AUGUST 2015

# LARGE EMPLOYERS' 2016 HEALTH PLAN DESIGN SURVEY:

## REDUCING COSTS WHILE LOOKING TO THE FUTURE

A *National Business Group on Health*® Publication

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# KEY FINDINGS

Results from the *National Business Group on Health*® Large Employers' 2016 Health Plan Design Survey indicate that employers remain committed to offering health benefits to their employees. However, the need to control rising health care costs has never been more necessary. Employers only have two more years to bend the cost curve before the excise tax goes into effect. As a result, employers are pursuing a number of strategies – promoting consumerism, reevaluating cost-sharing arrangements, and working with the health care system to make positive and sustainable changes.

**The majority of employers expect costs will continue to increase by an average of 5.0% in 2016** (Figure 1). That could mean trouble not too far down the road, as the excise tax is still scheduled to go into effect in 2018. Since the excise tax's threshold is tied to general inflation, which is estimated to grow at an average annual rate of 2.4% over the next decade, all plans will be hard pressed to avoid the tax indefinitely.

Given what employers know at this point, **most employers expect that if they didn't take action at least one of their plans will hit the excise tax threshold by 2020**, and their plan with the greatest enrollment will only be one year behind (Figure 2).

**Figure 1: Median Health Care Cost Increase Projections**

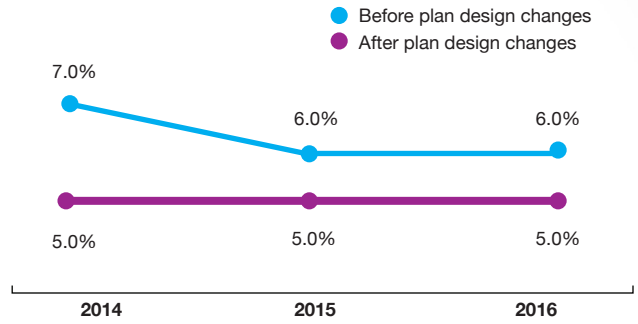
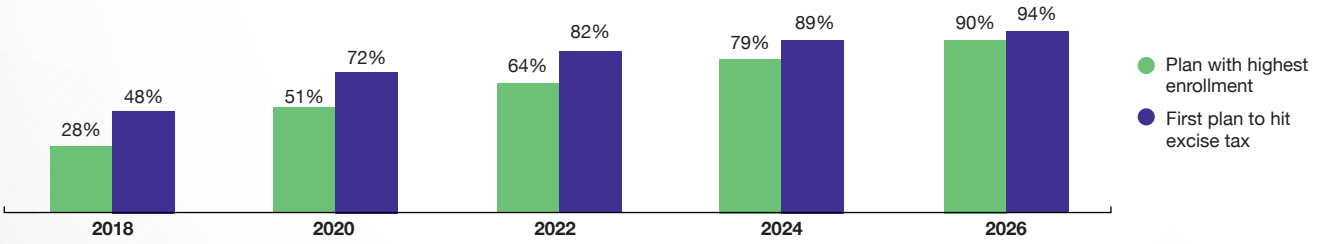
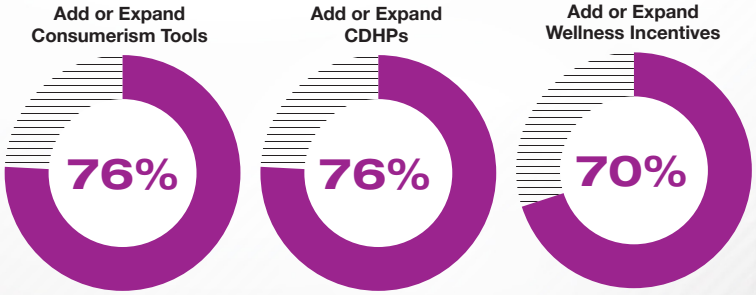



**Figure 2. When Employers Would Hit the Excise Tax if No Action Taken**




*Employers are taking steps to keep their plans under the excise tax threshold, but they estimate that their actions will only delay the impact by two to three years.*

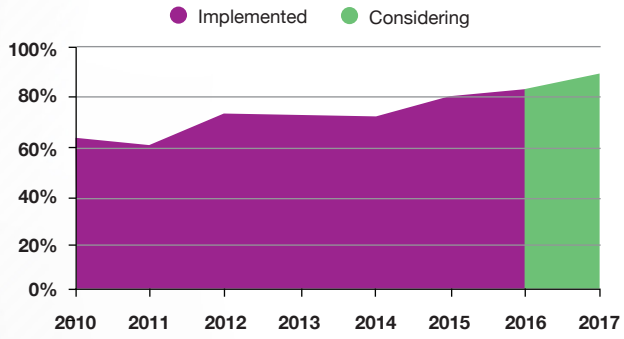
**Figure 3. Most Popular Actions Taken by 2016 to Delay the Excise Tax**



*Surprisingly, the number of employers adopting full replacement plans remained relatively steady at 33%. We expected to see more employers would move to full replacement plans next year but it appears many are taking a "wait and see" approach if congressional efforts to repeal the excise tax are successful. If those efforts don't materialize, we anticipate more employers will adopt a full replacement strategy in the coming years.*

In general, consumer-directed health plans (CDHPs) are becoming more common among large employers, with **83% offering at least one CDHP as an option**. In addition, a full third of respondents will offer only CDHPs in 2016 (Figure 4).

