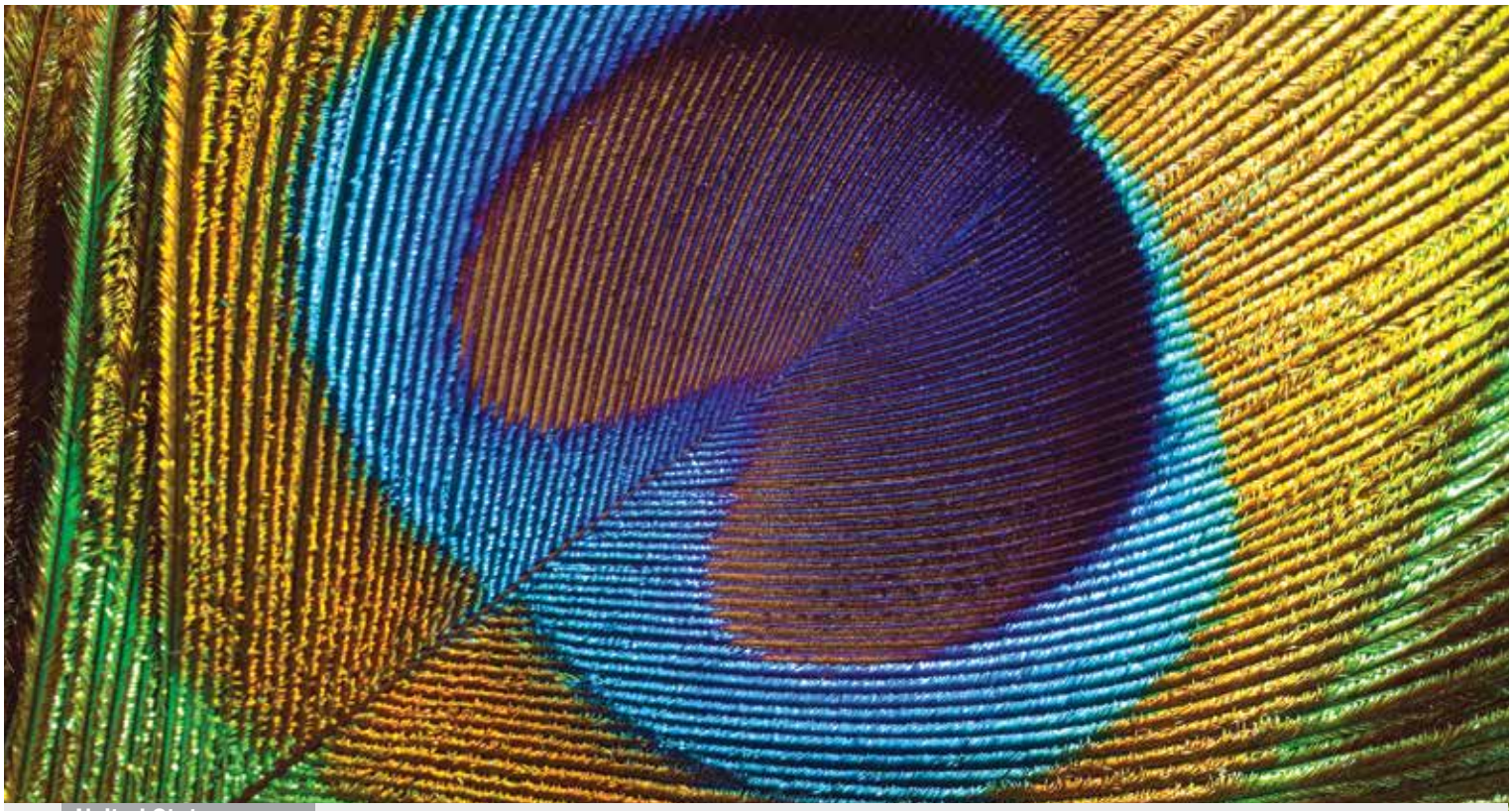

United States

The New Health Care Imperative

Driving Performance, Connecting to Value

2014

19th Annual Towers Watson/National Business Group on Health
Employer Survey on Purchasing Value in Health Care

National Business Group on Health

TOWERS WATSON

United States

2014

Employer Survey on Purchasing Value in Health Care

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Executive Summary

Employers are committed to providing subsidized health care benefits to active employees even in an environment of continued health care cost increases, uncertainty about some provisions of health care reform and an economy that is slow to recover, according to results of the 2014 Towers Watson/National Business Group on Health (NBGH) Employer Survey on Purchasing Value in Health Care.

Almost all (95%) companies indicate that subsidizing health care coverage for active employees will be a very important part of their total rewards package in the period covering 2015 and beyond — virtually unchanged from today (96%). However, 94% of respondents expect employer-sponsored health care benefits to undergo either modest or major changes by 2018. This expected change is impacting long-term confidence. Only 25% of respondents are confident that they will offer employee health care coverage 10 years from now.

Despite a moderate health care cost trend of 4.1% (after plan changes) in 2013, costs continue to rise above the rate of inflation, thereby exacerbating concerns about companies' long-term ability to provide these benefits. To find more effective ways to manage health care costs as part of their overall emphasis on business cost containment, most respondents are focused on recalibrating their health strategy: 18% have already updated their health strategy or developed a new one, and 57% are in the process. Thirty-two percent of respondents cite business performance and the economy as primary drivers of health care strategy (up from 21% in 2013), while 40% of respondents say the Patient Protection and Affordable Care Act (PPACA) is the primary driver (down from 57% in 2013).

The uncertainty is also due in part to the advent of exchanges — both public and private. Employers that no longer want to offer employer-sponsored health care benefits could send their employees to a public exchange, although we should note that employer confidence in public exchanges remains relatively low at this time. There is considerably more interest and confidence in private exchanges. In fact, 67% of respondents agree to a moderate or great extent that private health exchanges will provide a viable option for active employees as early as 2015. That confidence in private exchange viability is tempered, however, by a need for evidence of their effectiveness. Seventy-one percent of respondents say that evidence that private exchanges can deliver greater value than current self-managed models would be a reason to seriously consider offering one. In short, while private exchanges have already proved to be an effective option for retiree health, most employers are taking a wait-and-see approach for their active employees.

"To find more effective ways to manage health care cost trend as part of their overall emphasis on business cost containment, most respondents are focused on recalibrating their health strategy."

Highlights of the 2014 Survey

2013 cost trend increases remained low, but still more than double the rate of inflation

Health trend increases (employer costs after plan changes) fell to a 15-year low of 4.1% in 2013 and are expected to average 4.4% for 2014. Nonetheless, total health care costs (including both employer costs and employee contributions) are expected to reach $12,535 per employee in 2014, up from $11,938 in 2013. Best performers (defined as respondents that have maintained cost increases at or below the Towers Watson/NBGH median for each of the past four years) fared much better than other employers. Their cost trends (after plan changes) between 2010 and 2013 averaged 1.6%.

Employees pay an extra $100 a month for health care today compared to 2011

Employee affordability issues are a growing challenge. Employees' share of premium costs increased nearly 7% between 2013 and 2014, from $2,782 to $2,975. Out-of-pocket expenses also continue to increase, by nearly three percentage points over the last four years (from 15.9% to 18.7%). The total employee cost share, including premiums and out-of-pocket costs, has climbed from 34.4% in 2011 to 37% in 2014. Factoring in higher contributions and point-of-care costs, employees now pay over $100 more per month for health care than they did just three years ago.

Companies are changing their contribution strategy for spouses

Nearly half (49%) of companies say they have increased employee contributions for dependent tiers at higher rates than for individual coverage. Another 19% expect to take this step next year. What's more, about one-quarter of companies are applying spousal surcharges averaging about $100 per month when other coverage is available to the spouse. Looking ahead, only 56% of companies say that subsidized health care for spouses is important for 2015 and beyond — down from over 70% today — a clear indication that the trend toward increased cost sharing for spouses will likely continue.

Enrollment in ABHPs grows

Companies continue to adopt account-based health plans (ABHPs), and enrollment in them is growing. Nearly three-quarters of respondents have ABHPs as of 2014. Another 9% expect to add an ABHP for the first time in 2015. Meanwhile, median enrollment in ABHPs has surpassed 32% and continues to climb. Total-replacement ABHPs (where an ABHP is the only option) are also on the rise: Nearly 16% of respondents have taken this approach — more than double the rate in 2012. Based on changes expected for 2015, nearly one-third (30%) of respondents expect to offer an ABHP as their only plan option in 2015 if they follow through with their current plans.

ABHPs — especially full-replacement plans — have proved effective in helping employers hold the line on costs and are widely used by the survey's best performers. They also show promise for helping organizations avoid the 2018 PPACA excise tax on high-cost plans.

Financial support continues to erode for retiree medical benefits — but new opportunities arise

Employer subsidies for retiree medical coverage have declined sharply over the last two decades, especially for pre-Medicare-eligible retirees. The cost of pre-65 coverage has risen far faster than costs for active employees. Significantly, nearly two-thirds of companies that offer access to an employer-sponsored plan today say they are likely to eliminate those programs in the next few years and steer their pre-Medicare retiree population to the public exchanges.

"ABHPs — especially full-replacement plans — have proved effective in helping employers hold the line on costs and are widely used by the survey's best performers."

"Companies are taking steps to link employees' health and well-being, and their broader experience in the organization, to their employee value proposition in order to get the most out of their investments in health and to sustain good health behaviors."

Employers are also looking for cost savings in their post-65 health benefits. Almost three-quarters (74%) of respondents do not offer post-65 retiree access or financial support for new hires. Of those offering financial support or access, well over half have instituted financial caps on benefits for Medicare-eligible retirees. In addition, 43% of companies have included a health savings account (HSA) for active employees as part of a post-65 retiree medical strategy, and an additional 14% plan to do so in 2015 or 2016.

Private Medicare exchanges have emerged as a significant opportunity. Thirty-two percent of respondents offered access to a Medicare exchange in 2014, and another 39% are considering this option for 2015 or 2016.

Employers embrace emerging payment approaches to improve quality of care

Companies increasingly expect their health plans to adopt payment methodologies that hold providers accountable for the cost of an episode of care, replacing discounted fee for service. In fact, 18% of best-performing companies and 10% of all respondents plan to adopt these approaches next year. Actual figures are undoubtedly higher than indicated since many health plans have adopted these provider contracting approaches and implemented them for their employer clients. Many employers are only now beginning to understand these health plan actions taken on their behalf. In addition, value-based designs for pharmacy and medical plans are gaining traction.

New technologies can open new access points for care

Telemedicine, the remote diagnosis and treatment of patients using telecommunications, was adopted by nearly a third of high-performing companies in 2014, and another 30% plan to add it to their offerings in 2015. While telemedicine typically accounts for only incremental savings, it can be combined with other interventions to drive aggregate savings, and it provides a viable alternative to emergency room or physician office visits for nonemergency health issues.

Adoption of outcome-based incentives continues to expand

In 2014, 22% of companies adopted outcome-based incentives (other than for tobacco), and that figure is expected to reach 46% by 2015 if companies follow through with their plans. Two-thirds of companies also use financial incentives to encourage participation in wellness activities, and 22% of those companies (especially best performers) design these as penalties. And many employers are putting much greater amounts at stake. On average, employees who complete all available wellness activities can earn nearly $50 per month.

Increasingly, employers are embracing wellness as a family issue: Nearly 40% of companies extend wellness incentives to spouses, up from 34% in 2013. At these companies, employees and their spouses together can earn nearly $100 per month for completing all the requirements of the wellness program.

A healthy workplace culture is a top priority

Results from the 2013 Towers Watson Staying@Work Survey showed that companies around the globe recognize that simply adding more programs is not sufficient to engage employees in a healthy lifestyle. Instead, companies are taking steps to link employees' health and well-being, and their broader experience in the organization, to their employee value proposition in order to get the most out of their investments in health and to sustain good health behaviors.

