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HEALTH PLAN TRENDS

At the end of last year, Congress passed the Tax Cuts and Job Act. This law zeroes out the individual mandate penalty that taxpayers had to pay if they did not obtain health insurance coverage. It does not change the employer mandate requiring employers to provide minimum value, affordable health coverage to full-time employees or pay a penalty. Thus there is still a strong financial incentive for employers to continue offering full-time employees group health plan coverage. Controlling health plan cost, therefore, still remains a top priority.

The recently completed MMA-MI 2018 Southeast Michigan Mid-Market Group Benefits Survey showed that health plan costs increased 5 percent after employers made plan changes in 2018. Health plan costs also increased 5 percent after plan changes in 2017. Mercer reported health plan cost increased 2.6 percent nationally after plan changes in 2017. Participants in Mercer's survey expect a cost increase of 7 percent in 2018 before changes.

Historically, both surveys have shown a wide range in cost increases among employers. In

Michigan, employers in the lowest quartile averaged a 3 percent increase (after plan design changes in 2018). Nationally, Mercer shows a wide range in cost increases among large employers. While 31 percent of large employers had no increase or decrease in cost in 2017, 19 percent had an increase of 10 percent or more. Both surveys show that employers using a variety of cost control strategies have the most success.

Even with Republican efforts to dismantle the ACA, the law continues to affect employers and their health plans. Employers still have to cover employees working 30 or more hours a week or risk penalties. The effective date of the Cadillac tax has been pushed out to 2022. Employers need to keep an eye on cost to make sure they don't trigger the Cadillac tax, if it eventually goes into effect. Some employers have started to carve back health plan benefits now to avoid paying that tax in 2022.

This year the survey data indicates that, in general, employers made some incremental plan design changes, but kept



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employee contributions for health coverage relatively stable. Employers continue to be mindful of affordability. With increased employee contributions and cost sharing over the last five years, many employees struggle to afford necessary care. Thus employers are increasingly focused on cost control options that don't involve automatically shifting costs to employees. These options include encouraging cost-effective treatment venues, narrow networks, reference-based pricing and centers of excellence. They focus on strategies that allow employees to maintain current out-of-pocket costs and use benefits more efficiently, rather than face an annual increase in out-of-pocket costs.

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

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

It compares the results of MMA-MI's *2018 Southeast Michigan Mid-Market Group Benefits Survey* to our national benchmark, Mercer's *2017 National Survey of Employer-Sponsored Health Plans*. Mercer reflects large employer data (500 or more employees). Both sources provide specific data on what employers are currently doing to keep health plan costs in check.

ISSUES AFFECTING MEDICAL CARE AND COSTS

Many factors contribute to increasing health plans cost. Some factors are ongoing, others are new. Employers may influence some of these factors;

others may be outside their control. If employers can implement cost control strategies that impact these factors, perhaps they can influence health trend over time.

The following factors may affect health plan costs:

- **Our aging workforce and poor lifestyle choices.** As employees age, they tend to need more health services. In addition, many are facing the consequences of many years of poor lifestyle choices.

The statistics from the Centers for Disease Control and Prevention (CDC) are alarming:

- As of 2012, about half of all adults—117 million people—have one or more chronic health conditions. One in four adults have two or more chronic health conditions.
- Seven of the top 10 causes of death in 2014 were due to chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 46 percent of all deaths.
- Arthritis is the most common cause of disability. Of the 54 million adults with doctor-diagnosed arthritis, more than 23 million say they have trouble with their usual activities because of arthritis.



- Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults.
- In 2015, 50 percent of adults aged 18 years or older did not follow recommendations for aerobic physical activity. In addition, 79 percent did not follow recommendations for both aerobic and muscle-strengthening physical activity.
- More than 1 in 3 adults (about 92.1 million) have at least one type of cardiovascular disease. About 90 percent of Americans aged two years or older consume too much sodium, which can increase their risk of high blood pressure.
- In 2015, more than 37 percent of adolescents and 40 percent of adults said they ate fruit less than once a day, while 39 percent of adolescents and 22 percent of adults said they ate vegetables less than once a day.
- In 2015 an estimated 36.5 million adults in the United States (15.1 percent) said

they currently smoked cigarettes. Smoking accounts for more than 480,000 deaths each year. Each day, more than 3,200 teens younger than 18 years smoke their first cigarette, and another 2,100 teens and young adults who smoke every now and then become daily smokers.

