



BENEFIT *Advisor*

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In This Issue

In this fifth issue of the McGrawWentworth Benefit Advisor for 2014, we provide our annual review of health plan trends and actions employers are taking to control health plan costs. The factors contributing to rising costs are complicated. Some factors can be influenced by employers, while others can't. Health care reform added to rising costs in 2014. It will be interesting to see the impact on 2015.

This Advisor reviews local and national data on how employers are controlling health plan costs.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Health Plan Trends”

Significant changes occurred in the health insurance marketplace this year. The state Health Insurance Marketplaces launched, where health insurance can be purchased by anyone. Medical underwriting is no longer permitted in the individual market. Both individual and employer-sponsored plans must cover pre-existing health conditions as of the first day of coverage. As a result, the individual market has truly become a potential alternative to group coverage.

It will be interesting to see how employers react to these changes. For now, most employers intend to continue sponsoring a health plan. Eighty-nine percent of employers in McGrawWentworth's annual survey indicated they will offer coverage in 2015 and beyond. Similarly, in Mercer's 2013 survey, 94% of large employers (i.e., 500 or more employees) will continue offering coverage for the next five years. Both surveys show that the majority of employers see value in providing employer-sponsored health coverage as part of their total compensation package.

Since employers are continuing to offer coverage, they need to focus on cost and coverage benchmarks. McGrawWentworth recently completed the

2014 Southeast Michigan Mid-Market Group Benefits Survey, which showed that health plan costs increased 7% after employers made plan changes.



Part of this increase is due to the new taxes and fees imposed by the Affordable Care Act (ACA).

Nationally, Mercer reported a health plan cost increase of 2.1% after plan changes for 2013. This increase is significantly lower than was seen in other surveys for that year. McGrawWentworth's 2013 survey showed an increase of roughly 4%. Mercer attributes the minimal increase to a number of factors. Smaller employers (under 500 employees) tended to see increases of about 1%, which was primarily due to rising deductibles. Larger employers kept costs in check by increasing the prevalence of consumer-driven health plans (CDHPs) and driving enrollment to those plans.

Mercer is forecasting a 5.2% increase for 2014. This is slightly less than the 7% increase experienced in southeast Michigan, according to the McGrawWentworth survey. It is important to remember that the 2013 increase of 2.1% generally does not include the impact of the ACA-related taxes and fees.

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Some employers have been successful in controlling costs. The 25th percentile of McGraw Wentworth's survey participants saw an increase of 1% or less.

As you plan for 2015, it is important to keep the following in mind:

- The ACA's employer mandate will take effect for many employers in 2015. However, employers with 50 to 99 full-time and full-time equivalent employees may qualify for a one-year delay. Please see our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2014/Reform_Update_83.pdf to determine if your organization qualifies for the delay.
- Many employers may see increased costs as a result of the employer mandate. Employers who sponsor a health plan must cover "full-time employees" and their dependent children. The ACA has defined full-time employees as those working 30 or more hours per week. Employers have a number of options when it comes to full-time employees. They may choose to extend coverage or to reduce some employees' hours. If an employer chooses to extend coverage to individuals not previously eligible, they should budget for this additional expense.



- Large employers will have some wiggle room in 2015. To avoid the \$2,000 mandate penalty, employers need to offer coverage to only 70% of full-time employees and their dependent children. For employees that currently do not offer coverage to all employees working 30 hours or more per week, the 70% threshold allows them to phase in coverage on substantially all full-time employees. Please note, however, that employers may still be liable for the \$3,000 penalty if eligible full-time employees who are not offered employer-sponsored coverage secure subsidized coverage through the Health Insurance Marketplace.

The economy in southeastern Michigan continues to recover slowly.

Both the unemployment numbers and the housing market are much improved. However, the ACA presents challenges and potential cost increases for a number of employers in 2015. The impact of these increases may temper the recent positive economic news.

The ACA will likely influence planning for 2015. Some employers will be concerned about extending coverage to all full-time employees. In addition, employers must contend with new IRS reporting requirements. The ACA will continue to burden your human resources department.

