Health Benefit Trends: What’s New for 2014?

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Managing Cost & Risk

- Network Access / Discounts
- Carrier / PBM Negotiations
- Stop Loss Negotiations
- Bundling Discounts
- Disease Management
- Tiered Networks
- Tiered Benefits

- Spousal Surcharge/Carve out
- Expanded Family Tiers
- Lower Dependent Subsidy
- Dependent Eligibility Audits
- Extended Waiting Periods

- Culture of Accountability
- Targeted Wellness Initiatives
- HRM-based Incentives
- Outcomes-based Benefits
- Account-based Plans

- Plan Design Tweaks
- Value-based Benefit Design
- EE Contribution Tweaks
- Incentive-based Contributions
- Group Segmentation (salary, division, tenure, etc.)
<table>
<thead>
<tr>
<th>Established Tactics</th>
<th>Emerging Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumerism and Account Based Plans</td>
<td>Private Exchanges</td>
</tr>
<tr>
<td>Voluntary / Worksite Benefits</td>
<td>Price Transparency Services</td>
</tr>
<tr>
<td>Onsite Clinics or Other Onsite</td>
<td>Social Media</td>
</tr>
<tr>
<td>Resources</td>
<td>Telemedicine</td>
</tr>
<tr>
<td>Outsourcing</td>
<td>Tiered or Quilted Networks</td>
</tr>
<tr>
<td></td>
<td>Patient Advocacy</td>
</tr>
</tbody>
</table>

- Health Risk Management
  - Audits - Dependent Eligibility, Medical/Rx/Dental Claims
  - Carving Out Specialty Services (cancer, lab, surgery)
- Pharmacy Re-contracting and Plans Cost Controls
  - Value Based Plan Design
  - Narrow Networks (ACOs, PCMHs, & Centers of Excellence)
- Health Reform Modeling and Analysis
- Health Risk Management
- Technology
- Social Media
- Telemedicine
- Tiered or Quilted Networks
- Patient Advocacy
- Mobile Applications
Price Transparency Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In 2012</th>
<th>Added in 2013</th>
<th>Planned for 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide price and/or hospital quality transparency tools purchased through health plans</td>
<td>33%</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Require vendors to share data for employee outreach and integrated reporting</td>
<td>40%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Encourage plans and providers to offer patient access to online medical information</td>
<td>32%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Provide employees with healthcare service unit price info</td>
<td>18%</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Provide price and/or hospital quality transparency tools purchased separately through specialty vendors</td>
<td>7%</td>
<td>5%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Why It Matters/Key Considerations**

- Along with referenced-based pricing (RBP) and CDHPs, price transparency is necessary to find the best “deals” in healthcare services.
- 45% of “best performers” are putting pressure on plans and providers to offer patients access to online medical information, compared to only 29% of “low performers.”
- Best performers are those employers whose costs have increased over four years at a lower rate than the TW/NBGH median.
- Carriers can provide transparency tools and offer the most up-to-date pricing available.
- Independent firms provide additional benefits, like advocacy call centers, along with their transparency capabilities.

Price Transparency Services
People Are Paying Too Much

Prices of Services Within a Single Network, in the Same Area

<table>
<thead>
<tr>
<th>Service</th>
<th>Price</th>
<th>Multiplier</th>
<th>Total Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>$563</td>
<td>7x</td>
<td>$3,967</td>
</tr>
<tr>
<td>Primary care visit</td>
<td>$85</td>
<td>3x</td>
<td>$270</td>
</tr>
<tr>
<td>EKG</td>
<td>$27</td>
<td>5x</td>
<td>$143</td>
</tr>
</tbody>
</table>

Why It Matters/Key Considerations

- No correlation in the medical field between quality and price
- Wide variance in pricing for identical treatments
- Can be dependent upon physician or venue (the same doctor at different locations can have varying prices)
- Teaches employees and dependents how to be smart consumers
- Currently most employees either go where their physician recommends or to the most convenient location
- The employer is able to align incentives for ALL employees to meet the employer’s overall objective
  - Members that have not met their deductible
  - Members that have met their deductible and/or out-of-pocket maximum
Private Exchanges

Private Exchanges

- **Moving retirees to private exchanges**
  - 2013: 10%
  - 2014: 7%
  - Considering for 2015+: 40%

- **Moving active employees to private exchanges**
  - 2013: 1%
  - 2014: 30%

Why It Matters/Key Considerations

- An online resource set up by insurance carriers or benefits consultants, where individuals and employers can shop for health insurance, enroll in a plan, and receive customer support.