- Drinking too much alcohol is responsible for 88,000 deaths each year, more than half of which are due to binge drinking. American adults report binge drinking an average of four times a month, and have an average of eight drinks at each binge, yet most binge drinkers are not alcohol dependent.

These chronic conditions and poor lifestyle choices are driving up health care utilization and costs.

- **Shortage of primary care physicians.** A recent report by the Association of American Medical Colleges (AAMC) predicts that a shortage of physicians in the United States is going to grow worse. The report estimates a shortfall ranging from 34,600 to 88,000 doctors by 2025. The shortfall is expected to total anywhere from 40,800 to 104,900 doctors by 2030.

This shortage may affect a patient's ability to obtain primary care in a reasonable time period. The good news is that many health care plans are offering

incentives to use different care options. For example, CVS purchased Aetna and plans to encourage patients with routine care needs to use nurse practitioners in MinuteClinics across the country. In addition, many physicians use physician assistants to handle routine care visits so that the physician can treat non-routine cases.

It will be interesting to see how this shortage of primary care physicians will affect cost over time. Primary care physicians have been facing increased pressures as their patient bases expand. However, employees still need to be encouraged to have their own doctors instead of using more expensive urgent care or emergency rooms for non-emergencies. Patients with an established relationship with a primary care physician tend to get better quality care over time.

- **Specialty medications.** Specialty medications have been contributing to rising drug costs for several years. New specialty medications are often extremely expensive. In fact, spending for these drugs significantly outpaces spending for traditional drugs. Several years ago, for example, a new, expensive specialty medication to cure Hepatitis C caught many employers off guard. New medications to treat specific cancers can

be very expensive as well. Prescription expenses are becoming a higher percentage of cost. According to PricewaterhouseCoopers, although the percentage of spend on prescriptions



is relatively small, it has had the highest percentage of growth in the last decade. In 2008, pharmacy cost represented 15 percent of health

care spend. This year that figure will increase to 18 percent and will continue to rise since most drugs in the prescription pipeline are specialty medications.

- **Our complex health care system.** Patients with serious health issues often struggle to find appropriate treatment or get a useful second opinion. For example, back pain does not always warrant surgery; physical therapy may be more effective. Treatment options can vary widely; the best one is the one that works best for each patient. Since not all health providers can stay up to date on all the latest treatment guidelines and innovations, it may make sense for employers to offer expert opinion services. Experts may know of different treatments, perhaps non-invasive alternatives, for the same medical issue. In addition, many times experts find the original

diagnosis is incorrect. This service allows employees to make the best health care decisions using nationally recognized experts in the field. In addition, employers may contract with a health advocate program to help employees navigate the health care system.

- **Health care provider ownership.** Health insurance carriers have spent the last several years trying to “own” the entry point to the health care system. Aetna is doing this in conjunction with CVS’s MinuteClinics. CIGNA is purchasing primary care physician practices across the county. Insurance carriers believe owning the entry point to the health care system will allow them to improve the quality and lower the cost of care.

Hospital systems are also actively purchasing primary care physician practices. Their moti-

vation is slightly different. If they own the entry point to care, all specialty care will be done at a hospital-owned facility. This practice, however, often increases cost.

- **Opioid Epidemic.** The opioid epidemic seems to make the news almost every day. It is frightening to realize the extent of this epidemic in the workplace and the impact it has on our nation. It also directly affects health plan costs. According to a recent AJMC

study, a third of opioid prescriptions that employers pay for end up being abused. Four and half percent of employees who received opioid prescriptions show signs of abuse. What’s more, employers pay more for employees dependent on opioids. The AJMC study shows employers pay an average of \$19,000 a year in over-all healthcare expenses for members addicted to opioids compared with just \$10,000 a year for workers without such issues.

The impact is not limited to health plan cost. Opioid addiction affects productivity and safety. It also significantly impacts costs because of the resulting absenteeism.