In the coming years, expect the ACA to drive change in group health plan options. Although the cost of health care is a significant burden, mid-market employers may soon have some new tools available to them:

- Population health management
- Payment based on episodes of care, or reference-based pricing
- Alternative care delivery options, with a focus on the least costly venue. This may include telemedicine.

Carriers, providers and vendors are all looking for innovative approaches to help manage health plan costs.

This *Advisor* will review the following health plan trends and cost-control issues:

- Issues affecting medical care and costs
- Strategies employers use to control health plan costs

This *Advisor* compares the results of McGraw Wentworth's 2014 Southeast Michigan Mid-Market Group Benefits Survey to our national benchmark, Mercer's 2013 National Survey of Employer-Sponsored Health Plans. Both data sources provide specific information on what employers are currently doing to keep health plan costs in check.

Issues Affecting Medical Care and Costs

Health plan costs are a complex and sizable expense for all organizations. Trend increases have been in the single digits for the last decade. However, a line graph of health plan cost trend has historically resembled a roller coaster. After sustained periods of single digit increases, we often see a spike back up to double digit amounts. Employers are concerned that we are overdue for that spike in health plan cost increases.

McGraw Wentworth did see a higher increase in 2014, albeit still in the single digits. That higher increase is partially due to the new taxes and fees mandated by the ACA.

The news media has focused on increased utilization caused by changes the ACA made to the health insurance market. Certainly more people have coverage today compared with one year ago. Some individuals have gained coverage under Medicaid in states that expanded Medicaid eligibility, while others enrolled in individual plans subsidized by the federal government. Some have elected employer-sponsored coverage to comply with the individual mandate. When previously uninsured individuals gain coverage, utilization of health services tends to spike. Most of the increased utilization is likely occurring in Medicaid and individual health plans.

The ACA has prompted some new and innovative cost control options. Historically, employers managed costs through plan design and employee contribution changes. New options, currently being tested in the jumbo employer market, move away from traditional plan design and payment options. These options engage both providers and patients in the cost challenges, with

a focused effort to pay based on quality and outcomes. New pressures are being placed on members to better manage their health and chronic diseases.

These new options specifically target factors that increase health plan cost.

Employers should be aware of the following influences on health plan costs:

- As the economy improves, more employees will likely seek elective health care services. The poor economy did affect individuals' treatment decisions, and kept some individuals from undergoing elective procedures. Others postponed services because they were fearful of losing their jobs if they took time off for an elective procedure. At some point, employees will no longer feel the need to wait for these services. Some employers may see an increased use of the health plan as a result.
- Employee health directly influences plan costs. Many employers are struggling with an aging workforce. As employees age, they require more health services.

Health status tends to contribute a sizable portion of health plan costs:

- **Chronic Conditions:** The number of Americans living with one or more chronic diseases increases every year. About three-fourths

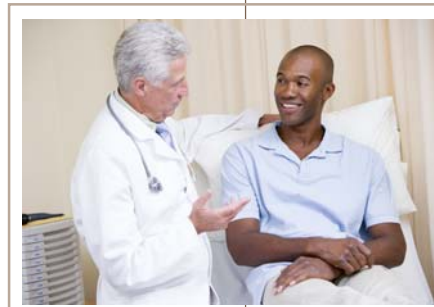
of America's health expenditures and two-thirds of health care spending over the last 25 years have been tied to chronic disease. Chronic conditions lead to additional spending on office visits, diagnostic services and prescription drugs. Further, complications may arise when the conditions are not properly managed. This also can contribute significantly to cost.

- **Lifestyle choices:** Lifestyle decisions influence health care needs. Smoking, poor nutrition, sleep deprivation and a sedentary lifestyle are all choices that adversely affect a person's health.

These choices contribute to the prevalence of chronic disease.

Sleep deprivation is a growing problem with far-reaching consequences. The Centers for

Disease Control and Prevention recommend that adults get between seven and nine hours of sleep each night. Roughly 30% of Americans, however, report sleeping six or fewer hours per night. Insufficient sleep is associated with a number of chronic diseases, and can also have an adverse impact on metabolism, immune system function, mood and safety.



