United States

Performance

in an Era of Uncertainty

2012

17th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care

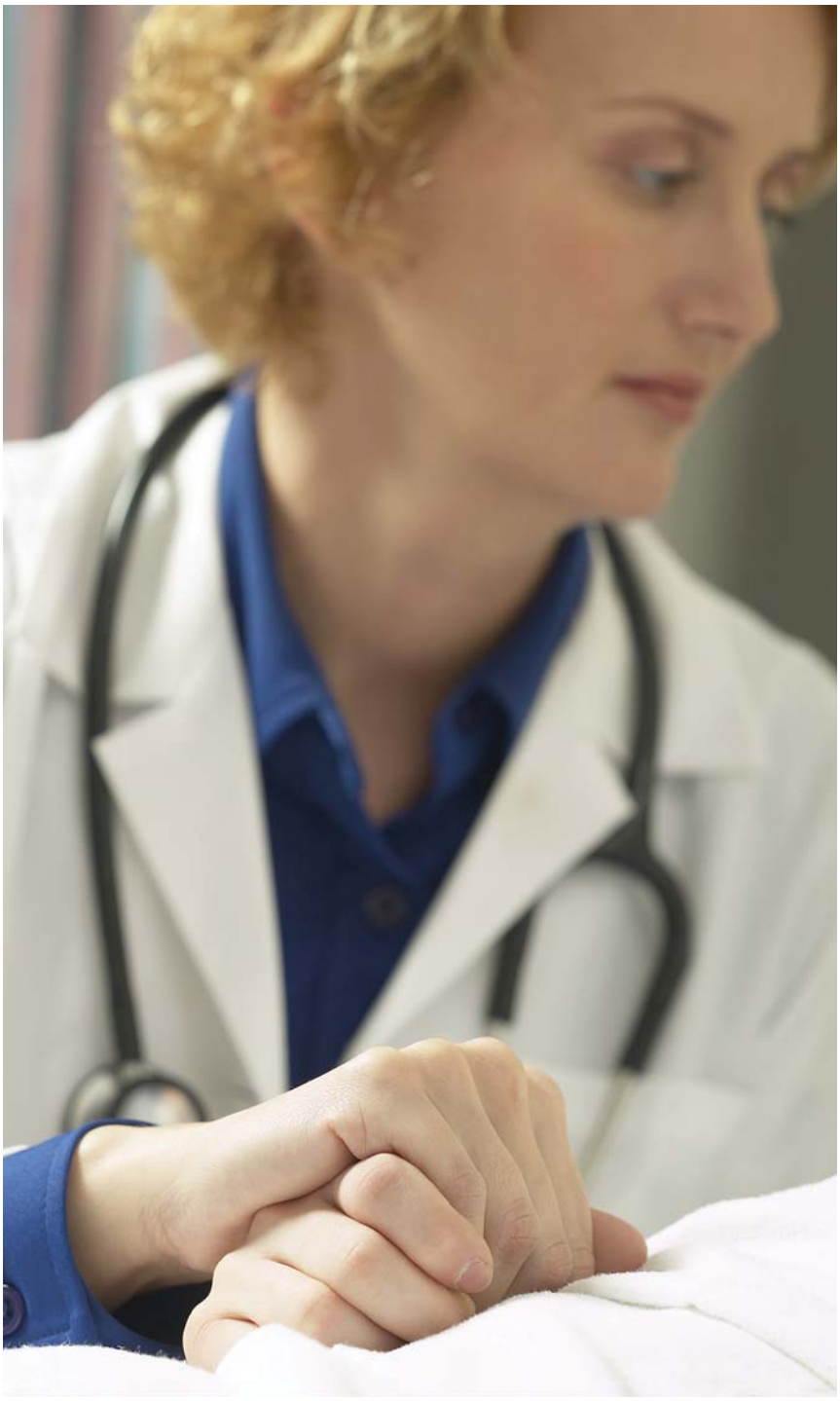
National Business Group on Health

TOWERS WATSON

United States

2012

Employer Survey on Purchasing Value in Health Care



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Executive Summary

The 2012 Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care provides many strategic insights into the actions and plans of leading U.S. employers. It also offers views of what the future of employer-provided health care in the U.S. may look like this year and in the coming three years.

This analysis comes at a time when employers are still facing a number of long-term challenges, such as controlling growing costs, improving employee engagement and accountability, and optimizing the total rewards mix. They are also determining how they'll comply with health care reform legislation (the Patient Protection and Affordable Care Act, or PPACA), with major implications scheduled to begin taking effect in less than two years, while keeping an eye on the game-changing impact of a Supreme Court challenge in June and a presidential election in November.

At the same time, employees continue to face a growing affordability gap as their out-of-pocket health care costs rise at a higher rate than their income and the Consumer Price Index (CPI), and it becomes more difficult to save for retirement.

Amid the political, legislative and judicial uncertainty, most employers are steadfast in their commitment to keeping active health care benefits as a central component of their employee value proposition. Through 2015, most employers will remain focused on optimally managing the design and delivery of their programs, with a select number tailoring their designs to facilitate the availability of federal subsidies in the Exchanges (in 2014 under the PPACA) for a portion of their workforce.

Total rewards is becoming a key driver in the employee value proposition at companies as employers use the significant changes to the U.S. health care system as an opportunity to revisit their entire reward portfolio. In particular, they are seeking to balance benefits with employees' need for access to affordable health care, a secure retirement and a competitive salary. They are also looking at the new roles both employees and vendors can play to help improve the overall health of employees and better address high-cost areas, such as chronic disease and complex care management. Finally, they are trying to manage the difficult task of controlling health care cost increases and lowering trend.

Our survey of 512 participants with a collective $87 billion in total 2011 health expenditures provides directional insights and details on their current programs, strategies and planned actions. As we analyzed their responses, we were able to identify a group of employers whose consistent performance stood out: They have maintained cost increases at or below the Towers Watson/National Business Group on Health (TW/NBGH) median for the past four years. The way these employers manage their health benefit programs provides vital insights for everyone studying health care trends today. The following overview of the survey findings highlights key trends influencing health care benefits today as companies build more decisive health care strategies for the years ahead.

Key Themes

Health care costs continue to grow — trend of 5.9% expected

Average total health care costs per employee are expected to reach $11,664 in 2012, up from $10,982 in 2011. Employers are taking more aggressive steps to manage these costs with greater emphasis on employee accountability, while concurrently investing in the programs and emerging technologies to support and cultivate a healthy and productive workforce. To help hold the line on costs, employers are also working with their health plan vendors and altering plan designs to improve the quality and efficiency of care received by members.

Affordability issues are a growing challenge

Trends remain double the rate of inflation. Employees' share of premium costs increased 9.3% between 2011 and 2012, with the dollar burden rising from $2,529 to $2,764. In fact, employees contribute nearly 40% more for health care than they did five years ago, compared with 34% for employers. Likewise, out-of-pocket expenses increased over the last year from 16% to 18%. That increase is partly due to subsidy shifts for dependents, as nearly half of companies increased employee contributions in tiers with dependent coverage. About a quarter of companies (24%) are using spousal surcharges, with another 13% planning to do so next year.

- The total employee cost share, including premiums and out-of-pocket costs, has climbed from 33.2% in 2011 to 34.4% in 2012.

"The out-of-pocket increase is partly due to subsidy shifts for dependents, as nearly half of companies increased employee contributions in tiers with dependent coverage."

Consistent performers are set up for long-term success

The median trend for employers that have maintained cost increases at or below the TW/NBGH median for the past four years (our consistent performers) was 2.2%, compared with 6.1% for all respondents. The findings of this year's analysis clearly show that the most successful companies stand above their competitors by making significant strides in six core areas:

- **H**ealth improvement
- **E**ngagement
- **A**ccountability
- **L**inking provider strategies
- **T**echnology
- **H**ealthy environment

Employers confirm their commitment to providing health care benefits for active employees, but long-term confidence declines sharply

Many employers are steadfast in their commitment to their active health care benefits as a central component of their employee value proposition. Through 2015, most employers will remain focused on optimally managing the design and delivery of their programs, with a select number tailoring their designs to facilitate the availability of federal subsidies in the Exchanges for a portion of their workforce. Looking to the end of the coming decade, employers are much less confident that health care benefits will be offered at their organization.

- Only 3% of employers are somewhat or very likely to discontinue health care plans for active employees with no financial subsidy in 2014 or 2015.
- 45% are somewhat to very likely to offer an employer-sponsored health plan to only a portion of their population and direct ineligible employees to the Exchanges.
- Today, 23% of companies are very confident that they will continue to offer health care benefits for the next 10 years, down from a peak of 73% in 2007.

Insurance Exchange openings will have a strong impact on retiree medical plans

The availability of insurance Exchanges coupled with changes to Medicare will lead many employers to exit sponsorship of retiree medical programs. However, many companies will provide a softer landing for current retirees by offering them account-based defined contribution alternatives that will make it easier to purchase insurance in the individual marketplace. Active employees and new hires will likely see a more significant shift in their company's role in their retiree health care coverage, although the growth in account-based health plans (ABHPs), which provide a tax-favorable savings opportunity, could provide an important and valuable vehicle for many of these employees.

Four out of 10 employers view subsidizing health care benefits for retirees of no importance to their employee value proposition.

- 8% of employers with retiree medical programs plan to make changes to their subsidy in 2013, and an additional 20% are considering making changes in 2014 or 2015.
- While only 10% of employers with retiree medical programs currently offer a retiree medical account, 4% are planning to offer them by 2013, and another 18% are considering them in 2014 or 2015.

Putting health and other benefits in a total rewards context is on the rise

As employers revisit their entire reward portfolio and seek to balance benefits with employees' need for a secure retirement and a competitive salary, some are quantifying the impact of changes to their reward programs, including health care benefits, on critical employee behaviors and actions, such as retention or engagement. They are using the data to reallocate reward programs and budget in ways that ensure the program delivers the highest potential value to employees for the lowest cost to the company.

- A top focus for nearly a quarter of employers is to review health care benefits as part of their total rewards strategy.

Employers are looking for success by improving vendor transparency and accountability

Employers have been asking for more from their health plan vendors — particularly in two areas: helping engage employees in better managing their health, and providing greater transparency on prices and quality. Although frustrations linger about the effectiveness of health plan vendors in these areas, plan services show signs of improvement in providing members with information to make clinical decisions concerning preference-sensitive care, identifying gaps in care and engaging members in health improvement programs.

- 38% of employers say their vendors offer only to a slight extent — if at all — a center of excellence (COE) network of facilities that provide the best outcomes and reasonable prices for procedures.
- Just 12% of employers say their vendors engage members in health improvement programs to a great or very great extent.
- While 34% of all respondents will require vendors to provide complete extracts of claim data (including discounts and identification of providers) in 2012, another 12% plan to do so in 2013.
- This year, 44% of employers will require vendors to share data for employee outreach and integrated reporting; another 16% plan to add that requirement in 2013.

"Four out of 10 employers view subsidizing health care benefits for retirees of no importance to their employee value proposition."

Use of ABHPs is surging but must be part of a broader strategy to be effective

Account-based health plans can be an important element in an organization's health benefit management if the right incentives and employee education are attached. Today, 59% of companies have an ABHP in place, with another 11% expecting to add one by 2013. But ABHPs will not necessarily result in lower costs without significant enrollment. Our results show that employers that take a comprehensive approach to ABHPs (e.g., increasing employee and provider accountability while at the same time helping to cultivate smarter health care consumers) are the ones that have gained the greatest advantage. Using a health savings account (HSA) can also effectively align with an employer's retirement strategy by providing employees with a tax-advantaged vehicle to pay for current costs while accumulating wealth for retirement.

- Total replacement ABHPs are also on the rise, representing nearly 12% of companies with an ABHP — up from to 7.6% in 2010.
- ABHP enrollment has nearly doubled in the last two years — surging from 15% in 2010 to 27% in 2012, and the move toward total replacement ABHPs is continuing.
- About 10% of respondents say employees and dependents enrolled in an ABHP are better at reducing lifestyle risks than those enrolled in non-ABHPs.
- Nearly four out of 10 companies currently consider their HSA for actives part of their retiree medical strategy, and another 20% are planning or considering such a strategy over the next three years.

"Account-based health plans can be an important element in an organization's health benefit management if the right incentives and employee education are attached."

Expansion of employee incentives to improve health continues

Although engaging employees to better manage their health is an ongoing challenge, companies have expanded their use of financial rewards to employees and their spouses to encourage participation in health management programs. These programs have become significant elements in the HR toolbox. In fact, more than two-thirds of respondents offer incentives today. This is hardly surprising since competitive pressure and the pace of change have increased the demands on everyone at all levels of any company. Companies have also been more willing to add penalties to their arsenal (used by 20% today), and some (10%) have adopted achievement standards. It's likely that achievement-based incentives will continue to grow as companies look to employees to change unhealthy life choices (lose weight and lower blood pressure), an important priority.

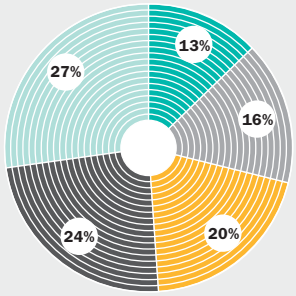
- Nearly one-third of employers plan to adopt or expand the use of financial incentives to encourage healthy behaviors as a main focus of their organizational health strategy. Conversely, one-fifth believe lack of sufficient financial incentives to encourage participation in programs is a major obstacle to changing employee behavior related to health.
- 43% of employers provide incentives to encourage participation in biometric screenings, and 30% offer incentives to engage in healthy lifestyle activities in the workplace.
- Employers are embracing incentives to encourage use of high-performance networks. While only 9% currently use incentives for this purpose today, 23% are planning to use them in 2013.

About the Survey

The 17th Annual National Business Group on Health/Towers Watson 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 were also asked about specific implications for their health care benefit programs attributed to the PPACA.

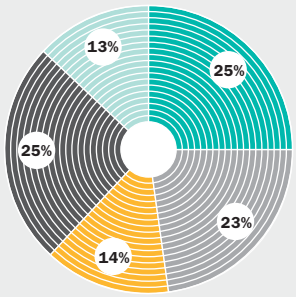
The survey was completed by 512 employers, between December 2011 and January 2012, and reflects respondents' 2011 and 2012 health program decisions and strategies and, in some cases, their 2013 plans. Respondents collectively employ 9.2 million full-time employees, have 8.0 million employees enrolled in their health care programs and operate in all major industry sectors (*Figures 2* and *3*). In 2011, respondents spent, on average, $10,982 per employee on health care, which equates to a collective $87 billion in total health care expenditures.

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



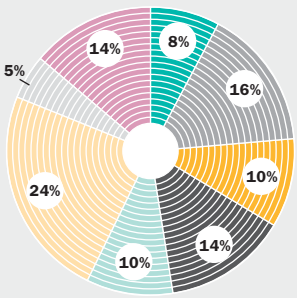
- **13%** 1,000 to 2,500
- **16%** 2,500 to 5,000
- **20%** 5,000 to 10,000
- **24%** 10,000 to 25,000
- **27%** 25,000+

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



- **25%** National
- **23%** Northeast
- **14%** South
- **25%** Midwest
- **13%** West

Figure 3. Industry groups



- **8%** Energy and Utilities
- **16%** Financial Services
- **10%** General Services
- **14%** Health Care
- **10%** IT and Telecom
- **24%** Manufacturing
- **5%** Public Sector and Education
- **14%** Wholesale and Retail

Cost Trends

Active Employees

Over the last five years, we have witnessed the longest period of stability in health care cost increases since this survey began in 1995. Medical cost trends have stabilized between 5% and 7% since 2007 after plan design and contribution changes *(Figure 4)*. In 2011, costs rose 5.4% compared with 6.0% in 2010 and are expected to increase by 5.9% in 2012. To put this stabilization in context, it is important to realize that without changes to plan design and increases in employee contributions, average cost trends would have been 8% in 2011 and anticipated to be only slightly lower (7.4%) next year.

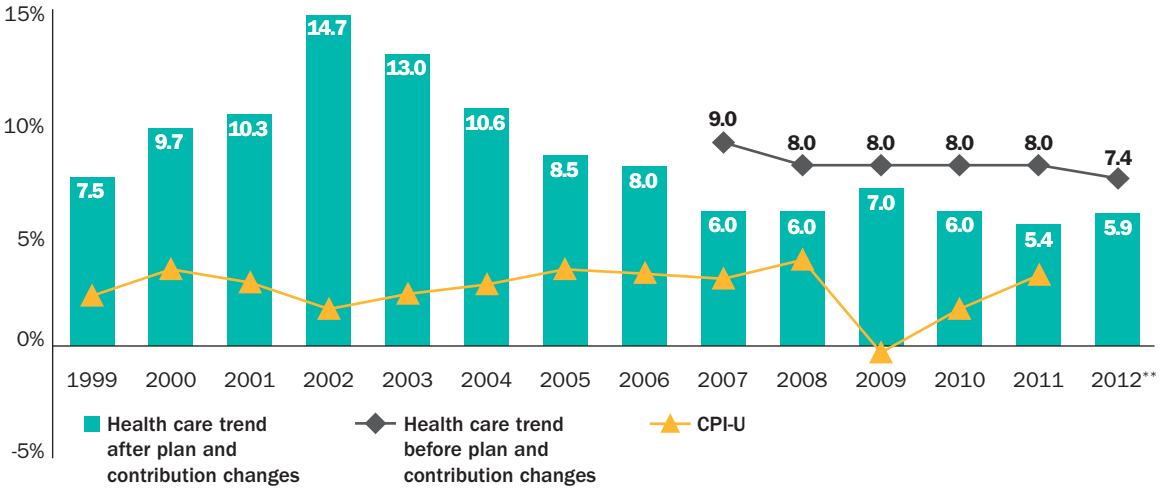
While increases in health care costs have leveled off at historically low levels, they are nonetheless growing at about twice the rate of the general CPI. Equally important to note, health care cost trends have outpaced wage growth for more than a decade. In fact, wages have been rising between 2.0% and 3.5% annually for much of the last decade, dipping to 1.5% over the last three years.[1] The slower pace of health care cost trends, then, does not diminish the growing affordability challenge for active employees, who see an increasing share of their total rewards going to health care benefits.[2]

Employers anticipate total health care costs will reach $11,664 per active employee in 2012, up from $10,982 in 2011 — a 6.2% increase in total costs over the period (*Figure 5,* page 8). The average employer share of total costs also continues to climb to unprecedented levels — $8,900 in 2012, compared with $8,453 in 2011.

Meanwhile, employees, on average, paid 23.0% of total premium costs in 2011 and are expected to pay 23.7% in 2012, as companies take steps to control their costs. In paycheck deductions, this translated into an average employee contribution of $2,529 to premiums in 2011, which is expected to rise to $2,764 in 2012 — a 9.3% increase in one year.

Employers' costs also continue to rise. On average, they pay 34% more than they did five years ago, while employees contribute nearly 40% more (*Figure 6,* page 8). For some employees, the question of affordability becomes even more evident as their paycheck deductions for health care premiums rise while their wage increases shrink in order to fund higher health care costs.