Employers may approach these complex factors through plan design. Many different strategies are now available to control health

plan cost. For example, employers can launch a value-based pharmacy plan for employees with diabetes, high blood pressure, heart conditions and asthma. The lower copays may encourage employees to take their prescribed medications. They may also invest in wellbeing initiatives to improve employee health.

STRATEGIES EMPLOYERS ARE USING TO CONTROL HEALTH PLAN COSTS

Employers must continue to monitor their health plan costs, projected increases and budgets. If projected costs exceed budget, they will have to make changes. In some cases, employers are reviewing health plan costs in a broader context. In our tight labor market, employers are concerned that health plan cuts may affect recruiting and retaining talent. Some employers are increasing health plan budgets to avoid this problem.

In Southeast Michigan, survey participants reported a 5 percent cost increase after plan changes in 2018. Nationally, the 2016 increase after plan changes was 2.6 percent.

A recent lead strategy to control health plan cost has been the consumer driven health plan (CDHP). Use of these plans has grown significantly over the last five years. While growth of these plans slowed locally in 2018, there was a big jump in enrollment. Growth in these plans also slowed nationally, but without the significant jump in enrollment.

Wellbeing initiatives also continue to be prevalent locally and nationally. These initiatives have broadened from a focus on physical health to all aspects of employee health. These initiatives are seen as a business strategy.

Finally, nearly 75 percent of employers both locally and nationally now commonly offer telehealth. The explosive growth of this benefit over the last several years is probably because insurance carriers are partnering with telehealth vendors to offer the service to members.

Both local and national survey data provide benchmarks for employers to consider when they look at strategies and tactics to control health plan costs.

Consumer-Driven Health Plans (CDHPs)

CDHPs have become steadily more common over the last five years. Locally in 2014, only 38 percent of employers offered CDHPs. By 2018, 53 percent of employers offered them. Nationally, in 2013, 39 percent of employers offered CDHPs. By 2017, 64 percent of employers offered them.

Because CDHPs increase out-of-pocket costs for services, most employers pair them with tax-favored accounts to help pay those costs. Many offer a qualifying high-deductible health plan (HDHP) along with a health savings account (HSA) as a CDHP. HSAs are individually owned, tax-favored trust accounts that employers and employees can fund. HSA accountholders must be enrolled in a qualifying high-deductible health plan. Various rules determine whether a person is eligible to contribute to an HSA.

The hope is that CDHPs will encourage people to choose less expensive treatments to lower their share of the cost. Independent studies support this theory, indicating that CDHPs can result in savings ranging between 5 and 14 percent.

The MMA-MI survey indicates that 53 percent of employers offered a CDHP in 2018. This is up slightly from 52 percent in 2017. Only 6 percent of employers, however, make a CDHP their only health plan. GM adopted this aggressive strategy for its salaried workforce several years ago. Some employers have followed GM's lead, but this strategy has lost steam in the last couple of years.



Nationally, the number of CDHPs increased slightly for 2017 among large employers. Among employers with 500 or more employees, 64 percent offered a CDHP in 2017. This was up from 61 percent in 2016. Only 14 percent of national employers offer CDHPs as the only type of health plan option.

Nationally, CDHPs paired with HSAs are the lowest cost plan. The cost for a CDHP with an HSA is roughly 25 percent less than a PPO plan. That is a difference of \$2,600 per employee. CDHPs have historically trended at a rate slightly lower than PPOs nationally. This year cost did not follow that trend. CDHPs with HSAs increased 4.9 percent while PPOs increased 3.1 percent in 2017. The continued possibility of a Cadillac tax is likely driving some employers to offer CDHPs. However, as the effective date for the tax has been pushed to 2022, many employers are questioning whether it will take effect at all.

Locally, the lowest cost plans this year in both the single and family tiers are HMO plans. Interestingly, HMO rates decreased 1 percent from 2017. CDHPs with HSAs cost more in both single and family tiers. Costs for these plans increased approximately 3.5 percent in 2018. Finally PPO plans are the most expensive plan options in Southeast Michigan. PPO rates increased just over 5 percent in 2018.

