SURVEY Report

August 2010

Large Employers' 2011 Health Plan Design Changes

National Business Group on Health

Contents

Introduction

The National Business Group on Health conducted its annual plan design survey with members in the spring/summer of 2010. This survey is one of the few surveys conducted mid-year just as employers are finalizing their plan designs for the following year. The survey asks members to provide information on their 2011 plan offerings, including:

- Medical plan costs
- Consumer-directed health care
- Healthy lifestyles and incentives
- Pharmacy benefits
- Retiree medical coverage

In addition, this year we asked questions regarding changes to overall health benefit programs as a result of the passage of the health care legislation.

This year, 72 members completed the survey.[1] The following report provides an overview of these findings. Where possible, comparisons to the 2009 and 2010 survey results are provided.

[1] Although 72 members completed the survey, they did not find all questions directly applicable. As a result, the number of responses varies by question.

Key Findings

Changes as a Result of Health Care Legislation

While there was uncertainty about the regulations determining grandfathered plan status, the majority of employers (53%) were still planning to make changes to their plan designs.

To comply with the law, employers are having to remove lifetime dollar limits on overall benefits (70%), make changes to annual limits on specific benefits (40%), remove annual dollar limits on overall benefits (26%), and remove pre-existing conditions exclusion clauses for dependent children under age 19 (13%).

Employers are still evaluating retiree health offerings as a result of new provisions related to taxation of retiree drug subsidies as well as changes in Medicare Advantage plans.

Medical Plan Costs

Employers estimated an average increase in health care costs of 7.0% for 2010, with reported estimates ranging from a 2.7% decrease to a 14.0% increase. For 2011, employers are estimating a slightly larger increase, an average trend of 8.9%.

According to 21% of employers, consumer-directed health plans (CDHP) were reported to be the most effective tactic to control costs. Whereas only 20% of employers indicated that wellness initiatives were the most effective tactic to control costs, 56% agreed that it was one of the top three most effective tactics in controlling costs.

In 2011, 63% of employers will be increasing the employee percentage contribution to premium costs, and 46% will increase out-of-pocket maximums, while 44% will increase in-network deductibles.

Consumer-Directed Health Care

Of the respondents, 61% will offer a CDHP in 2011. Of those offering a CDHP, 20% indicated that they will or have moved to a full replacement plan, up from 10% in 2010. The most common type of CDHP employers will offer in 2011 is a high-deductible health plan (HDHP) with a health savings account (HSA) (64%).

The most prevalent method used to load health accounts will be to contribute a pre-determined amount per participant. Sixty-eight percent of employers with health savings accounts load the HSAs in that way and 80% of employers with health reimbursement accounts (HRA) load the HRAs in that way.

Healthy Lifestyles and Incentives

Among those employers that offer incentives for healthy lifestyles, the average amount an employee could possibly earn is $386 a year, compared to $271 that a dependent could earn.

While three-quarters (76%) of employers offer wellness programs for employees who are obese or overweight, fewer employers offer these type of programs to spouses/domestic partners (42%) and children (25%).

Ninety-five percent of employers' CDHPs and 85% of employers' non-CDHPs covering preventive services at 100% with no deductible and no cost-sharing.

Pharmacy Benefits

To manage pharmacy benefits, the techniques employers are most likely to use are prior authorization (73%), followed by:

- step therapy (63%);
- three-tier design (63%); and
- mandatory mail order for maintenance medications (47%).[2]

To manage specialty pharmacy benefits, the three most prevalent techniques are prior authorization (67%), utilization management (59%), and step therapy (51%).

Retiree Health

Eighty-nine percent of employers offer retiree benefits to employees who are pre-65 and have already retired, compared to 68% that offer retiree benefits to post-65 retirees. Fewer employers offer retiree benefits to current active employees, with 46% covering all current actives and 33% covering a portion of their actives. Very few employers offer retiree health benefits for new hires, with 18% offering coverage to pre-65 retirees and 11% offering post-65 supplemental coverage to new hires.

The top strategies being used to control retiree health care costs are caps on company contributions (46%), increasing employee contributions (37%), and eliminating coverage for future retirees (33%).

[2] When an employer implements mandatory mail order, the employee may still receive their medications through retail. However, the employer only pays equivalent to the mail order cost level and the employee is responsible for the remaining portion.

All Survey Findings

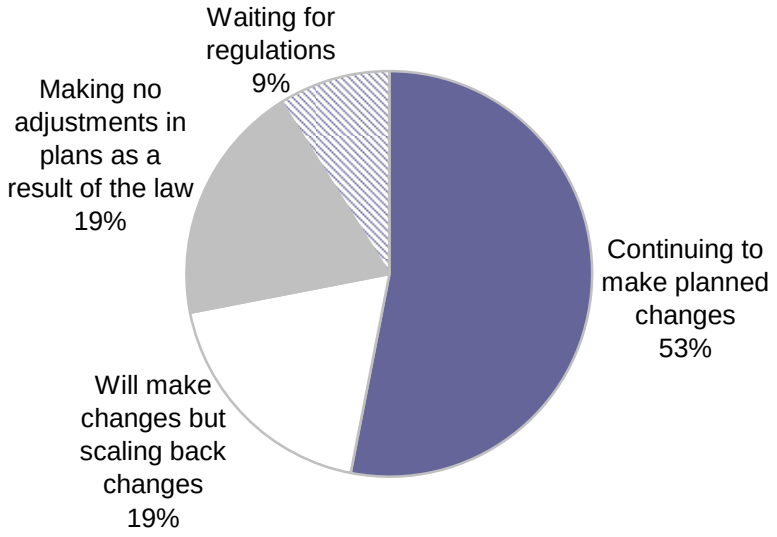
Changes as a Result of Health Care Legislation

The passage of the Patient Protection and Affordable care Act (PPACA) has presented employers with many challenges in terms of complying with the law while still attempting to control the rising costs of health care. In this year's survey, we asked employees to indicate what changes they anticipated making to comply with the law.

According to this survey, the majority of employers (53%) were continuing to make planned changes to their health plan design despite the uncertainty that existed around preserving grandfathered plan status **(Figure 1)**. However, 19% of employers were scaling back the changes they planned to make, 19% had decided to make no changes as a result of the new law, and the remaining 9% were waiting on the regulations to come out. (Note: this question was asked prior to release of the final regulations defining requirements for keeping grandfathered status.)