### Figure 4: CDHP Prevalence Among Large Employers

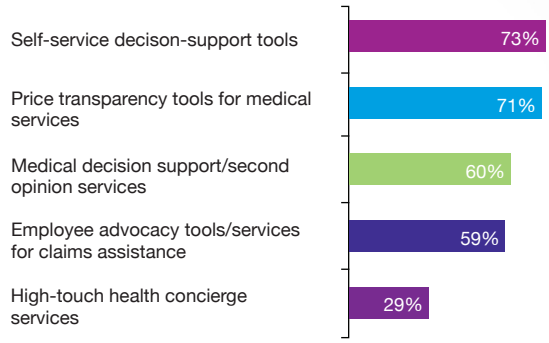



Because navigating the health care system continues to be a challenge for even the most engaged consumer, **employers are providing employees with more tools and resources than ever to help them**. Many employers have price transparency tools to help employees evaluate medical treatment decisions as well as medical decision support or second-opinion services (Figure 5).

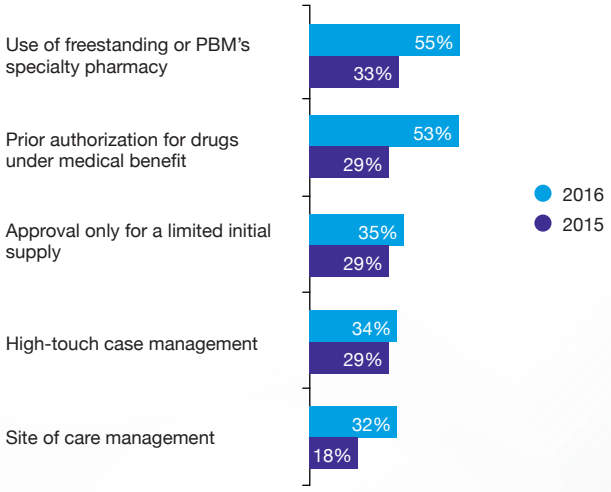
**The skyrocketing costs of specialty pharmaceuticals continue to be one of the largest drivers of medical trend in 2016**. As a result, employers are taking steps to control as much of the costs as possible. Tactics such as site-of-care management, pharmacy price transparency programs, requiring the use of a specialty pharmacy have all grown significantly since last year (Figure 6). Despite these steps, it is very likely that specialty pharmacy costs will continue to increase at a double digit rate, bringing all plans that much closer to the excise tax.

In the last few years, there has been much attention given to reforming the health care delivery system. Employers have expressed interest in influencing the supply side of health care, especially how health care is delivered to employees and their families. Much of the focus has been on centers of excellence (COE), accountable care organizations (ACOs) and use of high performance networks. Although employers have long embraced COEs, there is more reticence around use of high performance

### Figure 5: Consumerism Tools




### Figure 6: Key Management Techniques for Specialty Pharmaceuticals

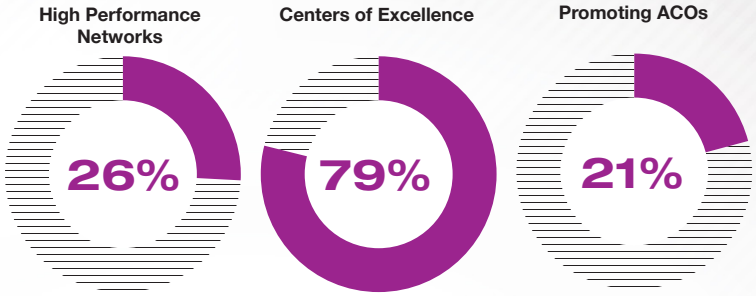


networks and ACOs. (Figure 7). Employers have struggled to understand how these reforms will improve care while controlling costs.

As employers look forward to 2016 and beyond, they continue to focus on three critical areas:

- Engaging employees to be better consumers by providing them with the tools they need to succeed in navigating the health care system;
- Ensuring employees have access to good quality health care; and
- Controlling health care costs in an effort to avoid the excise tax.

**Figure 7: Employer Delivery Reform Changes**




## ABOUT THE SURVEY

The Large Employers' 2016 Health Plan Design Survey is an annual survey of members of the National Business Group on Health. This year's survey asked employers to provide information on their 2016 plan offerings, including:

- Medical trend for 2016
- Changes due to the Affordable Care Act
- Consumer-directed health care
- Employee cost-sharing
- Pharmacy benefits
- Health care delivery reform

The survey was fielded between May 19 and June 24, 2015 and reflects the plan design changes of 140 employers. Collectively, these respondents represent a wide variety of industry sectors, and employ approximately 7.6 million employees in the U.S. (Figures 8 and 9). Respondents collectively insure more than 10 million people, including employees and their families.

**Figure 8: Industry Breakdown**

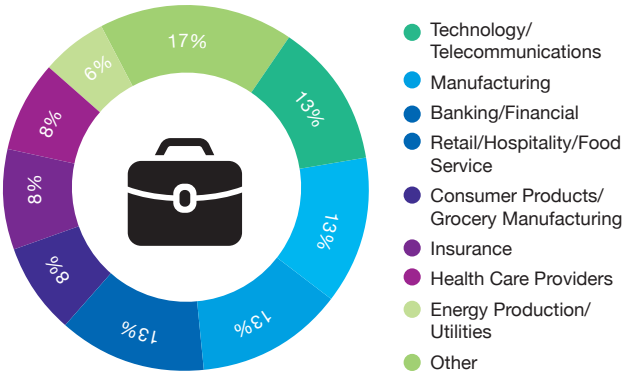
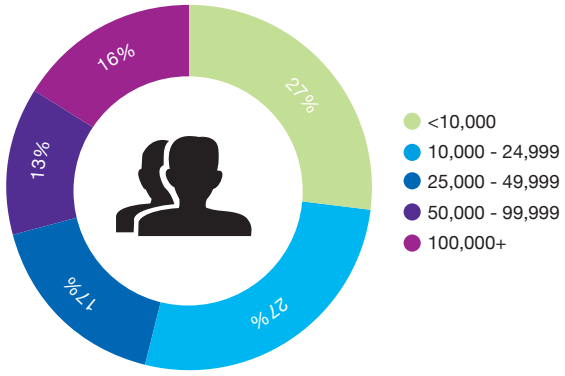