Locally and nationally, we again saw change in the median plan designs for CDHPs. The changes have been interesting. In 2017 nationally, the median single deductible was \$1,750, down slightly from \$1,800 in 2016. The family deductible was \$3,600, down from \$3,900 in 2016. It is unusual to see deductibles decrease year over year. This usually occurs when there is a significant uptick in new plans offered. However, there was no such uptick. The number of large employers contributing to HSAs increased as well. In 2017 nationally, 77 percent of large employers contributed to employees' HSAs. The median amounts have stayed steady at \$500 single and \$1,000 family. The potential employee liability after employer contributions to the HSA is \$1,250 single and \$2,600 family.

The changes in plans locally were a little different. Our median single deductible increased to \$2,000 and the family deductible stayed steady at \$4,000. Locally, only 60 percent of employers contribute to employees' HSAs. The median contribution to the HSA has stayed steady at \$500 single and \$1,000 family. The employee liability after employer contributions to the HSA is \$1,500 single and \$3,000 family.

Employers that fund part 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, wellbeing activities or business performance. A component of their plan costs can be modified independently from the CDHP design or employee contributions. Employers may also choose to stop funding HSAs after the plan has been in place a number of years and employees have built up their HSA account balances.

CDHPs have become more commonplace in the last five years. Not only are more employers offering these plans, but also more employees are choosing CDHPs. In 2017, nationally a third of all employees chose to be covered by a CDHP. Locally enrollment in CDHPs increased significantly in 2018, with 30 percent electing CDHPs, up from 25 percent in 2017.

Six Pillars of Wellbeing	2018	2017
Physical	89%	94%
Mental/Emotional	73%	71%
Financial	58%	46%
Social	38%	35%
Community	39%	32%
Professional Growth/Development	33%	26%

Employee Wellbeing

The concept of wellness has been evolving locally and nationally. Employers are focusing on employee wellbeing. Wellbeing broadens wellness initiatives beyond physical health to all aspects of life. The chart at the top of page 6 shows the percentage of Southeast Michigan employers that offer programs to bolster the six aspects of employee wellbeing.

Why focus on an employee's total wellbeing? Wellbeing has a positive effect on organizations and it supports business goals. A focus on wellbeing has been shown to:

- Increase quality and customer satisfaction
- Generate revenue and grow business
- Increase efficiency in operations
- Increase employee engagement and retention
- Improve risk management

Locally employers are reporting the many reasons they have invested in wellbeing (see table at bottom of page 6).

Locally, 82 percent of employers offer some wellbeing initiatives. Even though more employers are now concerned with wellbeing, their commitment to more traditional wellness programs has remained steady.

The commitment to traditional wellness plans has remained steady nationally as well in Michigan. This year 82 percent of MMA-MI's survey participants offered some type of wellness program and 27 percent 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 through either their health insurer's resources or vendors specializing in wellness programs.

Nationally in 2017, 52 percent of large employers worked with a specialty vendor to provide comprehensive wellness services. Another 32 percent purchased additional wellness services through their health insurance carriers.

Reasons for Investing in Wellbeing	2018	2017
Positive Impact on Medical Trend	64%	61%
Employee Feedback Surveys	56%	55%
Value of Investment	39%	26%
Decreased Absenteeism	22%	17%
Improved Productivity	13%	21%
Industry Recognition Awards	13%	10%

Incentives are critical. Our local survey data shows incentives work. Among the 66 percent of employers that offer incentives, the employee participation rate is between 76 and 99 percent. Among the 34 percent of employers that do not offer incentives, the participation rate is less than a 25 percent.

Lowering an employee’s contribution to the health plan is the most popular way to encourage participation in wellbeing programs. In 2018, the health plan premium contribution decrease for participating employees averaged \$430 a year for single coverage and \$895 for family coverage. Locally 33 percent of employers tie some portion of the incentive to achieving a health goal in an outcomes-based incentive arrangement.

In 2018, Southeast Michigan employers offer wellness activities as follows:

- 49 percent offered to all benefit eligible employees
- 32 percent offered to all benefit eligible employees and their spouses
- 8 percent offered only to employees enrolled in the health plan
- 12 percent offered only to employees and spouses enrolled in their health plan

In 2017, 57 percent of national employers made spouses eligible for key elements of health and wellbeing programs and 22 percent made children eligible for those programs.