Interest in private exchanges grows

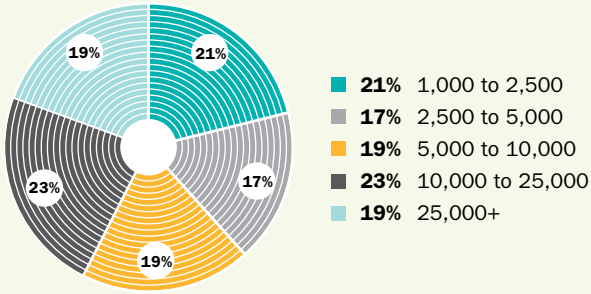
Two-thirds of companies believe that private exchanges will offer a viable alternative to employer-sponsored coverage for active employees as early as 2015. Despite strong interest, however, a clear majority appear to be waiting to see whether private exchange models for active employees demonstrate value, although many more are adopting private exchanges for Medicare-eligible retirees.

About the Survey

The 19th annual Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care tracks employers' strategies and practices, and the results of their efforts to provide and manage health benefits for their workforce. This report identifies the actions of high-performing companies, as well as current trends in the health care benefit programs of U.S. employers with at least 1,000 employees *(Figure 1).* Respondents are also asked about specific implications for their health care benefit programs attributed to the PPACA.

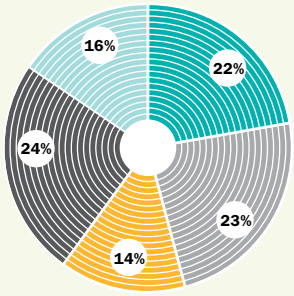
The survey was completed by 595 employers between November 2013 and January 2014, and reflects respondents' 2013 and 2014 health program decisions and strategies and, in some cases, their 2015 plans. Respondents collectively employ 11.3 million full-time employees, have 7.8 million employees enrolled in their health care programs and operate in all major industry sectors (*Figures 2* and *3*). In 2014, respondents anticipate spending, on average, $12,535 per employee on health care, which equates to a collective $98 billion in total health care expenditures.

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



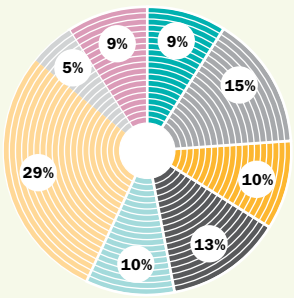
- **21%** 1,000 to 2,500
- **17%** 2,500 to 5,000
- **19%** 5,000 to 10,000
- **23%** 10,000 to 25,000
- **19%** 25,000+

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



- **22%** National
- **23%** Northeast
- **14%** South
- **24%** Midwest
- **16%** West

Figure 3. Industry groups



- **9%** Energy and Utilities
- **15%** Financial Services
- **10%** General Services
- **13%** Health Care
- **10%** IT and Telecom
- **29%** Manufacturing
- **5%** Public Sector and Education
- **9%** Wholesale and Retail

A Note About Health Care Costs

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

Health Care Costs per Employee

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

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

Health Care Cost Trends

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

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

Strategy and Planning

Concerns about costs, the PPACA and the economy are causing virtually all employers to recalibrate their health care strategy. Eighteen percent have already done so; 57% are in the process, and 21% are planning to do so *(Figure 4)*.

While 40% say the PPACA is still the primary driver of this activity (down from 57% in 2013), 32% cite business performance and the slow-to-recover economy — up significantly from only 21% in 2013. Perhaps the rising cost of employer coverage is driving them to find more effective ways to manage trend as part of their overall focus on business cost containment. At the same time, their confidence in some of the new alternatives to employer-sponsored health care for some or all of their workforce is gradually growing.

Figure 4. Many companies are focused on recalibrating health care strategy for 2015 and beyond

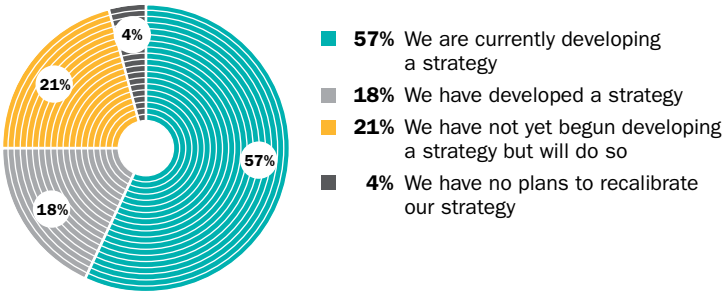
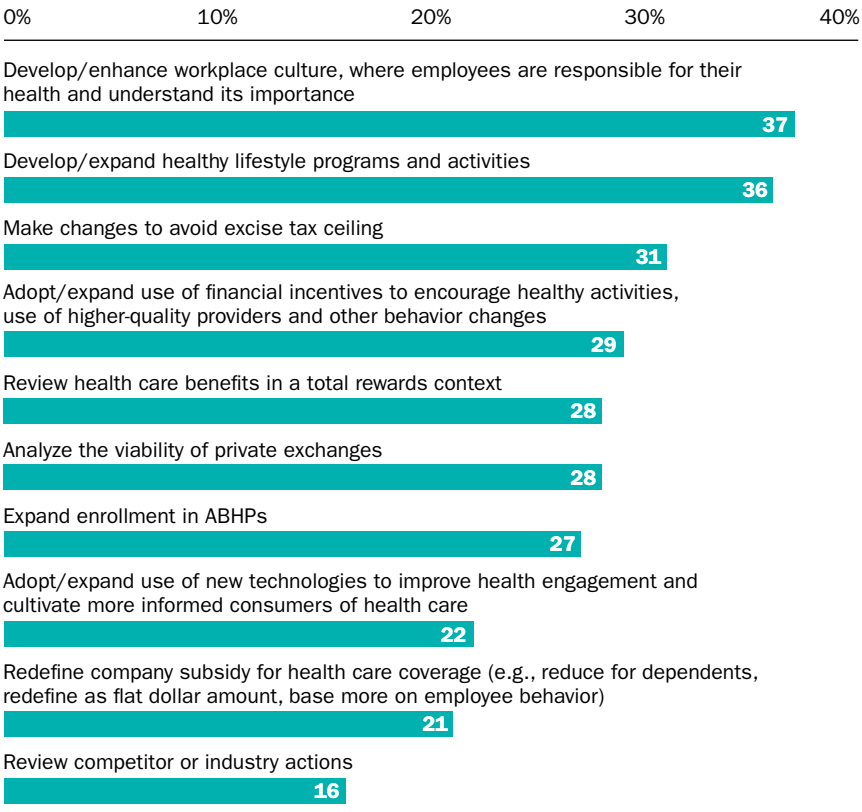


Figure 5. Top focus areas of employers' health care strategy in 2014



Top Strategic Focus Areas

Amid all this strategic activity, a number of areas are receiving a good bit of attention, including workplace culture, employee accountability for health, development of new and additional healthy lifestyle programs, expansion of financial incentives to family members and additional behavior changes. The top focus (37%) continues to be building a supportive workplace culture that includes physical environment, leadership support and education, and information to support more informed decisions about their health care and its cost *(Figure 5)*.

More than twice as many employers as last year are developing and expanding healthy lifestyle programs and activities. Yet they recognize that simply adding more programs is not sufficient to engage employees in a healthy lifestyle. As our 2013/2014 Staying@Work Survey shows, companies are taking steps to link employees' health and well-being to their employee value proposition in order to get the most out of their investments in wellness and sustain healthy behaviors.

About one in three employers (up noticeably from one in five last year) are making changes to avoid the upcoming excise tax in 2018, with the understanding that those actions are not likely to have an immediate impact. Finally, more than 20% of all respondents are focusing on a half-dozen other activities designed to encourage healthy behaviors and consumerism.

More Changes Ahead

If there is one thing that nearly all employers believe, it's that the health care marketplace is headed for more change by 2018, following the implementation of many PPACA provisions *(Figure 6)*. A full half expects either significant change or complete transformation, up slightly from last year, and an additional 44% expect at least modest change.

About half foresee care becoming more accessible as a result of technology and more consumerist as a result of transparency tools *(Figure 7)*. More than one in four expect growth in new value-based benefit designs (VBDs) and highly coordinated provider models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). Not surprisingly, nearly no one thinks the steady escalation of health care costs is about to change anytime soon.

"If there is one thing that nearly all employers believe, it's that the health care marketplace is headed for more change by 2018."

Figure 6. Nearly all employers anticipate modest or major changes

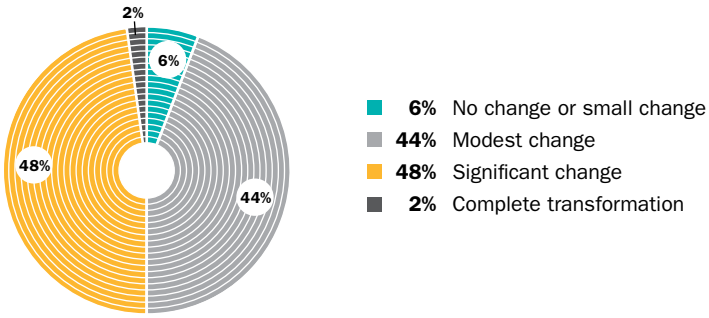
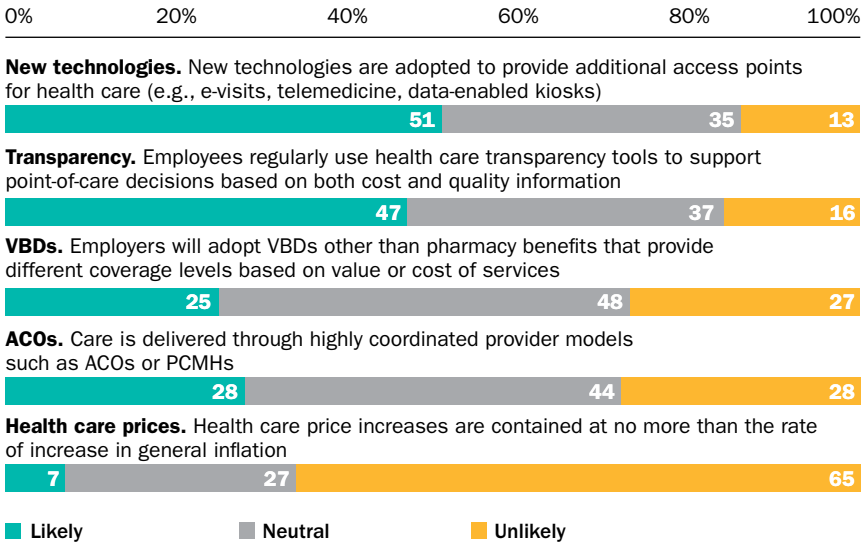


Figure 7. Companies are optimistic about new ways to access care that leverage new technologies

To what extent will the following changes to the health care marketplace occur over the next five years?



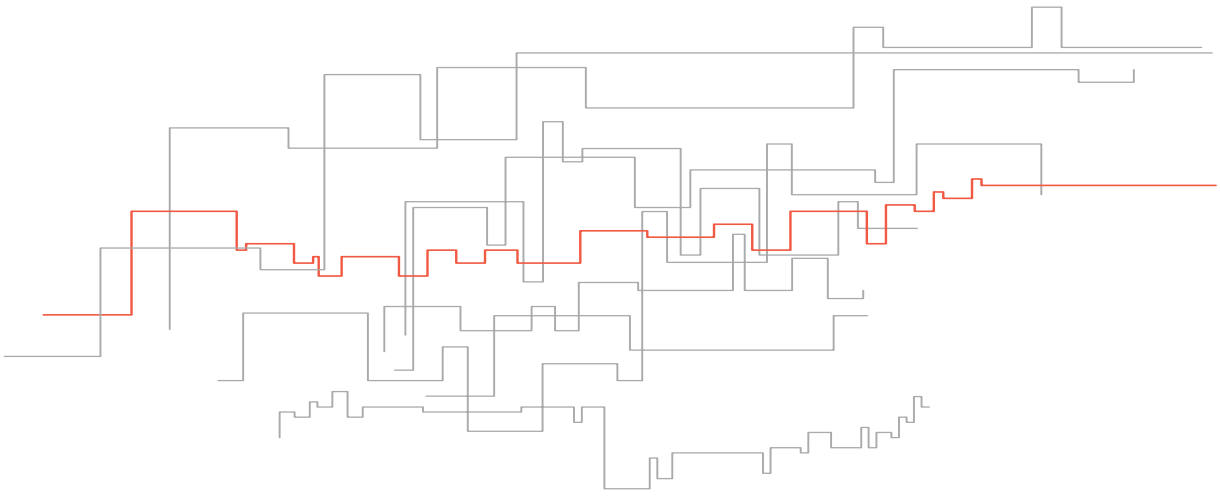


Figure 8. Employers redefine subsidies for spouses and retirees

How important will it be to provide subsidized health care benefits for each of the following populations?