Figure 1: Reconsidering Plan Design Changes Because of Grandfathered Plan Status Provisions

(Sample Size=70)

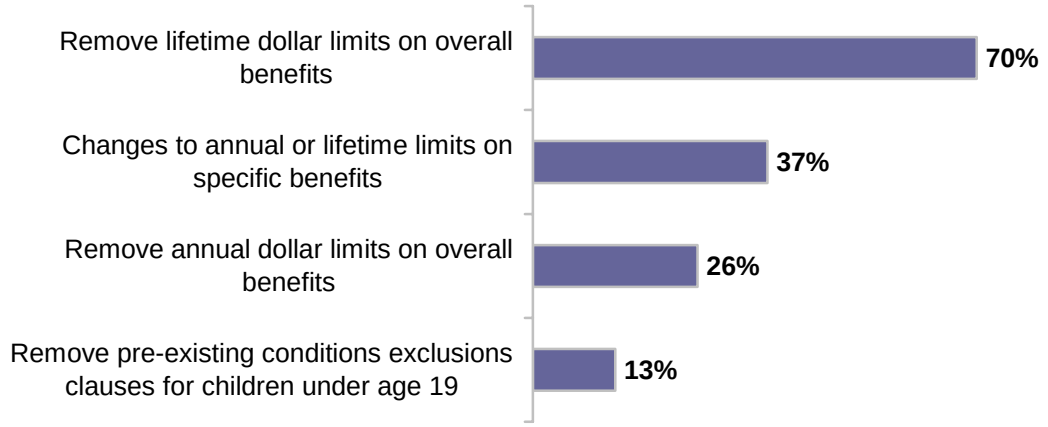


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

As a result of the new legislation, many employers will be making specific changes to their health benefit offerings to remain compliant. Among the respondents, 70% said they will need to remove lifetime dollar limits on overall benefits, 37% reported that they will need to make changes to annual or lifetime limits on specific benefits, 26% said that annual dollar limits on overall benefits will have to be removed, and 13% reported that they will have to remove pre-existing conditions exclusion clauses for children **(Figure 2)**.

Figure 2: Specific Plan Design Changes Due to Health Care Legislation

(Sample Size=54)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

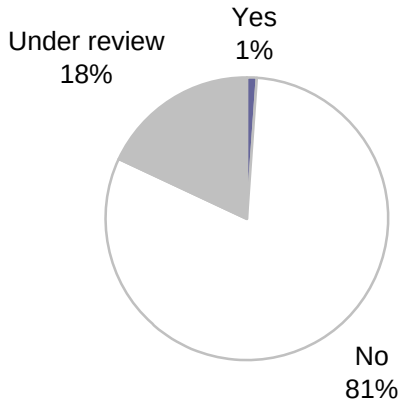
Of the 37% of employers who are making changes to limits for specific benefits, the particular benefits impacted include:

- chemical dependency;
- dental;
- durable medical equipment;
- hearing aids;
- home health care/ hospice;
- infertility benefits;
- mental health;
- occupational therapy;
- out-of-network limits;
- physical therapy;
- prosthetic devices; and
- speech therapy.

Despite the change that now disallows employees from using their health accounts to pay for OTC medications, most employers (81%) don't plan to make any changes to their covered benefits, while only 1% currently plans to make changes to their covered benefits. The remaining 18% are still reviewing the issue **(Figure 3)**.

Figure 3: Changes to Covered Benefits Due to New Health Account Permissible Expense Definitions

(Sample Size=71)

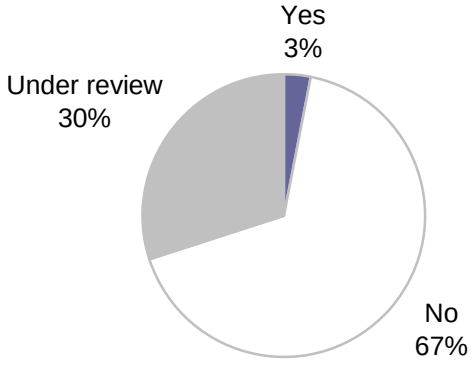


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Very few employers (3%) are currently planning to offer the voluntary community living assistance services and support (CLASS) in 2011, while another 30% of respondents reported still reviewing the issue. The remaining employers (67%) reported that they did not plan to offer the benefit in 2011 **(Figure 4)**.

Figure 4: Likelihood of Offering Voluntary Community Living Assistance Services and Support in 2011

(Sample Size=71)

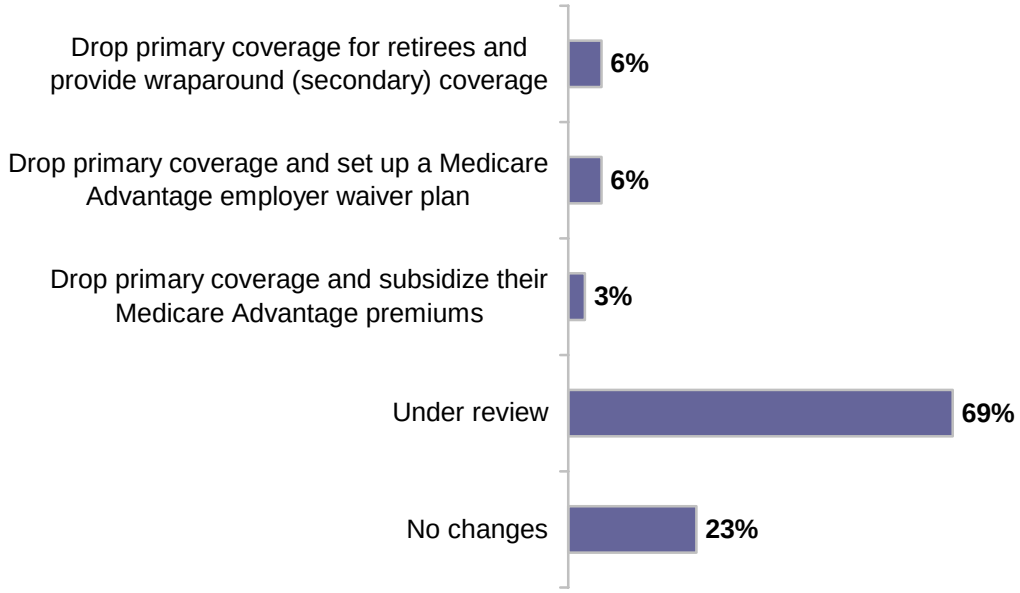


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In response to the taxation of federal retiree drug subsidies beginning in 2013, many employers (63%) are still waiting for further clarification from the regulations before making any changes. A few are dropping primary coverage and either providing wraparound (secondary) coverage (6%), setting up a Medicare Advantage waiver plan (6%), or subsidizing employee Medicare Advantage premiums (3%) **(Figure 5)**.

Figure 5: Retiree Benefit Changes in Anticipation of Taxation of Federal Retiree Drug Subsidies

(Sample Size=35)

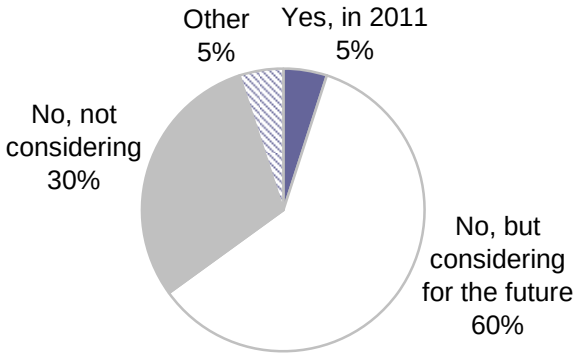


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

With the health care legislation making Medicare Part D benefits richer as the "doughnut hole" closes between now and 2020, some employers (5%) reported that they will be dropping retiree health coverage in 2011, and another 60% are considering doing so in the future **(Figure 6)**.