Figure 4. Health care cost increases have leveled off*



Note: 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 benefit expenses for insured plans include the premium paid by the company. For a self-insured plan, these expenses include all medical and drug claims paid by the plan, company contributions to medical accounts (FSA/HRA/HSA) and costs of administration minus employee premium contributions. The annual change in costs is based on costs for active employees after plan and contribution changes. Respondents are asked to report trends directly in the survey.

** Expected

[1]Wage and salary increases are based on the Bureau of Labor Statistics, U.S. Department of Labor, Employment Cost Index.
[2]See Steven A. Nyce and Sylvester J. Schieber, "Treat Our Ills: Killing Our Prospects," Towers Watson Research Paper. towerswatson.com/research/5216.

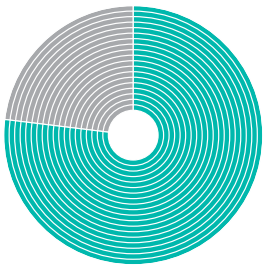
Figure 5. Medical and drug costs and employee premium share

	Total PEPY costs		Net PEPY costs	
Percentile	**2011**	**2012***	**2011**	**2012***
Mean	**$10,982**	**$11,664**	**$8,453**	**$8,900**
10th	**$7,636**	**$8,070**	**$5,707**	**$5,908**
25th	**$8,928**	**$9,367**	**$6,925**	**$7,238**
50th	**$10,619**	**$11,134**	**$8,318**	**$8,618**
75th	**$12,597**	**$13,478**	**$9,997**	**$10,544**
90th	**$14,256**	**$15,297**	**$11,301**	**$12,121**

Note: Costs include medical and drug claims for active employees. Total per-employee per-year (PEPY) costs include both employer and employee shares. Net PEPY costs are less employee contributions.
*Expected

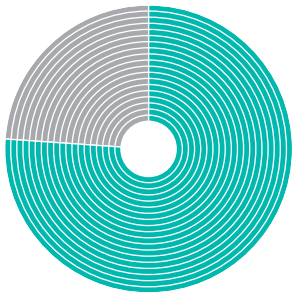
Figure 6. Total employee/employer health care costs

2007 Total cost = $8,597



$6,620 Employer paid
$1,977 Employee paid

2012 Total cost = $11,664



$8,900 Employer paid
$2,764 Employee paid

Figure 7. Annual premiums and rates of increase for retiree-only and family coverage for 2012

	Annual total premiums		Retiree premium share		Rates of increase	
	Retiree only	**Family**	**Retiree only**	**Family**	**2011**	**2012***
Retirees under age 65	**$8,419**	**$20,028**	**50.2%**	**52.8%**	**6.8%**	**5.9%**
Retirees age 65 and older	**$4,511**	**$11,184**	**44.3%**	**46.0%**	**4.7%**	**4.4%**

*Expected

Moreover, in addition to premium increases, companies anticipate that employees' out-of-pocket expenses will rise to 18% of total allowed charges in 2012, compared with 17% in 2010 and 16% in 2011. The unexpected 1% dip last year appears to be an anomaly. It likely reflected employers' reluctance to significantly change plan design amid the uncertainty of the economy and the health care reform legislation of 2010. Over the last year, however, companies have stepped up actions to position their programs for long-term success, especially with the PPACA's excise tax scheduled to take effect in 2018. Evidence of this trend to try to control costs can be seen in the rise of ABHPs and increased employee enrollment (see Account-Based Health Plans, page 30).

Altogether, the share of total health care expenses paid by employees, including premium and out-of-pocket costs, is expected to be 34.4% in 2012, up from 33.2% in 2011.[3] This means that for every $1,000 in health care expenses in 2012, employees pay $344 for premiums and out-of-pocket costs, and employers pay the remaining $666.

Pre-65 and Post-65 Retirees

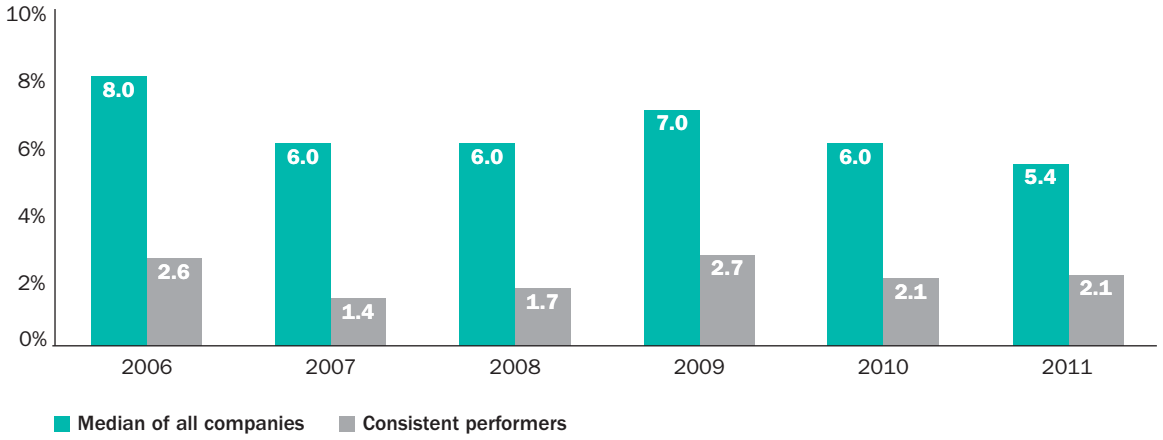
Retirees face even greater affordability challenges, paying a considerably larger share of coverage costs than active employees. Once retirees reach age 65 and become eligible for Medicare benefits, affordability improves: They pay, on average, $2,000 per year for single-only coverage and $5,200 for family coverage *(Figure 7)*.

However, retirees under age 65 pay more than twice that — nearly $4,226 per year in premiums for single-only coverage and over $10,500 per year for family coverage. Absent some form of subsidy, such as an employer plan, many of these employees may find it difficult to retire and secure affordable coverage. Even with an employer subsidy, some may still find it too costly.

The realization that their subsidy is not enough to enable retirees, especially those pre-65, to afford coverage is leading some companies to reassess the value of their retiree medical as well as the role retiree health benefits play in their total benefit mix. The opening of the health care insurance Exchanges in 2014, which could provide access to comparable health care at much lower rates, may prove a more cost-effective alternative for the company and its retirees (see Looking at Viable Alternatives to Current Retiree Medical Programs, page 14).

[3]Total health expenses include employer and employee portions of the premiums, administration costs and employee out-of-pocket costs (including deductibles, copays and coinsurance).

Figure 8. Consistent performers versus median annual cost trends (after plan and contribution changes) 2006 – 2011



Note: Median trends for medical and drug claims for active employees, net of employee premium contributions

Consistent Performers Deliver Long-Term Results

Organizations continue to show dramatic differences in their ability to manage their health care cost trends. A group of organizations that we refer to as "consistent performers" has been successful in maintaining health care cost trends at or below the TW/NBGH norm for each of the last four years.

Our research this year identified 43 companies that qualify as consistent performers.[4] *Figure 8* shows that the ability to keep cost increases low over an extended period of time distinguishes these companies from other organizations. In fact, the median trend across the last four years was 6.1%, versus 2.2% for consistent performers.

By contrast, some companies have experienced greater challenges in managing their cost increases. Low-performing companies — whose two-year average cost increases are in the top 25% — have a median 10% cost trend.

As shown in *Figure 9,* consistent performers are noticeably ahead in terms of cost management. In 2011, the cost difference between consistent performers and low performers was more than $2,200 per employee. For the average consistent performer with 10,000 employees, this equates to a $22 million cost advantage. Likewise, employees working for a consistent performer also fair much better than their counterparts at low-performing companies, paying nearly $400 less per year in premiums. In addition to the obvious advantage of reducing health care costs for themselves and their employees, providing affordable health care is key to a company's ability to provide a competitive reward package, succeed in the long term in supporting their employee value proposition, and meet attraction and retention goals (see Do the Math, page 10).

Figure 9. Annual costs and increases by performance group

				Difference
	Consistent performers	All company average	Low performers	Consistent vs. low performers
Total PEPY, 2011	$9,619	$10,982	$11,876	–$2,257
Net PEPY, net contributions, 2011	$7,407	$8,453	$9,273	–$1,866
Employee contribution, 2011	$2,212	$2,529	$2,603	–$391
Employee share of contributions, 2011	23.4%	23.0%	21.9%	1.5 % pts.
Two-year average trend, net contributions	2.1%	5.5%	10.0%	–7.9 % pts.
2011 trend, net contributions	2.1%	5.4%	10.0%	–7.9 % pts.
2011 trend, before changes	4.9%	8.0%	10.7%	–5.8 % pts.

Note: Consistent performers comprise 43 companies (out of 208) that have maintained trends at or below the Towers Watson/NBGH median trend for each of the last four years. Low performers are based on the highest quartile of two-year average trend.

[4]A company had to complete this year's survey and the 2010 or 2011 Towers Watson/NBGH survey to be eligible to be a consistent performer. The number of consistent performers is based on 208 eligible companies, which translates to 21% of companies reporting an annual trend at or below the all-company median for each year from 2008 to 2011.

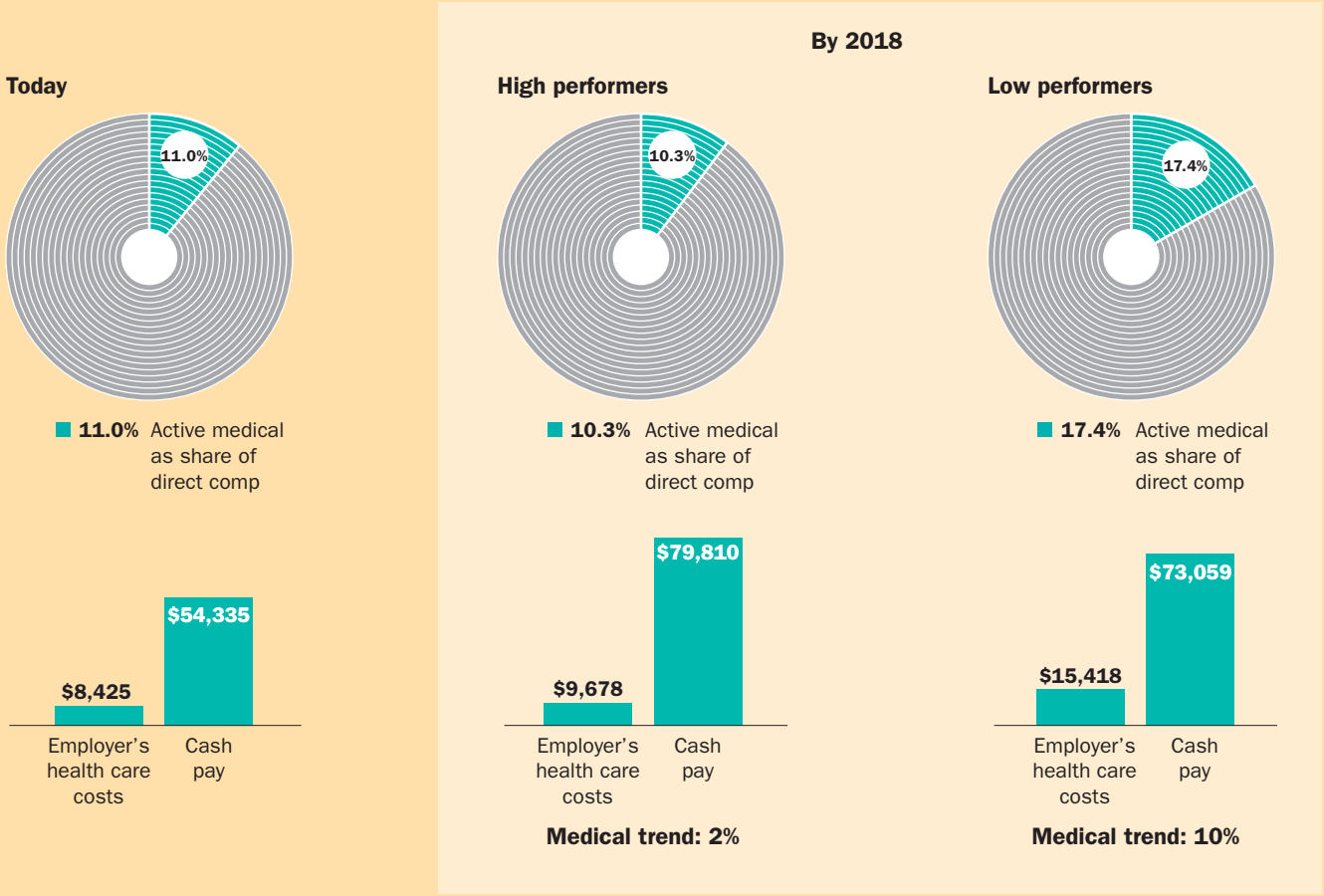
Do the Math

Efficiencies support workforce health objectives and remix the reward portfolio

Health care reform is a total business issue that influences benefits, the overall reward deal, workforce planning, administration and finances. This is an important time for employers to revisit their total rewards philosophy and strategy, and understand the kinds of changes that may be necessary to meet their business and growth goals, shifting talent requirements and the financial pressures they continue to face. Our survey results indicate that 30% of companies are taking steps to examine their health care benefits, employee subsidies and out-of-pocket costs (including health management, and worksite and prevention programs) in a total rewards framework for various population segments (e.g., pay groups). Another 29% are planning to do so in 2013. Organizations that are currently conducting this kind of comprehensive analysis — factoring in broader cost and talent implications — will no doubt have an advantage over their competitors as the economy improves and the implementation of health care reform becomes clearer.

As *Figure 10* illustrates, affordable health care not only lowers costs but can also be an important advantage to optimize employee rewards. In this example, the high-performing company would have, on average, nearly $7,000 more per employee per year by 2018 to spend on other aspects of the reward portfolio apart from health care benefits — notably increases in cash pay — and gain a key competitive advantage. There is no question, then, that companies able to hold the line on health care costs can get out in front of their competition in attracting and retaining top talent.

Figure 10. Linking performance to total rewards



Strategy and Planning

While insurance Exchanges have the potential to transform the health insurance market for consumers, many large employers anticipate health benefits will remain a core component of the value proposition for active employees beyond 2014. As *Figure 11* shows, 90% of companies indicate that will be the case in 2014 and beyond — virtually unchanged from 2012. However, the percentage of companies indicating the strongest response ("very important") dropped 13 percentage points between 2012 and the period after the opening of the Exchanges in 2014, which could reflect some uncertainty about their commitment longer term.

Companies have been steadily reducing their financial commitment toward retiree health care benefits. The results show a further decline in the importance of subsidized retiree medical benefits to a company's employee value proposition. If the PPACA works as intended, the health insurance market in 2014 and beyond will become an attractive alternative and further push companies to exit sponsorship of their pre-65 programs.

More than ever, companies recognize that a healthy workforce can have an important effect on their organization and bottom line. Over the last decade, companies have made significant investments in programs and activities to improve workforce health, and keep employees at work and doing their jobs as effectively as possible. All signs point to these programs remaining an essential part of companies' employee value proposition in the future, surpassing even their financial stake in active medical programs.

Figure 11. Importance of employer subsidies and health and productivity to company's employee value proposition in 2012 and beyond

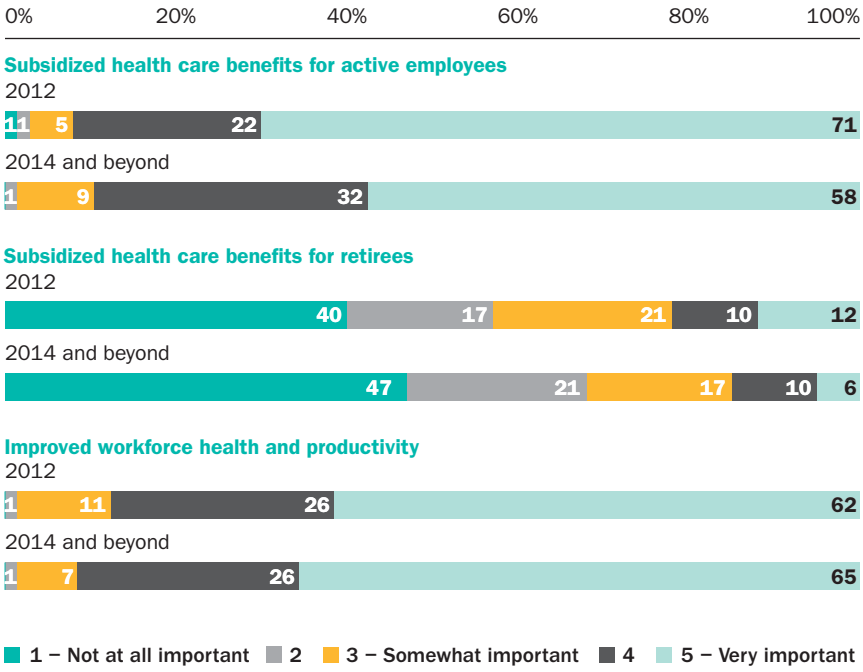
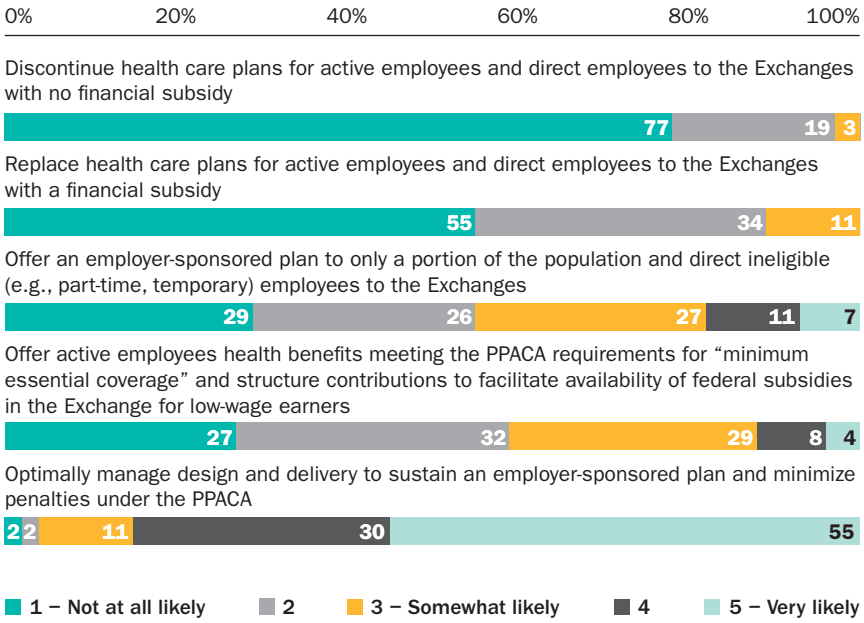


Figure 12. Likelihood organizations will take the following action in 2014 or 2015 with their active health care programs



Strong Employer Commitment Through 2015

While many employers are considering their options after the Exchanges open in 2014, the majority of large companies today remain committed to the optimal design and delivery of their health care programs *(Figure 12)*. But there is a range of opportunities for employers to consider that extends beyond a simple pay-versus-play decision (see A Spectrum of Responses to Reform, below). For example, nearly one in five companies is likely to offer health care coverage to a subset of its workforce and direct the remainder of its employees to the insurance Exchanges. In the end, few companies plan to either discontinue their health care programs or shift strategy to a defined contribution option by 2014 or 2015. All signs indicate that companies will continue to focus on the most effective ways to control rising costs and improve employee health and well-being.