- Employers have the ability to choose exchange based on specific needs (e.g., plans, carriers, system capabilities).

- Seek to mitigate healthcare cost increases by creating an efficient marketplace that offers an improved employee experience and greater choice for employees.

- Gives employees the ability to “shop” for the benefits they want.

Private Exchanges

**Private Exchange Uptake**
(Active Employees, Estimated)

- **2013**—100K Employees
- **2014**—1M Employees
- **2017**—10M (estimated)

**Pros**
- Plans are call-center supported
- More plan options
- Prepares employees for look and feel of public marketplace/exchange (exit strategy)
- Employer has incentive to stay engaged in health risk management

**Cons**
- No federal subsidy
- Carrier apprehension
  - Same products but higher cost
  - Don't want “slice” (adverse selection)

**Why It Matters/ Key Considerations**

- Large employers (>100 employees) are not eligible to purchase on the public exchanges until 2017
- In the meantime, some are considering private exchange options. Current offerings include Aon Hewitt (> 3,000 employees only, multicarrier, fully insured), Mercer (mixed model), Towers Watson (self-funded), and Willis
- A typical employer strategy is to provide a “defined contribution” (DC) subsidy to employees, who in turn use the subsidy to purchase coverage from the single or multiple carriers featured on the exchange.
- DC is a potential cost-management strategy in the short run, but is a doubtful long-term strategy unless the employer reinvests “savings” in health promotion and improvement initiatives
- DC does not eliminate employer cost issues (e.g., the risk hasn’t changed, it has just shifted from employer to employee), premiums on exchanges will typically be higher, products are no different, and the employer still has to administer a health benefit plan
- So, what are the advantages of an “exchange”? Employers can offer (and have for years) the same construct in a “traditional” plan
- Carriers are approaching with caution, especially multicarrier (slice) platforms like Aon-Hewitt’s. Prefer risk characteristics of “exclusive” platforms

Private Exchanges
Defined Contributions

Employers That Currently Use or Are Considering This Approach

- Core/Buy-up (same employer contribution) 33%
- Flat-dollar subsidy/voucher given so employee can go buy coverage on their own 14%
- Fixed employer increase (Employer decides to set the amount they will contribute separate from the total amount) 11%

Why It Matters/Key Considerations

- Company sets a defined amount that each employee is given to “buy” benefits
- If employee doesn’t want to buy benefits, the company can decide if and how much they would give to those non-electing employees
- When given the option, 65% of employees choose to “buy down” their coverage, electing less rich plan options
- As opposed to defined benefit plans, a defined contribution model shifts residual risk of incurring high healthcare costs from employers to employees. Plans are usually fully insured
- Employers could simply give people money to go to public exchange
- Private exchange platforms give the ability to offer a vast array of benefits. Employees have a “shopping” experience

Source: Mercer’s National Survey of Employer-Sponsored Health Plans
Narrow Networks
Accountable Care Organizations (ACOs)

- Primary Care Physician
  - Reduce hospital stays
  - Reduce emergency room visits
  - Reduce expensive specialist and testing services

$\$ Savings
(determined by specific network and services)

U.S. Population Accessibility
- Access 55%
- No Access 45%

Why It Matters/Key Considerations
- ACO-network of doctors and hospitals that share responsibility for providing coordinated care to patients with the goal of limiting unnecessary spending
- Similar to HMO model except an ACO patient is not required to stay in network for care
- With more than 200 ACOs located in 27% of local, mostly urban areas, 55% of U.S. population resides in accessible areas
- Approximately 14% of the population is already served by an ACO
- Savings estimates range from 2%-15% depending on population and services performed
- ACO providers get paid more for keeping their patients healthy and out of the hospital
- Doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases

Source: Kaiser Health News, August 2013
Health Services Research, October 2013
Narrow Networks
Centers of Excellence

% of Employers Differentiating Cost-Sharing (e.g., Reduced Co-Pays or Coinsurance)

- Transplants
  - Offer service, but do not differentiate cost-sharing: 31%
  - Offer service, and differentiate cost-sharing: 41%

- Other conditions
  - Offer service, but do not differentiate cost-sharing: 25%
  - Offer service, and differentiate cost-sharing: 34%

Why It Matters/Key Considerations

- Centers of excellence (COE) focus on efficiencies and outcomes of episode
- Contrary to popular belief, many high-profile facilities may offer the most competitive costs, advanced technologies, and the most qualified providers in their field
- Traditionally centers of excellence have focused on organ/tissue transplants and complex cancers
- Expansion has included renal treatment, bariatric surgery, and infertility, to name a few
- A medical facility center of excellence typically establishes best practices for complex, unusual, or rare procedures

