest in waiting to see how competitors will respond. We expect that reluctance to change significantly in the next year out of necessity, especially if costs or employees will be lower through the public exchanges.

Figure 38. Offering of health care benefits to part-time employees

	All companies	Industries that use a high number of part-time employees	Companies with at least 20% of employees working part time
Yes, with the same options as full-time employees	38%	26%	20%
Yes, but with more limited coverage or subsidy than full-time employees	29%	42%	42%
No, we do not offer coverage to part-time employees	29%	30%	37%
No, we do not have part-time employees	4%	2%	1%

Note: High part-time concentration includes companies in the following industries: health services, hospitality, entertainment, professional services, retail and wholesale trade.

Figure 39. Likelihood organizations will take the following action in the next five years with their part-time health care programs and workers



How Best Performers Get Ahead

With economic challenges persisting and landmark reform scheduled to transform the health care landscape, there has never been a more critical time for employers' health benefit programs to operate efficiently. Our research over the last few years has repeatedly shown that the most successful companies separate themselves from their competitors by making significant strides in six core areas:

- **H**ealth improvement
- **E**ngagement
- **A**ccountability
- **L**inking provider strategies
- **T**echnology
- **H**ealthy environment

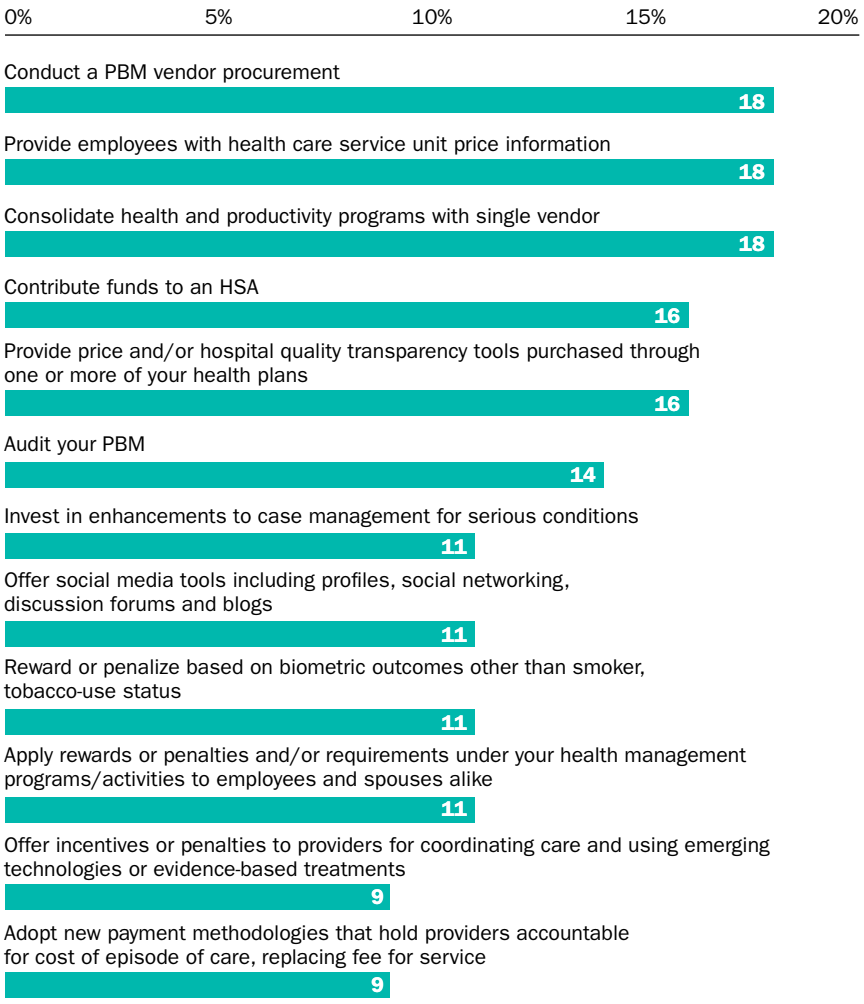
There is a lot to learn from these companies by looking at what they have been doing and where they are headed. How do the most successful companies get ahead? Simply stated, these companies have universally made greater strides in each of the six core areas, and they use health care metrics to gauge their strategies' impact on two critical success factors: cost reduction, and improvements in workforce health and productivity.