**Figure 9: Number of U.S. Employees**



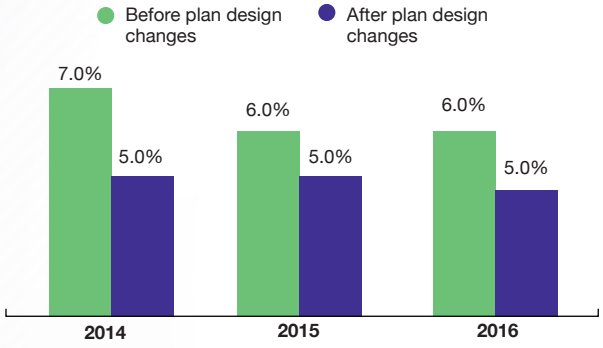

[1]Although 140 members completed the survey, not all members found all of the questions directly applicable to them. As a result, the number of responses varies by question.

# MEDICAL TREND

For 2016, employers are predicting that health care costs will increase by 6.0% over the course of the year, if no steps are taken to mitigate rising costs (Figure 10). Based on plan design changes, they expect that cost increases will be kept to 5.0%. This projection is similar to what respondents are expecting for this year. This is the third year in a row, where respondents have estimated a medical trend of 5.0%, post-plan design changes.

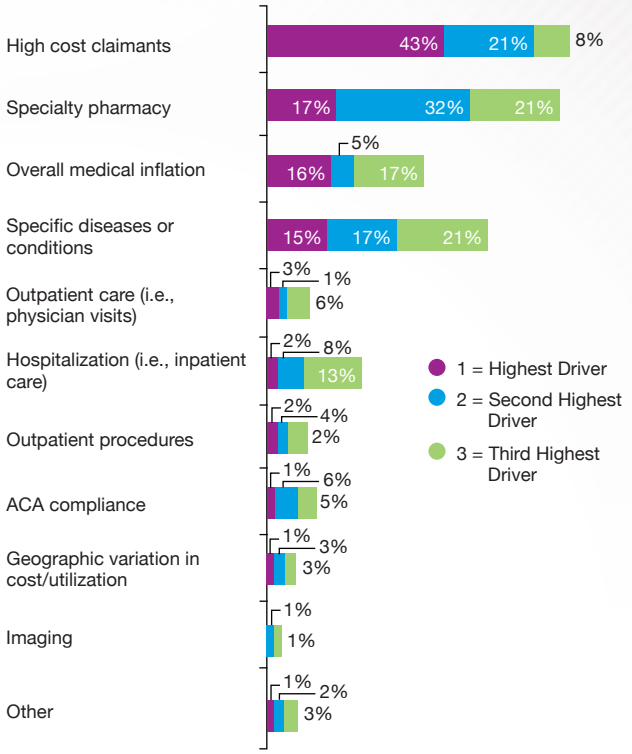
*After plan design changes, medical costs are expected to rise by **5.0%** in 2016.*

### Figure 10: Median Health Care Cost Increase Projections




**Note:** Projections are based on employers who had estimates for each year. Not all respondents were able to provide estimates for cost projections.

### Figure 11: Top Cost Drivers of Rising Health Care Costs



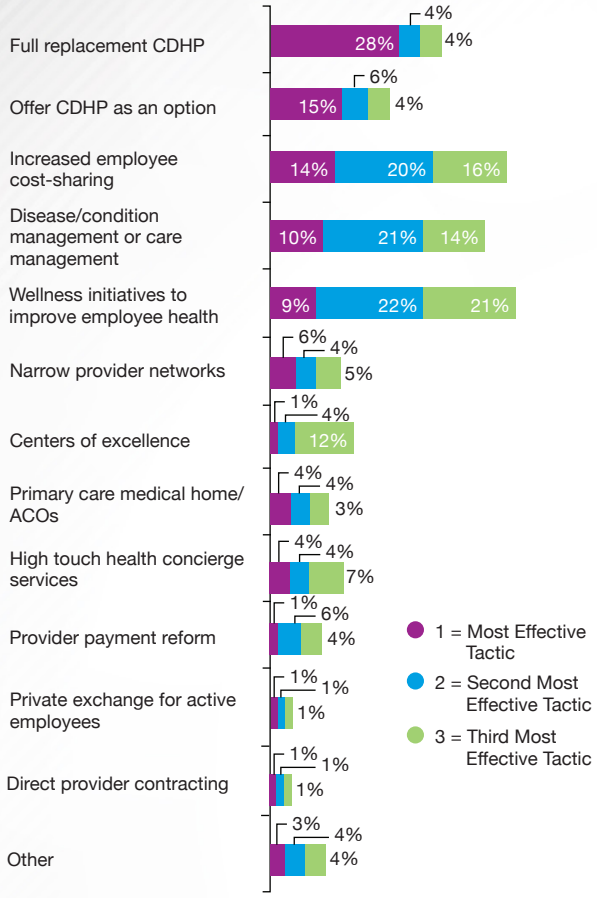

**Note:** Other responses included: pharmacy; maternity; chronic diseases; and an aging workforce.

Employers see a number of factors driving these rising costs. For many employers (43%), the number one driver of rising health care costs is high cost claimants (Figure 11). Respondents also cited three other drivers that all factor into rising health care costs: specialty pharmacy, specific diseases or conditions, and overall medical inflation. Specialty pharmaceuticals are continuing to come on the market to help manage and treat specific diseases or conditions, resulting in escalating pharmacy costs. Overall medical inflation shows no indication that it will slow down in the near future. The Centers for Medicare and Medicaid Services (CMS) is predicting an average of 5.8% annual growth in health care expenditures from now until 2024.[2] Employers have implemented various tactics to help combat rising costs. More than 60% of employers reported that implementing CDHPs as an option or going full