On-Site Health Clinics

Services Offered at On-Site Health Clinics for Employers with One or More Clinics

<table>
<thead>
<tr>
<th>Service</th>
<th>All clinics</th>
<th>Most clinics</th>
<th>Some clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health improvement programs</td>
<td>63%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Occupational health</td>
<td>58%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Acute care</td>
<td>54%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Primary care</td>
<td>46%</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Chronic care management</td>
<td>29%</td>
<td>6%</td>
<td>13%</td>
</tr>
<tr>
<td>Pharmacy services</td>
<td>29%</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>On-site EAP</td>
<td>29%</td>
<td>2%</td>
<td>21%</td>
</tr>
<tr>
<td>Selected specialty care</td>
<td>15%</td>
<td>4%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Why It Matters/ Key Considerations

- On-site clinics are often used to promote company wellness initiatives
- Although the results vary, many employers have been pleased with their return on investment through reduced health risks and better productivity amongst their workforce.

- 20-25% of companies with 1,000+ or more employees at one site have an on-site clinic.
- Services are typically provided at a reduced cost to employees to incent them to prevent and treat illness.

- Employers have the option of enlisting a third party to provide medical professionals and manage delivery of services, contract directly with outside medical professionals, or hire healthcare professionals as employees of the company to deliver services.

On-Site Health Clinics

Top Reasons for Establishing On-Site Clinics

- Enhanced worker productivity: 62%
- Reduced medical costs: 56%
- Central location to integrate health and productivity efforts: 52%
- Improve access to care: 38%
- Occupational health: 32%

Why It Matters/Key Considerations

- Increases productivity due to reduced time away from work
- Medical cost reduction achieved by lowering cost per service performed, improved outcomes, and fewer ER visits and hospitalizations
- Can optimize the value of on-site health improvement efforts by creating service for employees to be channeled into appropriate resources
- Able to offer on-site services ranging from flu shots, screenings, and urgent and primary/occupational care to wellness counseling and chronic condition management

Source: TowersWatson 2012 On-Site Health Center Survey Report
**Telemedicine**

### Why It Matters/Key Considerations

- Telemedicine reduces costly and unnecessary emergency room (ER) visits by providing convenient access to an affordable option
- Can be offered by employers that are self-insured or by carriers within a fully insured plan
- Video conferencing is now offered by most telemedicine vendors
- 85% of Americans who went to the ER said they couldn’t wait to see their regular medical provider
- However, only 55% of ER visits were classifiable as immediate, emergent, or urgent at triage
- Consultations cost between $35-$40 vs. an urgent care or ER visit cost of $150-$750
- Savings can be seen with utilization that surpasses 4-5%; employer utilization can be as high as 10-12%
- Self-insured employers can expect to pay $1-$3 per employee per month

Source: American College of Emergency Physicians Emergency Care Poll 2012

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**Telemedicine services**

- 7% In place in 2012
- 7% Added in 2013
- 20% Planned for 2014
### Employers Offering HSA and/ or HRA Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDHP with HSA</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>HDHP with HRA</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>HDHP with HRA and FSA</td>
<td>13%</td>
<td>18%</td>
</tr>
<tr>
<td>Other plan type with HRA (EPO or POS)</td>
<td>13%</td>
<td>8%</td>
</tr>
</tbody>
</table>

### Why It Matters/ Key Considerations

- Approximately 19 million adults with private insurance (15% of private market) were covered by a CDHP or HSA-eligible plan
- CDHP enrollees are more likely to take advantage of wellness program and activities
- Adults on CDHPs are significantly more likely to report being in excellent or good health
- Adults on CDHPs are significantly less likely to smoke and more likely to exercise
- CDHP enrollees are more likely to be highly educated
- CDHP medical cost trend was 13% lower than traditional plans during the first year: 20% lower in HSAs and 11% lower in HRAs
- Savings are likely to be an additional 2%-3% in subsequent years

Source: National Business Group on Health 2013
Source: Kaiser 2013 Annual Survey, Employer Health Benefits
Consumerism & Account-Based Plans
CDHP—Seeding

### Average Employer Contribution to Employee Account

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRA</td>
<td>$947</td>
<td>$1,800</td>
</tr>
<tr>
<td>HSA</td>
<td>$950</td>
<td>$1,680</td>
</tr>
</tbody>
</table>