Tobacco surcharges remained fairly steady in southeastern Michigan. In 2018, 19 percent of em-

MEDIAN PPO PLAN DESIGN

	2017	2018
Single Deductible	\$600	\$750
In-Network Coinsurance	80%	80%
Single Out-of-Pocket Max (includes deductible, coinsurance and copayments)	\$6,350	\$6,350
Office Visit Copay	\$25	\$25
Urgent Care Copay	\$40	\$40
Emergency Room Copay	\$150	\$150
Rx Copays	\$10 generic/ \$40 preferred brand/ \$80 non-preferred brand	\$10 generic/ \$40 preferred brand/ \$80 non-preferred brand

ployers required smokers to pay a median surcharge of \$50 a month. Nationally, tobacco surcharges are similar. In 2017, 22 percent of employers required a surcharge for smokers. The average amount was \$43 a month. Smoke free campuses are also popular. Locally, 32 percent of employers reported having a smoke free campus in 2018.

The ACA treats tobacco surcharges favorably. Under the employer mandate, at least one plan option must be affordable and meet the minimum value to avoid penalties. Employers can use non-smoker contributions to test for affordability.

Employers have been increasingly focused on the impact of employee wellbeing programs. Many employers invest in wellbeing to help employees through health and financial problems or even to aid the local community. Employers are moving beyond limiting wellness activities to physical health and looking for lower health plan costs. This broader focus will

benefit both employees and employers.

Employers that offer incentives for employees or spouses to complete a biometric screen, a health exam or assessment, should keep an eye out for revised guidance from the Equal Employment Opportunity Commission (EEOC). The most recent guidance on the types of incentives permitted will be vacated in 2019. The issue is reviewed in our 2018 *Special Alert*, Issue One at <http://mcgrawwentworth.com/resources/special-alerts>.

Plan Design

Southeast Michigan showed minor changes in median PPO plan design in 2018. The key plan provisions for 2017 and 2018 are shown in the table at the top of page 7.

The MMA-MI survey shows average deductibles continue to increase; the average 2018 single deductible is \$1,014. This is the first time the average PPO deductible in Southeast Michigan exceeded \$1,000.

Employers tend to approach out-of-pocket maximums in two ways:

1. **Embedded Coinsurance Maximum (ECM)** – the deductible and copays still apply to the out-of-pocket maximum. A separate out-of-pocket maximum applies to coinsurance cost-sharing. Plans that have a \$6,350 out-of-pocket maximum use an ECM set at \$2,500 single. This limits some of the out-of-pocket exposure, because coinsurance pays 100 percent once that \$2,500 maximum is met. Copays apply to the remaining out-of-pocket maximum until the \$6,350 is met. Fifty one percent of employers use an ECM.
2. **All Services Apply to the Maximum** – an employer may structure the maximum such that the out-of-pocket maximum applies to all services. In these cases, the out-of-pocket maximum is much lower at \$3,300 single.

Nationally, the median PPO plan for 2017 changed slightly. While the median individual deductible increased to \$650, the family deductible stayed at \$1,500.

MEDIAN HMO PLAN DESIGN

Plan Provision	2017 Mercer National	2018 MMA MI Local
% plans with overall deductible	42%	83%
Plan deductible	\$500/\$1,000	\$1,000/\$2,000
% of plans with coinsurance	37%	72%
Coinsurance	20%	20%
% of plans with inpatient deductible or copay	46%	19%
Inpatient deductible/copay amount	\$250	\$150
Office visit copay	\$20	\$25
% plans with split office visit copay	67%	75%
Split copay amounts	\$20/\$40	\$20/\$40
Urgent care copay	Not reported	\$50
Emergency room copay	\$100	\$150

The median HMO plan in Southeast Michigan showed very little change in 2018, but local HMOs have dramatically different benefit levels than national HMO, as shown in the table at the top of page 8.