*In the last year, employers have seen specialty pharmacy drive the claims costs. In 2014, only 6% of employers indicated that specialty pharmacy for the highest driver of health care costs. This year, 17% of employers indicate it is the highest driver.*

[2]Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2014-2024. 2014

## Figure 12: Most Effective Tactics to Control Health Care Costs




**Note:** Other responses included: specialty and traditional pharmacy management techniques; elimination of low-performing programs; price transparency tools; vendor management; and promotion of consumerism.

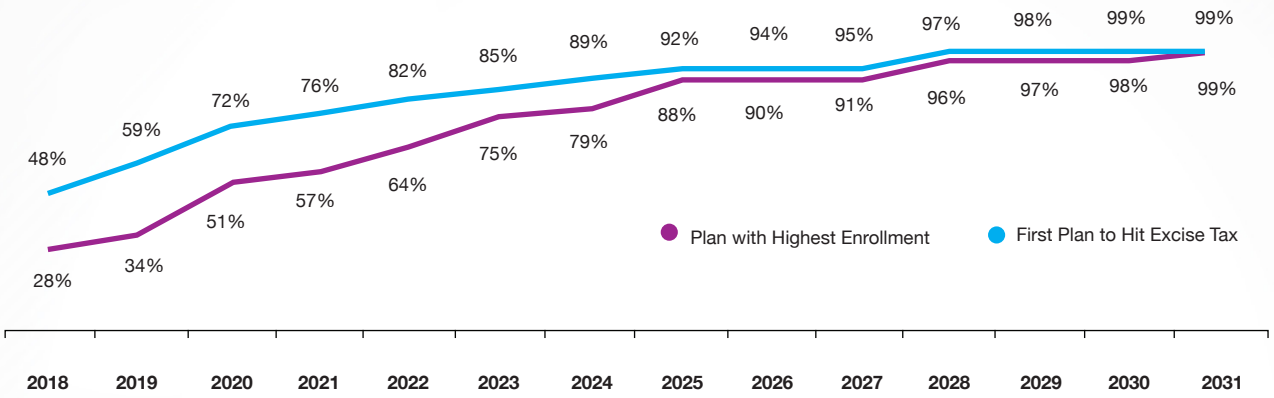
replacement was one of their most effective tactics (Figure 12). Fifty-two percent of employers indicated that providing wellness initiatives was one of their top three most effective tactics to control health care costs, and 45% indicated disease/condition management or care management programs. Figure 12 also highlights that at this time employers do not believe that delivery system reforms such as narrow networks, accountable care organizations or provider payment reform are effective tactics to control health care costs. It is hoped that in the future, they will lead to significant change in the health care system and result in more efficient use of health care dollars.

# EXCISE TAX

The excise tax is a 40% marginal tax on health insurance beyond a certain threshold, meant to fund the ACA by taxing only the most generous health plans. The tax is set to go into effect in 2018, and the threshold is tied to general inflation going forward.

*If employers made no changes, the majority of large employers will be subject to the excise tax by 2019 for at least one plan and their most popular plan by 2020.*

**Figure 13: When Employers Will Hit the Excise Tax if No Changes were Made**

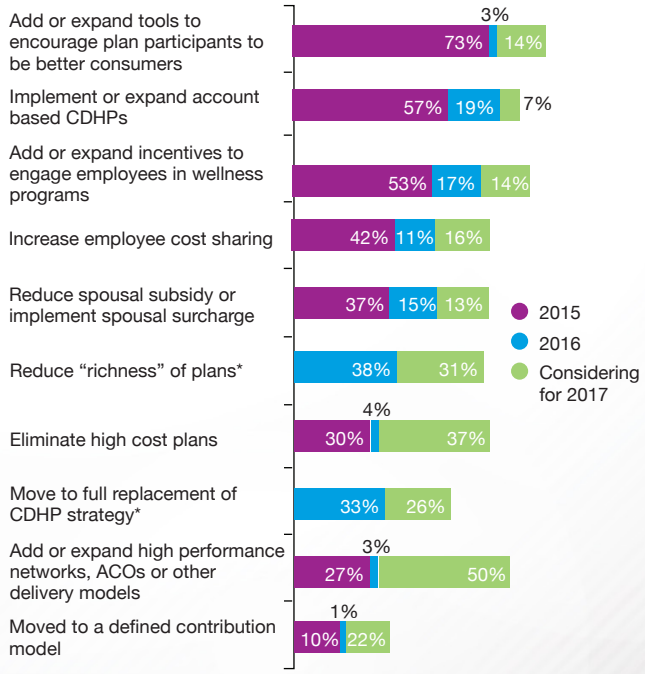



**Note:** These numbers are based on respondents who had an estimate of when their plans will trigger the excise tax.

Since the ACA was signed into law, employers have been concerned about the excise tax, and how it will impact their benefit offerings. With the excise tax threshold set to general inflation, rather than medical inflation, the concern is that all plans – not just "Cadillac" plans will end up having to pay the excise tax at some point. Based on internal analyses and estimates, 48% of employers expect that at least one of their health plans will exceed the excise tax threshold in 2018 if they did not make any changes. Many employers estimate that their most popular health plan will not hit the threshold in 2018, but the majority of respondents estimate that they will exceed the threshold in 2020 (Figure 13).

