THE HEALTH BENEFITS LANDSCAPE FOR 2016 AND BEYOND
WHAT SIGNIFICANT TRENDS ARE GOING TO AFFECT EMPLOYERS’ DECISIONS

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Principal
Norfolk, VA
TODAY’S DISCUSSION

• Governmental Employers vs. the Private Sector
  – Current Health Benefit Environment
  – Historical Perspective
  – Benchmarks

• Affordable Care Act
  – What’s Next in 2016?
  – 2018 Excise Tax

• Planning for the Future
  – What Private Sector Employers are Doing

• Considerations for Governmental Employers
CURRENT HEALTH BENEFIT ENVIRONMENT

- Continued employer actions hold down per-employee health cost growth, but enrollment is rising.
- Private exchanges gain a foothold.
- CDHP use accelerates; enrollment jumps 5 points.
- Employers struggle with ACA administrative burden and threat of excise tax in 2018.
- Employee engagement still lagging.
- Provider networks evolving in new directions.
- Industry continues to innovate.
- Global view on health care & wellness engagement.
GOVERNMENTAL EMPLOYERS VS. THE PRIVATE SECTOR
HISTORICAL PERSPECTIVE

• Governmental employers have historically provided richer benefits to offset typically lower wage rates

• The Affordable Care Act (ACA) is forcing all employers to evaluate the cost of their benefit programs, and consider options to manage current and future costs

• Governmental entities must consider the external environment, re-evaluate their benefit strategies, and design options to avoid future cost drivers

Status Quo is no longer a viable option
## GOVERNMENTAL EMPLOYERS VS. PRIVATE SECTOR LARGE EMPLOYERS

<table>
<thead>
<tr>
<th></th>
<th>Government 500+ (n=223)</th>
<th>National 500+ (n=1,605)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Salary</td>
<td>$43,946</td>
<td>$58,833</td>
</tr>
<tr>
<td>Average Age</td>
<td>44</td>
<td>43</td>
</tr>
<tr>
<td>Average % of Ees who waive coverage</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>Retiree Medical coverage offered (on an ongoing basis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-Medicare retirees</td>
<td>71%</td>
<td>26%</td>
</tr>
<tr>
<td>• Medicare eligible retirees</td>
<td>50%</td>
<td>19%</td>
</tr>
<tr>
<td>Actuarial Value for Medical Plan Offered in 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For Lowest Cost Plan (or only plan)</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>• For Highest Cost Plan</td>
<td>86%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Source: Mercer’s National Survey of Employer-Sponsored Health Plans 2014
## GOVERNMENTAL EMPLOYERS VS. PRIVATE SECTOR LARGE EMPLOYERS

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<th>Government 500+ (n=223)</th>
<th>National 500+ (n=1,605)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Medical Plan Cost per Active Ee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PPO</td>
<td>$11,796</td>
<td>$11,121</td>
</tr>
<tr>
<td>• HMO</td>
<td>$12,575</td>
<td>$11,719</td>
</tr>
<tr>
<td>• HSA-eligible CDHP</td>
<td>$10,872</td>
<td>$8,732</td>
</tr>
<tr>
<td><strong>Average Monthly Contribution for Employee Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PPO</td>
<td>$80</td>
<td>$126</td>
</tr>
<tr>
<td>• HMO</td>
<td>$71</td>
<td>$125</td>
</tr>
<tr>
<td>• HSA-eligible CDHP</td>
<td>$61</td>
<td>$73</td>
</tr>
<tr>
<td><strong>Average Monthly Contribution for Family</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PPO</td>
<td>$283</td>
<td>$441</td>
</tr>
<tr>
<td>• HMO</td>
<td>$258</td>
<td>$450</td>
</tr>
<tr>
<td>• HSA-eligible CDHP</td>
<td>$266</td>
<td>$303</td>
</tr>
</tbody>
</table>

Source: Mercer’s National Survey of Employer-Sponsored Health Plans 2014
GOVERNMENTAL EMPLOYERS VS. PRIVATE SECTOR
BENEFIT PROGRAM DIFFERENCES

The gap between Governmental Employer plans and those of the Private Sector will further widen, here’s why…
ACA REQUIREMENTS
WHAT’S NEXT?
THE ISSUE: Whether an IRS rule correctly permits all public insurance exchanges to provide premium subsidies or instead should limit subsidies to state-run exchanges.