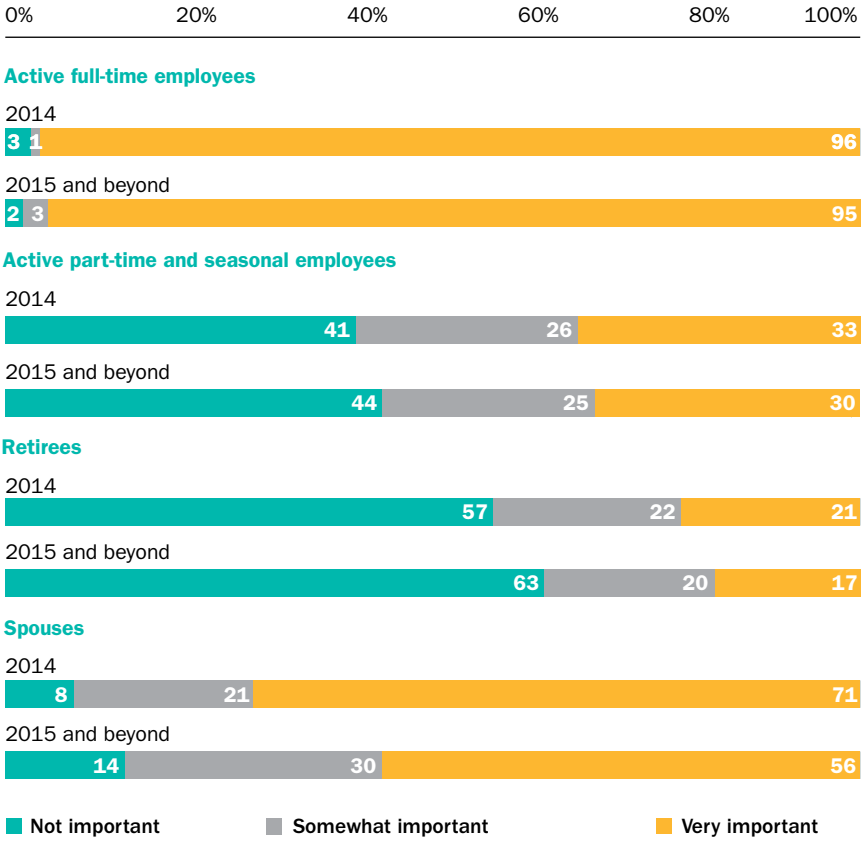
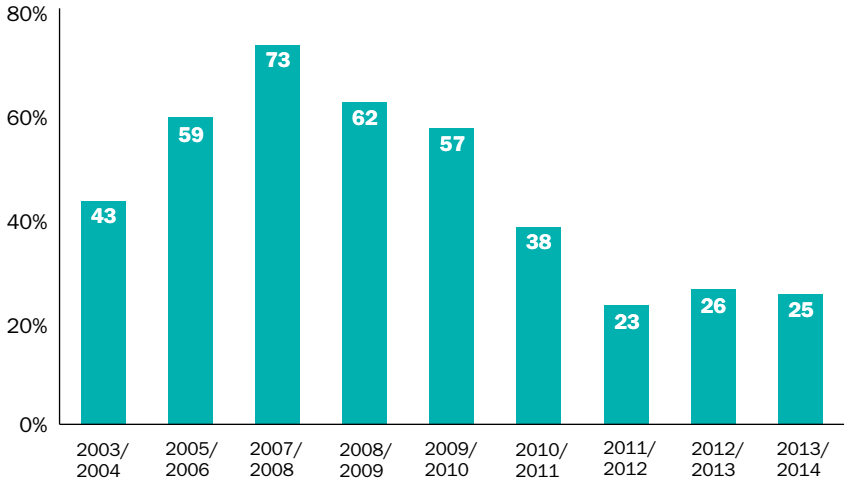


Figure 9. Employers that are very confident that health care benefits will be offered at their organization a decade from now



Responses in December/January of designated years

Employers Committed to Health Benefits for Full-Time Employees Through 2015

In spite of all their concerns about cost, 98% of employers remain committed to providing subsidized health care benefits to active full-time employees, at least for the short term. Their commitment is not as strong for part-time and seasonal employees *(Figure 8)*. Also, their solid support of spouses in this year's survey drops off significantly for 2015 and beyond when other coverage exists. Many employers have already ended their financial support to retirees. This year, 57% say it is not important to provide subsidized retiree health care to them, and even more (63%) agree that it will not be important in 2015.

When it comes to the longer term, employers' confidence about their role in health care coverage continues a decline that began with passage of the PPACA. Only 25% are confident they will offer coverage to their employees 10 years from now *(Figure 9)*.

"In spite of all their concerns about cost, 98% of employers remain committed to providing subsidized health care benefits to active full-time employees, at least for the short term."

Cost Trends

Affordability Still a Question

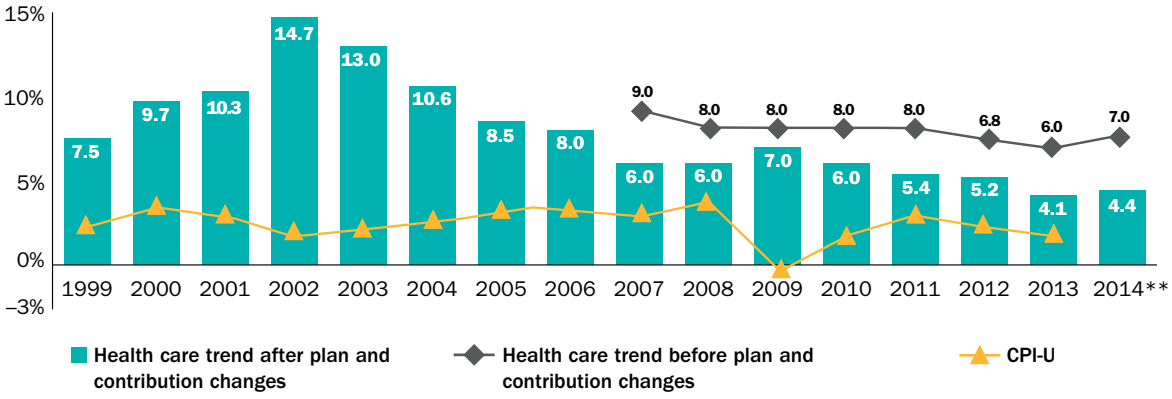
Changes to plan design and employee contributions have resulted in the lowest average cost trends since 1999: 4.1% in 2013 and 4.4% expected in 2014. Without these changes, trends would have been 6% and 7% for each year *(Figure 10)*.

Amid these modest but steady increases, company leaders are also trying to balance total rewards. And the rapidly changing health care marketplace has created many new opportunities for employers to explore. As in previous years, the best-performing companies continue to lead the way by adopting many new health care strategies most companies thought unthinkable not too long ago.

Actives: Full-Time Employees Paying More

Employers anticipate total medical and drug costs paid by their plan will reach an average of $12,535 per active employee in 2014 — up from $11,938 in 2013 — a 5.0% increase in total costs *(Figure 11)*. The average employer share of these costs continues to climb at a greater rate than the Consumer Price Index (CPI) and wages — to $9,560 in 2014, compared to $9,157 in 2013, up 4.4%. That's nearly 28% more than employers paid just five years ago. During the same period, however, employee costs have risen 32%.

Figure 10. Health care cost trend drops to lowest rate in 15 years*



Notes: Median trends for medical and drug claims for active employees. CPI-U extracted from the Department of Labor, Bureau of Labor Statistics.

*A company's medical and pharmacy benefit expenses for insured plans include the medical and pharmacy premiums paid by the company. For self-insured plans, this includes all medical and pharmacy claims paid by the plan, company contributions to medical accounts (FSA/HRA/HSA) and costs of administration. For administration costs, these include claim-processing fees, network access fees, utilization review fees, stop loss premiums, and any health management program costs and program participation incentives paid by the plan. This includes any carve-out plans for prescription drugs and mental health, but excludes costs for dental benefits and employee point-of-care (or out-of-pocket) costs for medical and pharmacy plans.

**Expected

Figure 11. Per-employee per-year medical and drug costs

	Total plan costs		Employer costs	
Percentile	**2013**	**2014***	**2013**	**2014***
Mean	**$11,938**	**$12,535**	**$ 9,157**	**$ 9,560**
25th	**$ 9,899**	**$10,323**	**$ 7,630**	**$ 8,047**
50th	**$11,288**	**$11,834**	**$ 8,810**	**$ 9,269**
75th	**$12,946**	**$13,626**	**$10,500**	**$10,915**

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

*Expected

Figure 12. Total employee/employer health care costs

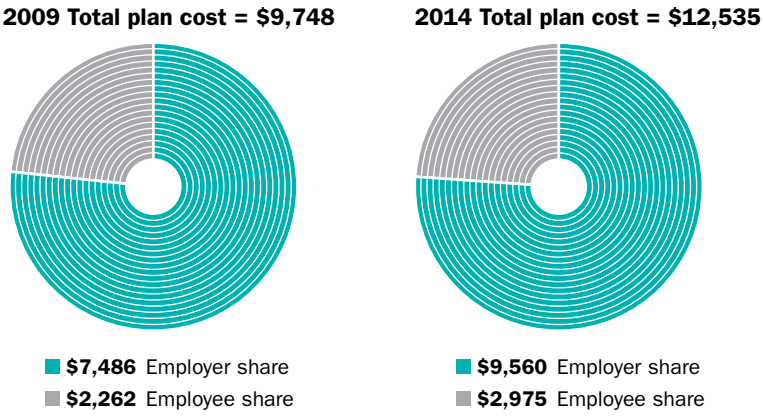
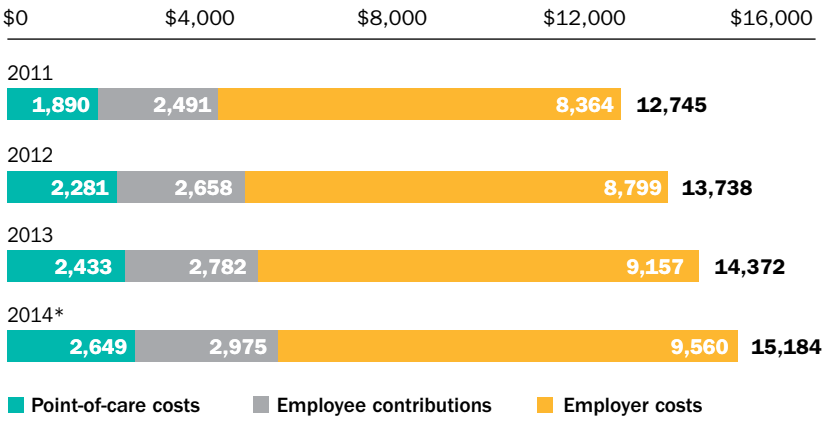


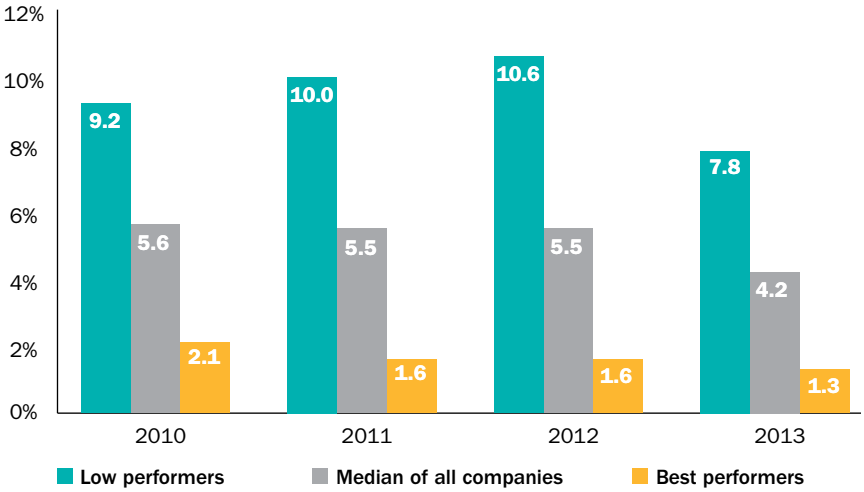
Figure 13. Total health care expenses, 2011 to 2014*



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

*Expected

Figure 14. Best performers versus median annual cost trends after plan changes, 2010 to 2013



Note: Median trends are for employer costs for actively enrolled employees.