A Spectrum of Responses to Reform

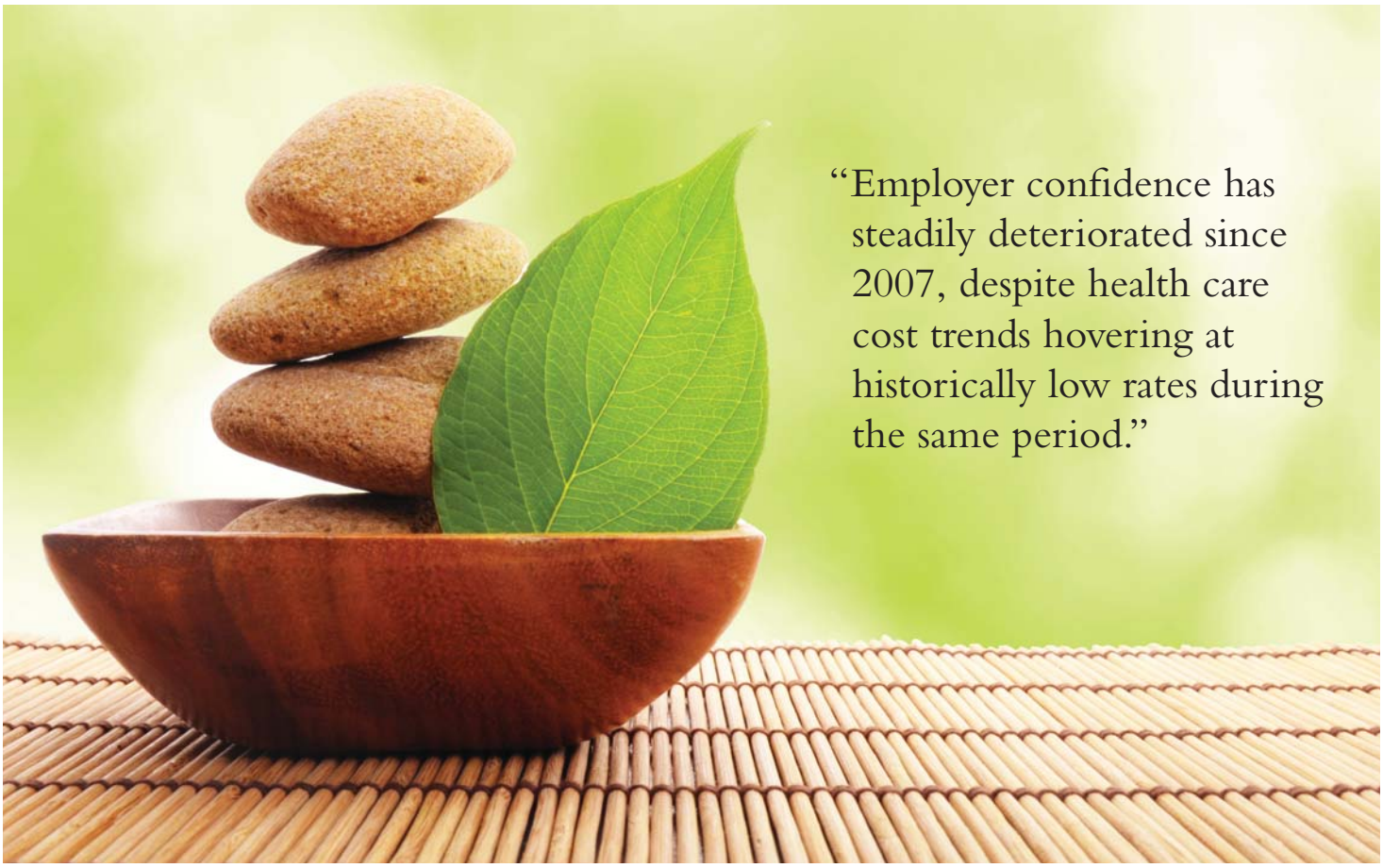
Health care reform presents unique challenges and opportunities for employers that sponsor health benefit plans for their employees and retirees. In particular, the prospect of an individual coverage mandate, the opening of insurance Exchanges and the availability of federal premium subsidies for low-income workers in 2014 require employers to decide whether to play (sponsor a health benefit plan that meets specific minimum requirements) or pay (forgo plan sponsorship, pay a penalty and require employees to secure coverage for themselves through the Exchanges).

But the decision is more complex than simply play versus pay. There is a spectrum of approaches to help employers optimize their own costs in 2014 and beyond, while at the same time directing employees to advantageous coverage options — either within the employer's plan or in health insurance Exchanges.

Employers need to select the approach that aligns with their total rewards philosophy and strategy, and provides optimal value in terms of both cost and talent. Other factors to consider include the demographic composition of their workforce, the consequences of alternate approaches (e.g., federal penalties and/or subsidies) and the choices made by other employers in their industry.

Play — **Spectrum of Opportunity** — **Pay**

Optimal play	Play and redirect	Selective play	Pay and redeploy	Pay and exit
Continue as a plan sponsor for all employees.	Restructure contributions to qualify low-paid employees for federal subsidies.	Limit eligibility to employer-sponsored plan, and direct ineligibles to Exchanges.	Discontinue plan sponsorship and provide some financial top-up for employees.	Discontinue plan sponsorship with no financial accommodation for employees.

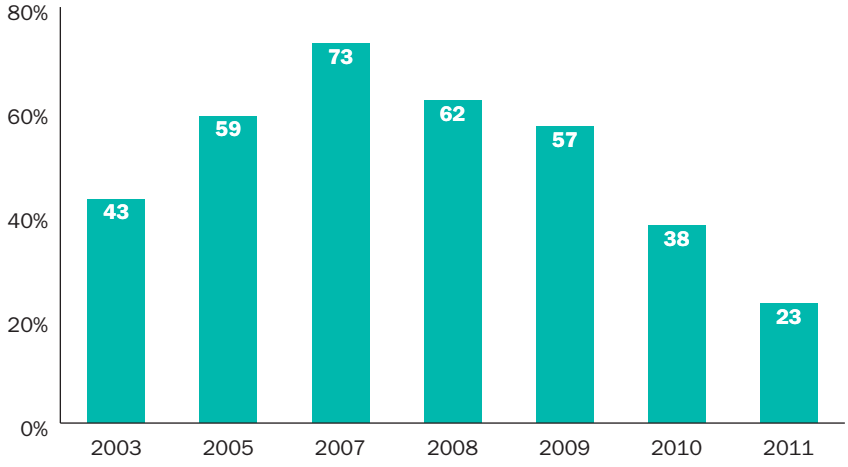


Confidence About the Long Term Fades

Economic conditions, frustration with high cost levels and limited success in encouraging employees to adopt healthier lifestyles have been persistent challenges for companies. Against the backdrop of health care reform, companies have never been more uncertain about the future of their health care programs over the long term.

For nearly a decade, Towers Watson has been tracking employers' confidence in their ability to sponsor health care benefits for active employees 10 years into the future. Employer confidence has steadily deteriorated since 2007, despite health care cost trends hovering at historically low rates during the same period. With the health care marketplace changing rapidly and parts of health care reform already starting to take effect, employer confidence is at its lowest point (23%) since we began tracking this data *(Figure 13)*. That could dramatically change if there is any interruption in the implementation of the various components of the PPACA. However, companies are much more confident about the next five years than they are about 10 years from now.

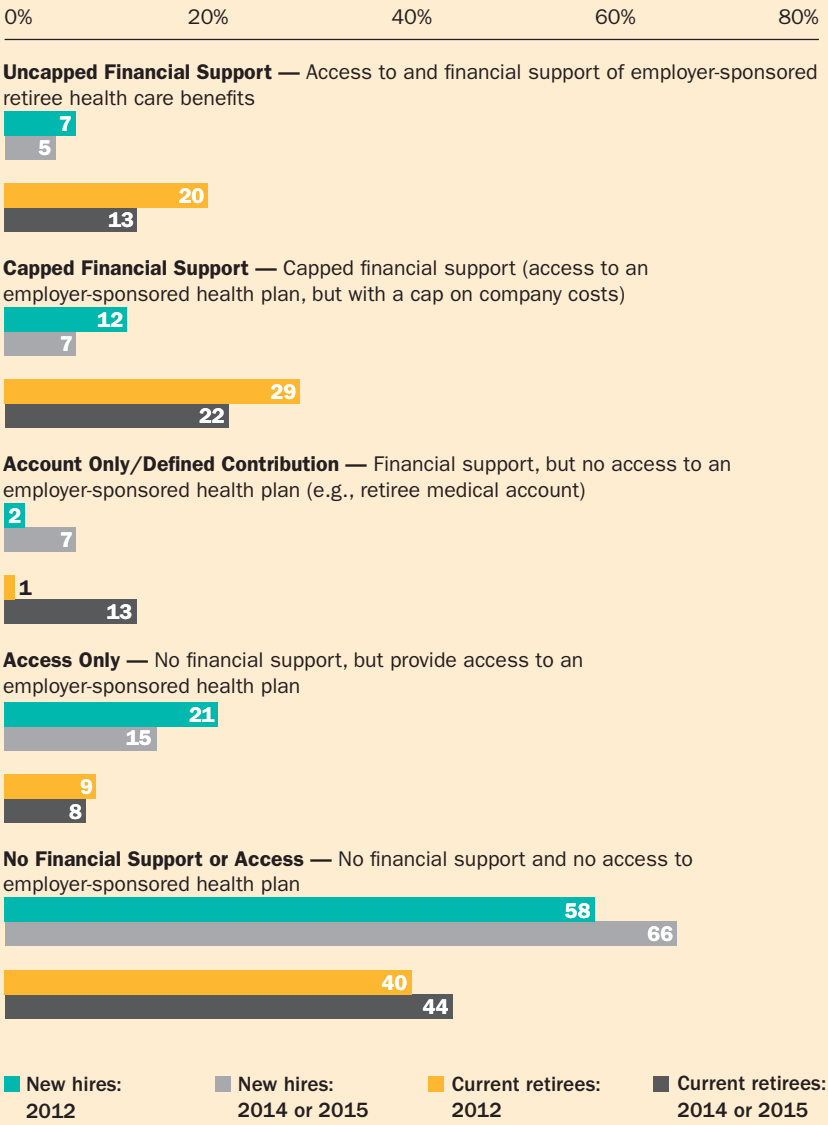
Figure 13. Employers' confidence that health care benefits will be offered at their organization a decade from now continues to erode



Note: High confidence represents responses of "very confident."

Looking at Viable Alternatives to Current Retiree Medical Programs

Figure 14. Pre-65 retiree medical support for various subgroups of the workforce for 2012, and expected for 2014 or 2015



Many employers are looking at health care reform and the opening of the insurance Exchanges in 2014 as a viable alternative to their current retiree medical programs. For two decades, companies have been reassessing their financial commitment to these programs and, as a result, employer subsidies have been steadily eroding. The ongoing health care cost challenges have reached a point where employees considering retirement, especially those under 65 and still ineligible for Medicare, find retiree health care coverage unaffordable even when subsidized by their employer.

If the health Exchanges launch as intended in two years, the health insurance market will become more attractive for pre-65 retirees, allowing companies to exit sponsorship of these programs. The additional subsidies provided by the elimination of the Medicare Part D prescription drug benefit donut hole and the potential emergence of new solutions may make it easier for employers to transition from their traditional role of providing direct financial support and plan sponsorship to simply providing account-based alternatives.

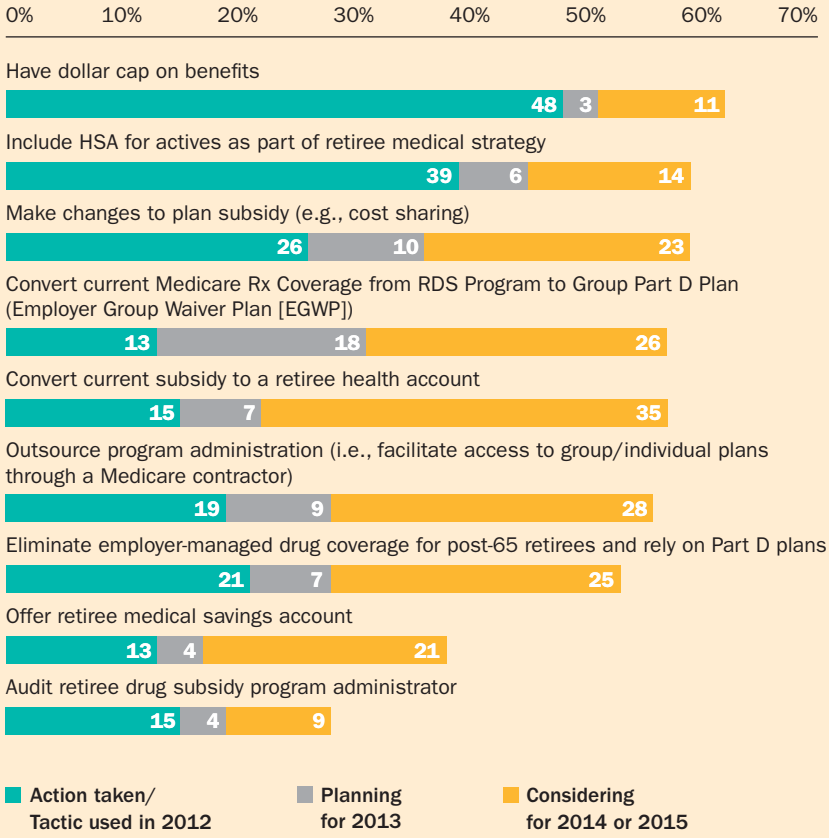
Results of this year's survey indicate that employer sponsorship of these programs will continue to decline over the next three years. As shown in *Figure 14*, half of the companies offer subsidies to current retirees under age 65, while only 21% will provide new hires with some form of financial support.

Looking ahead, many companies will provide a soft landing for current retirees by offering an account-based defined contribution alternative. In fact, account-only coverage for pre-65 retirees is expected to increase to 13% by 2014 or 2015 from only 1% today. Although the results are not shown here, employers are also planning to shift to a defined contribution approach for their current Medicare retirees in the next two years.

New hires will likely see more significant erosion in their company's retiree health benefits, as nearly three-quarters of companies will provide no financial support or access to an employer-sponsored retiree health plan by 2014 or 2015. However, the growth in account-based health care programs will likely emerge as a valuable, tax-effective way for active employees to pay for medical expenses during their working years and to save for medical expenses in retirement. In fact, 39% of companies currently consider their HSA for actives part of their retiree medical strategy, and another 20% are planning or considering such a strategy over the next three years *(Figure 15)*.

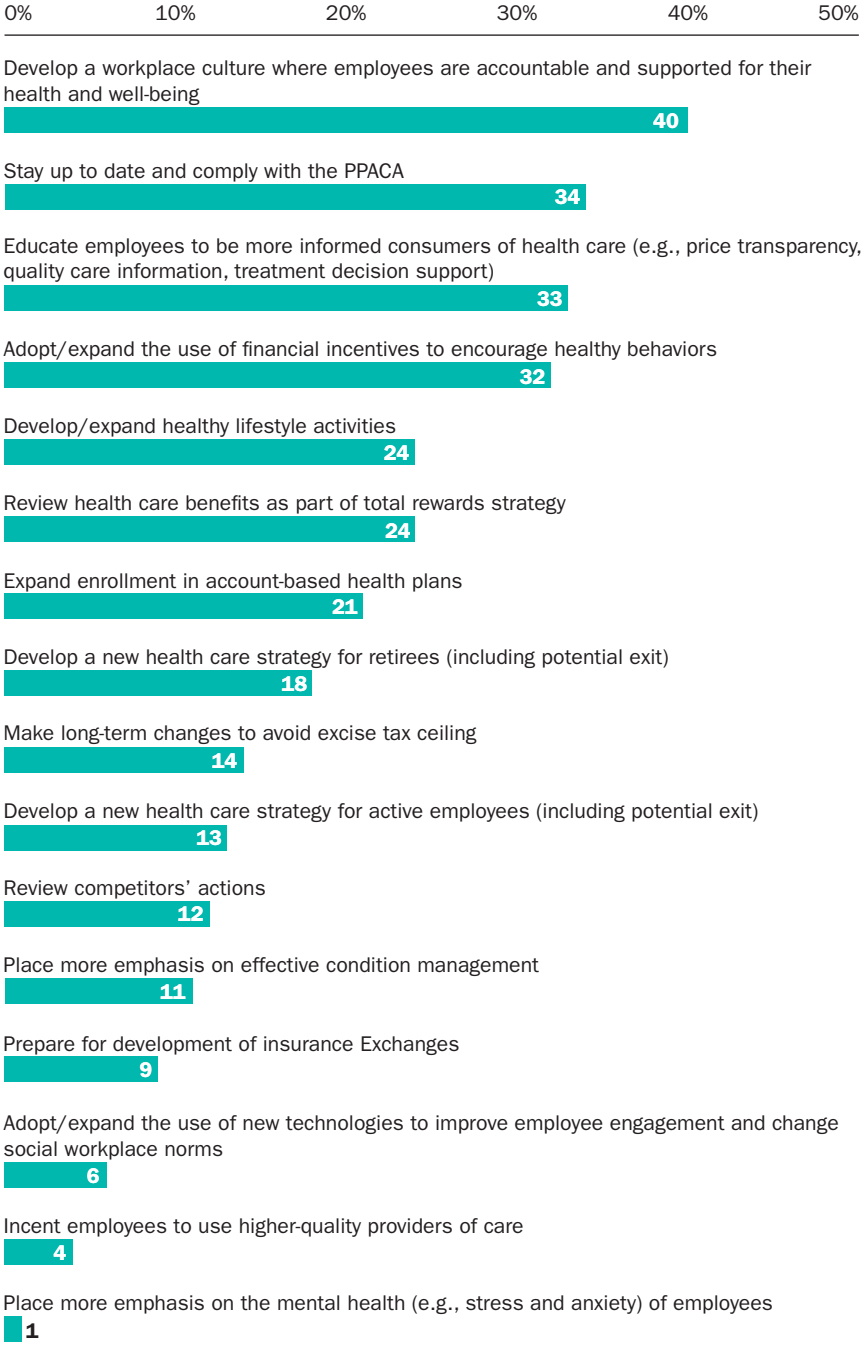
Health care reform legislation and changes in the Medicare marketplace also provide a strong incentive for employers to change their retiree drug programs. The majority of companies (57%) plan to or are considering converting their current Medicare drug coverage from the Retiree Drug Subsidy (RDS) program to an Employer Group Waiver Plan (EGWP) over the next three years. Likewise, 53% of companies plan to consider or are already considering dropping their employer-managed drug coverage for Medicare-eligible employees and relying on Part D plans.