WHAT WILL HAPPEN IF THE IRS RULE IS INVALIDATED?

- Subsidies continue in state run exchanges.
- Subsidies end in federally run exchanges.
  - More uninsured & more uncompensated care for providers.
  - Public exchanges in those states predicted to face lower enrollments, sicker enrollees.
- Likely some federally run states will become state run.
- Lessened employer exposure to assessments (not eliminated, particularly exposure to “a” payment).
  - Will depend on where employees live.
- Likely to affect employer exit strategies for actives and retirees.
- Other ACA requirements continue.
- Possible legislative responses….
FIVE YEARS AGO, LARGE EMPLOYERS WERE THREE TIMES AS LIKELY TO BELIEVE THEIR ORGANIZATION WOULD TERMINATE HEALTH COVERAGE

Sources:
Mercer Survey, Health Care Reform Five Years In, 2015.
ONGOING AREAS OF SIGNIFICANT CONCERN FOR EMPLOYERS UNDER THE ACA

**Increased Administrative Burden** 78%

**40% Excise Tax** 62%

Source: Mercer’s Survey on Health Care Reform in 2014
THE ADMINISTRATIVE BURDEN – THERE’S MORE AND IT’S COMPLICATED
ACA REPORTING BEGINS IN 2016 (FOR 2015 DATA)

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Minimum Essential Coverage (§ 6055)</th>
<th>Employer Shared Responsibility (§ 6056)</th>
<th>2016 Due Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Enforce individual mandate.</td>
<td>Enforce employer mandate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Validate public exchange premium</td>
<td>Validate public exchange premium subsidy eligibility.</td>
<td></td>
</tr>
<tr>
<td><strong>Who Reports</strong></td>
<td><strong>Every entity</strong> providing MEC to an individual.</td>
<td><strong>Every large employer</strong> with 50 or more full-time or equivalent employees</td>
<td></td>
</tr>
<tr>
<td><strong>IRS Reporting</strong></td>
<td>Include <strong>all covered individuals</strong> enrolled in MEC.</td>
<td>Include <strong>each full-time employee</strong>.</td>
<td>E-file: March 31, Paper: Feb. 29</td>
</tr>
<tr>
<td><strong>Individual Reporting</strong></td>
<td>To each “responsible individual” who enrolls self or others in MEC.</td>
<td>Each employee who was full time for at least one month during reporting year.</td>
<td>February 1</td>
</tr>
</tbody>
</table>
THE 40% EXCISE TAX ON HIGH-COST HEALTH PLANS

- **40% excise tax** starting in 2018 on “high cost” employer-sponsored coverage.
  - Employees include former employees and surviving spouses, and other primary insured individuals.
  - Tax is on the “excess benefit” (the amount over the dollar caps).
- Initial cap set at **$10,200/self-only** and **$27,500 “coverage other than self-only”** (family).
  - Higher thresholds ($11,850/$30,950) for retirees at least age 55 and not Medicare-eligible and workers in high-risk professions.
  - Higher threshold ($27,500) for single multiemployer plan coverage.
  - Complex cost indexing and adjustments may apply.
- Final guidance has not been issued.

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### Include in the calculation

- **Employee and employer share** of major medical cost/premium (e.g., PPO, HMO, HDHP, Rx) – including executive medical/physical benefits and some expatriate benefits
- **Health FSA, including pre-tax salary reductions.**
- **HRA**
- “Employer contributions” to an HSA, including pre-tax salary contributions.
- On-site primary care medical clinics (providing more than minimal services).
- Medigap, TRICARE supplemental insurance, and other “similar supplemental coverage”
- Stand-alone, self-insured dental and vision plans*
- Employee Assistance Programs*

*IRS considering excluding if excepted benefits.
Employers that will be subject to the tax if they make no changes to their current plans

33%

Source: Mercer’s National Survey of Employer-Sponsored Health Plans, 2014; Large employers 500+.