The effects of poor nutrition, obesity and sedentary lifestyles are well documented. Although most Americans understand they should choose healthy foods, eat less and be more active, lifestyle changes are difficult to make and sustain.

- The complexity of the health care system contributes to cost. Many individuals establish a relationship with a primary care doctor whom they use for routine services.

However, others do not have a regular doctor, and instead tend to use urgent care centers or the



emergency room. In addition, patients facing serious health conditions often struggle to receive appropriate treatment. They either seek care from their primary care physician or try to negotiate the system on their own.

As a result of the complexity, duplication of tests is a common occurrence. Unnecessary medical services are often incurred because patients do not always choose the best path for determining a diagnosis. It is a tough situation, but it can be improved by patients having relationships with a primary care doctor. This will hopefully improve over time as the prevalence of, and access to, electronic patient medical records (EMR) increases.

- Health care providers play a huge role in the cost picture. Providers run a business, so their costs are also impacted by the ACA. Providers are balancing the requirements of health care reform, potential cuts in Medicare reimbursements, an increased Medicaid patient load, and care liability issues. With government requirements becoming more onerous, it is difficult for doctors to maintain an independent practice. As a result, many are consolidating their practices or working

within the local hospital physician group.

In order to streamline administration, we expect hospital consolidations

to continue. For example, three prominent hospital systems in southeast Michigan recently consolidated (Beaumont, Oakwood and Botsford). These consolidations will probably impact the discounts negotiations with various PPO networks.

The market is pushing innovations in payment methodologies that will likely challenge providers. Payers want to focus on quality, outcomes and effectiveness. Providers will need to adjust to the increasing pressure to structure payments based on these criteria.

Employers need to understand the various underlying factors that influence the cost of health care. One of the benefits of the ACA is that these cost challenges are becoming a key focus for all health care payers. As a result, new tactics are evolving that

will provide a host of options for cost control. Both providers and patients will feel new pressure to maintain health and quality of care, and to make cost-effective treatment decisions.

Strategies Employers are Using to Control Health Plan Costs

Employers must annually review their health plan costs and projected increases. They have historically used proven methods for managing costs. The most popular strategy is cost-shifting to employees, which includes raising member cost-sharing for services and increasing employee contributions toward the premium. Over the last five years, both nationally and in southeast Michigan, more employers are offering CDHPs and wellness programs to help keep costs in line.

Employers may be considering a host of additional measures to manage future costs. Private exchanges paired with a defined contribution approach may be a good option for some employers. Others may focus on telemedicine, patient advocacy or population health management.

McGraw Wentworth's annual Southeast Michigan Mid-Market Group Benefits Survey reviews benchmark data for plan design, cost, contributions and cost-control strategies. This section compares the 2014 McGraw Wentworth benchmarks to Mercer's 2013 survey results. These benchmarks may provide cost control ideas for your organization in 2015. A review of the 2014 data compared with national benchmarks will provide a number of options for employers to consider for 2015.

Consumer-Driven Health Plans

CDHPs increase participants' out-of-pocket costs when services are used. Most employers offering a qualifying high-deductible health plan will pair it with a health savings account (HSA). HSAs are individually-owned, tax-favored trust accounts that employers and/or employees can fund. The IRS established many rules regarding HSAs, including the requirement that the account holder be enrolled only for qualifying high-deductible health plan coverage. There are a number of criteria for determining whether a high-deductible health plan is qualified.

CDHPs purport to control costs because members are assumed to make more cost-effective treatment decisions when they pay a greater share of the cost. Independent studies support this theory, indicating that CDHPs can result in savings ranging between 5% and 14%.

The McGraw Wentworth survey indicated that 38% of employers offered a CDHP in 2014. In addition, 6% of employers make a CDHP the only health plan option. That is a very aggressive strategy.

Nationally, the prevalence of CDHPs has increased among large employers. For employers with 500 or more employees, 39% offered a CDHP in 2013. In addition, 13% of employers offered CDHPs as their only plan option. This was a significant increase, as only 7% made it the only health plan option in 2012.