Figure 15. Declining subsidies for retirees with health accounts growing in popularity



Note: Based on respondents that provide financial support or access to coverage in 2012 and excludes responses of "not applicable"

Figure 16. Top focus areas of employer's health care strategy in 2013



Employee Well-Being Takes Center Stage

Although staying abreast of and complying with health care reform will remain in focus in 2013, companies will increasingly emphasize improving workforce health and productivity in the years ahead. This highlights a growing recognition among organizations that health and productivity strategies are a critical success factor in a fiercely competitive and highly connected world, regardless of the future of health reform. These strategies extend beyond physical and mental health to encompass the work environment, culture and interpersonal relationships that connect employees to the mission and goals of the organization.[5]

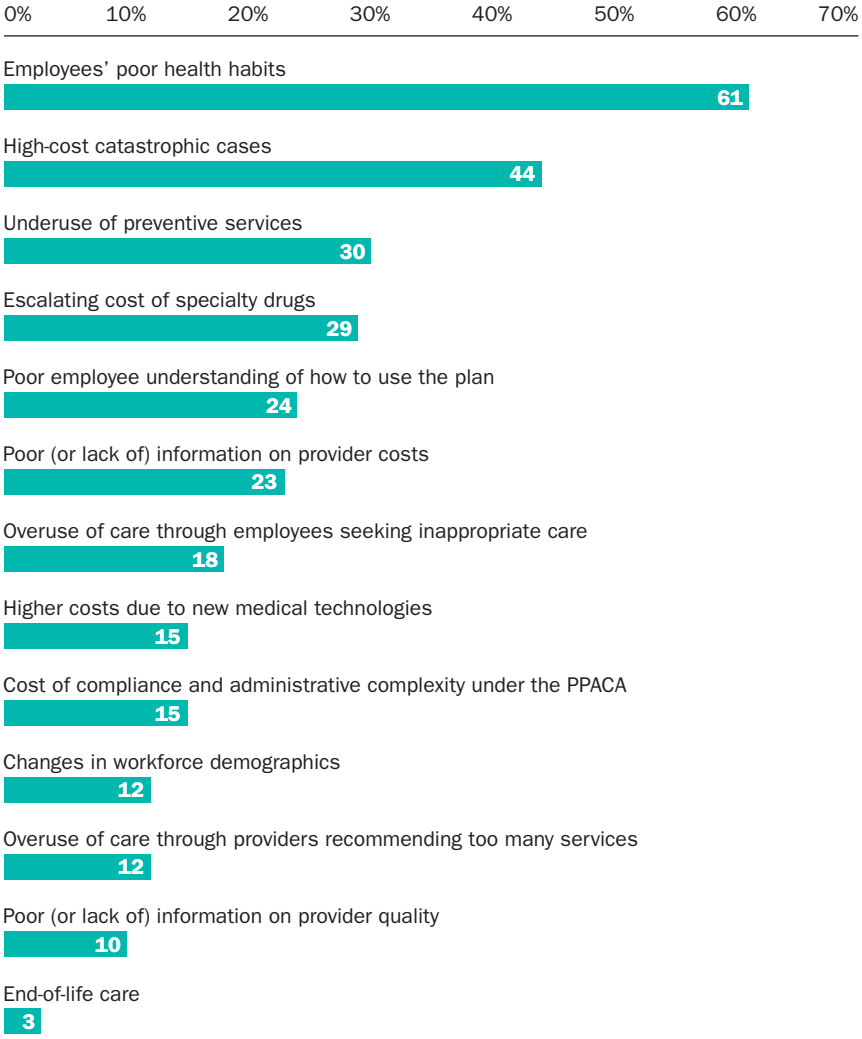
As shown in *Figure 16,* 40% of companies say that cultivating employee health and well-being is a central part of their health care strategy in 2013. Likewise, 33% of companies will take steps to educate and support more informed health care decisions through enhanced tools that promote price transparency and quality of care. But success ultimately lies in employees making smarter lifestyle choices and improving health behaviors. To help drive results, many companies will take steps to ensure that employees are accountable for improving, managing and maintaining workforce health by adopting and expanding the use of financial incentives (32%) and taking more aggressive steps to enroll employees in account-based health plans (21%).

[5]For a more detailed discussion, see *Towers Watson/National Business Group on Health 2011/2012 Staying@Work Survey: Pathway to Health and Productivity.*

Challenges Ahead

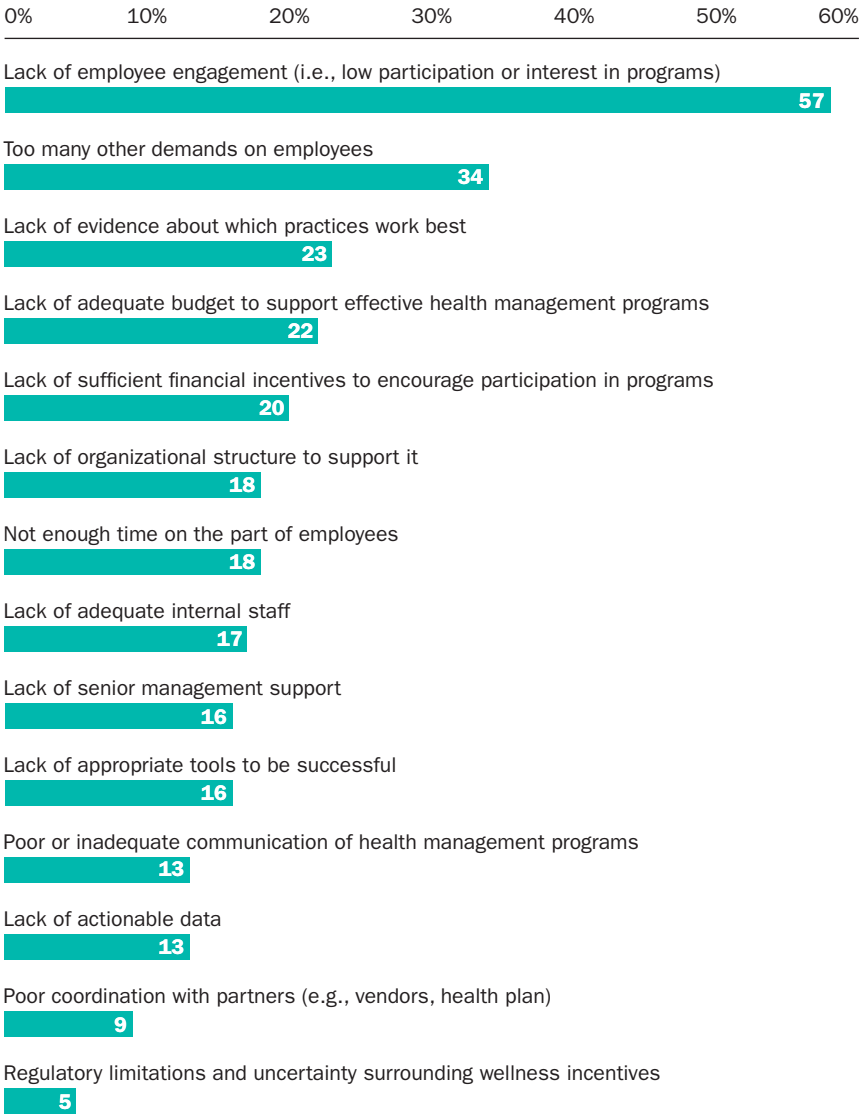
Consistent with findings in previous years, employee health habits is the top challenge employers face in managing their health care costs *(Figure 17)*. This persistent problem is a focus of many companies' health care strategies today and, as noted in the previous section, will continue to be in 2013. But these top challenges highlight the difficulty employers are having in managing costs across the entire health continuum, from the use of preventive services (30%) to the high cost of catastrophic cases (44%) and the escalating cost of specialty drugs (29%).

Figure 17. Biggest challenges to maintaining affordable benefit coverage



"Consistent with findings in previous years, employee health habits is the top challenge employers face in managing their health care costs."

Figure 18. Companies' biggest obstacles to changing employees' behavior related to their health



Changing employees' health behaviors has been a major obstacle for many companies. Above all, the lack of employee engagement (i.e., low program participation) is cited by 57% as the biggest obstacle to managing employee health *(Figure 18)*. In a business environment where employees are increasingly asked to do more (often with less), it is not surprising that more than one-third of companies (34%) indicate that too many other demands on employees is a barrier to improving healthy behaviors. Without a strong business case, it can be difficult to develop strong support within an organization. To that end, companies highlight the lack of evidence as a major obstacle (23%) to changing employee behavior. This ultimately can make it difficult to attain an adequate budget for additional programs (22%) and for financial incentives to encourage program participation (20%).

Asking for More From Health Care Vendors

There is growing recognition among employers that forging a strong connection with their health plan(s) and other vendors, actively supporting programs aimed at engaging employees, and promoting patient safety and quality improvement can be very effective in managing their health care costs and building a healthy workforce.

To that end, an increasing number of employers have been taking steps to consolidate their plans and health management programs with their health plan vendors to achieve greater end-to-end care management and improve active oversight. Our survey results indicate that nearly one-third (30%) of companies have consolidated their health plan vendors in the last two years, and another 11% plan to do so next year. Likewise, 22% of companies have consolidated their health and productivity programs with their health plan, and 15% plan to do so in 2013.

Are companies satisfied with the performance of their health plan vendors? In many regards, employer ratings are mixed, particularly in the areas where their vendors are in the best position to intervene *(Figure 19)*. On a positive note, employers rate their vendors more favorably on case management and to a lesser extent on the design of center-of-excellence networks and screening claimants to offer targeted health management interventions. Vendors receive less favorable ratings on their ability to use data to determine appropriate treatment plans for chronic conditions, identify gaps

in care and help make clinical decisions regarding preference-sensitive care. However, there are signs that plan services are improving in each of these areas *(Figure 20)*.

Companies say their biggest disappointment is the inability of their health plan vendors to drive behavior change that would result in more efficient use of the health care system and healthier lifestyles. These frustrations likely tie back to employees' lack of engagement in their health. Many employers recognize this as a significant challenge for their organization and have made it the cornerstone of their health care strategy this year and next.

Looking ahead, health plans are in a good position to actively manage chronic and catastrophic cases, and provide greater transparency on prices and quality in order to help employees make more informed decisions about their health care. Many employers are eager for their health plans to integrate into their health care strategy a new set of solutions emerging with the advance of new technologies and next-generation health care delivery models, such as Accountable Care Organizations (ACOs). While health plans are making strides, they are increasingly challenged with price transparency tools that lead to disintermediation, as companies contract directly with providers and adopt new solutions with other vendors that cut the health plan out of the equation. The next section examines a number of emerging trends in these areas.

Figure 19. Effectiveness of health plan vendors

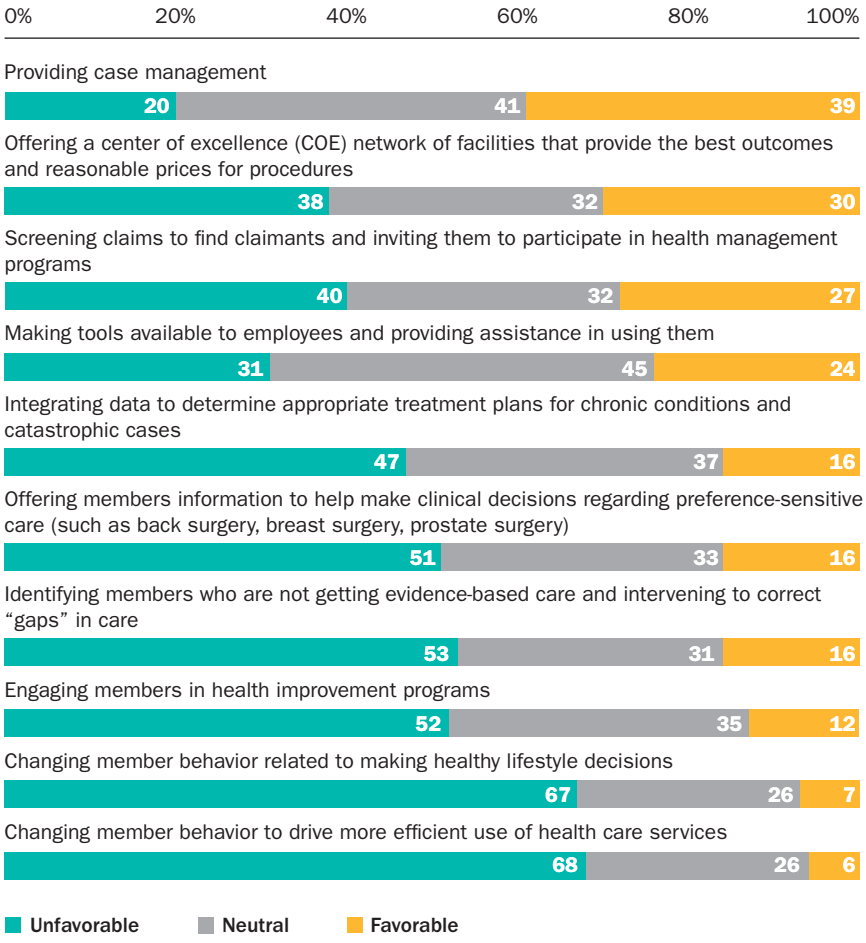
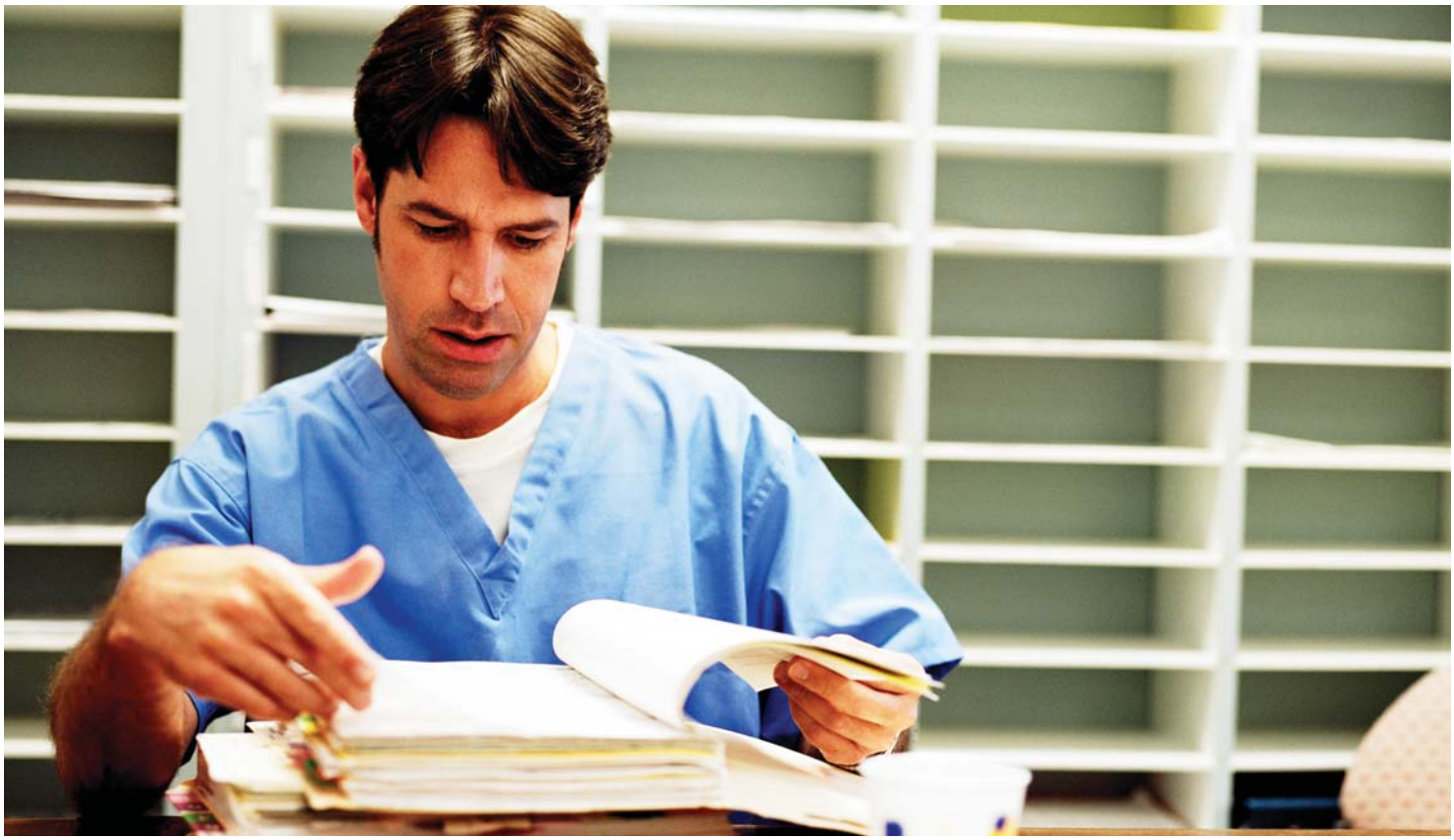


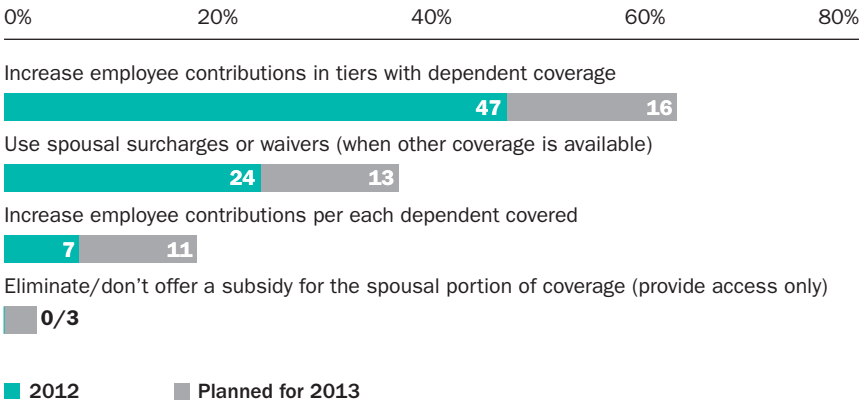
Figure 20. Effectiveness of health plan vendors improves

	Unfavorable			Favorable		
	2011	2012	Difference	2011	2012	Difference
Offering members information to help make clinical decisions regarding preference-sensitive care (such as back surgery, breast surgery, prostate surgery)	68%	51%	–17 % pts.	7%	16%	9 % pts.
Engaging members in health improvement programs	63%	52%	–11 % pts.	8%	12%	4 % pts.
Identifying members who are not getting evidence-based care and intervening to correct "gaps" in care	63%	53%	–10 % pts.	9%	16%	7 % pts.
Integrating data to determine appropriate treatment plans for chronic conditions and catastrophic cases	55%	47%	–8 % pts.	11%	16%	5 % pts.
Changing member behavior to drive more efficient use of health care services	75%	68%	–7 % pts.	4%	6%	2 % pts.
Changing member behavior related to making healthy lifestyle decisions	74%	67%	–7 % pts.	5%	7%	2 % pts.
Screening claims to find claimants and inviting them to participate in health management programs	43%	40%	–3 % pts.	21%	27%	6 % pts.