Strategies Implemented by Best Performers in 2013

The best performers took a number of significant steps in 2013 to improve the efficiency of their health care programs *(Figure 40):*

- Consolidated vendors to improve delivery and coordination of health management programs; also taking steps to incent providers to invest in new technologies to improve the coordination of care
- Focused more on communication to help employees make smarter health care decisions, leveraging popular culture technology like social media to make sure they have the best information on health care providers available
- Stepped up emphasis on transparency in provider prices as well as quality and results
- Invested in case management to more proactively and effectively manage their high-cost cases
- Placed more responsibility on employees, tying financial incentives to measurable improvements in their health; extended these incentives to spouses
- Started implementing new payment methods to providers, placing greater responsibility on them to deliver high-quality, efficient care

Figure 40. Most implemented strategies of best performers in 2013

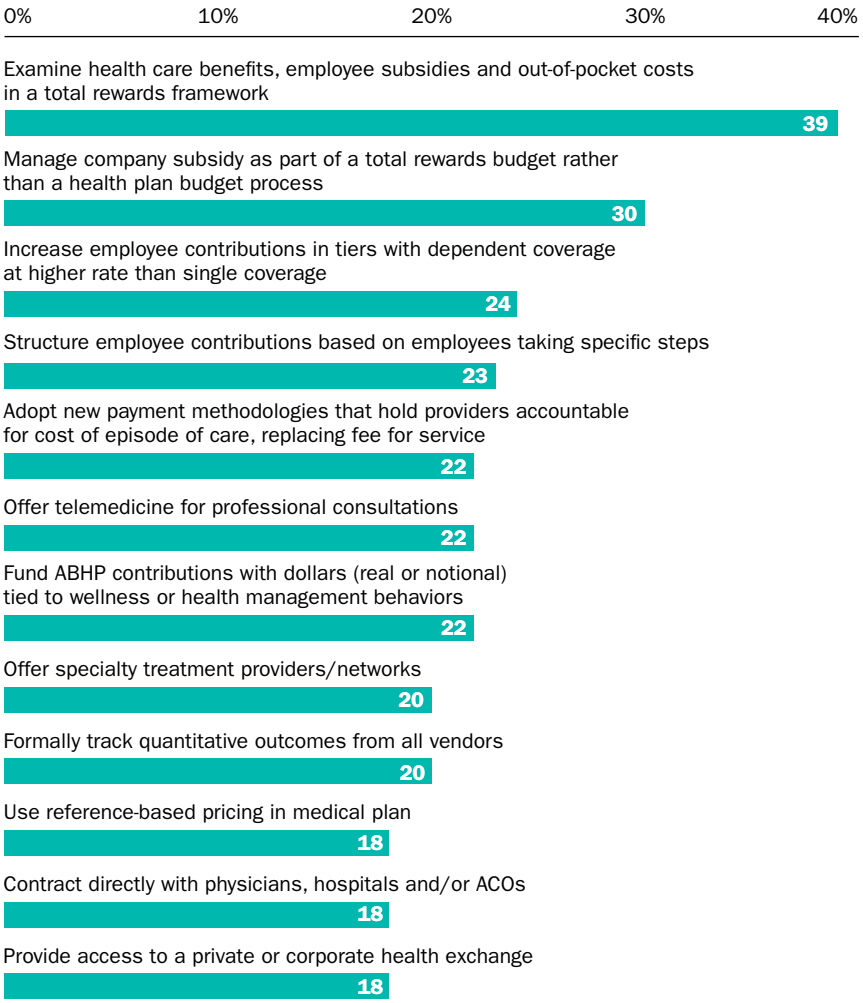


On the Drawing Board for 2014

Best performers are successful over the long term because they continue to look for new ways to lower costs *(Figure 41).* Their plans for next year include:

- Optimizing their health care spending by approaching it as part of their total rewards strategy. They intend to make plan design changes and redefine subsidies for dependents. Taking this broader view helps them remember that rising health care costs take their toll on other parts of compensation employees consider important, like salary and retirement contributions.
- Integrating their contribution strategy with their health management and wellness activities. Many more companies are tying their wellness incentive strategy to their ABHP account contributions.
- Focusing more on the supply side of employee health care — holding providers and other vendors accountable through payment reforms, delivery improvements, value-based designs and measurement of outcomes.
- Continuing to explore the development of private exchanges as a possible alternative to the current system of employer-provided health care.