CDHP designs remain remarkably similar on both the local and national levels. The median deductibles held steady at \$1,500 for single coverage and \$3,000 for family coverage. HSAs are the tax-favored account of choice. Nationally, employers tend to fund the HSA at a higher level,

with 75% of large employers funding a portion of the HSA. Locally, 62% of employers fund the HSA. Funding amounts were the same locally and nationally, with employers generally funding \$500 for single coverage and \$1,000 for family coverage.

Locally, the cost of CDHPs increased by roughly by 6%. Nationally, cost increases for CDHPs with an HSA were lower, at just over 3%. CDHPs are the lowest-cost plan option overall nationally. The annual cost for each employee covered by a CDHP with an HSA is more than \$2,000 less than the "benchmark" PPO and HMO plans.

Employers that fund a portion of the HSA have an additional cost-control strategy in their arsenals. They can choose to adjust HSA funding levels annually in response to cost increases, economic realities, wellness activities or business performance. A component of their plan costs can be modified independently from the CDHP benefit levels or employee contributions.

More employers may begin to offer CDHPs. The ACA requires employers to offer a "minimum value" plan, which must cover at least 60% of covered medical expenses. Because most employer plans cover between 75% and 85% of medical expenses today, they have some room to move. In addition, employers concerned about the "Cadillac tax" scheduled to take effect in 2018 may find CDHPs an attractive option. As employers contend with high increases, a CDHP may be a viable solution.

Focus on Employee Health

Wellness plans have remained a strong strategy nationally and in Michigan. In 2014, 22% of local employers offered a full-fledged wellness program. These programs typically include biometric screenings, health assessments and coaching to help improve health and lifestyle choices. Employers can offer these wellness programs using either health insurer resources or vendors specializing in wellness programs.

Nationally, 37% of large employers in 2013 worked with a vendor to provide comprehensive wellness services. Another 24% purchased additional wellness services through their health insurance carrier.

Locally, more employers are extending wellness activities beyond their employees. In fact, 32% of these employers offer the wellness plan to both employees and their spouses. Including spouses in the wellness activities

is a best practice when designing a wellness plan.

Incentives are a critical piece of the wellness picture. Locally, our survey data shows incentives encourage employees to participate in wellness. For the 62% of employers offering incentives, the employee participation rate is between 76% and 99%. The 38% of employers that do not offer incentives achieved less than a 25% participation rate.



Southeast Michigan provides significant incentives for wellness. Where the incentive is a reduced premium, the dollar amounts average \$364 a year for single coverage and \$730 for family coverage. Nationally, the average incentive in 2013 was \$317 a year, whether in the form of cash or a premium reduction. This amount is up significantly from 2011, when the average incentive was \$212.

The majority of southeastern Michigan employers communicate the incentive as a “carrot” rather than a “stick.” Eighty-three percent of employers communicate the incentive in a positive light, rather than as a penalty.

Tobacco surcharges remained steady in southeastern Michigan. For the last two years, 11% of employers required smokers to pay a surcharge. Nationally, the prevalence of tobacco surcharges continues to increase. In 2013, 17% of employers required it, which was up from 15% in 2012.

As employers try to encourage employees to make better lifestyle choices, tobacco surcharges may become more common.

The ACA treats tobacco surcharges favorably. For the employer mandate, at least one plan option must be affordable and meet the minimum value requirement. A plan is affordable if the premium for single coverage does not exceed 9.5% of the employee’s household income. Tobacco surcharges are not included when testing affordability. This means employers can use non-smoker contributions to test for affordability.

	2013	2014
Single Deductible	\$500	\$500
In-Network Coinsurance	80%	80%
Single Out-of-Pocket Maximum (includes deductible, coinsurance and copayments)	\$2,300	\$2,850
Office Visit Copay	\$25	\$25
Urgent Care Copay	\$30	\$30
Emergency Room Copay	\$100	\$150
Rx Copays	\$10 generic \$30 preferred brand \$60 non-preferred brand	\$10 generic \$35 preferred brand \$60 non-preferred brand

The next step for many employer wellness programs is to tie incentives to a targeted health goal. These types of programs are typically called outcomes-based wellness programs. As of the first day of the first plan year on or after January 1, 2014, employers can provide up to a 30% incentive for these plans. The permitted incentive is even higher for programs focused on reducing tobacco use, and can be up to 50%. The regulations also changed the requirements to allow these incentives. Outcomes-based programs must provide a reasonable alternative to participants who fail to meet the health goal. The alternative must be made available to any participant upon request.