However, employers are taking action to delay the impact of the excise tax. Employers – and especially large employers – have been focused on bending the cost curve for many years. However, with medical trend still exceeding general inflation, employers are redoubling their efforts. Many employers are focused on helping employees to be better consumers, by adding/expanding consumerism tools and implementing/expanding account-based CDHPs (Figure 14). The majority of employers will either add or expand current wellness incentives.

**Figure 14: Employer Actions to Minimize the Impact of the Excise Tax**



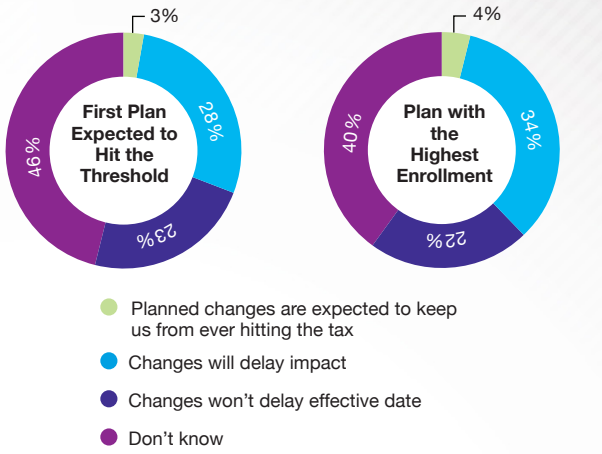

* Denotes options that were not asked in last year's survey.

*Employers expect that their efforts to avoid the excise tax will delay the tax by **two or three years**.*

One area of focus among employers is around improving the health care payment and delivery system. While only 30% of employers plan to have added or expanded their efforts around high-performance networks, accountable care organizations (ACOs), primary care medical homes or other delivery models by 2016, an additional 50% of respondents are considering making that a priority for the near future.

While many employers are not sure exactly how much of an impact their changes will have on when their plans will exceed the excise tax threshold, some employers have been able to estimate the impact of their changes. Among employers who will be able to delay the impact of the tax, the median delay is three years for their first plan to hit the tax, but only two years for their plan with the highest enrollment (Figure 15).

**Figure 15: Delaying the Impact of the Excise Tax**



# PRIVATE EXCHANGES

No employers in this survey indicated they will eliminate coverage in 2016 and pay the penalty for not offering coverage to their employees. However, some employers have been looking at the viability of private exchanges as another vehicle through which to offer coverage.

By 2016, 3% of responding employers plan to move their active employees to a private exchange (Figure 16). Almost a quarter of respondents (24%) are considering a private exchange for their active employees sometime in the future, which is a decrease from last year, when 35% were considering private exchanges.

Contrary to the active population, the trend of employers partnering with a private exchange for their retirees continues to grow. By 2016, 24% of respondents will offer their retirees coverage through a private exchange – compared to just 10% in 2013.

For the second year, respondents were asked how confident they were that private exchanges would be able to outperform employers in key areas. The three features that most employers were confident a private exchange would do better were providing more choice of plans, complying with regulations and supporting a defined contribution approach (Figure 17).

Respondents continue to be less confident in the ability of private exchanges to outperform employer efforts to control health care costs, assist employees with questions/ problems and engage employees in better health care decision-making.

**Figure 16: Employer Plans for Private Exchanges**

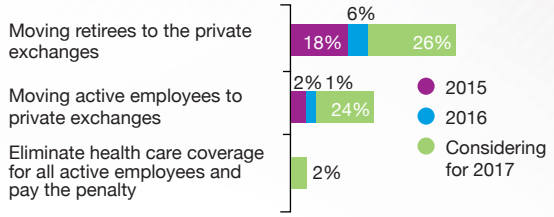
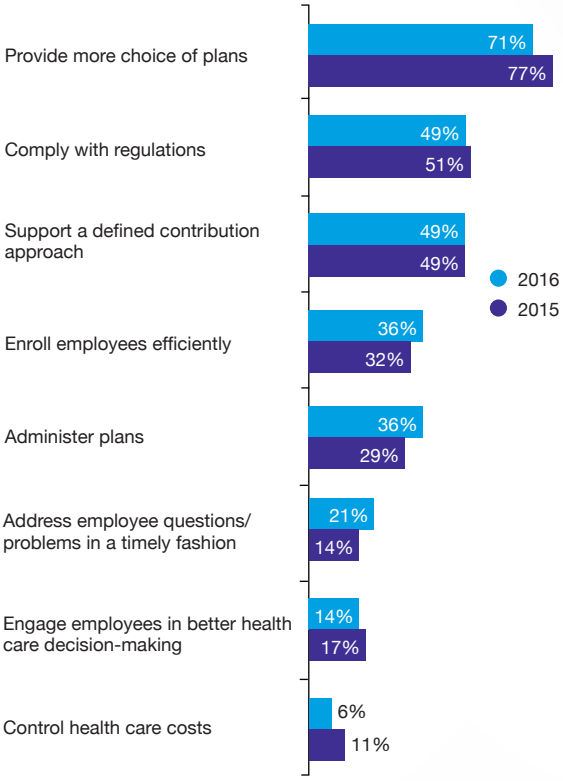



**Figure 17: Employers' Confidence That Private Exchanges Will do the Following Better Than Employers do Today**

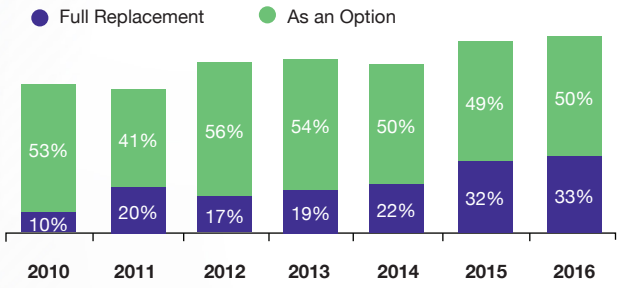



**Note:** The data above reflects the percentage of employers who selected 4 or 5 on a 5-point scale, where 5= very confident.