Figure 41. Top strategies planned by best performers for 2014



Conclusion

While health benefit cost trends continue to stabilize, they are still significantly above the overall rate of inflation. With the excise tax looming, the pressure is on employers to better control costs. As more of that burden shifts to employees, employers are looking to other strategies — particularly through changes in vendor relationships, use of ABHPs and a greater emphasis on wellness — to manage costs.

Most employers are waiting to see how the PPACA will play out before making radical changes to their plans, and most expect to continue providing health benefits over the next five years.

In our view, health benefits continue to be a differentiator for top organizations when it comes to attracting and retaining talent, but they should be viewed in the context of a total rewards program that carefully balances employee needs and employer costs, and leaves enough money in the budget for the most efficient employers to reward top performers.

The following strategies offer employers a way to manage health benefit costs, prepare for the PPACA, encourage employees to take an active role in their own health and well-being, and mitigate risks.

Strategies for Long-Term Success

Take a strong hand in financial management
Take steps to improve efficiency, including:

- Use data and metrics to understand the cost drivers of your health plan, vendor efficiency and population risk profile.
- Analyze health management programs designed to address population health risks, and evaluate ROI and cost savings.
- Negotiate financial arrangements with your vendors, including pharmacy benefit managers, that include risks for both parties.
- Audit claims and clinical programs to ensure plan designs and programs are administered appropriately.
- Develop a workplace culture that holds employees accountable for managing their health.

Understand the excise tax and your options for addressing it

The purpose of the excise tax, which starts in 2018, is to lower the high cost of employer-provided plans. The government believes these high-cost plans lead to the overuse of the health care system and fuel rising costs. If you have a high-cost plan, now is the time to recalibrate your health care strategy to lower costs and avoid the excise tax. This will mean:

- Restructuring your plan
- Adopting ABHPs
- Using spousal surcharges and dependent tiers
- Emphasizing accountability in year-round health care decision making
- Engaging employees in programs that promote healthy choices and responsibility for their health
- Restructuring and rethinking retiree health care
- Ensuring cost and quality transparency from vendors and providers

Keep an eye on the development of new delivery channels for health benefits

Consider whether the public or any of the emerging private exchanges might provide reliable alternative coverage for certain segments of your workforce. Pay special attention to the role public exchanges might play in covering pre-65 retirees, part-timers who work 30 or more hours a week, and lower-paid employees who might be eligible for subsidies. Watch the actions of competitors and leading companies in other industries.

Rethink retiree medical

Review your retiree medical in the context of your total rewards philosophy, and reconsider your role in providing this benefit. Even with employer contributions, the cost of retiree medical is becoming unaffordable for many workers, especially those not yet eligible for Medicare. Consider the benefits to both you and your employees of the public exchanges opening in 2014, which offer guaranteed coverage at likely lower costs. With the improvements in Medicare (especially drug coverage), take the opportunity to review your Medicare supplement plans. Finally, encourage active employees to invest in tax-advantaged medical savings accounts (HSAs and HRAs) that can be used in retirement.

Consider a total-replacement ABHP — and recognize that not all ABHPs are created equal

ABHPs can be very effective in helping to control both employee and employer costs, but long-term success is dependent on a comprehensive approach that emphasizes employee and provider accountability, cultivation of smarter health care consumers and taking advantage of the rapidly changing provider marketplace. Align your ABHP strategy with your health management strategy, and consider incentives and penalties to encourage the right employee behaviors. Encourage employee enrollment in your ABHP by tying your contributions to their HSAs and HRAs. Stress the tax and retirement savings advantages of those accounts in employee communications. Rethink subsidies for dependents. Finally, consider making an ABHP your only plan, and offer low premiums, reasonable deductibles and attractive contribution strategies. Remember, significant employee enrollment is key to the success of an ABHP. And don't forget spouses: Extend your incentives and communications to them as well.