Emerging Trends

Figure 21. Redefining dependent subsidies



As the economy continues to struggle and health care benefits increasingly squeeze merit raise budgets, many companies have made incremental changes to plan designs in order to help manage the rising cost of health care. In previous years, these changes have included increases in point-of-care cost sharing with employees and employee premium contributions. Over the last year, we've seen a blend of both of those cost-sharing strategies, with slight increases in both employee cost share and out-of-pocket share (see Cost Trends, page 7).

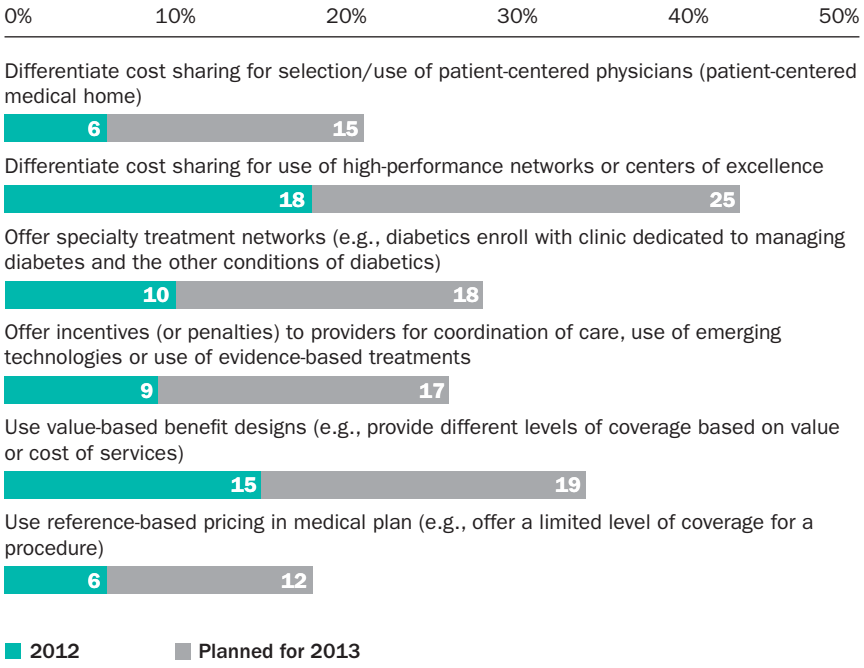
In addition, a number of companies are looking closely at their subsidies and redefining the financial commitment made between employees and dependents *(Figure 21)*. Nearly half of companies increased employee contributions in tiers with dependent coverage, and about a quarter of companies (24%) are using spousal surcharges, with another 13% planning to do so next year. A growing number of employers are considering adopting an approach in 2012 that increases contributions per each dependent covered (11%), although only 7% are doing so today.

Connecting Directly With Providers

In the coming year, employers are making a significant effort to adjust plan designs and use incentives to improve provider quality and enhance the value of services used by members *(Figure 22)*. For example, 25% of companies plan to differentiate cost sharing for the use of high-performance networks, and 18% plan to offer specialty treatment networks to provide dedicated treatment to employees with specific illnesses, such as diabetes. Likewise, value-based designs have been on the rise, with one-third of companies (34%) potentially using them by 2013, compared with only 15% today.

Now companies are considering a new strategy: offering direct incentives to providers for improved care coordination and the use of emerging technologies and evidence-based treatments. While there is growing interest in reference-based pricing, only 6% of companies are using it today, the same percentage as last year. This lag in adoption is probably due to the barriers companies face in accessing the pricing information needed to put this in place.

Figure 22. Emphasis on quality and value in plan designs



Growing Emphasis on Financial Management

Companies are also taking a much closer look at the financial management of their plans to curb waste by regularly reviewing plan eligibility and enrollment, and by auditing medical claim payments *(Figure 23)*. Making sure care is appropriate is also a financial management challenge for most plans. To this end, 41% of companies added or expanded their medical utilization management programs this year, and another 27% plan to do so next year. Companies are also taking steps to improve program evaluation by using hard-dollar return on investment (ROI) calculations to support decisions.

Figure 23. Emphasis on financial management in medical programs

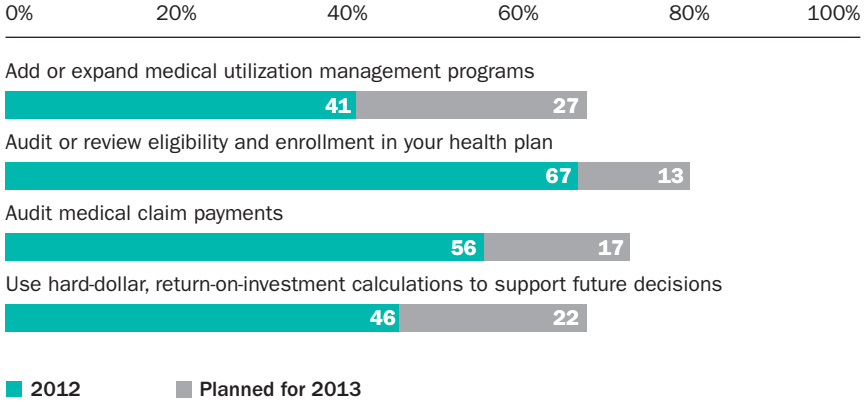
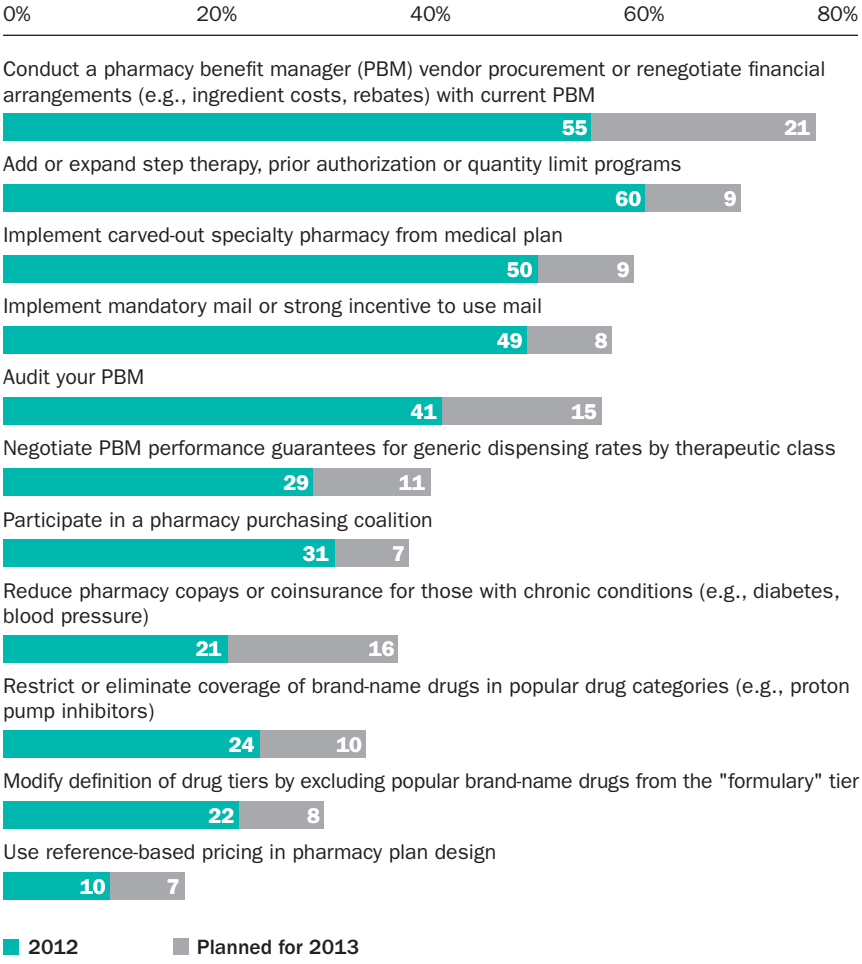


Figure 24. Pharmacy



Changing Pharmacy Landscape

More than half of the companies (55%) we surveyed are actively working to lower their pharmacy costs by taking advantage of the expertise of a financially accountable pharmacy benefit manager (PBM) to purchase drugs at the lowest possible cost, which increasingly includes negotiating PBM performance guarantees for generic dispensing rates. The opportunity for lowering costs by promoting generics over brands has never been greater, given the unprecedented number of drugs set to lose patent protection over the next few years.

Nearly half of companies are implementing mandatory mail order for chronic disease drugs, and about one-quarter are implementing restrictions on certain brand-name drugs or excluding popular brand-name drugs from their formulary altogether *(Figure 24)*. Focused on improving their generic dispersing rates, many companies today aim at having at least 80% generic usage. Companies are also taking steps to add value-based design features to their programs. For example, 21% reduced pharmacy copays last year for those with a chronic condition, and another 16% plan to do so in 2013.

While generics are growing in usage as a result of all these efforts to lower costs, there is no federal mechanism for approving the generic manufacture of specialty drugs (the common name for many groundbreaking and rapidly growing biologics, injectables and other pharmaceutical innovations). As these drugs become more important as elements of treatment for patients suffering from cancer, multiple sclerosis, rheumatoid arthritis, and other life-threatening or life-altering conditions and diseases, companies need to develop a comprehensive pharmacy benefit strategy.

"The opportunity for lowering costs by promoting generics over brands has never been greater, given the unprecedented number of drugs set to lose patent protection over the next few years."

Building the Case for Transparency

It is a well-understood fact that health care does not function as an efficient market because consumers do not know price and quality before they purchase a service such as an MRI or mammogram. The lack of transparency has led to massive price disparity for the same medical procedures across geographies, within geographies and even within a single health plan. As a result, far too many employees unknowingly pay excessive health costs at the most expensive providers with little assurance that those services result in better outcomes.

As shown in *Figure 25,* a growing number of employers recognize the need to improve transparency in prices and hospital quality to change an opaque health care market. Today, 15% of employers provide health care service unit price information to members, and another 22% plan to do so next year. In addition, more than one-third of companies are requiring plans to provide complete extracts of claim data, in part to educate employees, but also so they can identify pricing differences within their population.

While the health plans are the logical source of this information, some feel it is proprietary information and cite confidentiality agreements with providers that prohibit the release of negotiated rates. In an unintended consequence, some corporate clients have turned to independent sources for what they need.

In fact, 13% of companies have gone outside the health plan to provide price and hospital quality transparency tools to employees, and an additional 23% of companies are planning a similar approach next year. Health plans may need to change their ways — or rapidly evolve their own tools — to protect their interests against this trend toward disintermediation.

The case for transparency for employers and employees is rather straightforward: It helps employees choose the care they value and helps employers avoid unnecessary costs while still providing the health care coverage their employees need. Unfortunately, this ideal solution for possibly lowering total costs and improving access to better quality of care can only materialize when consumers and employers gain access to this information.

Figure 25. Emphasis on transparency

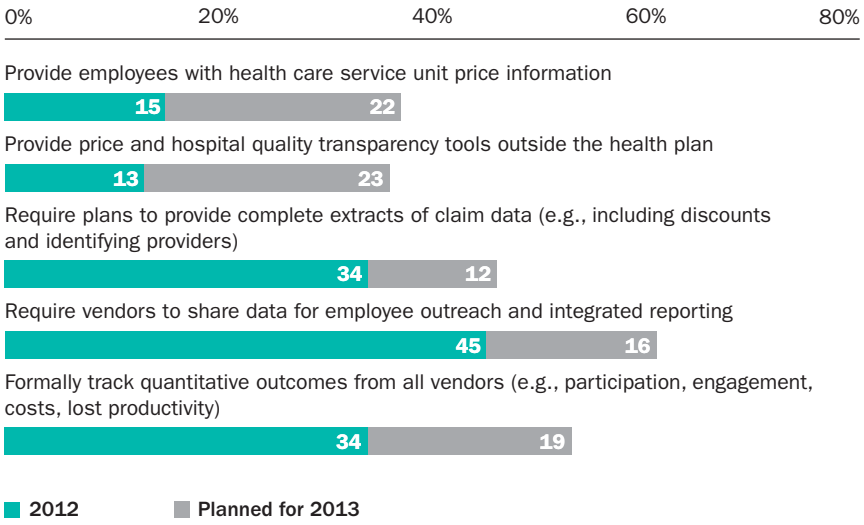
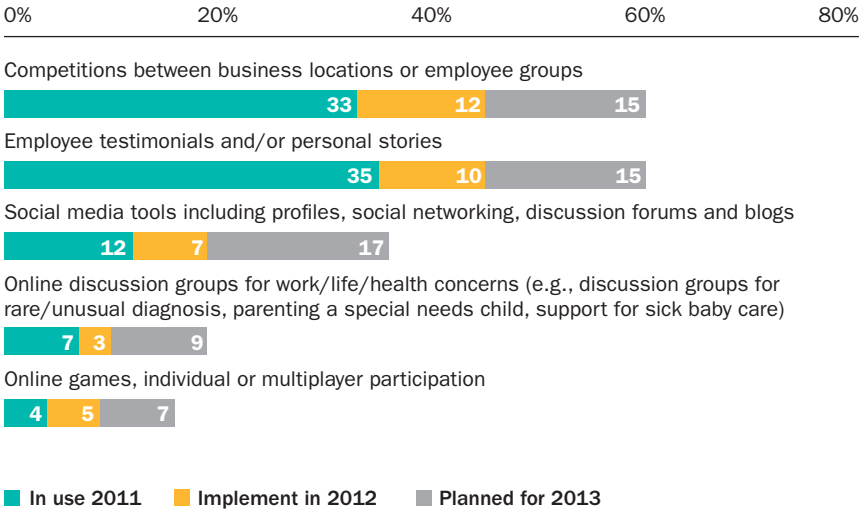


Figure 26. Personalized health and technology



Extending Wellness Incentives to Spouses

Sixty-eight percent of employers are offering cash, premium credits and account contributions to their employees to encourage participation in healthy lifestyle activities in 2012 — up from 58% in 2011. For the typical company that offers incentives, the maximum amount of cash employees can earn is $300, the same as last year. Companies have been increasingly offering incentives to spouses and dependents. Among companies that provide incentives, 53% are offering them to dependents today, versus 39% in 2010 and 46% in 2011. The highest cash total that can be earned by both employees and dependents has increased by $100 over each of the last three years to $700 today.

Embracing Technology to Engage Employees

Applying the most effective technologies to personalize the health experience and establish social communities can be a successful way for companies to promote a healthy workplace culture. There is a growing interest among companies in using social media tools, online discussion groups and gaming software to support their health and productivity strategy *(Figure 26)*. For example, the survey shows social media tools are used by 19% of companies today — up from 14% last year. This figure is expected to rise to 36% next year if companies follow through with their plans.

Technology can also be effective at promoting positive peer attitudes on health and healthy behaviors, which behavioral economics research showcases as a very effective strategy for motivating employee response and ultimately being a catalyst for behavior change. The use of competitions to promote a healthy workplace is up nearly 40% compared with last year (33% versus 45%) and is expected to rise by another 33% next year. Likewise, many companies have been putting a face on key messages and programs by creating personal interactions between company leaders or respected peers and the rest of the workforce. Forty-five percent of companies use employee testimonials and stories to create personal connections across the workforce about health, which could expand to 60% in 2013.

Expanding Use of Financial Incentives and Requirements

Companies have made considerable investments in their health management programs over the last decade. However, offering programs is not enough. Employers recognize that action — employee health decisions and behaviors — is the true measure of program success. Many companies are struggling to overcome lack of participation in wellness programs. While more frequent communication and emerging technologies can help, many companies are finding financial incentives effective in getting employees to take positive action.

As shown in *Figure 27,* the use of financial rewards has been steadily rising. In 2009, 36% of companies were offering rewards, compared with 61% today, and another 21% plan to do so by 2013. This is more than a 69% increase between 2009 and 2012.[6] Companies also recognize that improving healthy lifestyles is a family affair. Offering wellness incentives to spouses has two advantages: (1) Much of the cost in a typical employer plan is directly tied to dependents, primarily spouses, and (2) spouses can be key influencers of the overall family health environment. As a result, companies have increasingly directed incentives to spouses as well as employees (see Extending Wellness Incentives to Spouses, opposite page).

Figure 27. Wellness incentives: Use and tougher requirements

	2011	2012	Planned for 2013
Use financial rewards for individuals who participate in health management programs/ activities	54%	61%	21%
Use penalties (e.g., increase premiums and/ or deductibles) for individuals not completing requirements of health management programs/activities	19%	20%	22%
Reward (or penalize) based on smoker, tobacco-use status	30%	35%	17%
Reward (or penalize) based on biometric outcomes other than smoker, tobacco-use status (e.g., achievement of weight control or target cholesterol levels)	12%	10%	23%
Require employees to complete a health management program/activity (beyond simply enrolling in a program) in order to receive reward (or avoid penalty)	35%	44%	26%
Require employees to complete multiple activities in order to receive reward (or avoid penalty) (e.g., complete both a health risk appraisal and annual physical)	32%	37%	25%
Require employees to complete the health risk appraisal and/or biometric screening to be eligible for other financial incentives for healthy activities	35%	42%	26%
Require employees to complete the health risk appraisal and/or biometric screening to enroll in a higher-value plan option	5%	5%	13%

[6]Data from 2009 are based on the Towers Watson/National Business Group on Health 2011/2012 Staying@Work Survey: The Health and Productivity Advantage.

"Low levels of employee engagement in their health management programs are a persistent challenge for many companies."

Designing Achievement-Based Outcomes

Nearly all companies (90%) with an achievement-based program include weight/obesity as a requirement under the program, measured via body mass index (BMI) or waist-to-hip or body fat measurement. Three-quarters of companies include blood pressure, cholesterol and tobacco use as a requirement. Blood glucose level is used less often, by only 59% of companies.

In recent years, companies have taken more aggressive steps to boost program participation by using financial penalties, such as premium surcharges or higher deductibles, to give employees added motivation to complete a required health management activity. In 2009, only 8% of companies were using penalties.[7] That has risen to 20% today, which could more than double if companies follow through with their plans. This trend clearly telegraphs that companies are raising the bar in their efforts to develop a workplace culture where employees are accountable for managing and improving their health, and for contributing to enhanced workforce effectiveness and lower costs.