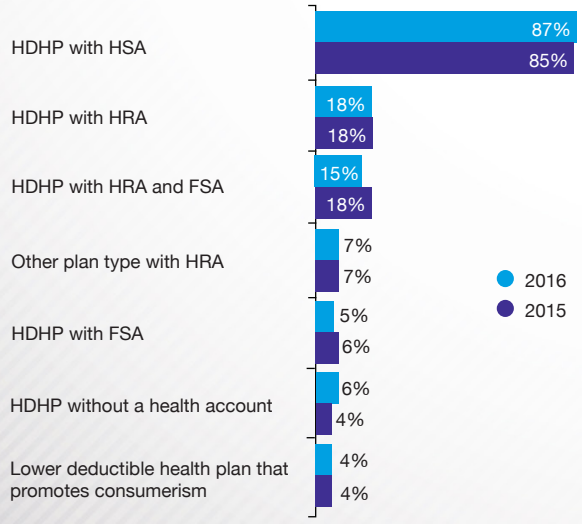
# CONSUMER-DIRECTED HEALTH CARE

The adoption of consumer-directed health plans (CDHP) continues to increase among large employers. In 2016, 83% of employers will offer at least one CDHP, up from 81% in 2015 (Figure 18). In addition, the percentage of employers who will only offer CDHPs to their employees has increased slightly from 32% to 33% in 2016. It is important to note that while CDHP is considered an effective tactic for controlling costs, we have seen only minimal increases in the percentage of employers moving to CDHP or to full replacement this past year.
It is anticipated that many employers are waiting to see if congressional efforts to repeal the excise tax are successful. If that does not happen, we believe more employers will adopt a CDHP strategy in the coming years.
While CDHPs are now offered by most large employers, not all CDHPs are the same. The most common design is that of a high-deductible health plan (HDHP) paired with a health savings account (HSA), which is offered by 87% of employers offering a CDHP (Figure 19).

### Figure 18: Availability of CDHPs Among Employers




### Figure 19: Prevalence of Consumer-Directed Health Plan Types

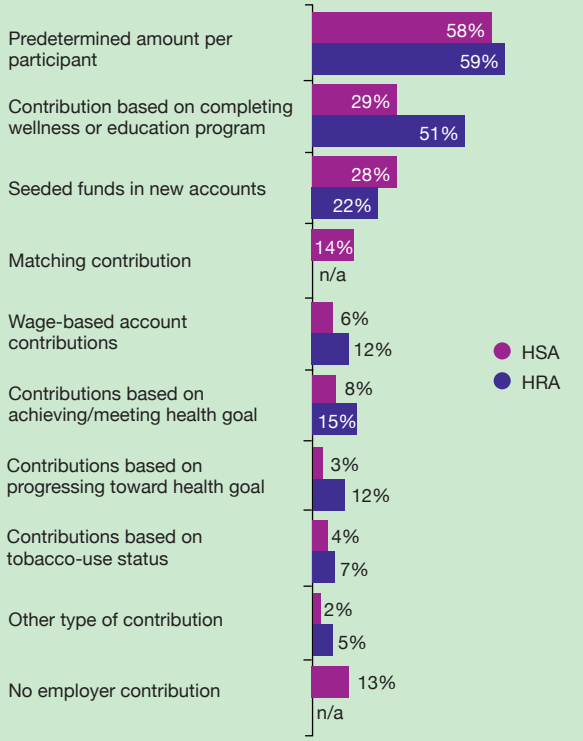



*The maximum amount an employee could receive from his or her employer (including both automatic and earned amounts) was a median of $750, an increase from a median $600 reported last year. If the employee's spouse or domestic partner was also enrolled under the health plan, the maximum contribution was a median of $1,250.*

## Employer Contributions to Health Accounts

CDHPs also differ based on how employers contribute to the health accounts linked to the plans. Among employers with each plan type, many will contribute a predetermined amount per participant to the HSA (58%) and HRA (59%). Many other employers will make contributions to the accounts if employees participate in select wellness programs (29% for the HSA/51% for the HRA). Other employers will seed funds in new accounts and/or provide a matching contribution. Thirteen percent of employers offering an HDHP with an HSA do not contribute any funds to the account (Figure 20).

### Figure 20: Employer Contribution to Health Accounts



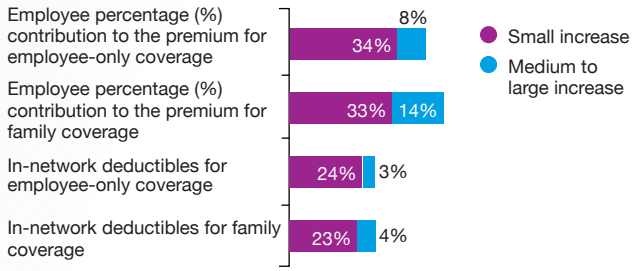

**Note:** Other contribution methods included: contributions based on completing disease management or medical decision-support program.

# COST-SHARING

One of the tactics often reported by employers as a method for controlling costs is increasing employee cost sharing. However, employers still pay the majority of their employees' health care costs.