Just how much can employees afford to pay for health care as salaries rise at the rate of inflation or just slightly more? Since 2009, employees' share of premium costs increased nearly 32%, from $2,262 to $2,975 in 2014 *(Figure 12)*. Their out-of-pocket expenses also increased steadily — by nearly three percentage points since 2011 — from 15.9% to 18.7%. The total employee cost share, including premiums and out-of-pocket costs, has climbed from 34.4% in 2011 to 37% in 2014. Employees now pay, on average, over $100 more a month for health care than they did just three years ago *(Figure 13)*.

As employers increase their employees' share of premiums, they are focusing intently on redefining the financial commitment to dependents. In fact, almost half say they have increased employee contributions in tiers, charging employees with covered dependents higher rates of increase than individuals.

Best Performers Manage to Lower Costs Significantly

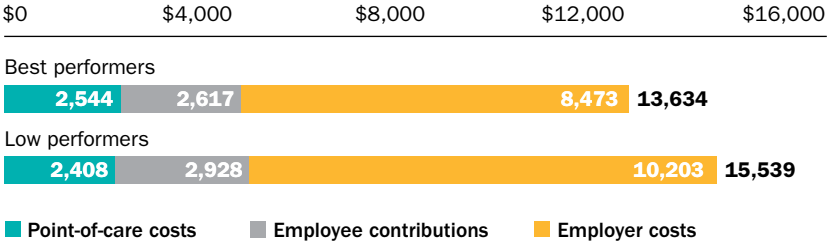
Employers continue to show dramatic differences in their ability to manage their health care cost trends. Our research this year identified 44 companies that qualify as best performers* for their ability to manage their health care cost trends at or below trend for each of the years 2010 through 2013 *(Figure 14)*. Their trend over that time is 1.6%, significantly lower than the 5.2% median trend for all companies.

On the other end of the spectrum, some companies have experienced far greater challenges in managing their cost increases. Low-performing companies — those with two-year average cost increases higher than 75% of all employers — have a median 9.2% cost trend. They are prime candidates for hitting the excise tax threshold without significantly improving the performance of their programs before 2018. Yet even these companies are starting to show some progress, adopting some strategies best performers implemented years ago.

*A company had to complete this year's survey and the 2012 or the 2013 Towers Watson/NBGH survey to be eligible to be a consistent performer. The number of consistent performers is based on 244 eligible companies, which translates to 18% of companies reporting an annual trend at or below the all-company median for each year from 2010 to 2013.

Best performers expect to pay $1,730 less for health care per employee in 2014 than low performers *(Figure 15).* For a best performer with 10,000 employees, this amounts to more than $17 million a year — a clear competitive advantage. For employees working for a best performer, premium costs are also lower — $311 less than if they were working for a low-performing company. Interestingly, out-of-pocket costs are $136 higher for employees at best-performing companies, which in part reflects higher take-up of — and enrollment of employees into — ABHPs with higher deductibles. For example, 89% of best performers have an ABHP in place today with a median enrollment rate of 40%, compared to only 65% take-up for low-performing companies and an enrollment rate of just 32%.

Figure 15. Total health care expenses, best versus low performers, 2014*

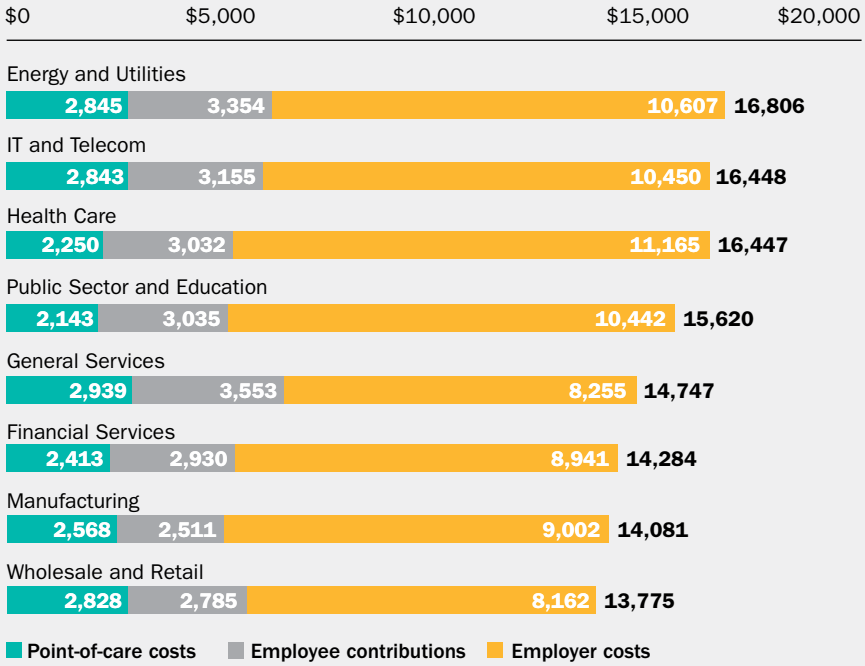


Note: Total health expenses include employer and employee portions of the premiums, administration costs and employee point-of-care costs (including deductibles, copays and coinsurance).
*Expected

What's the Difference?

There is nearly a 30% difference between low- and high-cost industries. While this disparity partially reflects differences in demographics, family size and geography, it also suggests that heath care makes up a larger part of some industries' total rewards programs. Notably, the total employee costs (point of care plus employee contributions) vary far less than employer costs. That may be due in part to the variation in take-up of ABHPs and employee enrollment in them. For instance, 45% of employees in Wholesale and Retail are enrolled in ABHP plans, compared to only 26% in Health Care (see page 24).

Total expected 2014 health care expenses by industry



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

Retiree Medical Plans: Affordability Challenges Erode Support

Fifty-eight percent of companies currently offer some form of retiree medical support — either subsidies or access to coverage through a Medicare coordinator *(Figure 16).* That support is down from 60% last year and is expected to decline dramatically in the next few years. The cost of pre-Medicare-eligible coverage, especially, has risen far faster than costs for active employees, and nearly two-thirds of companies that offer access to an employer-sponsored plan today say they are likely to eliminate those programs in the next few years and steer their pre-Medicare retiree population to the public exchanges. One of the major reasons: The cost is becoming less and less affordable for the retiree in contrast to options emerging in the public marketplace.

This year, the cost for those who retire before becoming eligible for Medicare at age 65 is, on average, $9,276 for single and $21,265 for family coverage *(Figure 17).* These retirees who have access to an employer plan pay an average 40% share of the cost for single and over 41% for family coverage — nearly 6% higher than in 2013. Even with an employer subsidy, some may find it unaffordable, especially those who leave the workforce involuntarily without prospects for a new job. Since the launch of the exchanges, these retirees are more likely to find coverage at a lower cost than an employer-provided plan.

Figure 16. Does your organization provide any financial support or access to coverage for any current or future retirees?

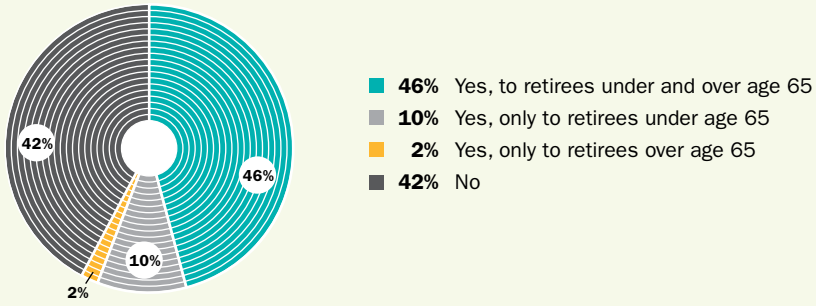


Figure 17. Annual premiums and rates of increase for retiree-only and family coverage for 2014

	Annual total premiums*		Retiree premium share**		Rates of increase	
	Retiree only	Family	Retiree only	Family	2013	2014
Retirees under age 65	**$9,276**	**$21,265**	**40.1%**	**41.1%**	**4.7%**	**5.8%**
Retirees age 65 and older	**$4,986**	**$11,689**	**35.6%**	**40.4%**	**2.4%**	**3.2%**

*Based on companies that offer an employer-sponsored plan
**Based on companies that offer an employer-sponsored plan and financial support

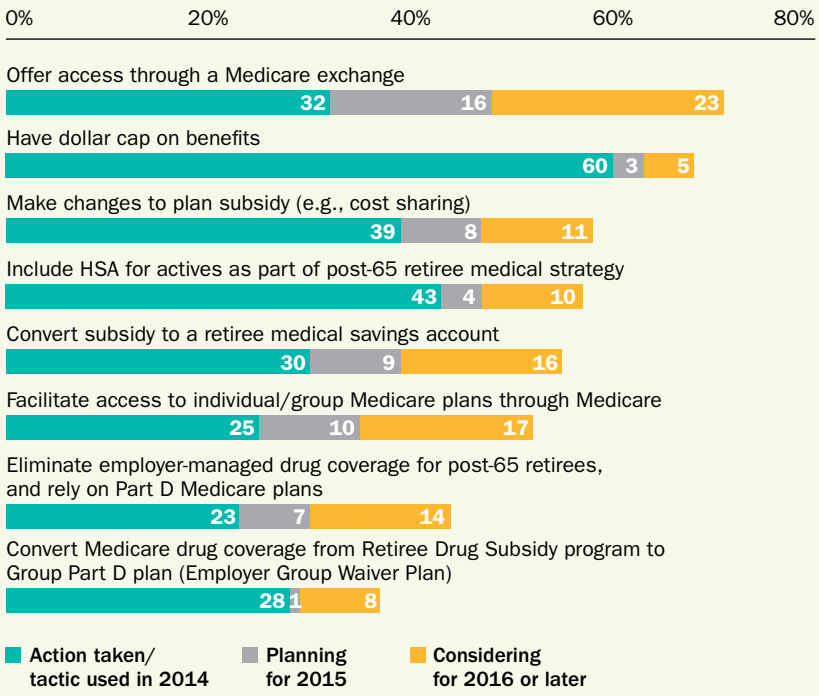
Medicare-Eligible Retirees

The cost for Medicare-eligible retirees averages $4,986 for single and $11,689 for family coverage, a 3.2% increase over last year. Retirees' share of the cost is 35.6% for single and 40.4% for family coverage.