Do You Know When Your Current Medical Plans Will Hit the Threshold?

It’s not too early!

All you need for an estimate is:

- Number of employees by tier
- Annual cost by tier

http://mercerexcisetax.scrollmotion.com/
WHAT ARE EMPLOYERS DOING, OR CONSIDERING TO MINIMIZE THE IMPACT OF THE EXCISE TAX ON HIGH-COST PLANS?

- Drop high-cost plan(s): 34% Considering, 17% Have taken action
- Steer more employees into existing CDHP: 22% Considering, 38% Have taken action
- Implement a CDHP: 23% Considering, 48% Have taken action
- Raise deductibles or other cost-sharing provisions: 48% Considering, 28% Have taken action
- Add or improve wellness programs: 43% Considering, 34% Have taken action

Source: Mercer, Survey, Health Care Reform Five Years In, 2015
PLANNING FOR THE FUTURE
WHAT PRIVATE SECTOR EMPLOYERS ARE DOING?
Respondents’ costs were analyzed based on their use of more than 25 cost-management best practices across three categories:

- **Plan Design**
- **Employee Well-Being**
- **More Advanced Strategies**

### National (500+ employees): $11,641

- **$11,432**
- **$12,132**

**Projected change in cost for 2015**:

- Employers using 16+ best practices: **4.3%**
- Employers using 7 or fewer best practices: **3.7%**

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*After changes to plan design*
INNOVATIVE APPROACHES PROVIDE ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS

“TAKE ACTION” LEVERS

Workforce Health
- Culture of health
- Behavioral economics of incentives
- Whole person view of wellness

Delivery Infrastructure
- Exchange solutions
- Contribution equity
- Vendor partners

Care Delivery
- Prevention
- Retail and technology providers
- ACOs and tiered networks

Consumer Accountability
- Design and accounts
- Transparency tools
- Voluntary customization

Absence and Disability
- Disability insurance
- Leave management
- Productivity measures

Innovation Spectrum

Important Objective for All Employers:
- Save money
- Improve health
- Simplify delivery
- Enhance value
- Better quality

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ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS
WORKFORCE HEALTH

“TAKE ACTION” LEVERS

WORKPLACE ENVIRONMENT THAT SUPPORTS CULTURE OF HEALTH

PLAN-BASED AND/OR OUTCOMES-BASED INCENTIVES

EFFECTIVE PROGRAM & VENDOR INTEGRATION

DATA-DRIVEN SOLUTIONS TO ADDRESS KEY HEALTH RISKS

PERSONALIZED INCENTIVES TO DRIVE ENGAGEMENT

COMPREHENSIVE, 3–5 YEAR STRATEGIC PLAN IN PLACE TO EVOLVE PROGRAM
WORKFORCE HEALTH INCENTIVES

Financial incentives clearly improve participation rates in key health management programs

More employers are driving engagement through financial incentives, most often cash or contribution reductions

Large employers using incentives report higher participation rates

*Average % of identified persons actively engaged in program

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Large employers are moving more slowly to add outcomes-based incentives

Offer lower premium contributions to non-tobacco users

Provide incentives for achieving or maintaining targets for BP, BMI, cholesterol

Median reduction in annual premium: $480
Large employers are using a range of activities and technologies to provide a more engaging member experience.