Going into 2016, some employers will be increasing cost sharing provisions for their most popular plans. Most employers making changes will be making small incremental changes to cost sharing provisions, while other employers will be making more significant changes (Figure 21).

### Figure 21: Changes in Cost-Sharing for 2016




In 2015, employers' plans with the highest participation were split between PPOs (52%) and CDHPs (41%). Across all plan types, the median percentage contribution to the premium for employee-only coverage is 20% and 24% for family coverage. Across all plan types, the median in-network deductible for 2015 will be $950 for employee-only coverage and $2,000 for family coverage (Figure 22). For PPOs, employees are responsible for more of the premium, but have lower deductibles, whereas CDHPs will have the lower premium with increased deductibles.

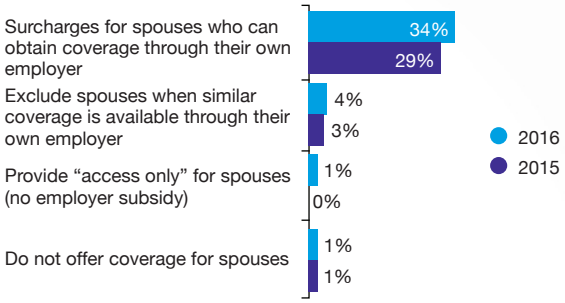
### Figure 22: Median Employee Cost-Sharing Amounts for 2015

| | All Plan Types | PPOs | CDHPs |
|---|---|---|---|
| **Employee % of the premium** | | | |
| Employee-only | 20% | 21% | 19.5% |
| Family coverage | 24% | 25% | 22% |
| **In-network deductibles** | | | |
| Employee-only | $950 | $500 | $1,500 |
| Family coverage | $2,000 | $1,000 | $3,200 |

**Note:** Employers were asked to provide cost sharing information for their plan with the greatest participation. Of the 140 respondents, 52% reported that a PPO was their most common plan type, and 41% indicated a CDHP.

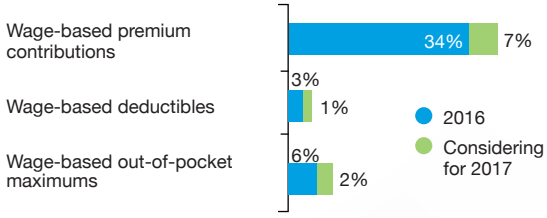
Respondents were also asked specifically about spousal coverage. Surcharges for spouses who can obtain coverage through their own employers are becoming more common (34% in 2016 vs. 29% in 2015) (Figure 23). A few employers have other provisions in place such as not covering spouses if they have other coverage available, providing access to coverage (but with no employer contribution to the premium) or not covering spouses at all.

### Figure 23: Spousal Coverage




Despite the movement toward greater cost-sharing, some employers continue to assist lower income employees, by having wage-based cost sharing arrangements in place. The most common is wage-based premium contributions (Figure 24). Other employers have wage-based deductibles or out-of-pocket maximums. For those employers with health accounts, some even have wage-based health account contributions (see Figure 20).

### Figure 24: Wage-Based Cost-Sharing Arrangements



# PHARMACY BENEFITS

Overall spending on prescription drugs continues to grow. Pharmacy spend is expected to increase by 10.6% per-member-per-month (PMPY) in 2016; most of this increase is due to rising specialty pharmacy costs. Traditional pharmacy spend drugs is projected at 3.9%, but specialty trend is 22.3% for 2016.[3] To manage these rising costs, employers will continue to utilize a variety of pharmacy benefit management tactics.

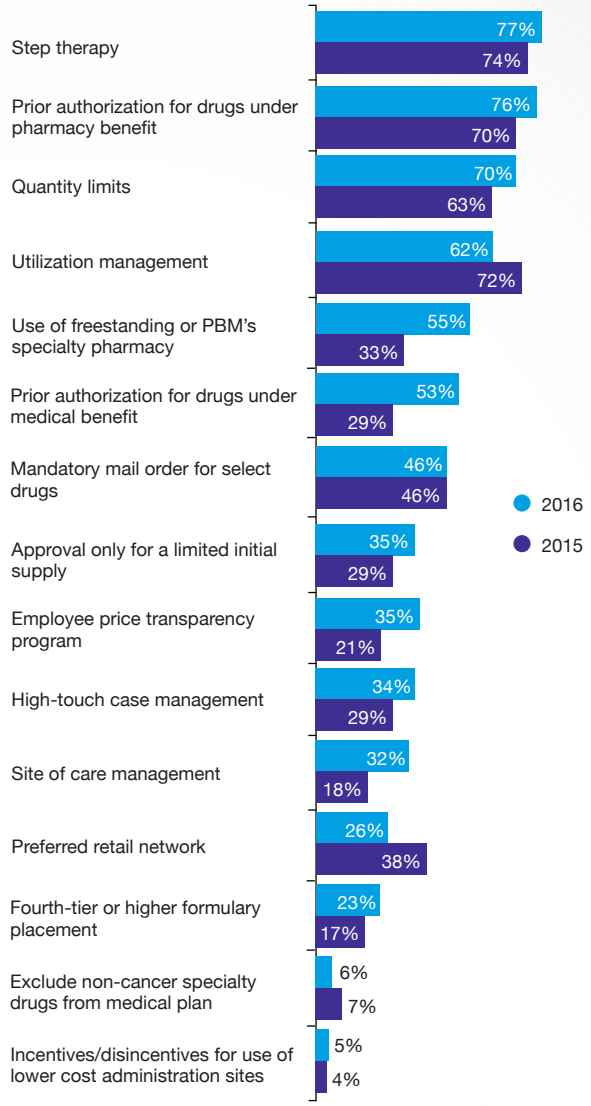
For specialty pharmacy, the most common management techniques are the ones the plans have been using for years to manage certain traditional medications, including: step therapy (77%); prior authorization under the pharmacy benefit (76%); quantity limits (70%); and utilization management (62%) (Figure 25).