HMO plans have taken two different paths both locally and nationally and neither path resembles the HMOs of a decade ago. In the past, most HMO plans required a physician gatekeeper and included 100 percent coverage with a number of copays. HMO benefits were traditionally far better than PPO benefits. Now, nationally, HMO and PPO median plan designs are similar. Locally, HMO plan designs tend to be worse than PPO median plan designs and slightly better than the median

CDHP plan design. The differences appear in the cost of these plans. HMOs nationally are very close in cost to PPO plans. Locally, HMOs are the least expensive plan option for employers.

Contribution Strategies

The chart below shows monthly employee contributions in southeast Michigan for 2017 and 2018 as a percentage of the premium.

For the most part, cost-share percentages stayed relatively flat. However, the employee contributions in terms of percentage and dollars decreased in 2018 for CDHPs. From an employee contribution perspective, CDHPs are the lowest cost plans.

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	PPO		HMO		CDHP	
	\$ Amount	% of Premium	\$ Amount	% of Premium	\$ Amount	% of Premium
2018 Single	\$147	26%	\$113	24%	\$81	18%
2017 Single	\$139	26%	\$107	24%	\$88	21%
2018 Family	\$478	29%	\$398	29%	\$282	21%
2017 Family	\$457	28%	\$365	29%	\$294	24%

Since the affordability test is based on household income, employers could use income-based contributions to pass the affordability test. Some employers have considered moving to an income-based contribution to pass that test more easily. Locally, only 5 percent of employers base contributions on an employee's income in 2018. Nationally, however, income-based contributions are more popular. Twelve percent of large employers base contributions on income in 2017. These contributions can be difficult to implement. They increase the number of possible contributions you need to track in your HRIS system depending on the number of salary bands you use and plan options you offer. They also can be difficult for employees. If they get a raise, they might jump a salary band and have to increase their contributions. Ironically, the raise may result in lower take home pay.

Prescription Drugs

Prescription drug prices continue to be a key aspect that employers need to watch. According to PriceWaterhouseCooper, they will account for 18 percent of health plan costs in 2018. Over the last ten years, the prescription component of health plan costs has been growing faster than any other health care cost component (inpatient, outpatient and so on).

Specialty medications continue to be an issue. Relatively few people use them, but these drugs represent a substantial amount of cost. The BCBSM book of business claim data illustrates this challenge. In 2011, only 0.7 percent of prescriptions were for specialty medications. In 2011, even with this very low dispensing rate, these medications repre-

Program Type	2017 Mercer National	2018 MMA MI Local
Prior authorization/step therapy	61%	60%
Mandatory generic	34%	49%
Eliminate coverage for certain specialty drugs	Not reported	7%

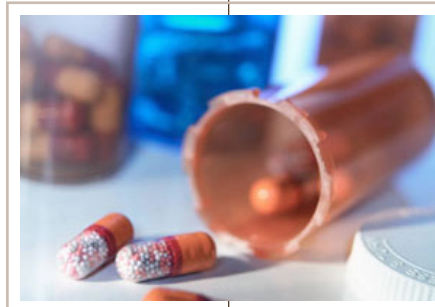
sented 19.4 percent of dollars paid for prescriptions. In 2017, prescriptions for specialty medications stayed steady at 1 percent of prescriptions dispensed but represented 41 percent of total dollars paid for prescriptions.

Most medications being developed are considered specialty medications and are likely to be very expensive. They are often injectable and require special administration or handling. These drugs treat complex or life-threatening conditions. In many cases, they are biologics that work in limited circumstances for certain patients. They can profoundly affect the quality of life for patients with serious health conditions. There are some approaches employers can take to control costs for these specialty medications.

One method employers can use to manage prescription cost is to structure copays in tiers. These tiers encourage effective drug use. Nationally, 57 percent of plans had three-tier prescription drug copays in 2016. Locally, 66 percent of PPO plans had a three-tier copay. More and more employers are now adding copay tiers. Nationally, 28 percent of drug plans have a fourth or fifth tier. Locally, 37

percent of PPO prescription plans have a separate fourth or fifth tier. If there are five tiers, typically the employer has a list of preferred specialty medications available in the fourth tier. The fifth tier is reserved for non-preferred specialty medications.