Even with more stringent rules, outcomes-based wellness plans continue to be popular. Twenty-seven percent of local employers tie incentives to the achievement of a health goal. According to Mercer, 20% of large employers nationally do the same. There is growing interest in structuring programs to make members more responsible for their poor lifestyle or health decisions.

As wellness plans continue to evolve, some jumbo employers are implementing population health management programs. These programs start with data aggregation, combining medical claims data, prescription plan data, biometric data from wellness initiatives, and possibly even information from a member’s health assessment. Once the data is aggregated, the vendor has a more complete picture of a member’s current health and potential risks. The vendor then targets efforts to optimize each member’s health based upon their current status. For example, a prescription for a chronic condition may go unfilled. The vendor will reach out to the member or physician directly to make sure there are no lapses in taking a necessary medication. Similarly, a review of the claims data may indicate a member failed to have a routine mammogram. An outreach call may again be in order.

Population health management is a more precise approach to wellness and health management. Health and lifestyle issues can be addressed at the member level because of data aggregation and a detailed examination of the resulting data. Targeted communications can also be used to educate members about health risks, and to provide information about improving lifestyle choices. It could include incentives for members to participate in health and disease management activities.

Plan Design

Southeast Michigan showed very little change in median PPO plan design. The key plan provisions for 2013 and 2014 are shown in the table on page 6.

The McGraw Wentworth survey shows average deductibles continue to increase, with the average single deductible being \$822. This means some employers have moved beyond the standard \$500 deductible to even higher amounts.

Nationally, the median PPO plan for 2013 is remarkably similar to southeast Michigan’s median plan. National plans, however, have a few differences:

- Slightly lower prescription drug copays (\$10/\$30/\$50)
- Slightly lower emergency room copay (\$100)
- Slightly lower out-of-pocket maximums (\$2,250)

The median HMO plan in southeast Michigan showed some plan design changes in 2014. They differ from the typical national HMO plan in several ways:

- In 2014, 57% of local HMO plans included coinsurance. Of those with coinsurance, the median amount was 80% coverage after the employee paid any applicable deductibles and copays.
- A deductible applies to 59% of local HMO plans, with the median deductibles being \$500 for single coverage and \$1,000 for family coverage. In addition, 18% of plans report having an inpatient hospital deductible or copay. Nationally, 49% of HMO plans have adopted an inpatient hospital deductible. Both nationally and in southeast Michigan, the median inpatient hospital deductible is \$250.
- Office visit copays are a standard feature of HMO plans. Both locally and nationally, the office visit copay is \$20.
- Split copays are a plan design feature where one copay is applied for primary care visits and a higher copay applies to



specialist visits. Fifty-two percent of national HMO plans have higher copays for specialist visits, with the median specialist copay being \$35. Forty-three percent of HMO plans in southeast

Michigan have this design feature; the median copays are \$25 for primary care visits and \$40 for specialist visits.

- Both locally and nationally, HMO plans

include an emergency room copay of \$100.

The HMO market in southeast Michigan is vastly different from the national market. Nationally, HMO plans remain the most expensive plan option, but in southeast Michigan they are one of the most affordable choices. They continue to be a cost-effective option locally because of strong competition and innovative plan designs. Locally, the median HMO plan design is very similar to the median PPO plan design.

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	PPO		HMO		CDHP	
	\$ Amount	% of Premium	\$ Amount	% of Premium	\$ Amount	% of Premium
2014 Single	\$116	23%	\$95	21%	\$79	17%
2013 Single	\$112	24%	\$99	23%	\$70	16%
2014 Family	\$391	27%	\$308	25%	\$260	20%
2013 Family	\$353	26%	\$293	27%	\$227	19%

Contribution Strategies

Employee contributions in southeast Michigan, in monthly dollars and as a percentage of the premium, are shown in the table at the bottom of page 7.