"Remember, significant employee enrollment is key to the success of an ABHP. And don't forget spouses: Extend your incentives and communications to them as well."

Influence engagement through employee education and communication

To overcome poor employee health habits — one of the biggest challenges to maintaining affordable benefit coverage — develop a culture of health. In addition to working with vendors to improve employee health through better information on health outcomes and cost, consider social media and incentives to drive change. Use behavioral techniques such as online discussion groups and games, team-based and individual competitions, online and in-person classes, and other strategies that encourage healthy behaviors.

Consider biometric and achievement standards initiatives

Go beyond providing incentives for participating in biometric screening. Provide meaningful rewards for employees who meet health improvement goals such as losing weight or quitting smoking. Consider following the lead of companies that charge penalties to smokers who do not enroll in smoking-cessation programs. Involve spouses as allies in reward programs.

Emphasize accountability and vendor partnerships

Leverage the PPACA's reform provisions (value-based purchasing, ACOs, bundled payments and medical homes — all targeted at improving quality and efficiency) to lower your costs. Implement performance-based contracts with vendors and set specific performance targets. Differentiate cost sharing for use of high-performance vendor networks, and offer incentives and penalties to providers to improve quality, efficiency and health outcomes. Require vendors to share information on care outcomes and costs to guarantee your employees have access to quality information they can use to make their health care decisions.

Get in front of the specialty pharmacy trend curve now

More employers are becoming acutely aware of the impact specialty drugs have on their total health care spend and in particular, their pharmacy spend. However, a relatively small number of employers actually know how much they spend in this area. Specialty drugs are trending at an exorbitant rate

relative to traditional products, and it is estimated that employer spend in this area will double in the next three to five years. In light of this, employers should understand their total specialty pharmacy cost exposure and explore new strategies to address this fastest-growing area of pharmacy, including utilization management, site-of-care optimization, specialty pharmacy networks and formulary management.

Take advantage of new care delivery models and treatment settings

Follow the progress of companies that are experimenting with lower-cost alternatives to doctor visits and high-cost emergency rooms. Consider offering onsite health care (e.g., a clinic that provides preventive, primary or urgent care) in at least one location. Explore telemedicine (remote monitoring and real-time interactive services that leverage mobile collaboration technologies) for professional consultations. Monitor the experience of the technology industries that have been early adopters of telemedicine.

Consider your health plan in the context of total rewards

Are you using your rewards to drive employee engagement and organizational performance? If so, what role do your health benefits play? Your health care costs may be depleting resources that could be better spent elsewhere, such as on performance bonuses, base salary or any of the other components of a total rewards program. By making these trade-offs transparent to employees, you can help them understand the impact that increasing health care costs have on rewards and benefits.

Adapt the strategies of best performers

Best performers use a variety of these strategies. The key is to first understand your costs, employee demographics and overall employee health profile. Armed with that information, you can begin to understand how the PPACA will affect your current health plans and your employees. For example, how many of your employees will fall into the part-time category? Will any employees be eligible for a subsidy? Is your plan high cost? If so, how will you avoid the excise tax? Once you've identified areas to target for improvement, you can work with vendors and providers to develop a strategy that focuses first on your most pressing issues. Build in metrics so you can track the progress of your initiatives.

About the National Business Group on Health

The National Business Group on Health is the nation's only nonprofit membership organization of large employers devoted exclusively to finding innovative and forward-thinking solutions to their most important health care and related benefits issues. The Business Group identifies and shares best practices in health benefits, disability, health and productivity, related paid time off and work/life balance issues. NBGH members provide health coverage for more than 50 million U.S. workers, retirees and their families. For more information about the NBGH, visit www.businessgrouphealth.org.

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