Nationally, copays changed slightly in 2017. Median prescription drug plan copays were \$10 for generics, \$35 for formulary brands and \$55 for non-formulary brands. If the employer has a fourth tier,



the copay for specialty drugs is \$115. Local median prescription drug plan copays stayed steady in 2018. The copays are \$10 for generics, \$40 for formulary brands and \$80 for non-formulary brands.

Medical management programs can also ensure the plan pays for high cost medications only when they are necessary. Employers adopt a number of medical management programs to keep cost in check (see table at top of page 9).

Employers may want to consider limiting first fills is to limit liability for specialty medications. A plan can, for example, limit first fills of these medications to 14 days. Many of these medications have harsh side effects that patients cannot tolerate. If the first fill is allowed for 30 days or even more, the potential waste can be significant.

will turn to the plan of choice for coverage. The MMA MI survey shows 58 percent of employees elected dependent coverage in 2018. Nationally, Mercer data indicates 54 percent of employees elected dependent coverage in 2017. If your dependent coverage elections are significantly higher than the benchmark, you are likely looked at as a plan of choice.

Employers that self-fund their health plans need to keep a close eye on drug costs. As pharmacy costs become a larger percentage of



Locally, employers use two tactics to discourage employees from enrolling their spouses: force-outs and surcharges. In 2018, 10 percent of survey respondents have

expense, employers should consider adding them under stop loss protection. In 2018, 84 percent of local employers covered prescription drugs under their stop loss policy. Mercer does not report this metric on the national level.

a spousal force-out. Under this provision, if spouses have coverage available through their own 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 prevalence dropped from 2017 when 18 percent of employers reported having a force-out.

Employers have aggressively adopted medical management programs and incentives to drive down their prescription drug costs. This diligence has been effective. Employers are now using medical management programs to keep cost in check rather than continually raising copays. As a result, prescription drug copays, both locally and nationally, have changed very little in the last five years.

Twenty-one percent of local employers use a surcharge. With this strategy, employees pay an extra premium to cover their spouses on your plan, if their spouses could have obtained coverage through their own employers. The median monthly surcharge in 2018 is \$100.

Eligibility Strategies

Employers use a variety of eligibility strategies to keep health plan costs in check. Some employers offer above benchmark medical plans at below benchmark contributions; these plans become the plan of choice. In other words, when both spouses work, they

These strategies are not as popular nationally. In 2017, only 10 percent of large employers had a spousal force-out and 14 percent applied a spousal surcharge. The median monthly surcharge is \$100.

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

CONCLUDING THOUGHTS

The MMA-MI *Southeast Michigan Mid-Market Group Benefits Survey* showed health plan costs increasing at 5 percent after plan changes in 2018. Nationally, health plan cost increased 2.6 percent after plan changes in 2017.

Employers intend to continue offering health plans. Over the last several decades, health plans have become a sizable expense for many organizations. Our survey and national surveys show that employers most successful in controlling health plan cost use a variety of strategies.

It takes a lot of work to control, rather than merely shift, costs. Employers looking to control cost tend to try innovative reimbursement models or take more steps to engage employees in the problem of lowering health care costs. More and more employers are concerned they can't continue to shift cost without making care unaffordable for employees.

The good news is, more and more innovative options are being introduced locally and nationally to offer solutions beyond simply cost shifting. Employers should look for cost control strategies that prompt members to consider cost, steer them to cost effective

venues, inform them of cost/transparency tools and engage them in their health. Options to consider include:

- High performance or narrow networks
- Centers of excellence
- Reference-based pricing
- Population health management
- Spousal surcharges
- Consumer driven health plans
- Telemedicine or coverage for retail clinics
- Expanded copay tiers in prescription drug program
- Competitive PBM discount/rebate arrangements
- Health assessments/biometric screenings
- Health coaching
- Activity challenges
- More healthy options in cafeteria/company meetings
- Financial wellbeing programs

- Focused communication strategies
- Year-round communication efforts
- Carrier provided transparency systems
- External transparency systems
- Expert medical opinions

Many options are available. Your strategies and tactics should engage employees in choices regarding medical care and encourage them to think about their health. Make sure to keep your employees informed so they not only understand their benefits but also consider the costs.

If you have any questions about health plan trends, please contact your Marsh & McLennan Agency | Michigan Team Leader. [MMA](#)

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