The dollar amount increases were fairly low. In some case, we saw very small decreases. Single coverage contributions are close to national contribution benchmarks, while family contributions are lower in both dollars and percentages.

Most employers have not launched per-dependent contributions. Only 3% of our local survey participants vary contributions based on the number of dependent children. The median contribution is \$34 per month per child. Most employers cap the contribution at five children.

Income-based contributions have not taken off, even though the ACA tests affordability as a percentage of

household income. Six percent of employers in southeast Michigan vary contributions based on income. Nationally, income-based contributions have increased, from 12% of large employers in 2012 to 14% in 2013.

Keep in mind that affordability is based on the cost of single coverage. Employers in southeast Michigan have historically funded a larger share for family coverage than is seen nationally. Therefore, they may have room to move on the cost of family coverage.



Prescription Drugs

The news on prescription drugs is mixed. The good news is that most plans have achieved high generic utilization, with generic use rates in the mid-eighties as a percentage of all covered drugs. Employers are encouraging generic use through copay differentials, generic enforcement and, in some cases, mandatory generic provisions. As a result, trend increases are generally kept in the single digits.

While generic use is having a positive impact, employers need to keep an eye on specialty medications. These are typically high-cost medications requiring special administration or handling. They are often injectable, and treat complex or life-threatening conditions. In many

cases, specialty medications are biologics that work in limited circumstances for certain patients. They can have a pronounced impact on the quality of life for patients

battling serious health conditions.

In 2012, according to Express Scripts, there were more than 800 biologics in the research pipeline. New specialty drugs are coming to market with increasing frequency. As the specialty drug category continues to grow at this fast pace, the possible cost implications grow at an increasing rate as well.

In 2013, Express Scripts reported that specialty medications represented less than 1% of the prescription volume, but accounted for 27.7% of drug spending. They estimated that, by 2017, specialty medications will account for 50% of drug

spending. This makes specialty pharmacy an issue of growing concern. Unlike the blockbuster brand-name medications of the past few decades, specialty medications will not be a short-term concern. There will never be generic versions for many of these medications, because the manufacturing of bio-similar medications is very specific. There are questions about whether these medications can be safely manufactured at different sites.

To offset rising costs, employers are driving cost-effective use through copay structures. Nationally, 71% of plans (and locally, 65% of PPO plans) have a three-tier prescription drug copay structure.

The copays themselves have not changed significantly over the last three years. Nationally, the median prescription drug plan has a \$10 copay for generics, a \$30 copay for formulary brands and a \$50 copay for non-formulary brands. Locally, the median prescription drug plan has slightly higher copays, with a \$10 copay for generics, a \$35 copay for formulary brands and a \$60 copay for non-formulary brands.

Employers are addressing specialty medications in a number of ways. One option is to create a higher copay tier for these medications. Eighteen percent of southeast Michigan employers have adopted a fourth tier to help manage costs. In addition, 10% of employers have added a fifth tier. If there are five tiers, the employer has a list of preferred specialty medications available in the fourth tier. The fifth tier is reserved for non-preferred specialty medications.

Medical management programs are also important in managing utilization. Prior authorization will require a physician to authorize the necessity of a specific medication. Step therapy also ensures that the patient is first trying less costly medications, before moving on to more costly options.

In some cases, medications are prescribed for very specific situations and will not work for all patients. The side effects may be so harsh that the patient cannot continue therapy. Because of this, many plans will limit the first fill of certain drugs to a two-week supply.

Employers have been aggressive with medical management programs and incentives to drive down their prescription drug costs. This diligence has been effective. In fact, employers have been using medical management programs instead of continually raising copays. As a result, prescription drug copays, both locally and nationally, have changed very little in the last five years.

Eligibility Strategies

Employers rely on a variety of eligibility strategies to keep health plan costs in check. Locally, employers have adopted two tactics to discourage employees from enrolling their spouses. Eighteen percent use a somewhat aggressive spousal force-out. Under this provision, if spouses have coverage available through their employers, they are not eligible for coverage under your health plan. Spousal force-outs are **not** popular with employees, because they can force the family to deal with different plans, deductibles and out-of-pocket maximums.