Figure 6: Dropping Retiree Health Benefits As the "Doughnut Hole" Closes

(Sample Size=40)

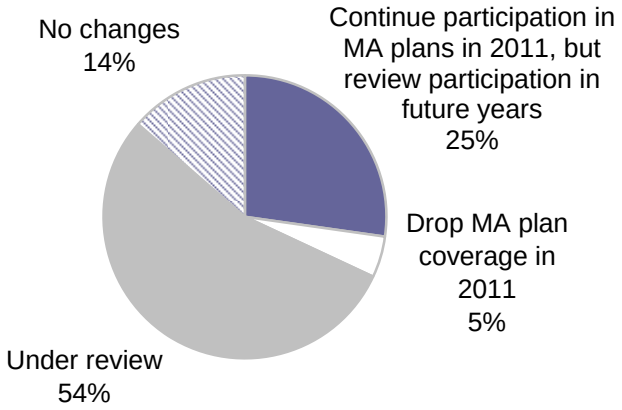


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In response to government payments for Medicare Advantage becoming frozen in 2011 and eventually phased out by 2017, employers are considering dropping their Medicare Advantage plan coverage with 5% of employers planning to drop coverage in 2011, 27% keeping their coverage for 2011 but still reviewing for future years, and 54% are still reviewing the issue **(Figure 7)**.

Figure 7: Responses to Medicare Advantage Plans Being Frozen in 2011

(Sample Size=22)

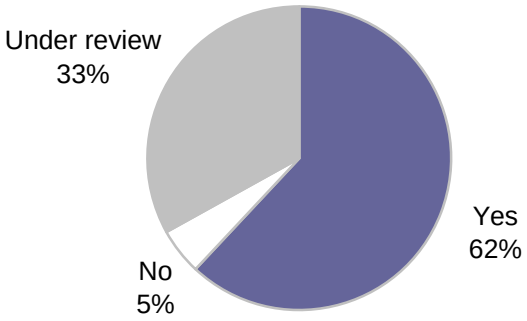


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Many employers that currently offer early retiree coverage are planning to apply for the new temporary government reinsurance program (62%), while another third are still reviewing what they will do **(Figure 8)**.

Figure 8: Employer Participation in Temporary Government Reinsurance Program

(Sample Size=55)



Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Medical Plan Costs

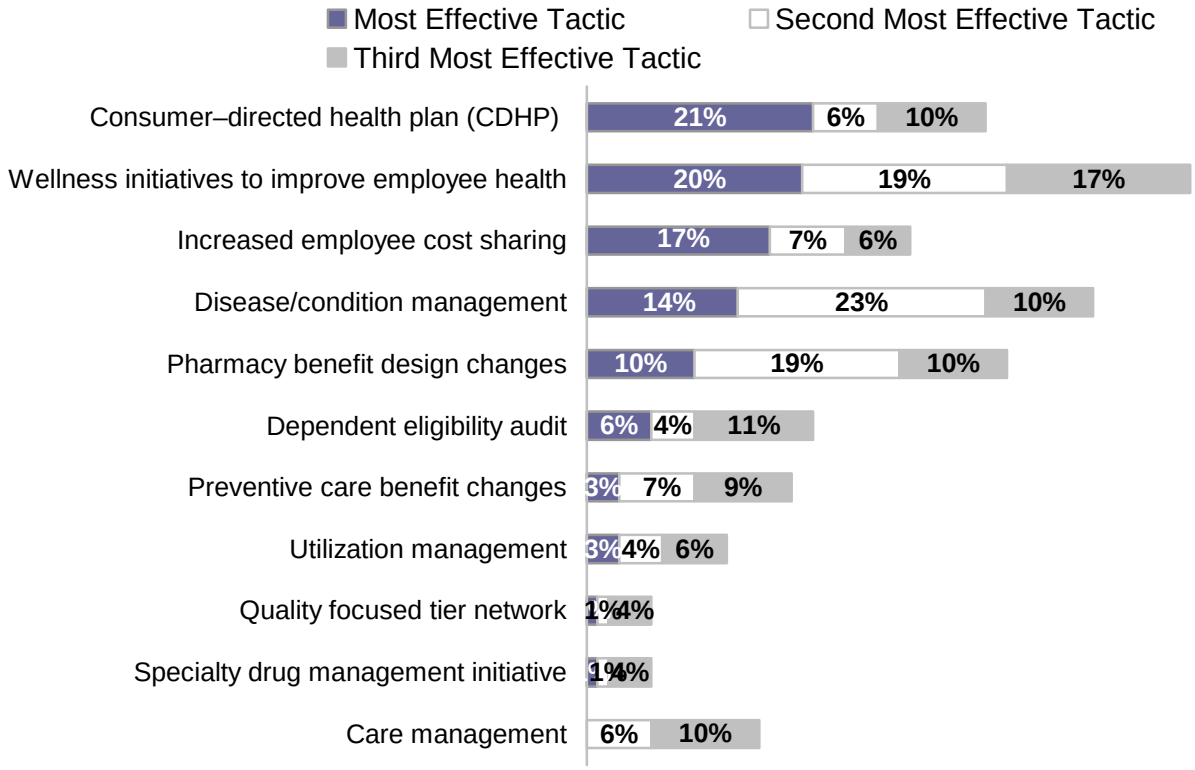
In this section respondents were asked about current and future health care costs as well as their efforts to control these costs.

Employers were asked, for budgeting purposes what percentage increase they were planning for 2010. The average increase was 7.0%, but it varied between a 2.7% decrease and a 14.0% increase. For those employers who indicated an estimate for 2011, the average increase was 8.9%.

When employers were asked what they consider the top three most effective steps they have taken or will take to control health care cost increases, the tactic that was most often reported as the most effective tactic was offering a consumer-directed health plan (21%), followed by wellness initiatives (20%), and increased employee cost-sharing (17%). The tactics that were most often reported as one of the three most effective tactics were wellness initiatives (56%), disease/condition management (47%) and pharmacy benefit design changes (39%) **(Figure 9)**.

Figure 9: Most Effective Steps to Control Health Care Costs

(Sample Size=70)



Note: Other responses included: vendor management, switching PBMs, behavioral surcharges, and increasing deductibles/coinsurance to promote consumerism.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In comparison to the last two years, employers are using a wider variety of cost-sharing strategies to help control health care cost increase in 2011 **(Figure 10)**. The most prevalent strategy is increasing the employee percentage contribution to the premium with 63% of employers in 2011 using this strategy compared to 57% in 2010. Additionally, 46% of employers plan to raise out-of-pocket maximums in 2011 compared to only 36% in 2010 and 32% in 2009.