However, employers are also seeking ways to offer more value for these retirees. More than half (54%) do not offer post-65 retiree access to an employer-sponsored plan or financial support for current retirees, and that figure will rise to nearly 60% within two years. When it comes to new hires, almost three-quarters of respondents (74%) do not promise access or financial support, and that number is expected to rise to 80% by 2016. Notably, 43% have included an HSA for active employees as part of a post-65 retiree medical strategy, and an additional 14% plan to do so in 2015 or 2016 *(Figure 18)*.

Private Medicare exchanges have emerged as a significant opportunity, considering the maturity of the individual marketplace and the economic value of having retirees select plans most suited to their health care and financial situation. About one-third (32%) of respondents offered access to a Medicare exchange in 2014, and another 39% are considering this option for 2015 or 2016.

Figure 18. Post-65 retiree changes



Note: Based on respondents that provide financial support or access to coverage in 2014 and excludes responses of "not applicable"

"Private Medicare exchanges have emerged as a significant opportunity, considering the maturity of the individual marketplace and the economic value of having retirees select plans most suited to their health care and financial situation."

Emerging Trends: Glide Path to Value

Over 61%* of employers say their current plans will trigger the PPACA's excise tax on high-cost plans in 2018, and that percentage is expected to grow even larger in the next four years as cost increases compound. To avoid the tax, which is designed to drive employers to create more efficient plans, and achieve a sustainable health benefit program, employers have some choices to make. They could decide to wait and see what happens over the next four years, trusting that two more major election cycles will diminish the law's tough provisions. Or they could shift much of the cost to employees through increased point-of-care payments, or even eliminate some benefits. However, we find that many employers — especially best performers — are wasting no time considering the best way to achieve a high-performance health plan: one that reduces cost and the future trend rate, and improves workforce health, as well as the efficiency and quality of care delivered. To get there, employers are implementing any of a number of new tactics that are part of what we call a strategic glide path. An organization's specific glide path should reflect its guiding principles as well as strategies specific to these five components:

- Benefit delivery channel optimization
- Benefit restructuring
- Network optimization
- Population health and care management
- Employee accountability and engagement

Benefit Delivery Channel Optimization

The advent of the public exchanges under the PPACA and the rapid growth of new private exchange arrangements are giving companies new options for providing employee health care benefits. Now they can consider whether a self-managed plan or an exchange-based solution adds the best value for the organization, its employees and retirees. To select the right strategy for connecting their people with value, employers need to understand the opportunities and fit for both the organization's health and welfare benefit strategy, and its broader total rewards strategy. They are discovering that the right strategy might vary for each unique population segment (full-time actives, part-time and seasonal actives, pre-65 retirees and post-65 retirees), and they need to determine which channel by itself — or as part of a hybrid solution — provides optimal value for each.

Public Exchanges: A Solution for Some Segments

The new public marketplaces have gotten off to a highly publicized rocky start, and confidence in them as a viable alternative remains low at this time (12%*), but confidence more than doubles for 2015 (29%*). Many employers are watching their development closely as a possible option for certain population segments, including those working less than 30 hours a week, certain low-wage workers, COBRA continuees and pre-Medicare retirees. Public exchanges may be promising for these populations thanks to guaranteed-issue coverage, plan choice, favorable underwriting for older workers, and the potential availability of subsidies that reduce premiums and improve benefits at the point of care. For employers with very low-wage populations, the expansion of Medicaid creates an opportunity to channel these workers to the new Medicaid programs without penalty.

*2013 Health Care Changes Ahead Survey

Private Exchanges: A New Solution

Respondents show considerably more interest and confidence in private exchanges: 67% believe they will provide a viable alternative to employer-sponsored coverage in 2015, more than twice those that see them as a possibility for 2014 *(Figure 19).*

This increasingly favorable attitude may be partly attributable to the documented success of private exchanges for retirees over the last few years, when a gradually increasing proportion of employers (30%) have chosen private Medicare exchanges to connect over-65 retirees to the individual Medicare insurance market.

In the last year, these established private exchanges and a growing number of new entities have entered the full-time active employee market to help employers determine how to sustain their health plans for the future. These private exchanges can offer employers an opportunity to buy a high-value solution to lower costs and avoid the tax if they don't want to build a platform of their own. While approaches vary, hallmarks of a private exchange can include aggressive plan design, increased employee engagement, more effective care and condition management, state-of-the-art pharmacy management and robust provider contracting.

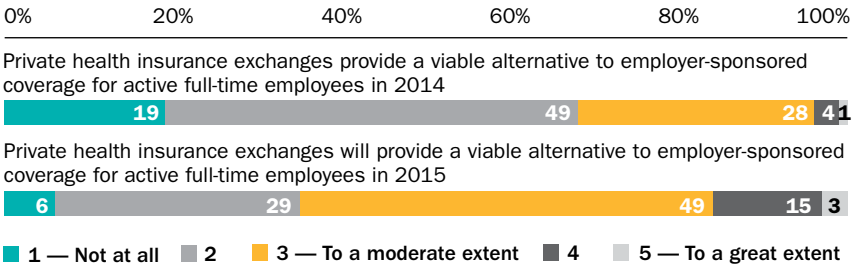
Prove It!

Most employers continue to take a wait-and-see approach toward private exchanges — although a subtle change in attitude can be detected now that the PPACA's main provisions are in effect and employers are learning more about these new vehicles *(Figure 20).* When asked what would make them move to a private exchange, 71% want to see hard evidence that a private exchange can deliver greater value than their self-managed plans. Less than half want to see how their industry peers react. And 36% want to see if they can bring their costs below the tax threshold on their own before considering a private exchange.

Notably, while last year only 6% of employers said they would consider a private exchange in order to reduce health care spending as part of their total rewards, nearly six times more employers chose a better total rewards balance this year as a reason to move to a private exchange.

Figure 19. Private exchanges

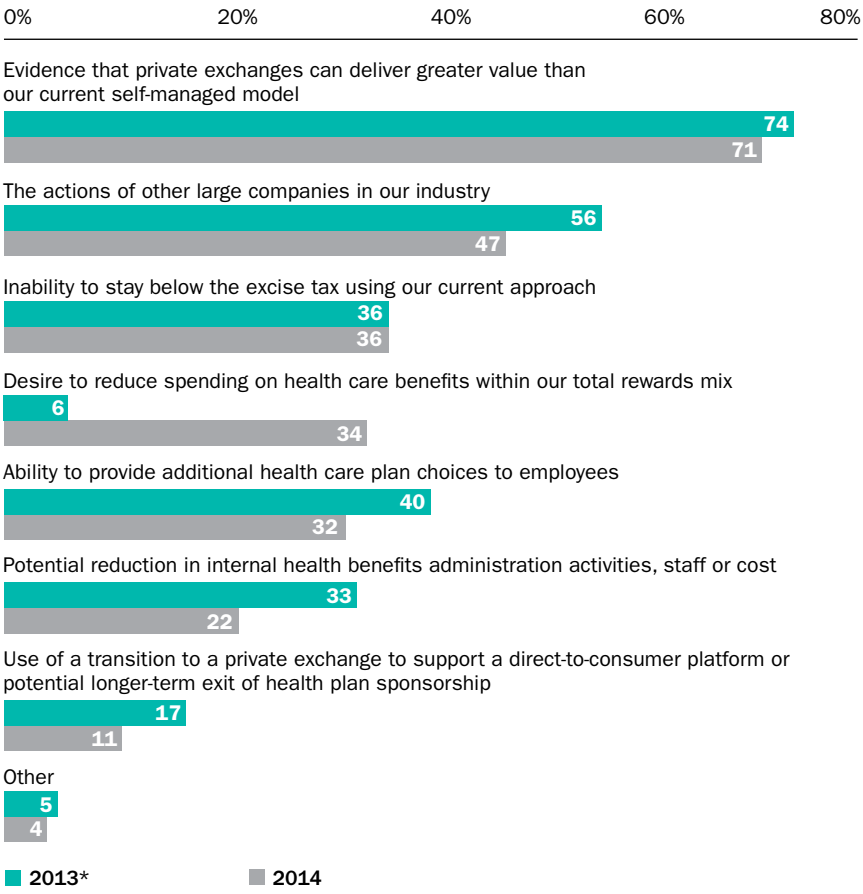
To what extent do you agree with the following statements about private health insurance exchanges?



Note: Based on a scale of 1 to 5

Figure 20. Reasons to consider a private exchange

Top three factors that would cause employers to seriously consider a private exchange for active full-time employees



*2013 Health Care Changes Ahead Survey

Restructuring Benefits

A number of employers are restructuring their plans to make sure they are sustainable over the long term. These changes include reducing plan values, modifying plan options, examining tiered contributions for dependents, restructuring program components, minimizing or eliminating FSA contributions, and paring back other benefits.

Figure 21. Changes in contribution structure for active employees

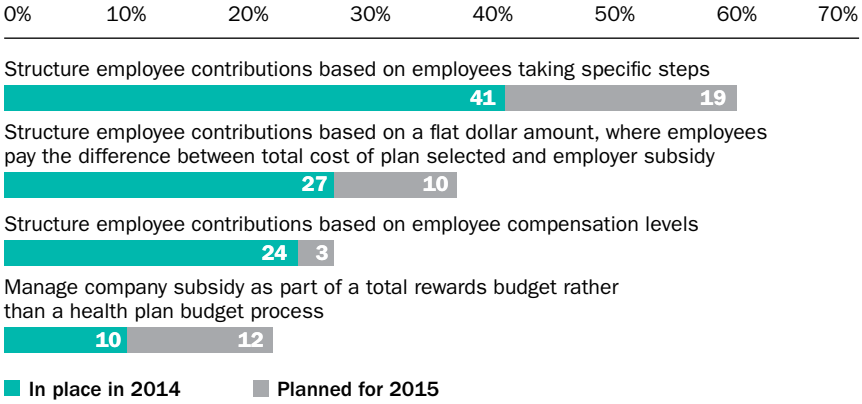
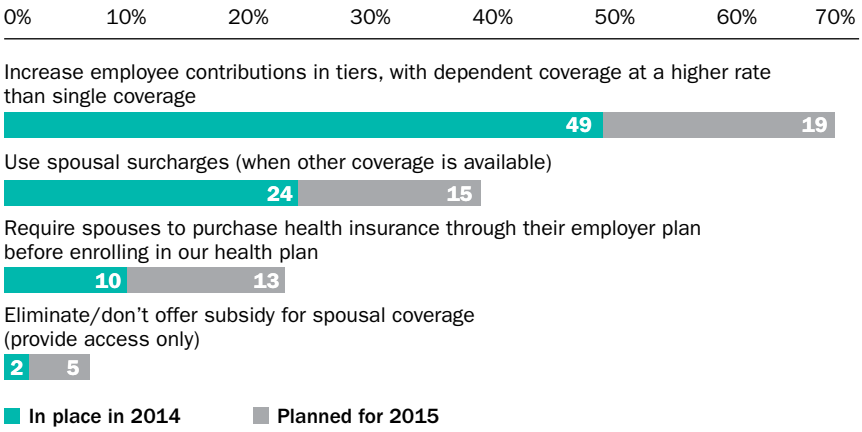


Figure 22. Redefining the commitment to spouses



Tying employee contributions (premium amounts) to successful completion of specific tasks, such as health assessments and screenings, remains the most popular change in contribution strategies for actives as employers continue to look for ways to optimize their plans and make them more efficient *(Figure 21).* Last year, 37% of employers used this tactic; 41% have done so this year, and an additional 19% say they will adopt it next year.