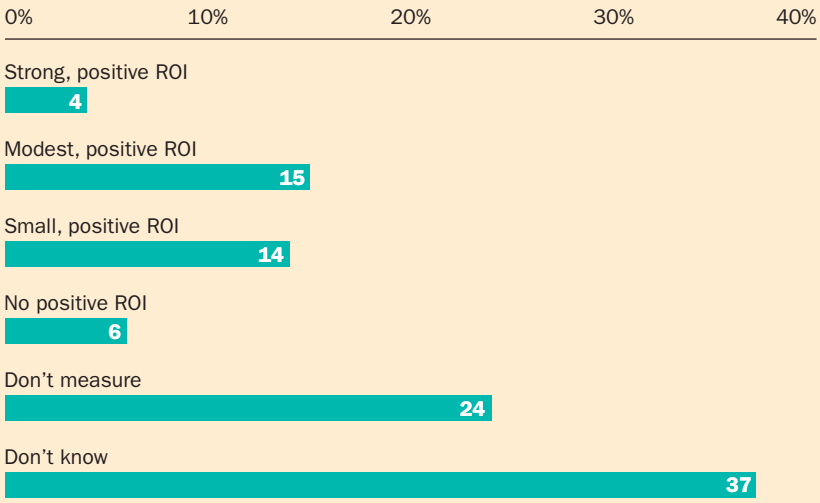
Companies are also rethinking their current incentive designs and imposing tougher, more specific requirements, including some that are outcome-based. In fact, more than one-third of companies use rewards (or penalties) to discourage tobacco use, a trend that could rise to more than half by 2013. There is growing interest in incentive designs that pinpoint specific outcomes for weight control and cholesterol levels. However, few employers have added these requirements to their arsenal over the last year.

Instead, companies appear to be more comfortable raising the bar on what it takes to earn an incentive. For example, 44% of companies are requiring employees to complete a health management activity in order to receive an incentive — up from 35% last year. Likewise, 20% more companies than last year are using health risk appraisals and biometric screenings as gateways to other incentives.

Measurement Gap Around the ROI of Wellness Programs

Many companies have embraced the connection between employee well-being and lower health care costs and improved workforce productivity. Today, 87% of companies indicate they have a workplace wellness program in place. Undoubtedly, most companies view these as long-term investments. But are workplace wellness programs showing a positive ROI? The reality is, most companies (61%) don't know or don't measure results *(Figure 28)*. For those that measure outcomes, 14% indicate a small positive ROI, and 15% cite a modest positive ROI.

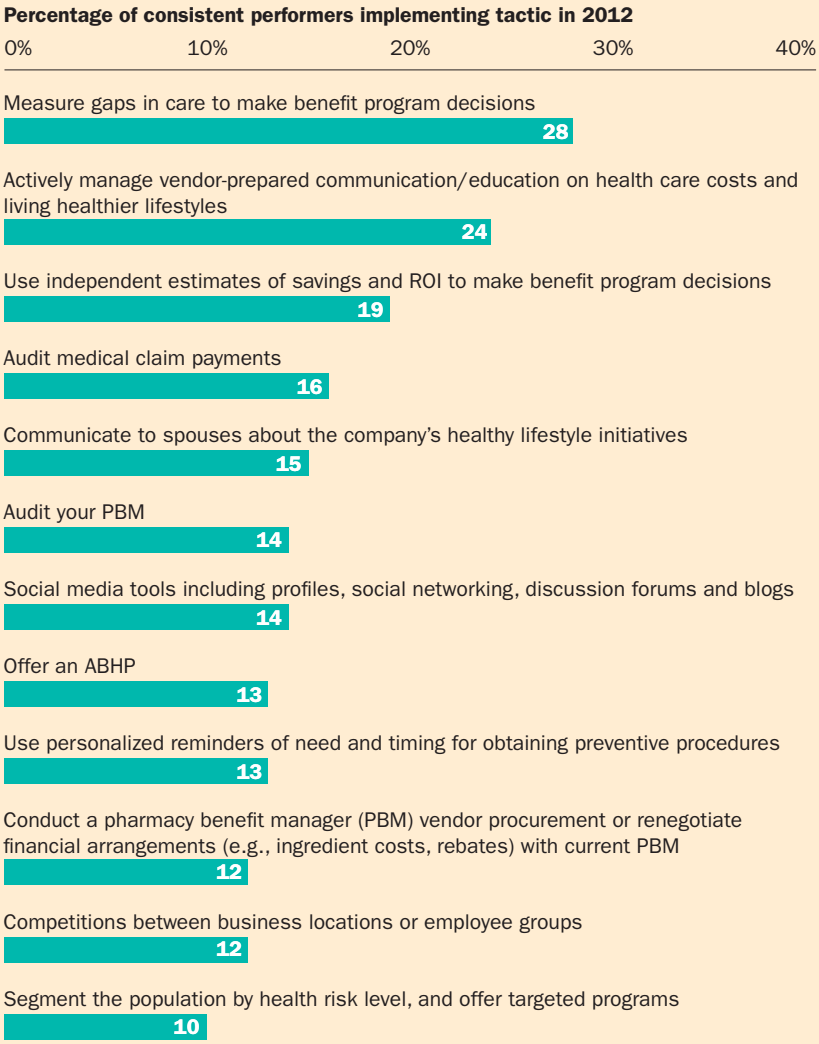
Figure 28. Wellness program ROI



[7] Ibid.

Following the Lead of Consistent Performers

Figure 29. Top programs and activities added by consistent performers in 2012



Most Implemented by Consistent Performers in 2012

The consistent performers took a number of significant steps in 2012 to improve the efficiency of their health care programs *(Figure 29)*. In particular, the most successful companies extensively used data and metrics to evaluate their programs and, over the last year, increased their analysis of care gaps and use of independent estimates of savings and ROI. They also optimized plan and PBM efficiency through audits and fee renegotiation. In addition, 13% of consistent performers added an account-based health plan in 2012 to help manage costs and to further develop a workplace culture where employees are accountable for managing and improving their health.

Low levels of employee engagement in their health management programs is a persistent challenge for many companies. The most successful companies are boosting their program communication by actively managing vendor-prepared materials and expanding communication to include spouses. Consistent performers are also investing in communicating health messages through new technologies, such as social media tools, and promoting friendly team competitions among employees, which can add significantly to a healthy workplace culture.

Top Plans Considered by Consistent Performers for 2013

As companies plan for 2013, the most successful companies have made transparency a top objective *(Figure 30)*. Nearly one-third of the consistent performers are planning to provide employees with unit price information next year, and many will partner with vendors other than their health plans to do so. However, challenges in accessing the data could ultimately limit the implementation and effectiveness of these tools. Consistent performers are looking to help members make more informed choices by adopting decision-making support tools next year (21%).

In the coming year, consistent performers are also planning to take steps to improve provider quality by offering specialty treatment or narrow networks, and providing incentives for the use of evidence-based care. New technologies and enhanced telecommunications are also changing the way care is delivered. High-performing companies are looking closely at the emergence of telemedicine as a way to improve access and efficiency of care delivery to members.

There are many specific factors that contribute to the superior results of consistent performers. There is a lot to learn from these companies by looking at what they have been doing and where they are headed. On page 34, Strategies for Building a Healthy and Productive Workforce, we show that the most successful companies use a combination of tactics in seven main areas to hold the line on cost increases while engaging employees to adopt habits for a healthy lifestyle.

Figure 30. Top programs and activities being considered by consistent performers in 2013

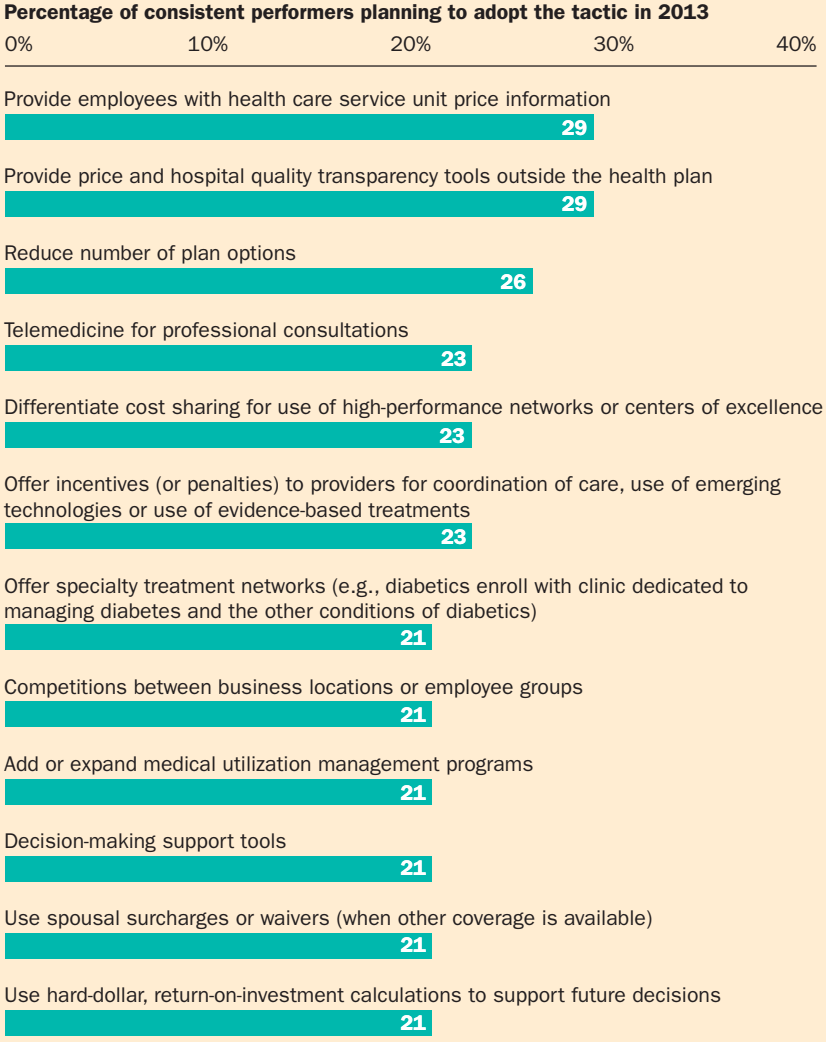
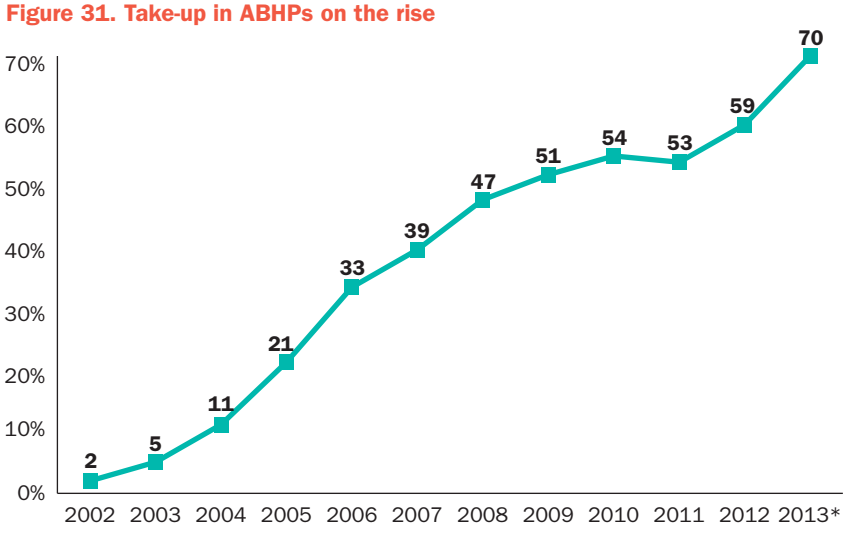


Figure 31. Take-up in ABHPs on the rise



*Planned for 2013

What's an ABHP?

We define an account-based health plan (ABHP) as a plan with a deductible offered together with a personal account (i.e., health savings account or health reimbursement arrangement) that can be used to pay a portion of the medical expense not paid by the plan. ABHPs typically include decision support tools that help consumers better manage their health, health care and medical spending.

Account-Based Health Plans

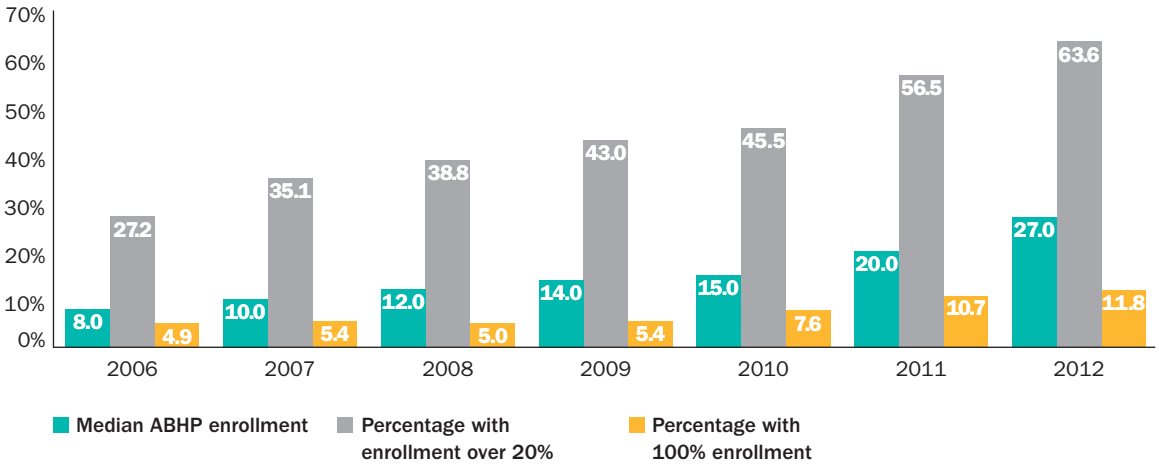
In general, ABHPs can be a valuable tool in helping employers stave off the impact of the scheduled 2018 excise tax by reducing plan costs per employee. The momentum in the adoption of ABHPs, temporarily suspended last year as companies reassessed the implications of reform legislation, has returned. Currently, 59% of companies have an ABHP in place — up from 53% last year *(Figure 31)*. Another 27% of companies without a program today (11% of all respondents) are expected to adopt an ABHP in 2013.

As we have shown in previous years, companies able to successfully migrate employees into an ABHP can achieve significant savings. Our research shows again that companies with at least 50% of employees enrolled in an ABHP report that their total costs per employee are more than $1,000 lower than companies without an ABHP ($10,673 versus $11,714). Nonetheless, an ABHP alone, even with high employee enrollment, does not guarantee long-term success. Companies with more than half of their employees enrolled in an ABHP report a two-year average trend of 5.4% — nearly identical to the TW/NBGH norm of 5.5%. We see a significant difference, as shown in the next section, in those companies that take a comprehensive approach to (1) increasing employee and provider accountability, and (2) helping to cultivate smarter health care consumers. These companies prove most successful at holding the line on costs.

These plans also benefit employees in both the short and long term by helping them pay for current costs while giving them a tax-effective vehicle to accumulate wealth for retirement. This is particularly important as companies redefine their financial commitment to their retiree medical programs by shifting toward a defined contribution approach.

ABHP employee enrollment has been increasing at a moderate pace for most of the last decade. This past year, there was a significant spike in enrollment *(Figure 32)* at companies offering an ABHP: 27% of eligible employees enrolled — a 35% increase over last year and an 80% increase since 2010. The number of companies willing to migrate their entire workforce to an ABHP has also picked up steam. Today, nearly 12% of companies with an ABHP are total replacement — an increase of more than 50% over the last two years.

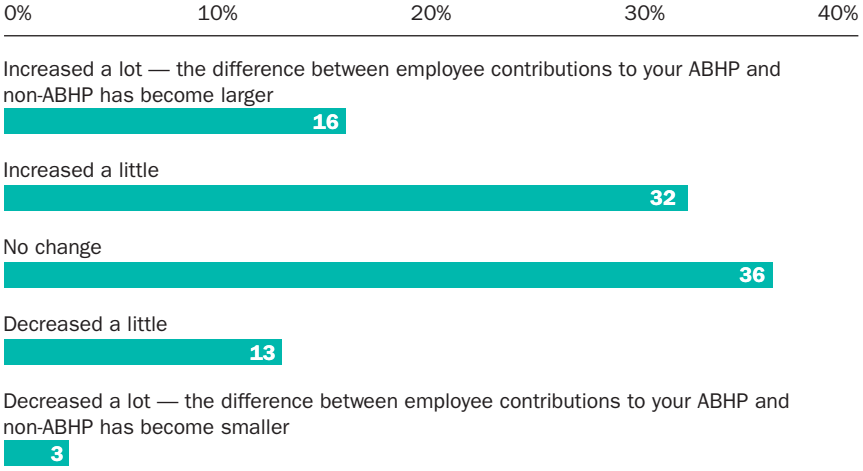
Figure 32. ABHP enrollment rates spike



Note: Estimates are based on companies that offer an ABHP in various years: 2006 is based on the 12th annual National Business Group on Health/Towers Watson Survey; 2007 is based on the 13th annual survey; 2008 is based on the 14th annual survey; 2009 is based on the 15th annual survey; 2010 is based on the 16th annual survey, and 2011 and 2012 are based on the 17th annual survey (current).

To encourage enrollment, many companies set employee premium contributions for ABHPs significantly lower than their traditional copay plans. For nearly 60% of companies, employees pay ABHP premiums that are at least 20% less than those for non-ABHP plans, and almost 40% of those companies set contributions at more than 50% less. As shown in *Figure 33,* the gap between employee contributions to the ABHP and the non-ABHP has been widening, making the ABHPs more attractive to employees. In fact, companies with an ABHP are three times more likely to indicate that the gap between ABHP and non-ABHP contributions has become larger over the last three years rather than smaller (48% versus 16%).

Figure 33. Change in employees' contributions to an ABHP compared to non-ABHPs over the last three years



Note: Based on companies that offer an ABHP in 2012; excludes companies with total replacement ABHPs

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

	2007	2010	2012	2013*
ABHP with HRA	20%	20%	23%	29%
ABHP with HSA	25%	38%	48%	60%
Contribute funds to an HSA	15%	30%	39%	50%
Total replacement ABHP to at least one employee group	5%	8%	8%	14%
Offer an ABHP as our default plan option	—	11%	17%	29%
Offer an ABHP as our only plan option	—	—	7%	17%

Note: Based on all companies with or without an ABHP
*Includes companies indicating "planned for 2013"

Figure 35. Health behaviors/outcomes for employees and dependents enrolled in an ABHP compared to non-ABHPs

	Worse in ABHP	About the same	Better in ABHP	Not sure
Getting recommended preventive screening procedures	1%	27%	15%	56%
Having an annual physical	1%	26%	14%	58%
Using ER for non-emergent conditions	1%	11%	29%	59%
Avoiding inappropriate care	0%	13%	23%	64%
Participating in healthy lifestyle activities	0%	19%	15%	65%
Reducing biometric risks (e.g., blood pressure, cholesterol)	1%	17%	11%	72%
Reducing lifestyle risks (e.g., body mass index, tobacco use, nutrition, physical activity)	1%	16%	10%	73%

Note: Based on companies that offer an ABHP in 2012

"In general, ABHPs have become mainstream, and companies are migrating a greater share of their workforce into these programs."

For account-based programs, HSAs continue to expand at a steady pace *(Figure 34)*. Nearly twice as many companies have an HSA today than they did five years ago (25% versus 48%), with an expected increase of 12% in 2013. In addition, 39% of companies contribute funds to the HSA in 2012, and another 11% are planning to do so next year. This can help boost enrollment and alleviate the affordability challenges with these plans. On the other hand, the percentage of companies with a health reimbursement arrangement (HRA) has been flat over the same period.