Figure 10: Employee Cost-sharing Strategies

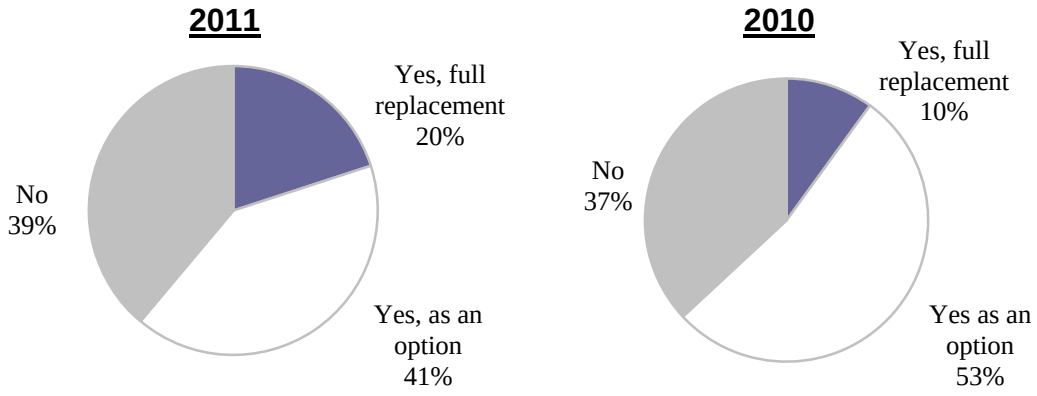
% of Employers Increasing Cost-sharing for:	2011	2010	2009
Employee percentage contribution to the premium cost	63%	57%	62%
Out-of-pocket maximums	46%	36%	32%
In-network deductibles	44%	45%	38%
Out-of-network deductibles	40%	47%	35%
Co-pay/co-insurance for specialist care	21%	13%	15%
Co-pay/co-insurance for primary care	6%	11%	15%
Sample Size	*52*	*47*	*34*

Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Consumer-Directed Health Care

More employers moved to full-replacement consumer-directed health care (CDHP) than in previous years. In 2011, 20% of employers have or plan to go to full-replacement CDHPs and 41% offered a consumer-directed health plan as an option **(Figure 11)**.

Figure 11: CDHP Offerings in 2011 and 2010

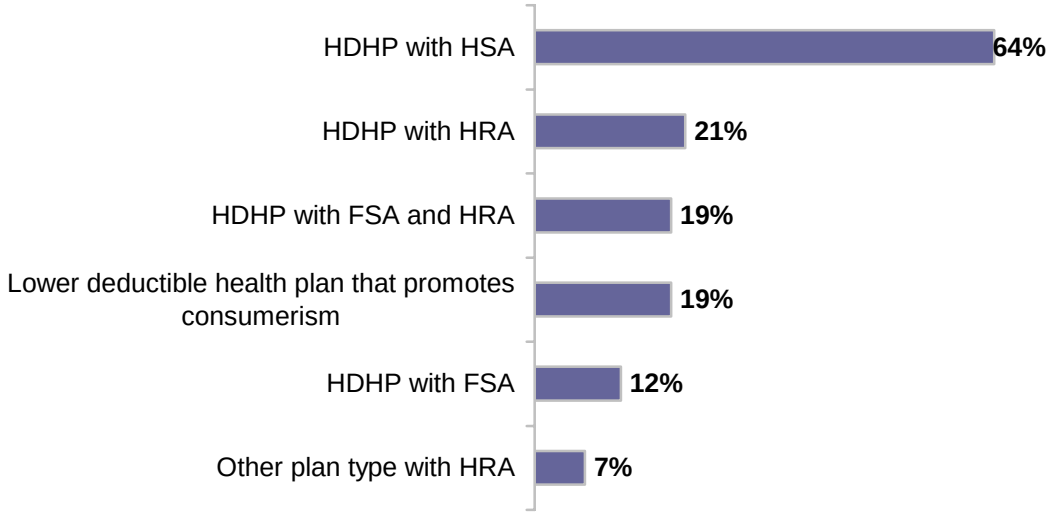


Sample Size=69 *Sample Size=68*

Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Among respondents of the survey with at least one CDHP, the most prevalent type of CDHP was a high-deductible health plan (HDHP) with a health savings account (HSA) (64%) **(Figure 12)**. The remaining options had a much lower prevalence rate with 21% offering an HDHP with a health reimbursement account (HRA), 19% offering an HDHP with an FSA and HRA, 19% offering a lower deductible health plan that promotes consumerism, 12% offering an HDHP with an FSA, and 7% offering another plan type with an HRA.

Figure 12: Prevalence of Consumer-Directed Health Plan Types in 2011
(Sample Size=42)

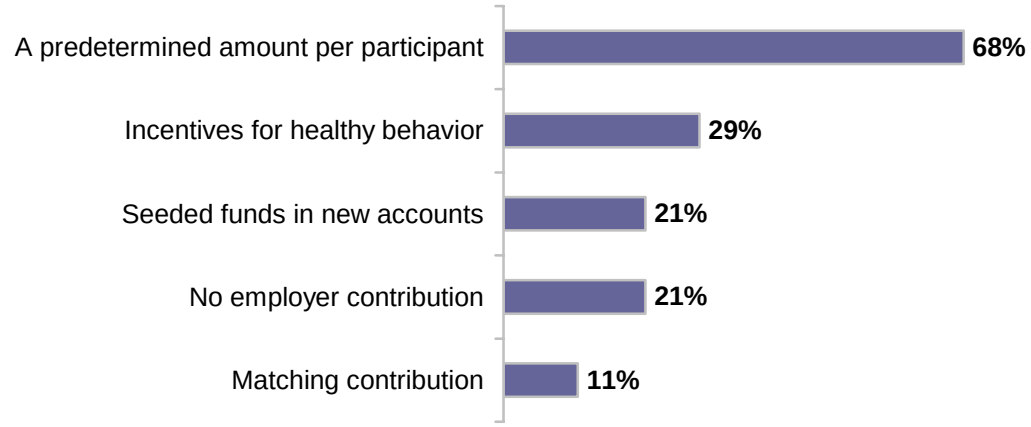


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Employers that offer a health plan with a health savings account (HSA) were asked how they contribute to the account. Sixty-eight percent said they contribute a predetermined amount per participant. Other contribution strategies included incentives for healthy behavior (29%), seeding funds in new accounts (21%), and matching employee contributions (11%). Twenty-one percent of respondents reported that they did not contribute to the accounts **(Figure 13)**.

Figure 13: Employer Contribution to Health Savings Accounts

(Sample Size=28)

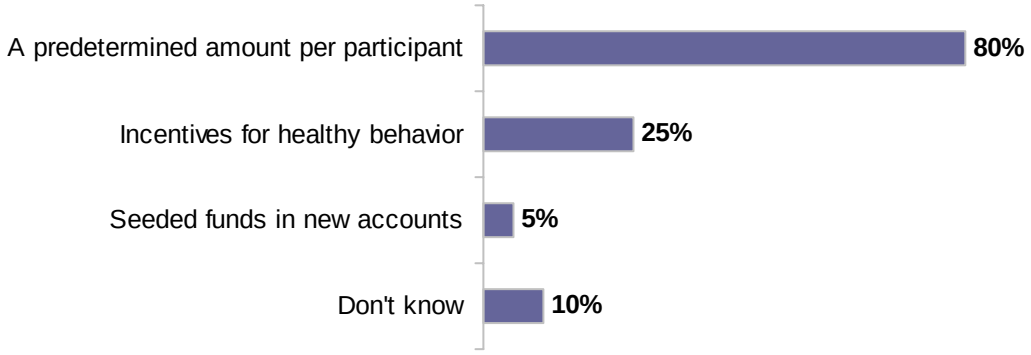


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

For employers that offer a health plan with a health reimbursement account (HRA), nearly all (80%) employers contribute to the employee's account a predetermined amount per participant. Other contribution strategies included incentives for healthy behavior (25%) and seeding funds into new accounts (5%) **(Figure 14)**.