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
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</thead>
<tbody>
<tr>
<td>Worksite biometric screening event</td>
<td>59%</td>
</tr>
<tr>
<td>Business unit / location group challenges</td>
<td>44%</td>
</tr>
<tr>
<td>Onsite exercise or yoga classes or weight loss programs (such as Weight Watchers)</td>
<td>50%</td>
</tr>
<tr>
<td>Personal challenges</td>
<td>41%</td>
</tr>
<tr>
<td>Peer-to-peer support</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TECHNOLOGY-BASED RESOURCES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile apps</td>
<td>31%</td>
</tr>
<tr>
<td>Devices to monitor activity</td>
<td>35%</td>
</tr>
<tr>
<td>Devices to transmit health measures to providers</td>
<td>10%</td>
</tr>
<tr>
<td>Onsite kiosks</td>
<td>9%</td>
</tr>
<tr>
<td>Other web-based resources / tools</td>
<td>47%</td>
</tr>
</tbody>
</table>
ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS

CARE DELIVERY

“TAKE ACTION” LEVERS

- Workforce Health
- Delivery Infrastructure
- Absence and Disability
- Consumer Accountability
- Care Delivery

BEST PRACTICE ELEMENTS

- High Performance Network with Incentives
- Center of Excellence Steerage
- Pay for Performance and Promotion of ACOS
- Onsite Clinics (where appropriate)
Innovations that reward high-quality, efficient providers are growing among the largest employers

- Surgical centers of excellence: 41% in place in 2014, 37% in place in 2013
- High performance networks: 34% in place in 2014, 27% in place in 2013
- Accountable care organizations: 33% in place in 2014, 25% in place in 2013
- Medical homes: 20% in place in 2014, 13% in place in 2013
- Reference-based pricing: 15% in place in 2014, 12% in place in 2013

*Employers with 20,000 or more employees
WITH 370+ FORMAL ACOS CURRENTLY IN THE MARKET, AND HUNDREDS OF ADDITIONAL PILOTS BEING TESTED, THE SHIFT TO VALUE IS UNDERWAY

National ACO activity¹

There are over 370 ACOs with shared savings or risk financial models, and ~150 more who are actively preparing

Updated as of September 2013. Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis; 1. ACOs defined as providers participating in Pioneer ACO, Medicare Shared Savings, a Medicaid ACO, PGP Transition, or in a shared savings/risk arrangement with a commercial payer; Prep activity defined as participation in a learning collaborative or providers preparing to become an ACO
ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS

DELIVERY INFRASTRUCTURE

“TAKE ACTION” LEVERS

BEST PRACTICE ELEMENTS

- STRATEGIC MARKETING & CONTRACTING
- REGULAR AUDITS OF MAJOR VENDORS
- DATA WAREHOUSE FOR PROGRAM MANAGEMENT
- CONFIGURED BENEFITS PLATFORM WITH MEMBER ADVOCACY TOOLS
- ANNUAL VENDOR SUMMITS
- LEADERSHIP DASHBOARDS ON PROGRAM PERFORMANCE

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Private health benefit exchanges gain a foothold as interest continues to build

For active employees: 28% use now, 3% expect to use within 5 years

For pre-Medicare-eligible retirees*: 28% use now, 8% expect to use within 5 years

For Medicare-eligible retirees*: 15% use now, 17% expect to use within 5 years

* Among current retiree medical plan sponsors; data reflects large employers
ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS

CONSUMER ACCOUNTABILITY

“TAKE ACTION” LEVERS

BEST PRACTICE ELEMENTS

CDHP WITH HSA

DEFINED CONTRIBUTION APPROACH WITH RANGE OF PLAN OPTIONS

SPOUSAL COVERAGE PROVISIONS

TRANSPARENCY TOOLS

HIGHER COST-SHARE FOR DEPENDENT COVERAGE TIERS

VOLUNTARY BENEFIT PROGRAMS

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Average PPO deductible for individual, in-network coverage

Small employers:
- 2009: $1,113
- 2010: $1,192
- 2011: $1,410
- 2012: $1,452
- 2013: $1,663
- 2014: $1,681

Large employers:
- 2009: $511
- 2010: $565
- 2011: $587
- 2012: $666
- 2013: $684
- 2014: $785

+15%
CONSUMER ACCOUNTABILITY
CDHP GROWTH

Nearly a fourth of all covered employees are enrolled in a consumer-directed health plan (large employers)