While HSAs are becoming more popular, average HSA enrollment lags considerably behind the older HRAs. In fact, HSA enrollment is only half that of HRAs in 2012 (16% versus 31%), likely because HSAs are a newer savings vehicle, taking effect in 2004. While we see significant growth opportunity for HSA enrollment in the years ahead, companies will want to consider which account is right for their workforce composition. They need to take into account the range of affordability issues that could make an HSA less valuable to employees — notably lower-paid employees — and new restrictions on HSAs. Beginning in 2011, for instance, over-the-counter medications cannot be paid with HSA dollars without a doctor's prescription.

In general, ABHPs have become mainstream, and companies are migrating a greater share of their workforce into these programs. If companies follow through with their current health plan strategy, this could mean that 17% of companies would offer an ABHP as their only plan option in 2013. In addition, 29% of companies would offer an ABHP as their default plan option to further increase employee enrollment.

An important question is whether ABHPs are having a positive or negative effect on employees' utilization of health care services and ultimately on improving health outcomes. As shown in *Figure 35,* there are significant information gaps about health behaviors and outcomes for employees and dependents enrolled in an ABHP, compared with non-ABHPs. This could be a sign that many companies lack access to data or measurement capabilities to assess differences in member behavior. For those companies that have measured these differences, many employers indicate their ABHPs are outperforming their non-ABHPs, particularly in reducing the use of inappropriate care and curbing unnecessary visits to the emergency room.

PPACA Winners: Part-Time Workers

The health care reform law has the potential to completely change the approach companies take to providing health care coverage to part-time workers. After the opening of the Exchanges in 2014, the health insurance market will greatly improve for part-time workers, with government subsidies providing more affordable alternatives to employer-sponsored coverage.

Coverage for part-time workers today varies widely by industry. Industries that traditionally have a higher concentration of part-time workers — such as retail, wholesale and hospitality — are more likely to offer health care coverage to part-timers than companies with lower concentrations *(Figure 36)*. However, those that rely more on part-time employees typically provide them with more limited coverage or lower subsidies — sometimes significantly lower — than full-time employees. In fact, more than half (55%) of these companies with the most part-timers contribute at least 20% less to those workers versus full-timers, and 40% offer subsidies to part-time employees that are at least 30% less than those offered to full-timers.

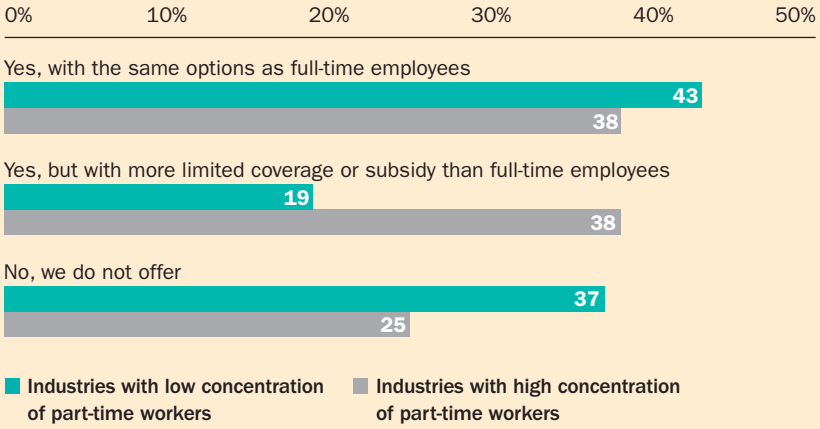
In a notable departure from tradition, the new legislation will change the definition of "part time" for health benefits to anyone who works an average of 130 hours per month, rather than the current standard of minimum hours per week. This could have a dramatic effect on industries that use a large number of part-time workers and dramatically increase the number of employees who receive health care coverage. Companies looking to avoid the related cost increase for benefits may need to monitor more closely the hours worked by their staff.

Today, on average, 61% of employers require an employee to work a minimum of 20 hours per week to be eligible for health care benefits. Fourteen percent set a minimum below 20 hours, and 25% set the minimum above. Thirty hours per week is the next most common threshold, used by 13% of companies.

As companies look to redefine their part-time benefits, there are a variety of options to consider. Survey results indicate that very few companies have made changes to their part-time programs. But a number of companies are planning to take action over the next two years. Notably, 43% of companies have or are planning to change the definition of "part time" to comply with PPACA requirements by 2014. Among those with a high concentration of part-time workers, 54% say they will comply with the government standard.

Overall, only 18% of companies have already eliminated, or are considering eliminating, part-time health care coverage by 2014, although 25% of companies that use a high number of part-time workers plan to do so. Companies are also looking to manage part-time workers' hours more closely. Nearly 40% of companies that traditionally use a high number of part-time workers expect to limit them to less than 30 hours per week by 2014 to escape having to pay benefits. At this point, few companies (7%) are planning to overhaul their workforce structure by hiring fewer part-time employees.

Figure 36. Offering of health care benefits to part-time employees



Note: High part-time concentration includes companies in the following industries: health services, hospitality, entertainment, professional services, retail and wholesale trade.

Strategies for Building a Healthy and Productive Workforce

With economic challenges persisting and landmark reform scheduled to transform the health care landscape, there has never been a more critical time for employers' health benefit programs to operate efficiently. The findings of this year's analysis clearly show that the most successful companies separate themselves from their competitors by making significant strides in six core areas:

- **H**ealth improvement
- **E**ngagement
- **A**ccountability
- **L**inking provider strategies
- **T**echnology
- **H**ealthy environment

To achieve the right outcomes, the most successful companies recognize the inextricable link between their health benefits and workforce health and productivity, and they integrate the link in every aspect of their health plan strategy. How do the most successful companies get ahead? Simply stated, these companies have universally made greater strides in each of the six main areas and use health care metrics to gauge their impact on two critical success factors: cost reduction and improvements in workforce health and productivity. As shown in *Figure 37,* the consistent performers have made greater strides than low performers in each of the core tactical areas, especially these two: (1) investing in a comprehensive set of programs to engage employees in living healthier lifestyles, and (2) altering benefit plan designs to increase employee and provider accountability.

Figure 37. Key drivers of performance

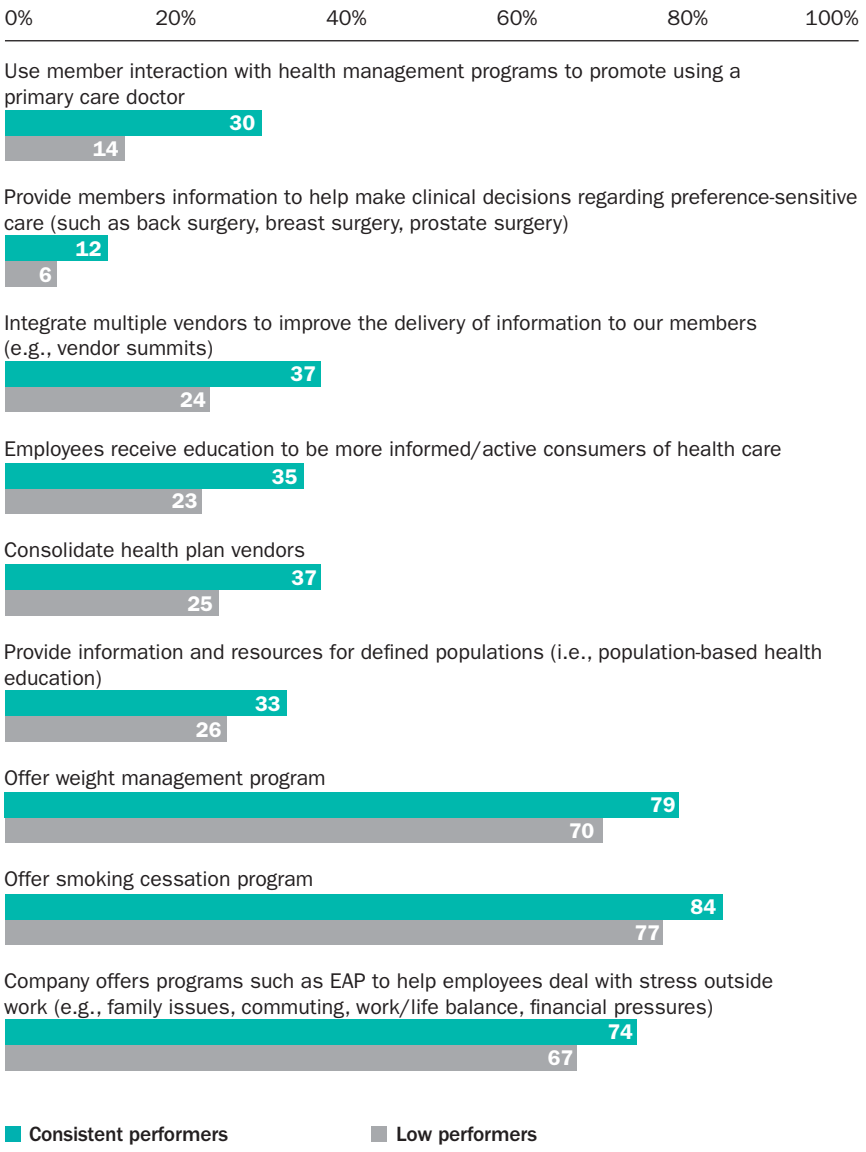
	Summary of program use		Percentage difference in program use*
	Consistent performers	Low performers	Consistent to low
Engagement	33%	20%	63%
Accountability	34%	21%	62%
Technology	33%	23%	47%
Healthy environment	40%	27%	46%
Linking provider strategies	30%	21%	40%
Metrics	43%	33%	30%
Health improvement	48%	37%	29%

* Difference in program is the increased percentage that consistent performers are using the tactics in each of the seven areas compared to low performers. For example, consistent performers are using 63% more of the activities around employee engagement than low performers.

Health Improvement

At the core of a healthier workforce is a company's commitment to provide employees with the tools and resources they need to lead healthy and productive lives *(Figure 38)*. Consistent performers actively communicate messages that help employees make wise, active choices about their benefits and well-being, spanning the gamut from broad-based messages to the entire population, to targeted and personalized messages to individuals. These companies also recognize the importance of integrating the information and tools from their health plans and other vendors to streamline delivery, and simplify and improve the quality of health improvement materials. While health management programs are more commonplace today than they were a decade ago, the consistent performers have made greater investments in lifestyle behavioral change programs, such as weight management and smoking cessation.

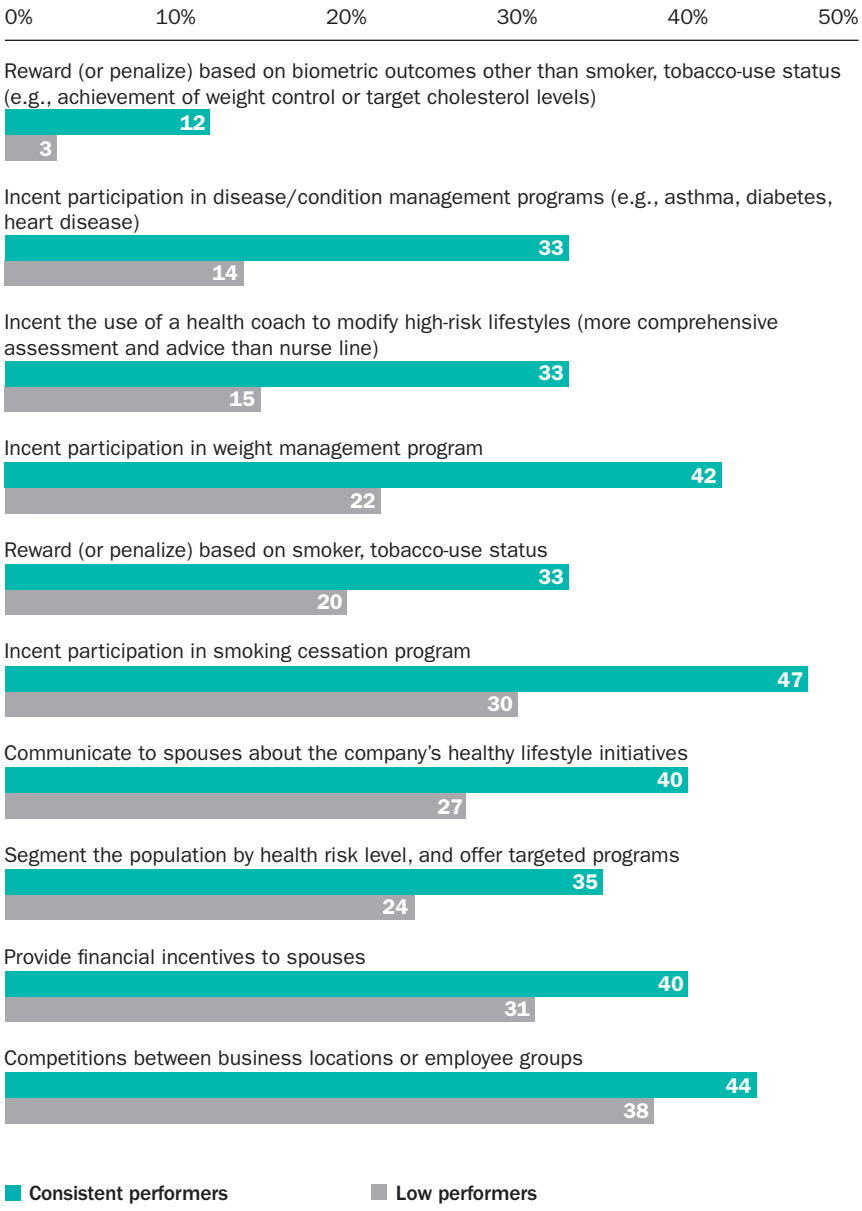
Figure 38. Health improvement



Engagement

Companies are asking employees to take on more responsibility for managing and improving their health. To encourage employees to accept this challenge, consistent performers boost employee involvement by offering financial incentives to participate in various healthy lifestyle programs *(Figure 39)*. These companies are using incentives to encourage employees with a chronic condition to speak to a health coach or join a disease management program. These companies have also been more likely to introduce achievement-based standards to earn financial rewards (or avoid penalties), including designs that pinpoint specific outcomes for weight control, cholesterol level and tobacco use. The most successful companies recognize that engaging spouses and winning their hearts and minds can help to accelerate the change in their employees' lifestyles. Consistent performers achieve this by directly communicating with spouses about the company's healthy lifestyle activities and by providing them with the same opportunity to earn financial rewards.

Figure 39. Engagement

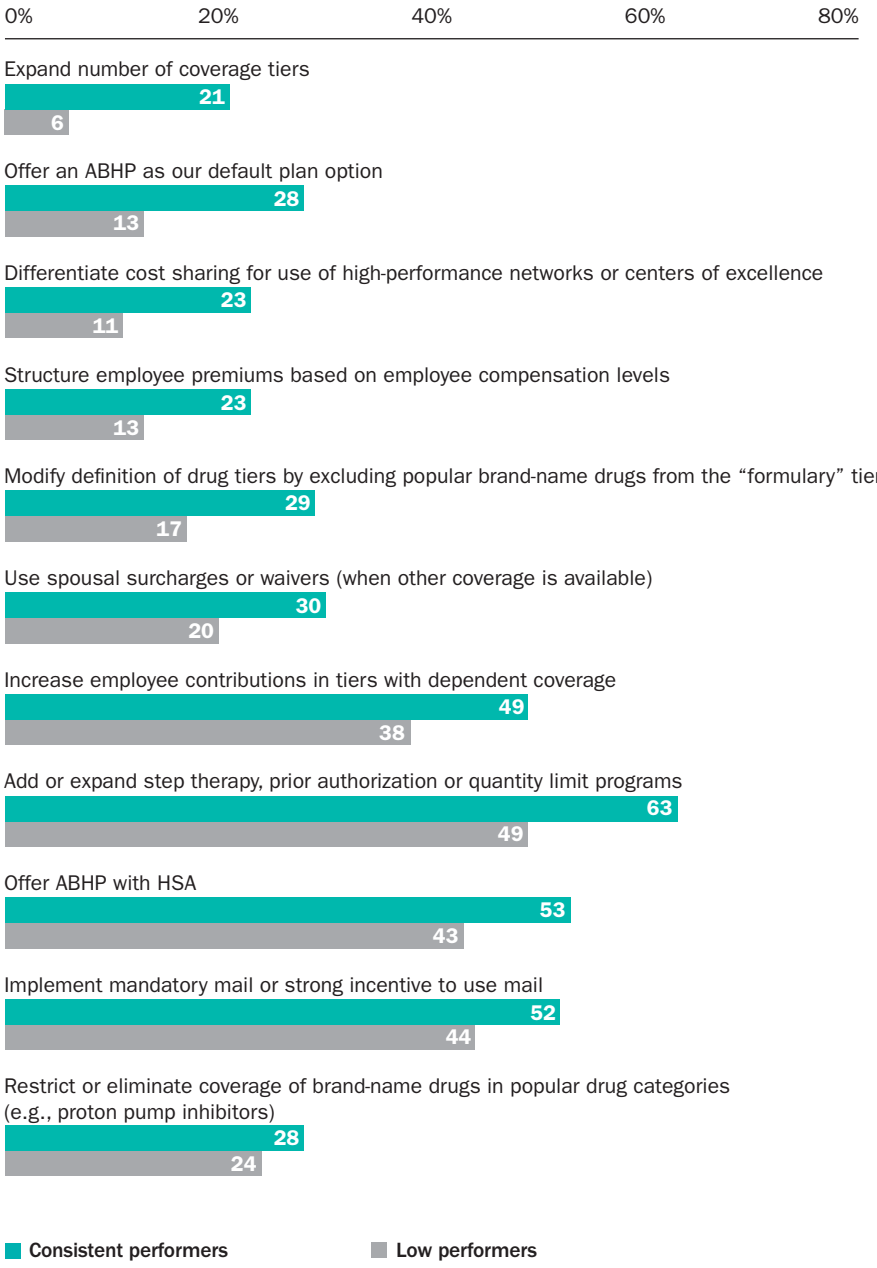


Accountability

Consistent performers have been taking measured steps to increase employee accountability for their health and care by changing program designs to drive employees to more cost-effective health care services *(Figure 40)*. For example, these companies are more than twice as likely as high-cost companies to reduce cost sharing for the use of high-performance networks or centers of excellence. The consistent performers have also been particularly focused on driving value through their pharmacy program by modifying drug tiers to exclude popular brand drugs, adding or expanding step therapy, and requiring mandatory mail order.

Consistent performers have also taken a harder-line position with their ABHP strategy by using these plans as default options and offering higher deductibles with an HSA. In addition, these companies have been more aggressive in revising their financial commitment toward specific groups, particularly dependents. Actions taken include expanding the number of coverage tiers, using spousal surcharges and increasing contributions in tiers with dependent coverage. Likewise, the consistent performers have also been more likely to address affordability issues by tying employee contributions to compensation levels.