Figure 14: Employer Contribution to Health Reimbursement Accounts

(Sample Size=20)

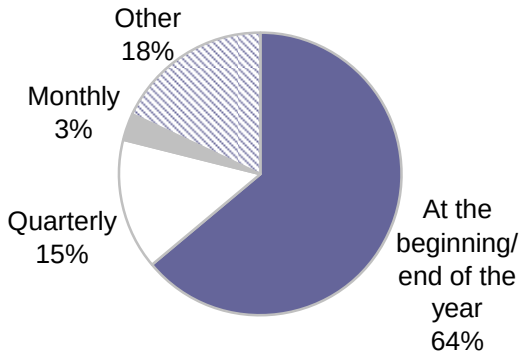


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Most employers (64%) load an employee's health account at the beginning of the year, while others will load the accounts quarterly (15%) or monthly (3%). Another method that was used by some employers included loading a portion of the amount every pay period **(Figure 15)**.

Figure 15: Loading of Funded Medical Accounts

(Sample Size=33)



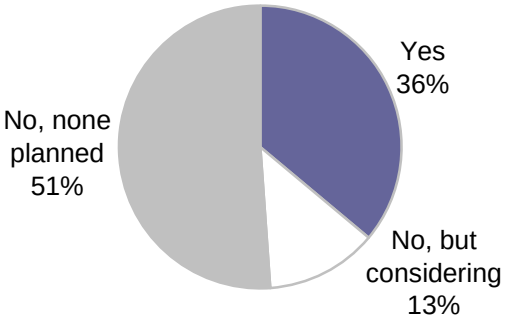
Note: Other responses included: per pay period contributions; splitting half of the amount at the beginning of the year and the other half loaded monthly.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Healthy Lifestyles and Incentives

In this section of the survey, employers were asked about a variety of initiatives that are being used to manage the health of their employees. The first question in this section asked about the prevalence of on-site health clinics. Of the 70 respondents, 36% said in at least one of their locations they had an on-site health clinic, and another 13% were considering implementing a clinic in the future **(Figure 16)**.

Figure 16: Prevalence of On-Site Health Clinics

(Sample Size=70)

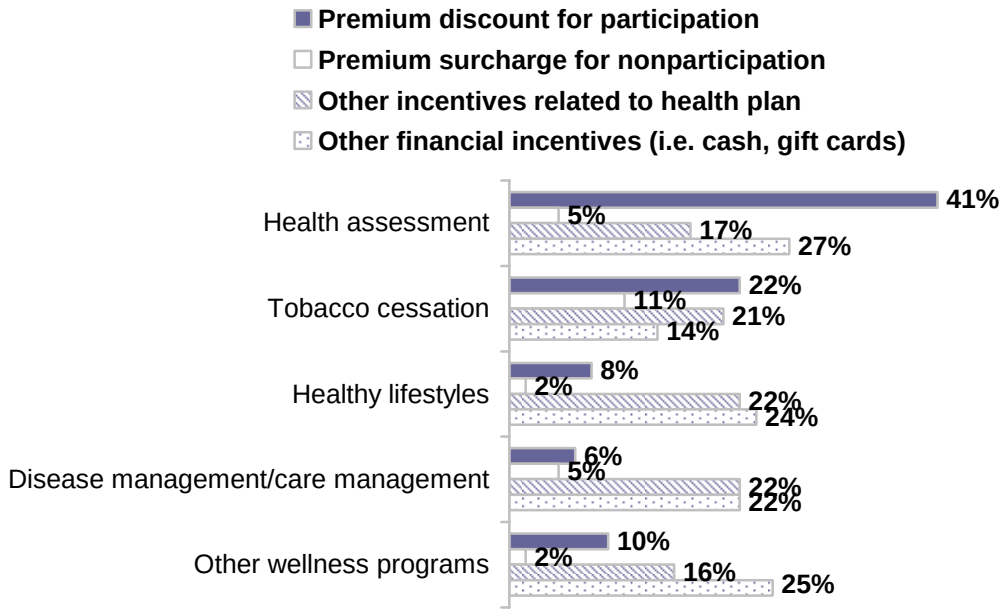


Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In regard to incentivizing wellness programs, the most prevalent type of incentive varied by the type of wellness program **(Figure 17)**. Premium discounts were the most prevalent type of incentives offered for health assessments (41%) and tobacco cessation programs (22%). For disease/care management programs, the most prevalent type of incentive was tied between other types of incentives relating to the health plan such as lower deductibles or cost-sharing (22%) and other financial incentives such as cash or gift cards (22%). Other financial incentives were the most prevalent type of incentive offered for healthy lifestyles programs (24%) and other wellness programs (25%).

Figure 17: Incentivizing/Penalizing Employees

(Sample Size=63)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Among employers that offer incentives for healthy lifestyles and/or participating in wellness programs, the amount of incentives that could be earned by the employee in 2010 ranged between $50 and $1,200. The average amount was $386. In 2009, the average incentive possible for employees was $318. For dependents, the amount that could be earned in 2010 ranged from $50 to $980 with an average amount of $271 **(Figure 18)**.

Figure 18: Incentives for Healthy Lifestyles

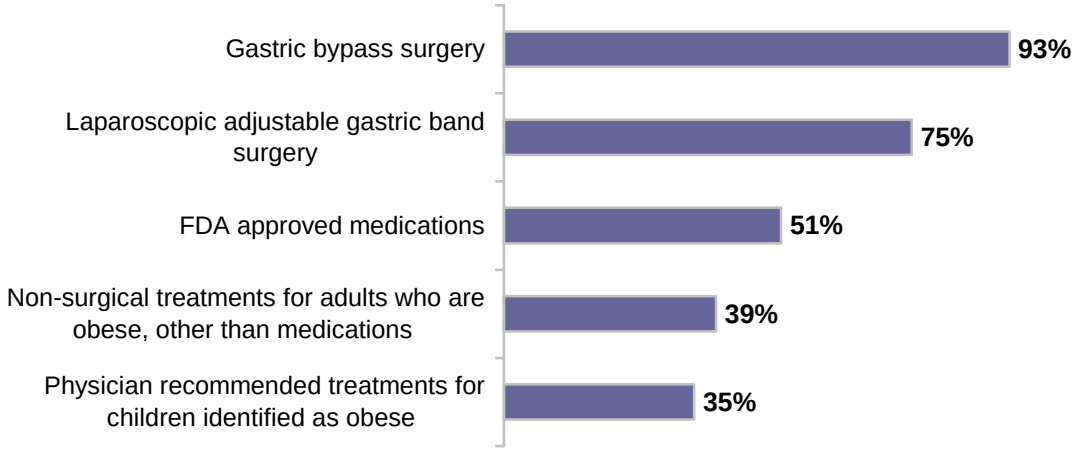
	Employee	Dependent
Average	$386	$271
Median	$250	$203
Minimum	$50	$50
Maximum	$1,200	$980
Sample Size	*49*	*24*

Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

A number of different treatments options for obesity are covered by employers, with 95% of respondents covering gastric bypass surgery, 75% covering laparoscopic adjustable gastric band surgery, and 51% covering FDA approved treatments for obesity **(Figure 19)**. Other treatment options that are covered by a smaller percentage of employers include: non-surgical treatments for adults other than medications (e.g., office visits, behavioral counseling for diagnosis of obesity, and meal replacement programs) and physician recommended treatments for children who are identified as being obese (e.g., specialist visits and medically supervised programs).