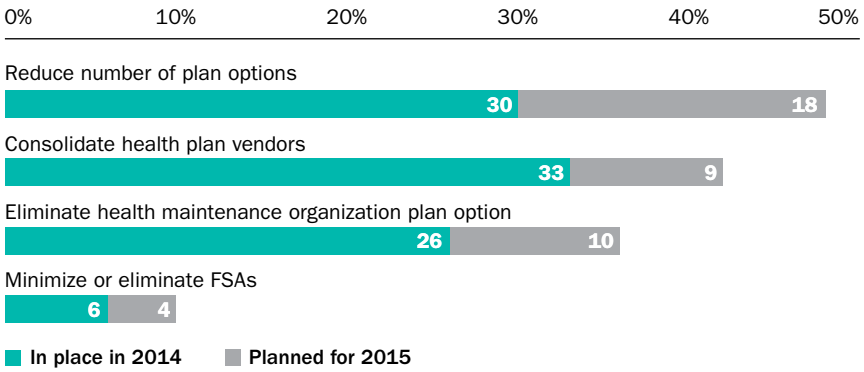
Covering Spouses: Higher Rates and Surcharges

The rise we see in employee premiums this year is partly due to subsidy shifts for dependents. Almost half (49%) of employers have already increased employee contributions in tiers, charging employees with covered dependents higher rates than individuals *(Figure 22).* Another 19% plan to do so next year.

The details of these changes show some interesting signs of what's to come. For instance, of those charging more for dependents, 66% have as many as four rate tiers for different numbers of dependents, and 5% have different tiers for each additional dependent. What's more, approximately one-quarter of companies are using spousal surcharges of about $100 per month when other coverage is available to the spouse. Currently, 10% of respondents require spouses to get their coverage from their own employer, while 2% offer no spousal coverage. These tactics are expected to increase to 13% and 5%, respectively, for 2015. Looking ahead, only 56% of companies say that subsidized health care for spouses is important for 2015 and beyond — down from over 70% today — a clear indication that spousal coverage is no longer a given, at least, not without a surcharge.

When it comes to plan management strategies to reduce the costs of covering active employees, the most popular strategy is a reduction in plan options *(Figure 23).* Thirty percent did that this year, and an additional 18% plan to do it in 2015. Other strategies include consolidating plan vendors, eliminating health maintenance organizations as a plan option and, far behind, minimizing or eliminating FSAs.

Figure 23. Plan management strategies



What's the Difference?

Although 24% of all companies use spousal surcharges, there is some variation by industry, with about 30% of respondents in Manufacturing, and IT and Telecom using them, compared to less than 20% in Energy and Utilities, General Services, and Public Sector and Education. However, the Energy and Utilities companies that use surcharges impose $300 more a year than the respondent average.

Spousal surcharge by industry

	In use	Annual amount
All companies	24%	$1,200
Energy and Utilities	18%	$1.500
Financial Services	20%	$1,105
General Services	17%	$1,200
Health Care	26%	$1,200
IT and Telecom	30%	$ 944
Manufacturing	29%	$1,200
Public Sector and Education	7%	$ 630
Wholesale and Retail	26%	$1,185

Note: Median surcharge for spouses

Network Optimization

Employers, in partnership with health plans, are adopting various payment strategies to motivate providers to reduce unit costs as well as operational costs, and improve quality of care and outcomes. The trend includes evaluating risk transfer arrangements, centers of excellence and alternatives to the traditional discounted fee-for-service arrangements. Companies increasingly expect their health plans to adopt payment methodologies that hold providers accountable for the cost of an episode of care, replacing traditional arrangements that reimburse providers for each unit of service. In fact, 24% of all companies — twice as many as this year — expect these approaches to be adopted by next year *(Figure 24)*.

We believe the actual number of employers already leveraging emerging payment methodologies is much higher, as many health plans have adopted these provider payment approaches for their employer clients. And while the plans may have communicated the strategy, many employers are only now beginning to understand these new and historically unconventional actions taken on their behalf. These plans are responding to the PPACA's payment reform provisions — including value-based purchasing, ACOs, bundled payments and PCMHs — that target improvements in quality and efficiency.

In addition, VBDs for pharmacy and medical plans are gaining traction: 41% plan to use them for pharmacy and 28% for medical next year, compared to only 26% and 9%, respectively, this year *(Figure 25)*.

Figure 24. Network optimization and emerging payment approaches

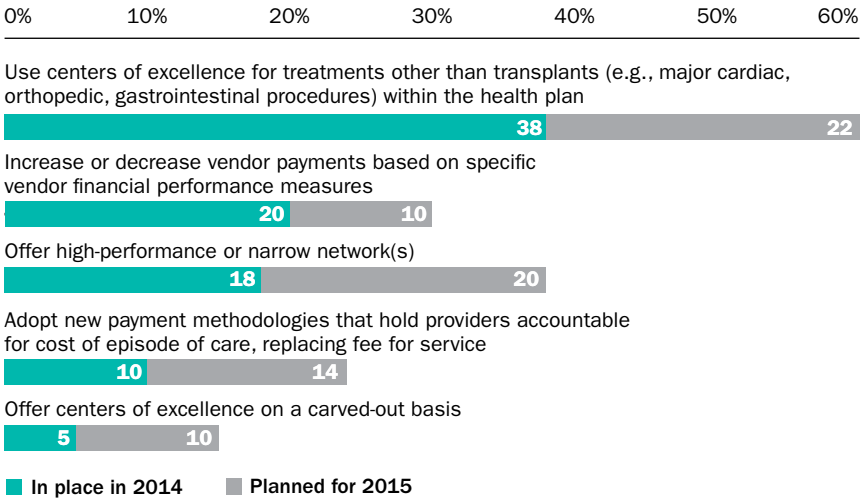
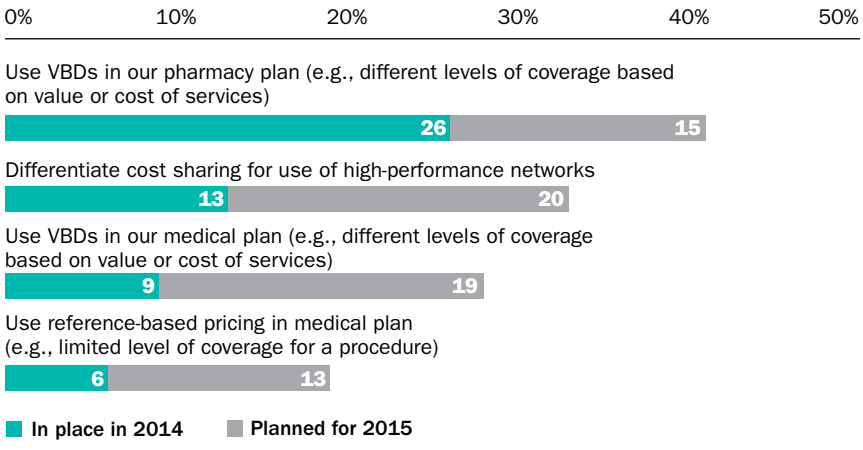


Figure 25. VBDs to improve quality and efficiency of care delivered



Employers are also looking for health plan vendors that add value. An overwhelming number of employers say it is important to know the results and effectiveness of new contracting strategies (93%), to select a provider system based on evidence of coordination of care (89%), to have new payment methodologies that include bundled payments for episodes of care (81%), and to have ACOs and PCMHs with incentives and penalties based on quality, efficiency and outcomes (77%) *(Figure 26).*

By next year, most employers expect to employ pharmacy benefit management strategies including evaluating contract terms (83%), designing a formulary management strategy targeted to increase generic drug utilization (77%), developing a specialty pharmacy cost management strategy (61%) and conducting an audit of their pharmacy benefit manager (57%) *(Figure 27).*

Figure 26. Factors in selecting a health plan vendor

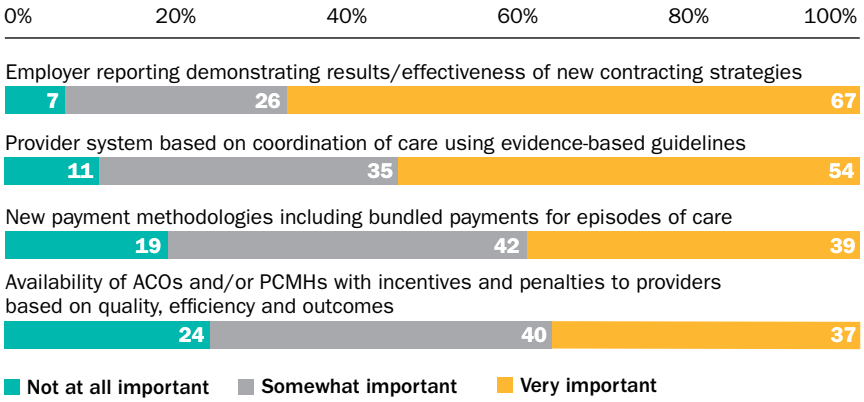
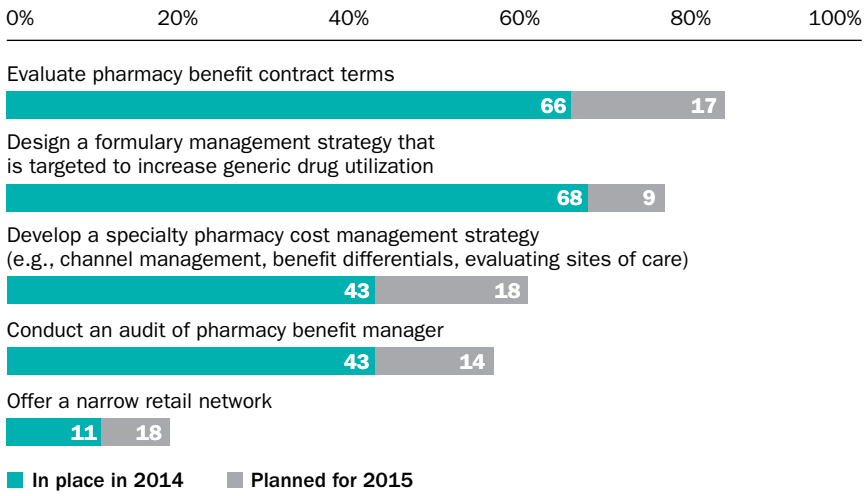


Figure 27. Pharmacy benefit management strategies



Population Health and Health Care

An increasing number of employers are focused on strategies to improve the health of their organization, including improving condition and care management; reducing risk factors; improving closure of care gaps; enhancing population stratification, segmentation and predictive modeling; and tailoring communications and change management to targeted segments of employees and family members.

Figure 28. Vendor and program integration to support risk stratification and employee awareness

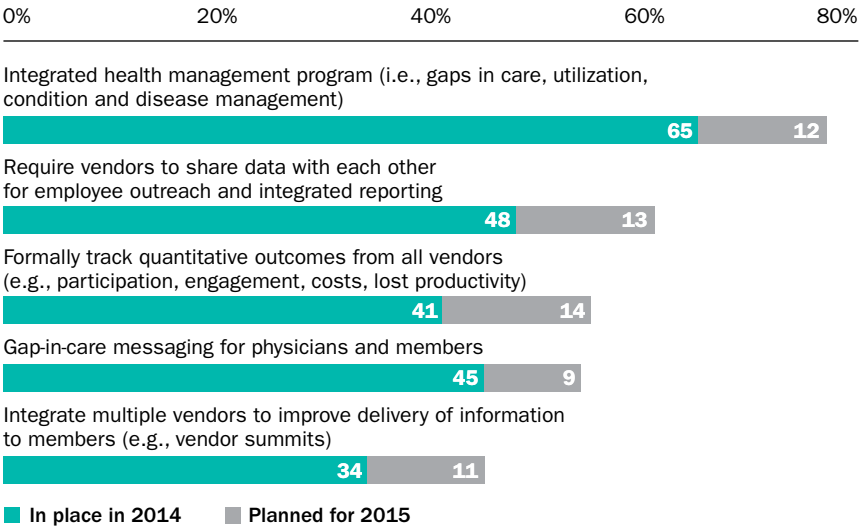
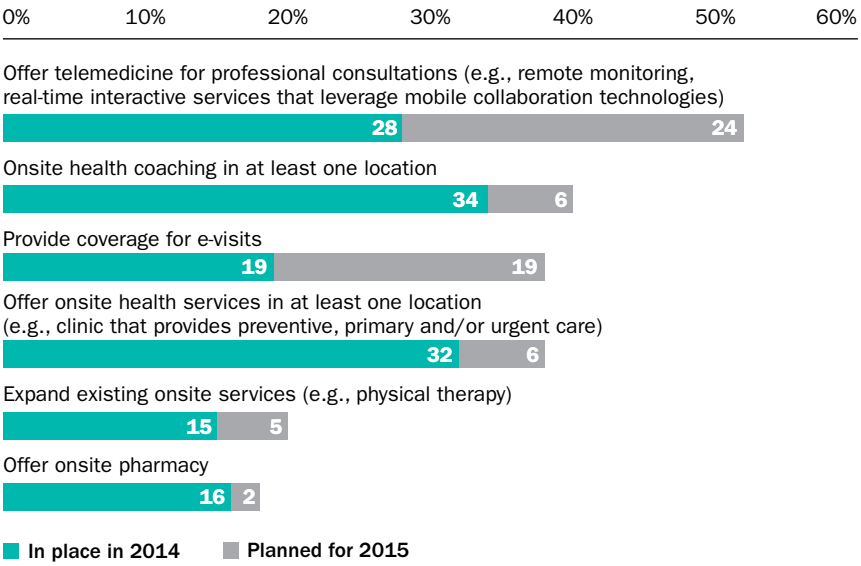