The other way to limit spousal enrollment is through a surcharge, which is used by 20% of local employers. With this strategy, employees are charged an extra premium to cover their spouses on your plan, if their spouses are eligible for coverage sponsored by their own employers. The median monthly surcharge in 2014 is \$100.

These strategies are not as popular nationally. Only 7% of large employers have a spousal force-out, while 9% apply a spousal surcharge. Nationally, large employers tend to charge more for family coverage overall, rather than limiting spousal coverage.

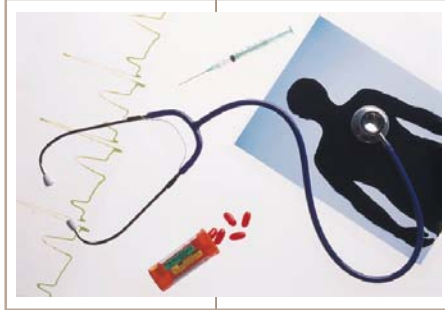
The “play or pay” rules that go into effect in 2015 will require employers to cover “full-time” employees and their dependent children or potentially to pay a penalty. Employers are not, however, required to cover spouses as part of the “play or pay” rules. As a result, a third, very aggressive option may be considered. Employers could choose to exclude all spouses from coverage. (Kroger adopted this aggressive stance at the beginning of 2014.) An ineligible spouse may purchase coverage through the Health Insurance Marketplace. The spouse may be eligible for premium subsidies in the Marketplace based on household income.

Employers should continue to manage eligibility carefully to keep their health plan costs in check.

Concluding Thoughts

The McGraw Wentworth Southeast Michigan Mid-Market Group Benefits Survey showed health plan costs increasing at 7% after plan changes in 2014. Last year, health plan costs increased at just 4% after plan

changes. Some of the higher increase can be attributed to new ACA-related taxes and fees that plans had to pay beginning in 2014.

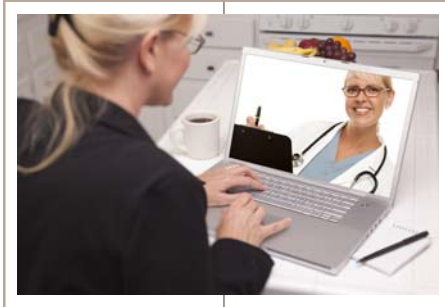


Both the McGraw Wentworth and Mercer surveys indicate that employers continue to embrace CDHPs and wellness as long-term cost control strategies. It certainly appears that employers who adopted CDHPs and wellness plans early are now reaping the benefits. We expect this trend to continue over the next few years.

New cost control options may become available to employers in the near future. Very large employers are pushing carriers and health care providers to focus on quality, outcomes and effective therapies. New options that may become available to the middle market include:

- Accountable care organizations (ACOs), formed by health care providers, negotiate a fee to manage specific treatments. There is a strong focus on quality. If the health care provider delivers care for less than the negotiated fee, then the ACO keeps that extra amount.

- Patient-centered medical homes focus on strong primary care relations and expand the role of the primary care physician.
- Reference-based pricing is also a newer option. This approach sets a fee for certain services based upon the fee determined for quality care. Some providers will accept the reference-based price. If a member selects a provider that charges more than the reference-based price, then the member pays the difference in cost.



Employers are also focused on cost-effective treatment venues. For example, an employer may offer telemedicine with a low copay, or no copay at all. A telephonic physician visit is less costly than a regular office visit, an urgent care visit or emergency room treatment. It is not uncommon for individuals with non-emergent conditions to use urgent care or even the emergency room when they can't immediately see their physician. Some employers are structuring cost-sharing to steer members to outpatient facilities, stand-alone imaging centers and other less costly treatment venues.

Employers need to understand what emerging payment models may be available in the future to help control costs.

If you have any questions about health plan trends, please contact your McGraw Wentworth Account Director. **MW**

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