Figure 19: Treatments for Obesity

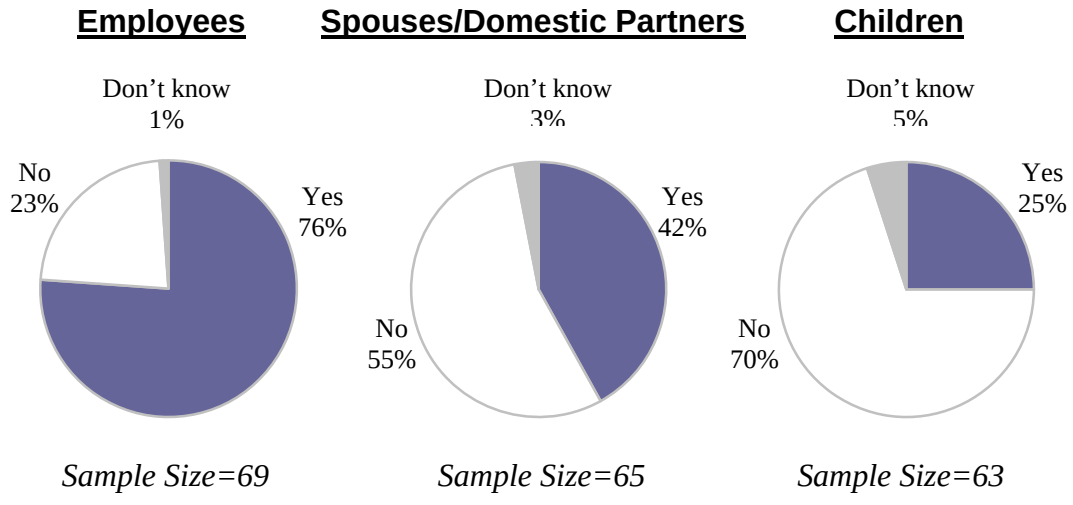
(Sample Size=57)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

When asked about wellness program eligibility, 76% of employers offer wellness programs to obese and overweight employees, 42% offer wellness programs to obese and overweight spouses/domestic partners, and 25% offer wellness programs to obese and overweight children **(Figure 20)**.

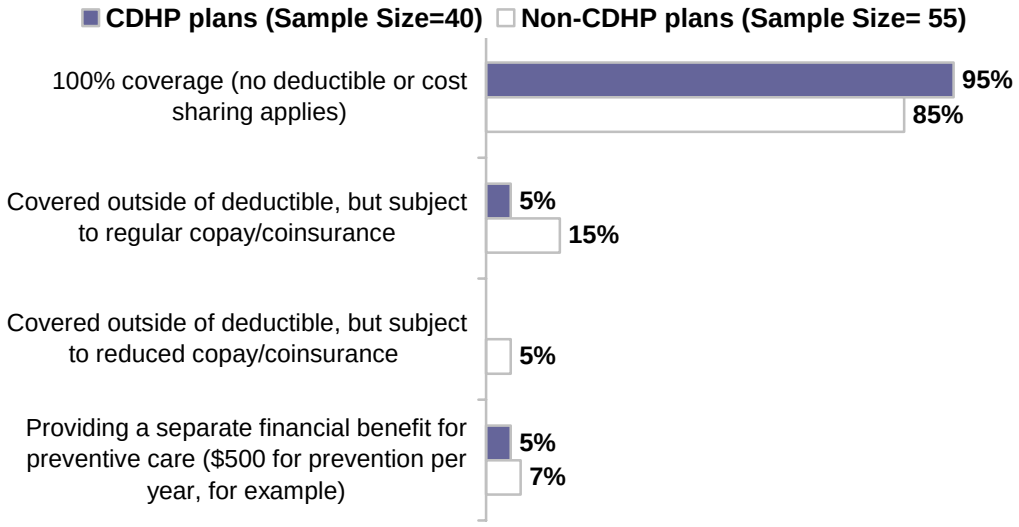
Figure 20: Wellness Programs Targeted at Obesity



Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In terms of covering preventive services, nearly all CDHPs offered by responding employers (95%) cover preventive services at 100% with no deductible or cost-sharing, and 85% of responding employers' non-CDHPs also covered preventive services at 100% **(Figure 21)**.

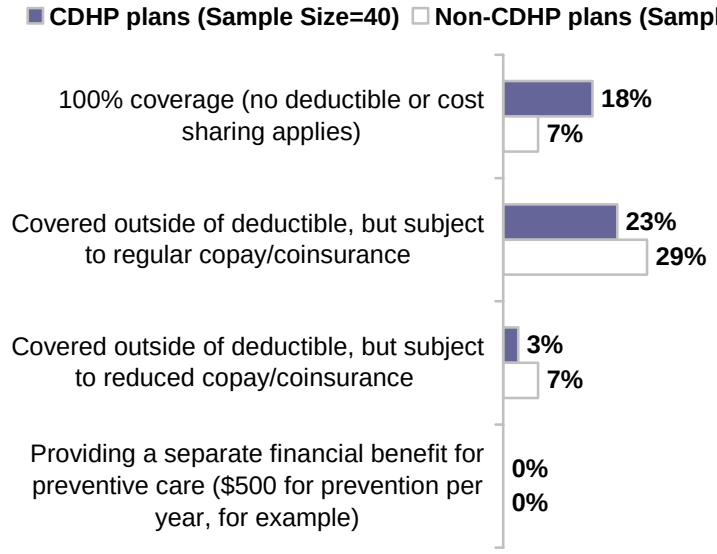
Figure 21: Coverage Level for Preventive Services



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

When looking at preventive medication coverage, only 18% of CDHPs and 7% of non-CDHPs covered preventive medications at 100%. More employers covered preventive medications outside of the deductible, but subject to regular co-pays/co-insurance for both CDHPs (23%) and non-CDHPs (29%) **(Figure 22)**.

Figure 22: Coverage Level for Preventive Medications



Note: Respondents were allowed to select more than one option.
Note: Some employers did not indicate any level of coverage for preventive medications, so it is possible that the prevalence rates for each of the coverage options is slightly understated.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Pharmacy Benefits

In terms of pharmacy benefits in 2011, employers are planning to raise the co-pay/co-insurance for retail pharmacy (25%) and mail-order pharmacy (21%) to help manage the rising costs of pharmaceuticals **(Figure 23)**.