Figure 29. Alternative treatment and support settings



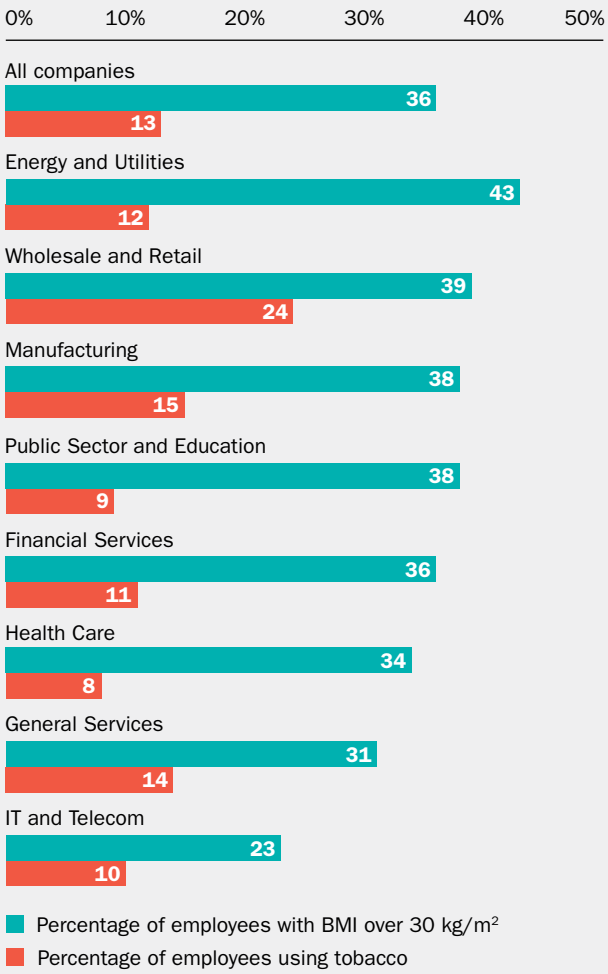
By next year, 77% of employers expect to integrate their health care plans' health management programs (up 20% over this year); 61% expect to require vendors to share data with each other for employee outreach (up 27%); 55% expect to formally track outcomes from all vendors (up 34%); 54% expect to use targeted gap-in-care messaging for both physicians and members (up 20%), and 45% expect to integrate multiple vendors to improve delivery of information to members through vehicles such as vendor summits *(Figure 28)*.

In addition, more and more employers expect to use new technology and other alternative approaches to open new access points for care *(Figure 29)*. By next year, 52% of employers expect to offer telemedicine for consultations (nearly double those in 2014), even though it typically accounts for modest savings. However, when telemedicine can provide a relatively low-cost alternative to emergency rooms or physician office visits for nonemergency health issues, it is also a productivity boost, saving travel and waiting time, and early adopters indicate that telemedicine is highly valued from an employee engagement perspective.

Also by 2015, 40% of employers expect to offer onsite health coaching in at least one location (up 17%); 38% expect to provide coverage for e-visits (twice as many as this year), and 40% expect to expand onsite health services for services such as physical therapy (a 33% increase). Even onsite pharmacies, now offered by only 16%, are expected to grow a bit.

What's the Difference?

Obesity and tobacco use by industry



Smoker surcharge by industry

	In use	Annual amount
All companies	42%	$520
Energy and Utilities	35%	$480
Financial Services	42%	$480
General Services	41%	$420
Health Care	41%	$600
IT and Telecom	34%	$420
Manufacturing	52%	$600
Public Sector and Education	13%	$480
Wholesale and Retail	48%	$480

Note: Medians

Tobacco Action

In 2014, 47% of companies **ban tobacco use** outside buildings/on campus, and **5%** ban hiring smokers (where legal).

In 2015, 54% plan to **ban tobacco use** outside buildings/on campus, and **7%** plan to ban hiring smokers (where legal).

86% of companies offer **smoking-cessation programs:** **31%** use rewards; **12%** use penalties.

Accountability and Engagement

Employers have become more aware of the importance of holding employees accountable for their own health and are using a wide range of strategies to engage them, including point-of-care cost sharing, ABHPs, incentives, onsite wellness activities, transparency tools and year-round communication support.

The use of incentives (rewards and penalties) to lower employer risk related to workforce health risk continues to grow significantly — with more focus on results than mere participation in programs. Requirements for rewards are increasingly linked to achievements measured against specific health standards. By next year, 58% of employers expect to reward or penalize employees based on tobacco use, a 38% increase over 2014 *(Figure 30)* and twice the number doing it in 2011. Outside of tobacco use, 22% of employers are using rewards and penalties to motivate employees to achieve certain biometric standards this year (e.g., weight control and cholesterol management), and more than twice as many (46%) expect to use them next year, nearly four times as many as used them in 2011.

As health plans continue to expand their price and quality transparency tools, employers are adopting them to give employees the information they need to make better consumer choices. In 2013, 43% reported offering these tools to employees. By next year, 60% say they will be using them, a 30% increase over 2014 *(Figure 31).*

Figure 30. Participatory and outcome-based incentives

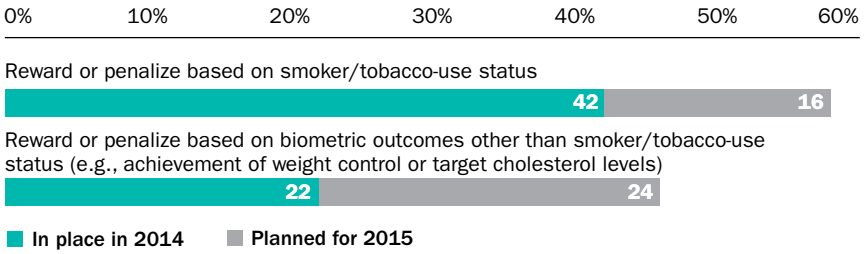
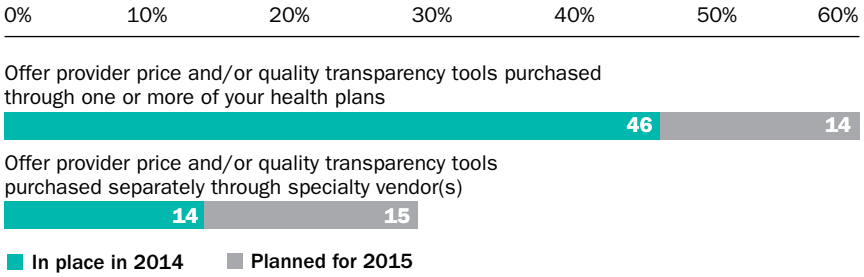


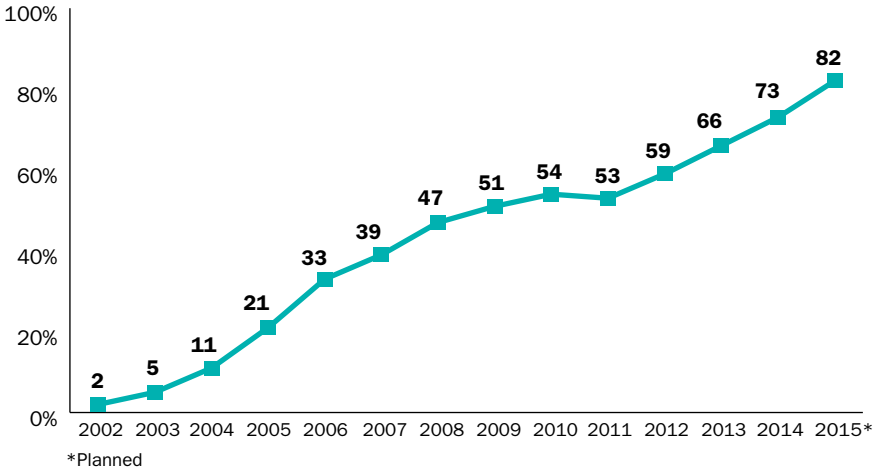
Figure 31. Transparency tools




Our research shows 69% of employers offer healthy behavior incentives to employees. Recognizing healthy behavior is a family issue, 56% of these employers also offer incentives to dependents. This could translate to an average of $500 for each employee and $1,000 for a family.

Account-Based Health Plans

Figure 32. Take-up in ABHPs on the rise



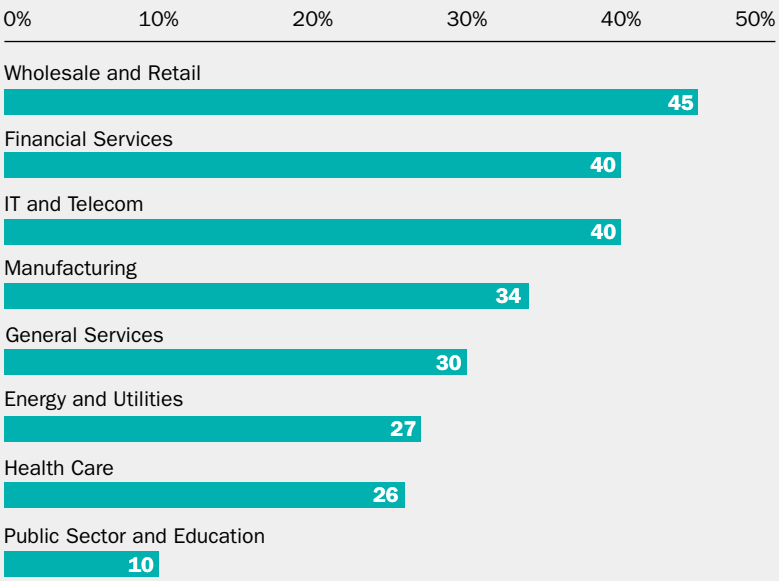
Tax-advantaged ABHPs,* new to the marketplace about 15 years ago, are now prevalent in every industry: 82% of employers expect to offer them by next year *(Figure 32).*

The effectiveness of ABHPs depends on a number of factors, including whether the plan is the only option offered, the size of the deductible, the percentage of employees who enroll in an ABHP, and whether ABHPs are used as a means of facilitating wellness initiatives and encouraging employee and member engagement in their health and well-being. Over the years, employers have taken steps to make ABHPs more attractive to employees by contributing funds to an account and subsidizing premiums at a higher level than other options they might offer. Increasingly, more companies are helping ease the transition to ABHPs through a year-round communication strategy and by incorporating education into retirement planning materials. Fifty-two percent (32% in 2013) have a year-round communication strategy, with another 20% planning to next year. Thirty percent include HSA education in retirement materials (19% in 2013), with another 22% planning it next year. These companies are also more likely to offer price and quality transparency tools and decision support tools for preference-sensitive care.