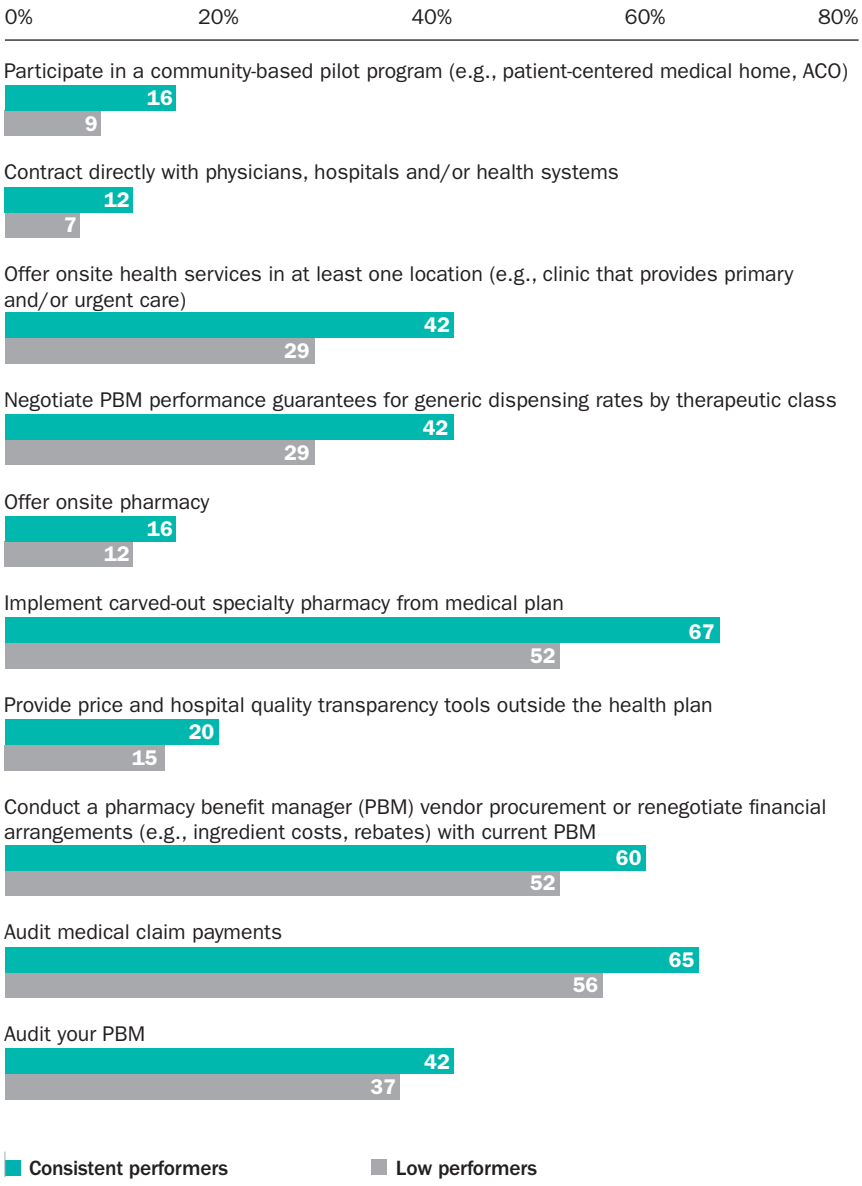
Figure 40. Accountability



Linking Provider Strategies

Access to high-quality, cost-effective health care solutions is an essential part of consistent performers' health care strategy. In many regards, consistent performers are pioneers in their quest to improve the quality of care within their health program by participating in pilot programs for patient-centered medical homes and by leading the way in an emerging trend to contract directly with providers *(Figure 41)*. These employers have also taken steps to improve access by offering onsite health services and onsite pharmacies. Consistent performers are actively managing their PBMs by negotiating performance guarantees, reworking financial arrangements and aligning plan design to drive higher levels of generic drug use. Likewise, consistent performers are taking steps to boost transparency of health care prices and quality so employees can be more informed in choosing health care services.

Figure 41. Linking provider strategies



Technology

There is enormous advantage in using rapidly evolving technologies to transform virtually all aspects of the health care system from care delivery and financial management to engaging employees in healthier lifestyles. Consistent performers are embracing these new technologies to provide personalized information when needed for primary care visits, send reminders about obtaining preventive procedures and identify potential gaps in care *(Figure 42)*. While social media has been slow to take off with benefit and HR managers as a way to connect with employees about health care, consistent performers are early adopters of online games and social media tools. But as the social media environment increasingly evolves, with more trusted sites tailored to engage employees around their health, it's likely that many more employers will embrace this vehicle to support their health and productivity strategies.

Figure 42. Technology

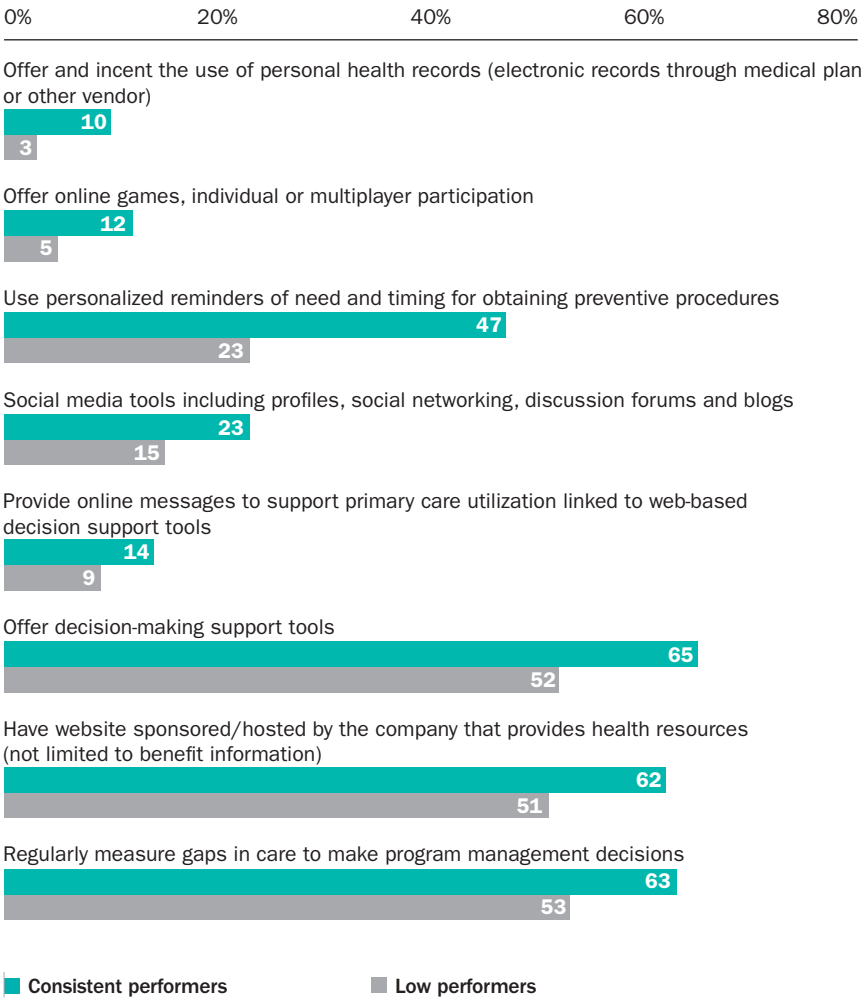
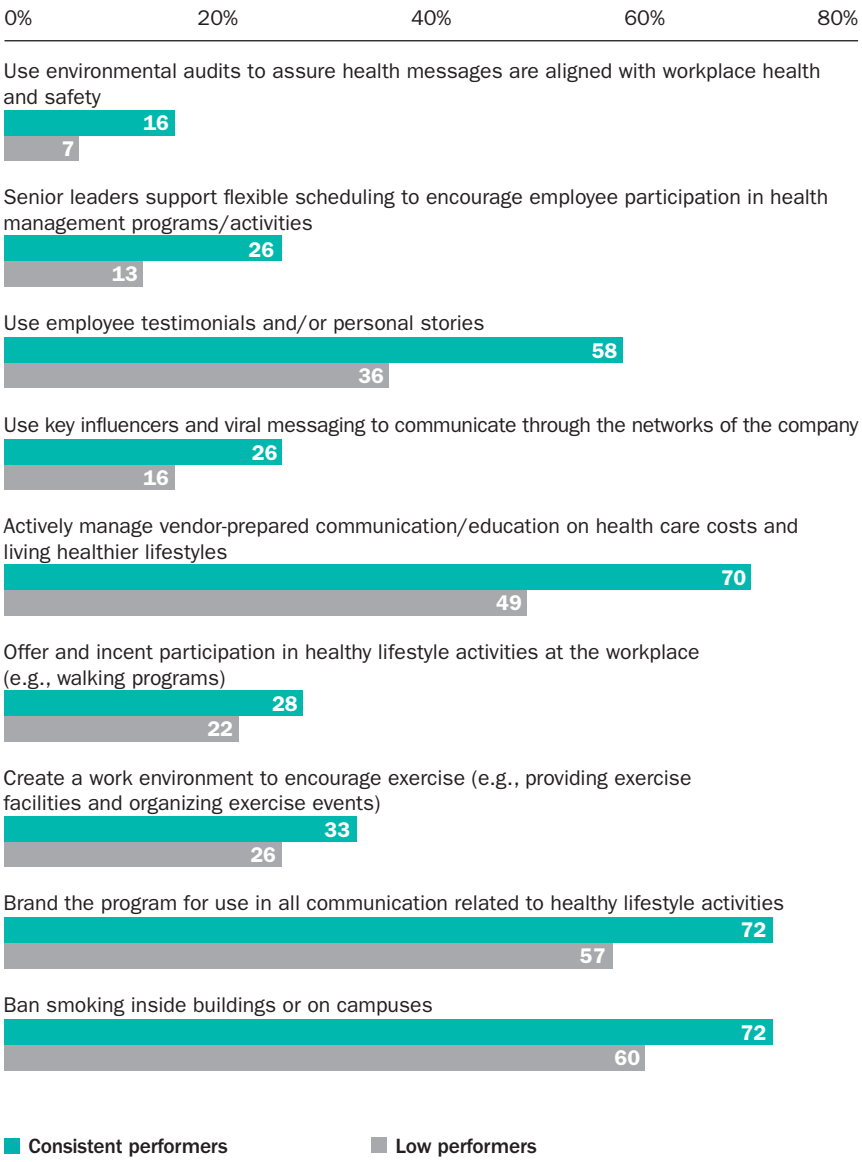


Figure 43. Healthy environment



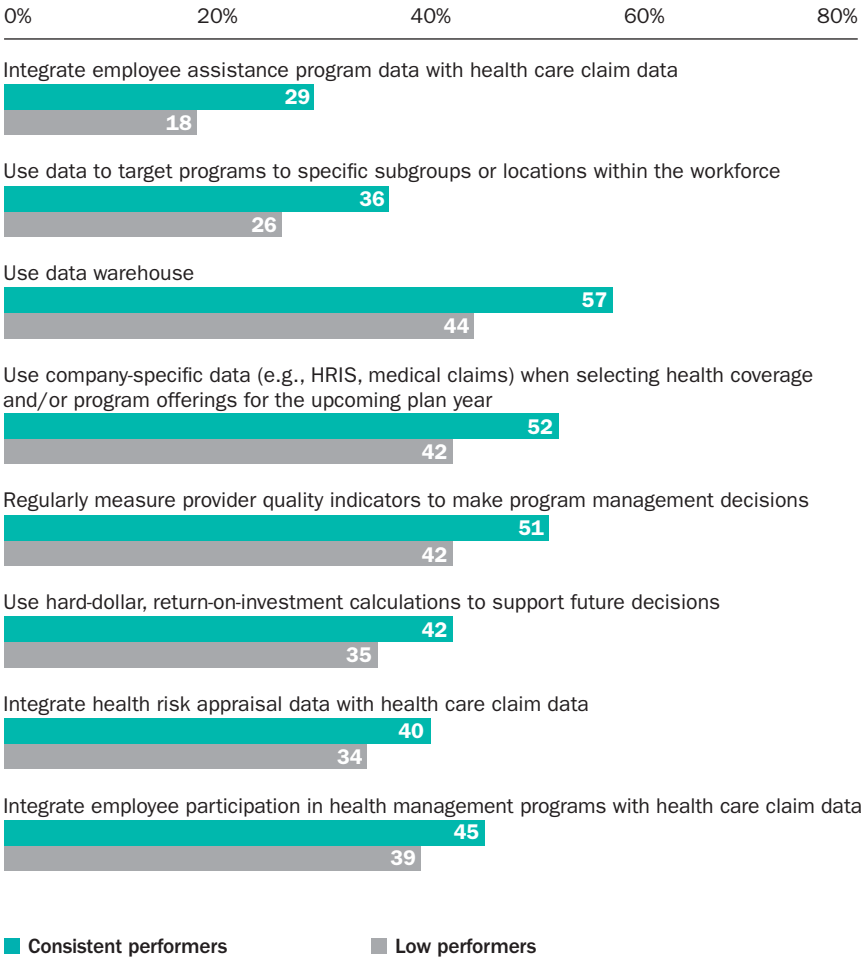
Healthy Environment

Consistent performers recognize that employees need a supportive workplace structure to become more accountable for, and improve, their health and well-being. The most successful companies have taken steps to alter the physical work environment, including offering exercise facilities and taking a hard-line approach to smoking by banning it inside or around campus facilities *(Figure 43)*. Likewise, senior leaders at these companies support flexible scheduling to help alleviate the time pressure many employees experience. Consistent performers also recognize that ongoing operational support is equally important. This includes using environmental audits to ensure health messages are aligned with other workplace health initiatives and actively managing vendor-prepared communication and education. Behavioral economics research has shown that hidden persuasion and peer pressure can be highly effective in motivating employees. Consistent performers have embraced a number of these techniques, such as using key influencers, employee testimonials and sponsoring workplace activities.

Metrics

As this research has shown in previous years, consistent performers use a data-driven approach to making ongoing and regular improvements in their health care program. Consistent performers tap into a wide range of company-specific data, such as human resource information systems (HRIS) information and medical claims *(Figure 44)*. They incorporate quality information to support benefit or program management decisions for the upcoming year. Consistent performers also use data to make important connections by integrating their health plan information with health risks, program participation and employee assistance program data. These companies tend to use a data warehouse vendor to help facilitate the integration of their program data. Consistent performers not only put greater emphasis on assessing the impact of their programs but also use integrated analyses in making decisions about their health care programs and target programs to specific subgroups. Applications also include estimates of program savings and ROI analyses.

Figure 44. Measurement



Conclusion

Although trends have stabilized somewhat since 2007, total health care costs continue to rise for both employers and employees. The pressure is on employers to aggressively manage their health care programs to both keep trend as low as possible and ensure the best return on their investment — and that of their employees. In addition, companies that put their health benefits in a broader total rewards context can better understand the effect that increasing health care costs have on other parts of the reward program, gain deeper insight into employee benefit preferences and manage their programs accordingly. In addition, improving the health and productivity of employees is essential to both controlling costs and improving organizational productivity.

Regardless of the future of health care reform, providing a cost-effective health benefit plan will remain a differentiator for many companies when it comes to attracting and retaining top talent. The following practices, gathered from our research and work with clients, are some that employers can use now to maximize plan effectiveness, control costs, mitigate risks and help employees manage their own health.

Know your numbers

Consistent, proactive management of your benefit plans begins with a clear understanding of your data — from costs, to usage rates, to organizational health metrics, to the drivers of annual cost trends. Some health care vendors resist providing figures on prices and hospital quality, but independent sources can help employers verify and understand these costs. These data provide both a road map for areas of improvement and a baseline for measuring change.

Follow the lead of consistent performers

Consistent performers are successful at managing their costs over the long term and keeping their trend well below average. In 2012, they took a number of steps to improve efficiency, including using data and metrics to understand the performance of their health plans, analyzing care gaps to make benefit program decisions, determining ROI and cost savings, negotiating financial arrangements with their pharmacy benefit managers and regularly auditing claims. Many also develop a workplace culture that holds employees accountable for managing their health.

Put health care benefits in a total rewards context

Many employers have a total rewards approach to benefits and compensation that focuses on using rewards to improve employee engagement and drive organizational performance. Employers that take this approach can make decisions about health benefit plan design and cost sharing within the context of their retirement benefit program, base salary and bonus philosophy as well as nonfinancial benefits, such as training and development. By making these trade-offs transparent, employers can help employees understand how continued increases in health benefit costs affect reward benefits.

View ABHPs as part of a broader health benefit strategy

ABHPs can help control both employer and employee costs, but effectiveness is not guaranteed, especially if enrollment is low. Encourage enrollment in HSAs or HRAs to align incentive strategies and save for medical costs in retirement. You can also make the best possible use of ABHPs by increasing provider accountability and educating employees on ways to be better health care consumers.

Partner with vendors

Develop stronger relationships with your health care vendors, and seek their help in increasing employee engagement and improving quality of care. Consolidating vendors and plans can make it easier to achieve workforce management goals. Looking ahead, they can be valuable partners in introducing new technologies and next-generation health care delivery models.

Use social media and incentives to increase employee accountability

Survey respondents report that poor employee health habits are the biggest challenge to maintaining affordable benefit coverage, and their top focus is developing a culture of health. In addition to working with vendors to improve employee health, consider social media and incentives to drive change. Online discussion groups and games, team-based and individual competitions, and other so-called behavioral health techniques can be effective. And consider moving beyond incentives for participating in biometric screening. Instead, or in addition, provide meaningful rewards for employees who meet health improvement goals, such as losing weight or smoking cessation.

Consider changes in plan design

Some employers are rethinking their current plan design to align it with health care reform's emphasis on employee accountability. They may have been reluctant last year, given all the uncertainty about the PPACA, but they are learning that small plan changes, such as high-performance networks and reference-based pricing, can add up to big cost savings for both employer and employee. In exchange, they are aiming to improve the value of other aspects of their total rewards that employees value as much as health benefits and gain an advantage over competitors. Other plan changes under consideration include spousal surcharges or waivers, and increasing employee contributions in tiers with dependent coverage or per covered dependent.

Rethink retiree health

As the cost of health plans becomes prohibitive for pre-65 retirees, employers are looking for better solutions. The expected implementation of the health Exchanges in 2014 could provide an answer. Many companies are also taking the opportunity to look at post-65 retiree plans due to Medicare changes and the upswing in Medicare coordination. Now is the time to review your retiree health program in light of your total rewards philosophy and reconsider your role in providing this benefit. At the same time, encouraging active employees' participation in an HSA or HRA can help them save now for future medical costs.

Keep abreast of regulatory changes

Health care reform and its many regulations are ever changing, and the jury is still out on the final disposition of the PPACA. Since it was enacted, the Departments of Labor and Health and Human Services have issued regulations and clarifications to the law, many of which affect employers. If the PPACA stands, major changes, such as the excise tax (set for 2018) and the health Exchanges (to be implemented in 2014), could have a profound effect on your organization's total rewards approach, recruitment and retention, and change management issues.

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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