Figure 23: Pharmacy Cost-sharing Strategies

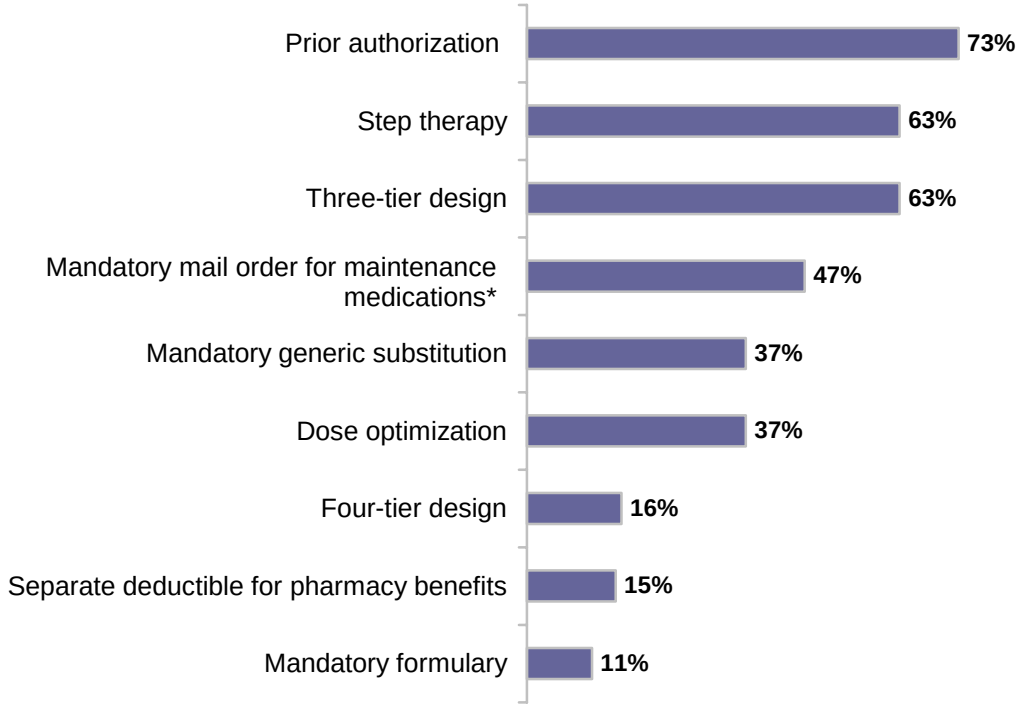
% Employers Increasing Cost-sharing for:	2011	2010
Co-pay/co-insurance for retail pharmacy	25%	30%
Co-pay/co-insurance for mail-order pharmacy	21%	17%
Sample Size	*52*	*47*

Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

When asked about what techniques employers are using to manage their pharmacy benefits, the three most prevalent techniques were prior authorization (73%), step therapy (63%), and three-tier design (63%). A few other techniques that are becoming more prevalent include mandatory mail order for maintenance medications (47%) and mandatory generic substitution (37%) **(Figure 24)**.

Figure 24: Pharmacy Benefit Management Techniques in 2011

(Sample Size=62)



***** When an employer implements mandatory mail order, the employee may still receive their medications through retail. However, the employer only pays equivalent to the mail order cost level and the employee is responsible for the remaining portion.

Note: Respondents were allowed to select more than one option.

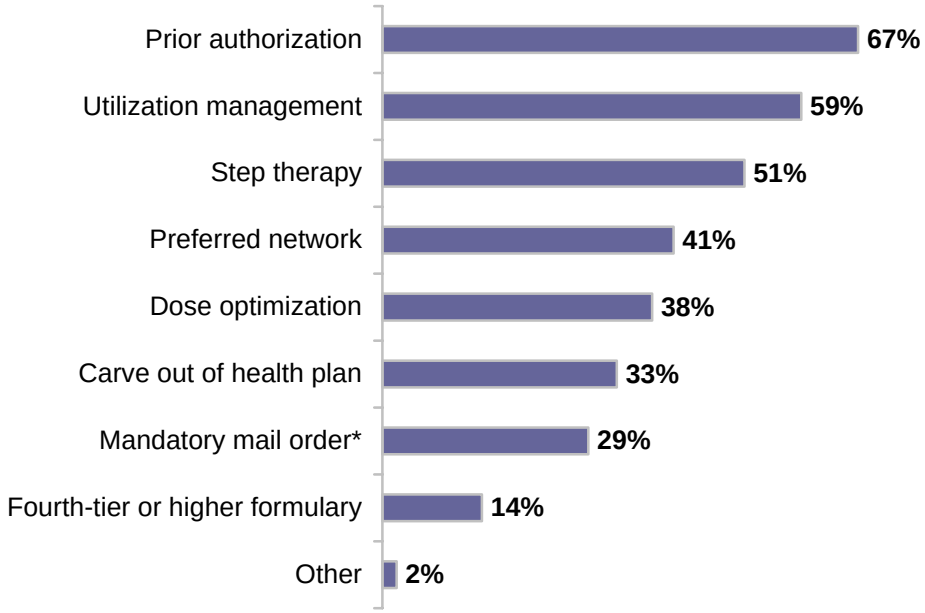
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Employers who used prior authorization were also asked whose guidelines they used to determine appropriateness of care. Ninety-three percent reported that they use the guidelines set by their PBM, 5% said they use guidelines set by a specialty society working with their PBM, and 2% reported that they use the guidelines devised solely by a specialty society.

In comparison to general pharmacy benefits, there seems to be a larger number of techniques being used to manage the rising costs of specialty pharmaceuticals. Some of the most prevalent methods include prior authorization (67%), utilization management (59%), step therapy (51%), preferred networks (41%), dose optimization (38%), carve-out from the health plan (33%), and mandatory mail order (29%) **(Figure 25)**.

Figure 25: Specialty Pharmacy Management Techniques in 2011

(Sample Size=63)



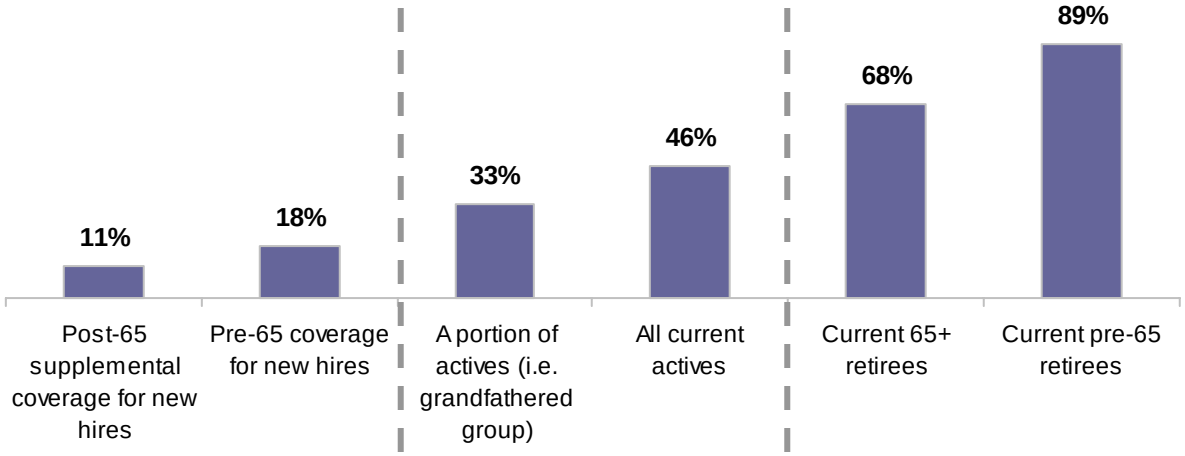
***** When an employer implements mandatory mail order, the employee may still receive their medications through retail. However, the employer only pays equivalent to the mail order cost level and the employee is responsible for the remaining portion.
Note: Respondents were allowed to select more than one option.
Note: For Other, 1 company reported that they use drug quantity management.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Retiree Health

Like in previous years, employers were asked for which groups they provide or will be providing medical coverage upon retirement. Among employees who have already retired, 89% of employers provide medical coverage for pre-65 retirees and 68% provide coverage for 65+ retirees. Among current active employees, 46% cover all current active employees and 33% cover only a portion of actives (i.e., grandfathered group). Very few employers offer retiree health benefits for new hires, with 18% offering coverage to pre-65 retirees and 11% offering post-65 supplemental coverage to new hires **(Figure 26)**.