*We define an ABHP as a plan with a deductible offered together with a personal account (i.e., HSA or HRA) that can be used to pay a portion of employee medical expenses not covered by the plan. ABHPs typically include decision support tools that help consumers better manage their health, health care and medical spending. Contributions from both the employee and the employer can be carried over into subsequent years and into retirement.

What's the Difference?

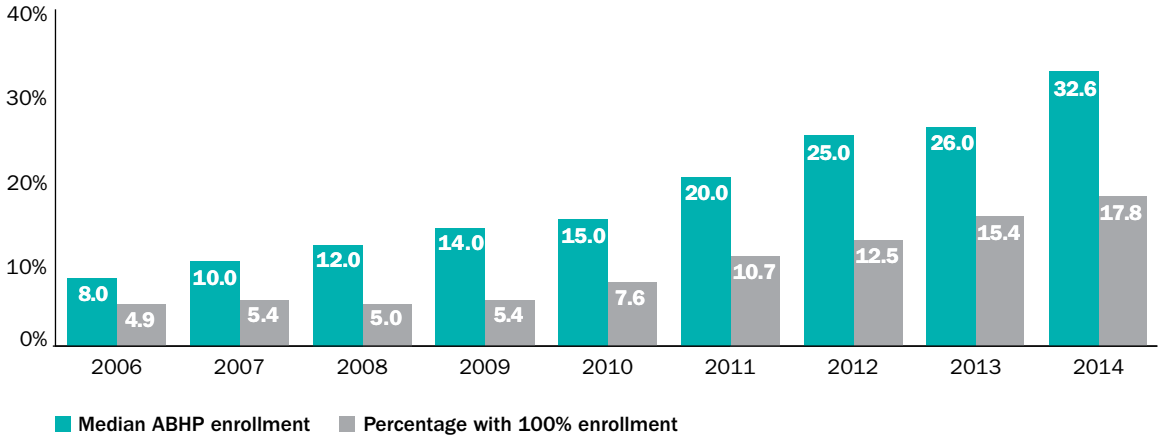
Median ABHP enrollment by industry



"More companies are helping ease the transition to ABHPs through a year-round communication strategy and by incorporating education into retirement planning materials."

By aligning their ABHP and health management strategies, companies have been able to move to a full-replacement ABHP more quickly — driving enrollment up significantly. Enrollment has increased from 15% to nearly 33% in four years, largely because employers replaced all their plans with ABHPs *(Figure 33).* Nearly 30% of employers expect to offer ABHPs as their only plan option in 2015; at the same time, ABHPs with HSAs and HRAs have risen steadily *(Figure 34).* Although participation is not required, nearly 80% of employers with an ABHP now contribute to an HSA, seeding the account with the hope that employees will also contribute *(Figure 35).*

Figure 33. ABHP enrollment rates are rising at a rapid pace



Note: Estimates are based on companies that offer an ABHP in various years — 2006 is based on the 12th annual Towers Watson/NBGH survey; 2007 is based on the 13th annual survey, etc.

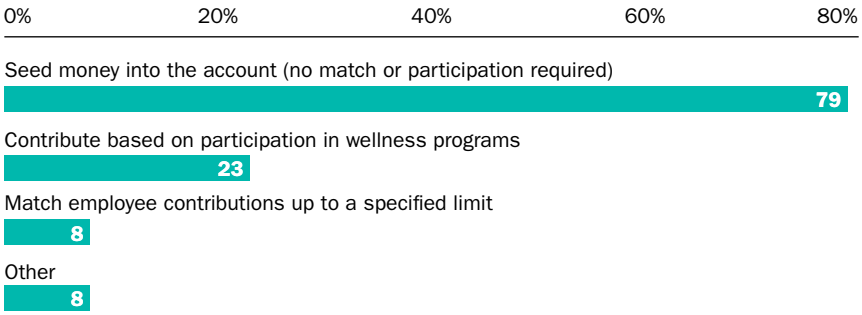
Figure 34. ABHP as the only plan option is on the rise

	2014	2015*
ABHP with HRA	**25%**	**30%**
ABHP with HSA	**63%**	**74%**
Contribute funds to an HSA	**54%**	**65%**
Offer an ABHP as our default plan option	**29%**	**44%**
Offer an ABHP as our only plan option	**16%**	**30%**
Offer an ABHP to collectively bargained employees	**24%**	**27%**
Subsidize premiums of ABHP plan(s) at a higher level than other plan options	**43%**	**51%**

Note: Based on all companies with or without an ABHP.

*Includes companies indicating "planned for 2015"

Figure 35. HSA contributions



Note: Based on companies with an ABHP that currently contribute money to an HSA

Best Performers: How They Got That Way and Where They Are Going

For the last four years, we have tracked a group of successful companies that distinguish themselves from their competitors by taking a strategic lead in workforce health improvement, employee engagement and accountability, provider accountability, technology, and workforce health and well-being — strategies that other companies are just beginning to adopt years later. These companies' financial results speak for themselves, including cost trends averaging 1.6% for 2010 – 2013, significantly below the median trend of 5.2%. (See Best Performers Manage to Lower Costs Significantly, page 10.)

Meanwhile, companies on the other end of the spectrum — those with an average cost trend of 9.2% — are beginning to take a page from the best performers' playbook as their need to contain costs and improve workforce health and well-being becomes more urgent.

Yet a comparison of the prevalence of the strategies used by both groups reveals why the best performers continue to have the advantage *(Figure 36)*. Across the board, they are focusing on emerging strategies we outlined as part of a glide path to sustainable organizational health care, including the top two focus areas of all companies: workplace culture and healthy lifestyle programs. But they are the only companies whose top five focus areas include two new emerging strategies: analyzing the viability of private exchanges and the use of new technologies to improve access to care.

Employers eager to emulate the results of best performers can look closely at their action plans for next year to get a glimpse of where employee health care is headed *(Figure 37)*.

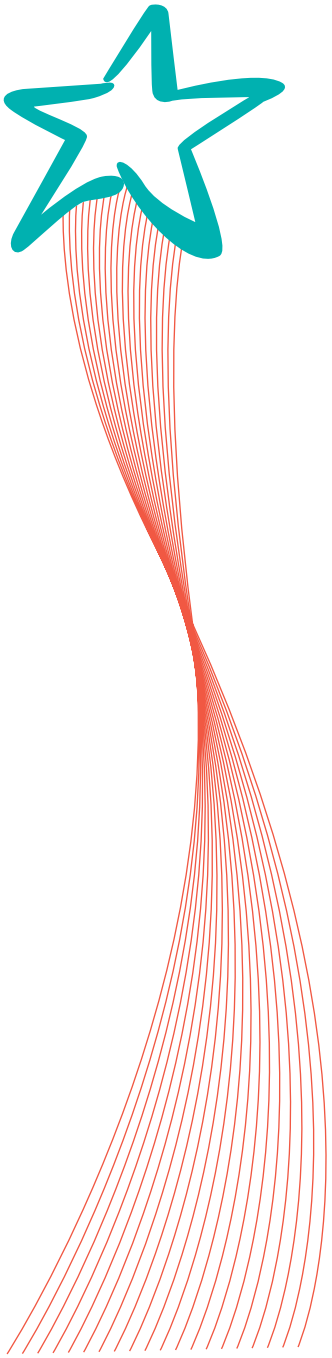
Figure 36. Top five focus areas of best performers and low performers in 2014

All companies		Best performers		Low performers	
Workplace culture	37%	**Viability of private exchanges**	41%	Healthy lifestyle activities	37%
Healthy lifestyle activities	36%	Workplace culture	34%	Financial incentives	37%
Avoid excise tax ceiling	31%	Healthy lifestyle activities	34%	ABHPs	34%
Financial incentives	29%	Financial incentives	34%	Workplace culture	31%
Total rewards review of health benefits	28%	**New technologies**	30%	Total rewards review of health benefits	28%

"Best performers are the only companies whose top focus areas include two emerging strategies: private exchanges and new technologies."

Figure 37. Top actions planned by best performers for 2015

Note: Responses indicate the percentage of best-performing companies that plan to add the tactic in 2015. Some best performers have already adopted these tactics prior to 2015.



Conclusion

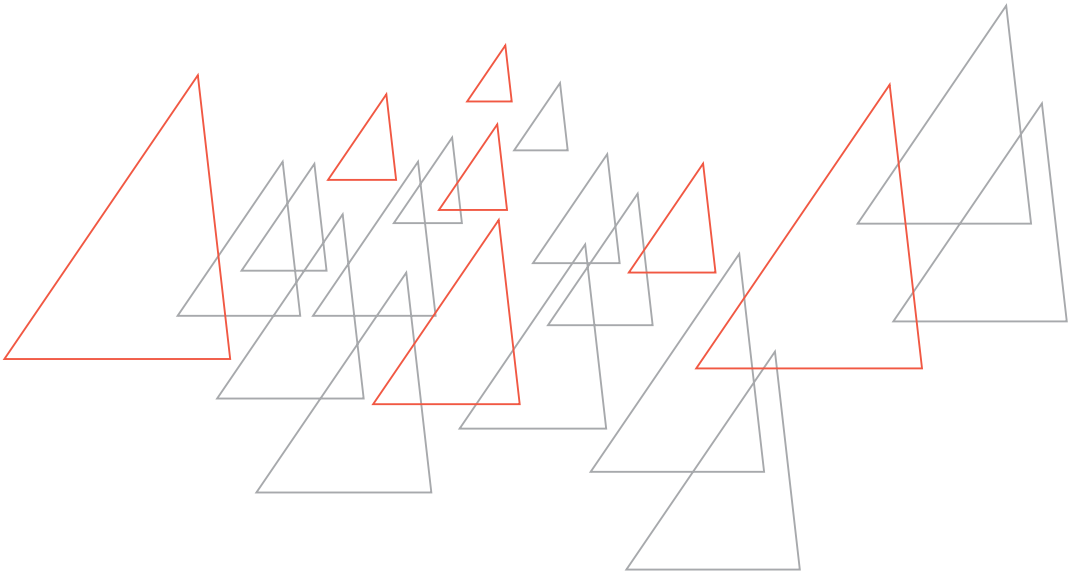
Driving Value in Health Benefit Programs Is More Critical Than Ever

As responses to this year's Towers Watson/NBGH Survey show, employers continue to take steps to derive the most value from their health benefit programs. In the current financial and competitive environment, these actions are more important than ever. Best performers are more assertive than other employers in taking steps to both improve their health cost trend and help employees manage their well-being. The best performers' health cost trend of 1.6% in 2013 was driven by several critical actions. In general, best performers:

- Design health plans that emphasize high performance
- Establish favorable contracts with pharmacy benefit managers and drive members to use generic drugs
- Understand and respond to the underlying population health risks of their employees
- Contract with highly effective partners (health plans, pharmacy benefit managers and providers) and aggressively negotiate financial terms with a growing focus on VBDs
- Establish coverage tiers based on the number of covered dependents

In our view — which is borne out by best performers' actions — employers that want their health plans to remain viable over the long term must take a holistic approach that focuses on five areas:

- **Benefit delivery channel optimization** including improvements to self-managed programs and exploration of alternatives such as private exchanges or hybrid arrangements
- **Benefit restructuring** including new plan options, benefit redesign, a recalibrated contribution strategy and tier structures, and a link between HSA strategy and the company's retiree health benefit approach
- **Network optimization and value-based contracting** including reductions in unit costs and improvements in efficiency, quality and outcomes, as well as risk transfer arrangements to providers
- **Population health management** including chronic-condition management improvements, risk factor reduction and care-gap improvement
- **Employee accountability and engagement** including use of quality and transparency tools, point-of-care cost-sharing designs, ABHPs and incentive approaches



About the National Business Group on Health

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

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Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With more than 14,000 associates around the world, we offer consulting, technology and solutions in the areas of benefits, talent management, rewards, and risk and capital management.

TW-NA-2013-34364

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