By 2017, 66% of large employers expect to offer a CDHP

Majority of large employers expect to offer a CDHP by 2017 – but most see it as an option, rather than a full replacement

Percent of employers offering CDHPs
Percent of covered employees enrolled in CDHPs

Small employers (10-499 employees)
Large employers (500+ employees)

By 2017 (projected)

Percent of employers offering CDHPs

Percent of covered employees enrolled in CDHPs

By 2017, 66% of large employers expect to offer a CDHP as the only plan to at least some employees within the next 3 years

By 2017, 66% of large employers expect to offer a CDHP as the only plan to at least some employees within the next 3 years.
CONSUMER ACCOUNTABILITY
VOLUNTARY BENEFITS

As employers add lower-cost plan choices, voluntary benefits provide employees the opportunity to supplement them.

PROFILE OF A SUCCESSFUL VOLUNTARY PROGRAM
✓ Employee-valued products
✓ User-friendly platform
✓ Multi-faceted enrollment solutions
✓ Robust education and communication program
✓ Program coordination

Why employers offer a voluntary benefits program

- Help drive participation in lower-cost plans: 20%
- To maintain employee benefit options as core benefit plans change: 39%
- Accommodate employee requests: 60%
- Offer additional benefits at no cost to the employer: 67%
- Give employees opportunity to fill gaps in employer-paid benefits: 77%
CONSUMER ACCOUNTABILITY
SPOUSAL COVERAGE PROVISIONS

The largest employers are adding surcharges for employees’ spouses with other coverage available

Employers with 500 or more employees

- Spouses with other coverage are not eligible: 7% in 2013, 9% in 2014
- Spouses with other coverage must pay surcharge: 9% in 2013, 9% in 2014

Employers with 20,000 or more employees

- Spouses with other coverage are not eligible: 20% in 2013, 27% in 2014
- Spouses with other coverage must pay surcharge: 3% in 2013, 5% in 2014

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ACTIONABLE COST CONTAINMENT LEVERS FOR EMPLOYERS
ABSENCE AND DISABILITY

"TAKE ACTION" LEVERS

- Workforce Health
- Care Delivery
- Delivery Infrastructure
- Absence and Disability
- Consumer Accountability

BEST PRACTICE ELEMENTS

- Integration with Well-Being Programs
- Work Enabling Benefits
- Encourage Return to Work through Incentives
- Robust Disability/Leave Tracking & Reporting
ABSENCE AND DISABILITY
TOP STORIES

• Employers are concerned about indirect costs of absence

• Measuring and reducing the impact on operations is a top priority for over two-fifths of survey respondents

• Outsourcing of FMLA administration has increased significantly over the past six years

• Musculoskeletal conditions and cancer are the most costly disabilities under the STD/SC/EIB plan and cancer and depression/anxiety/mental health are the fastest-growing disabilities

• Use of PTO plans is accelerating

• Over a quarter of employers do not have a company policy or guideline for termination of employee status when on LTD

• Over half of employers have not considered the impact of ACA on their absence and disability programs

More than half of survey respondents say senior management is concerned about the indirect costs of absence – which Mercer estimates to be at least as much as the direct cost

Source: Mercer’s Absence and Disability Management Survey 2013
INVESTMENT IN INNOVATION

LEGEND KEY
- Low Employee Impact
- Moderate Employee Impact
- High Employee Impact

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CONSIDERATIONS FOR GOVERNMENTAL EMPLOYER PLANS…

| Recognize a changing competitive benefit landscape | • ACA is forcing Private Sector employers to aggressively manage benefit costs  
• Consider risk of being “benefit plan of choice” for two income households |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Develop a Strategic Plan                            | • Establish a vision for the future, with specific steps your organization will take to transition from the current to a future state  
• Write it down! |
| Have the courage to be a leader and not a follower   | • Over the next several years, Private Sector employers will significantly change how they deliver benefits  
• Lagging trends in the market may result in significantly higher plan costs |
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