Figure 26: Retiree Medical Coverage by Employment Type

(Sample Size=57)

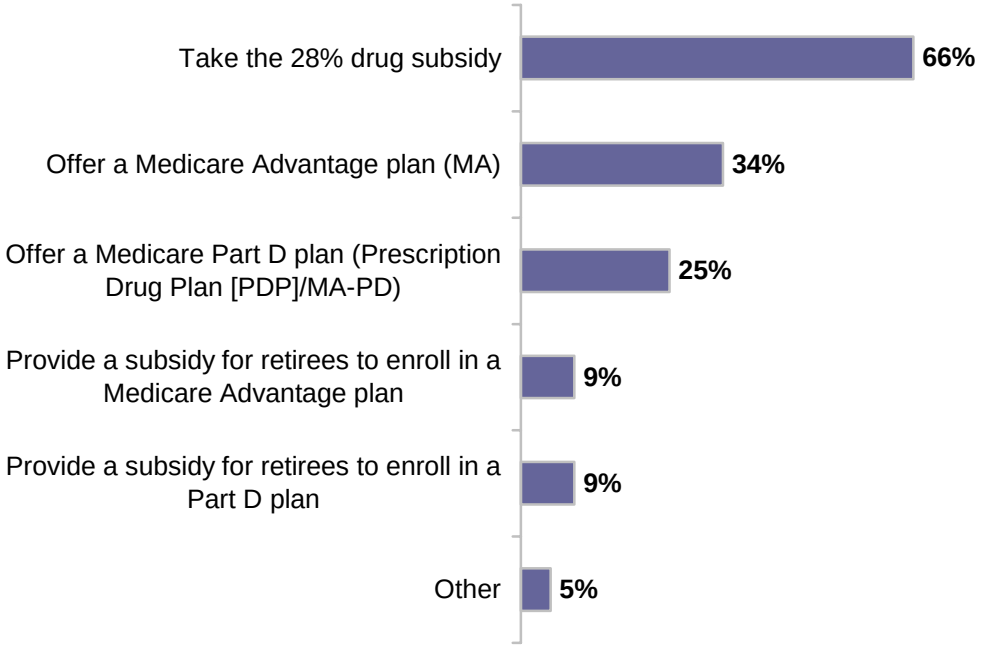


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

The most prevalent type of retiree offering in 2011 was the 28% drug subsidy (66%). Roughly a third of employers (34%) offer a Medicare Advantage plan, and 25% offer a Medicare Part D plan. A smaller percentage of employers also offer subsidies for retirees to enroll in a Medicare Advantage plan (9%) or Medicare Part D plan (9%) **(Figure 27)**.

Figure 27: Retiree Offerings in 2011

(Sample Size=39)

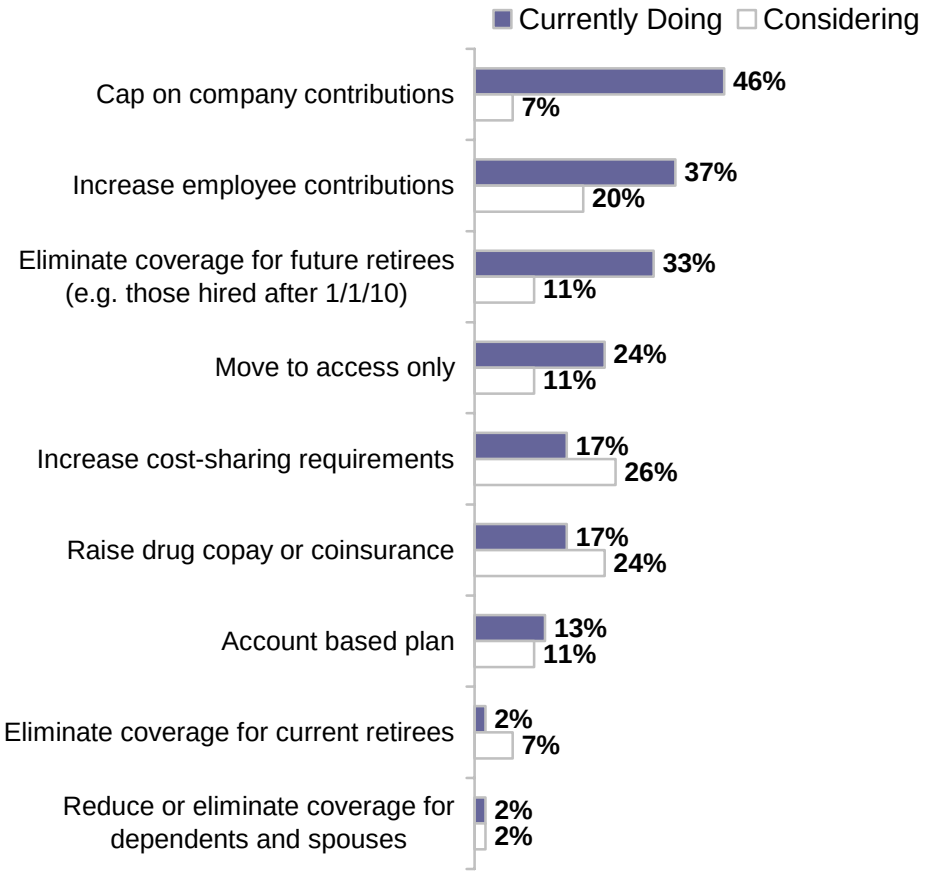


Note: Respondents were allowed to select more than one option.
Note: Other responses included: allowing retirees to keep coverage under the same health plan as active employees; and offering a Medicare supplement.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

In terms of strategies for controlling retiree health care costs, many employers have placed caps on company contributions (46%) and increased employee contributions (37%). Strategies that focus on limiting the role of employers in retiree health benefits in the future are also prevalent with 33% of employers eliminating coverage for future retirees and 24% moving to access only **(Figure 28)**.

Figure 28: Strategies for Controlling Retiree Health Care Costs

(Sample Size=38)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2011 Health Plan Design Changes*, August 2010.

Conclusion

The results from the survey indicate that employers are continuing to make changes to their plan designs, but that they are still wary of making too many changes in anticipation of the release of further health care legislation regulations and clarification of existing/recent regulations. Employers are expecting a larger increase in health care costs this year than in the year before, possibly attributed to increased health care costs relating to health care legislation, and are making the necessary changes to their plan designs to remain both compliant with the new laws and to manage anticipated rising costs.

SURVEY Report

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Survey Report

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About The National Business Group on Health

The National Business Group on Health (the Business Group) is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care and health benefits challenges.

Business Group members are primarily Fortune 500 companies and large public-sector employers— representing the nation's most innovative health care purchasers—that provide health coverage for more than 50 million U.S. workers, retirees and their families. The Business Group fosters the development of a safe, high quality health care delivery system and treatments based on scientific evidence of effectiveness. Business Group members share strategies for controlling health care costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.