### Employer HSA Funding Frequency

- Fully prefund: 36%
- Payroll deduction: 34%
- Monthly: 9%
- Quarterly: 8%
- Other: 13%

### Why It Matters/Key Considerations

- HRAs are funded as claims are incurred
- Unused HRA amounts generally roll over into future years
- Balance reverts back to employer if employee terms coverage
- 51% of employers offering HSA-qualified plans do not seed accounts

Source: Kaiser 2013 Annual Survey, Employer Health Benefits
Pharmacy Re-Contracting & Plan Cost Controls
Non-Specialty Pharmacy

Non-specialty Pharmacy Benefits Strategies of 2014

- Prior authorization: 76%
- Step therapy: 69%
- Quantity limits: 69%
- Mandatory generic substitution: 50%
- 90-day supply available at retail: 45%
- Integrate medical and pharmacy data: 44%
- Mandatory mail for maintenance meds: 40%
- Dose optimization: 27%

Why It Matters/Key Considerations

- Plan controls will affect each employee in a different way
- Oversight helps mitigate potential fraud, waste, and abuse
- Ensures pharmacy dollars are spent appropriately
- Removes unnecessary cost from the benefit
- Improves quality of access and quality of care
- Takes advantage of the generic onslaught

Pharmacy Re-Contracting & Plan Cost Controls
Specialty Pharmacy

How Employers Manage Specialty Drugs

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization</td>
<td>83%</td>
</tr>
<tr>
<td>Clinical care management</td>
<td>82%</td>
</tr>
<tr>
<td>Require use of contracted specialty pharmacy</td>
<td>72%</td>
</tr>
<tr>
<td>Formulary for specialty classes</td>
<td>70%</td>
</tr>
<tr>
<td>Step therapy</td>
<td>61%</td>
</tr>
<tr>
<td>Limit specialty to 30-day supply</td>
<td>58%</td>
</tr>
</tbody>
</table>

Specialty Cost-Sharing

- Co-pay (flat dollar amount for each Rx): 12%
- Coinsurance (fixed % for each Rx): 49%
- Coinsurance with min and max co-pay: 32%
- Other: 4%
- Not Sure: 3%

Why It Matters/Key Considerations

- Specialty medications are used by a small percentage of the population (1%-5%)
- Specialty medications accounted for 21% of U.S. drug expenditures and are growing at a rate of 20% per year
- Challenges remain to obtain comprehensive and specific cost and utilization information, especially for medications covered through medical plan
- Financial and clinical management approaches to mitigate drastic cost increases are being implemented
- Identification and reduction of inappropriate specialty utilization, as the emergence of off-label use continues
- 47% of specialty pharmacy is billed under a medical benefit as it is ordered and administered by a healthcare provider
- The complexity of the disease, medications, and the administration and handling create a need for nontraditional distribution methods, extensive patient education, and follow-up
- Due to this, adherence is particularly problematic for specialty drugs
Tobacco Surcharge

Tobacco Users Cost Employers $6,112 More Than Nontobacco Users

- Smoking Breaks: $3,077
- Excess Healthcare: $2,056
- Excess Absenteeism: $517
- Presenteeism: $462

Percentage of Employers That Use Surcharge For Tobacco Users

- 2012: 35%
- 2013: 42%
- 2014 (planned): 62%

Source: Gallup-Healthways Well-Being Index
Spousal Surcharge

What Are Employers Doing with Spouses?

<table>
<thead>
<tr>
<th>Option</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal carve-out</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Spousal surcharge</td>
<td>20%</td>
<td>33%</td>
</tr>
<tr>
<td>Considering limiting coverage to spouses</td>
<td>24%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Note: Surveyed population includes groups with a minimum of 1,000 employees. Of the respondents surveyed, 60% had 5,000 or more employees. 

Audit – Dependent Eligibility, Medical/ Rx/ Dental Claims

Dependent Eligibility Audits

Percentage of Average Ineligible Dependents

- Eligible 93%-95%
- Ineligible 5%-7%

Why It Matters/ Key Considerations

- Average audit results in a reduction of 5% to 7% of ineligible dependents
- The average post-health reform cost per dependent is $3,400 (varies by industry and company size)
- Audits help fulfill employer’s fiduciary responsibility to manage the plan for the exclusive benefit of eligible participants and beneficiaries
- Reduce compliance risk under Sarbanes-Oxley, ERISA, and DOL guidelines
- Establish ongoing verification procedures
- Given the opportunity, 46% will try to reenroll an ineligible dependent

Sources: 2012 HRAdvance Enterprises, Consova
Questions/Comments?