*The percentage of employers implementing programs to manage site-of-care issues for specialty medications continues to increase with 32% of respondents planning to have something in place by 2016, compared to 18% in 2015 and 10% in 2014.*

However, specialty medications are different than traditional in many ways. They often involve much higher costs (i.e., upwards of thousands or tens of thousands of dollars per treatment). Many are biologics that require special handling in how the medications are both distributed and administered. They also can have very significant side effects, meaning that special monitoring of patients is required and that adherence can be a challenge.

As a result, employers – along with their health plans and PBMs – are implementing techniques specific to specialty medications, such as use of a freestanding specialty pharmacy (55%), requiring prior authorization for any specialty medication prescribed under the medical benefit (53%), and employee price transparency programs for specialty medications (35%).

**Figure 25: Specialty Pharmacy Benefit Management Techniques for 2016**



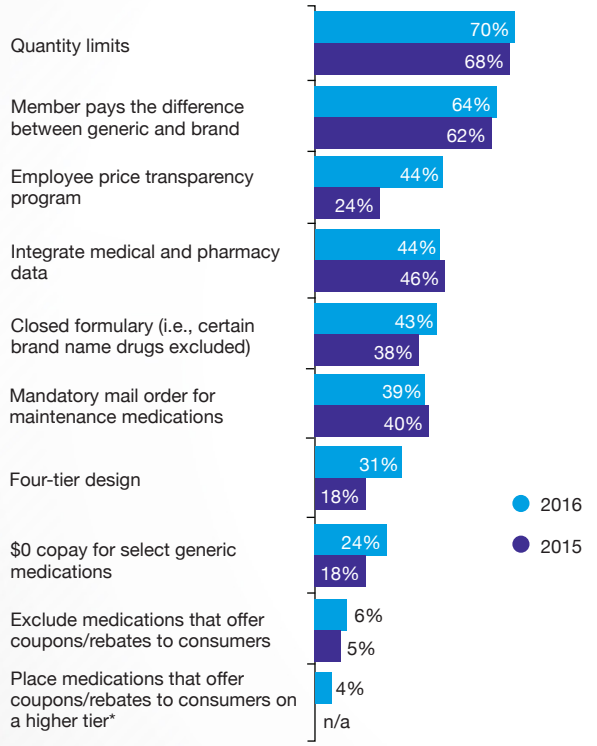

**Note:** Other responses included: employees pay higher copay for maintenance medications at retail pharmacy after the third fill.

[3] Express Scripts Inc., 2014 Drug Trend Report, March 2015.

While traditional pharmaceuticals are not rising at nearly the pace of specialty medications, employers are still taking steps to manage these costs. While almost all employers use prior authorization and step therapy, other common techniques used to manage costs are quantity limits (70%); member pays the difference between generic and brand prices (64%), and an employee price transparency program including traditional medications (44%) (Figure 26).

One issue that arose in 2014 was a sudden spike in the cost of compounded medications. Compounded medications are drugs combined, mixed or altered by a pharmacist to create a medicine tailored to the needs of an individual patient. Over the course of 2014, the per member per year costs of compounded medications increased by 128%.[4] During the latter half of 2014 and the beginning of 2015, most employers worked with their health plans and/or PBMs to put in place cost management techniques to better manage the use and cost of these medications. Going into 2016, 50% of respondents indicated that compounded medications will be subject to prior authorization, 24% will require that plan participants try traditional medications before using the compounded medication, and 22% will have quantity limits in place. Beyond these traditional pharmacy management techniques, some employers are excluding certain bulk ingredients from their plans at the recommendation of their PBMs (Figure 27).

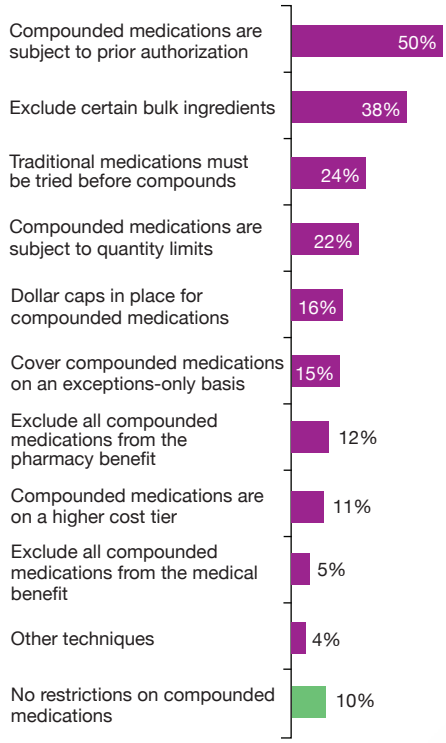
## Figure 26: Traditional (Non-Specialty) Pharmacy Benefit Management Techniques for 2016




* Denotes options that were not asked in last year's survey.

**Note:** Other responses included: no co-pay for select maintenance medications; no co-pay on select OTC medicines; employees pay higher copay for maintenance medications at retail pharmacy after the third fill; and dose optimization.

## Figure 27: Compounded Medication Management Techniques in 2016




**Note:** Other responses included: exclusion of topical analgesics; follow PBM's recommendations; only cover hormonal and pediatric compounded medications; and still considering.

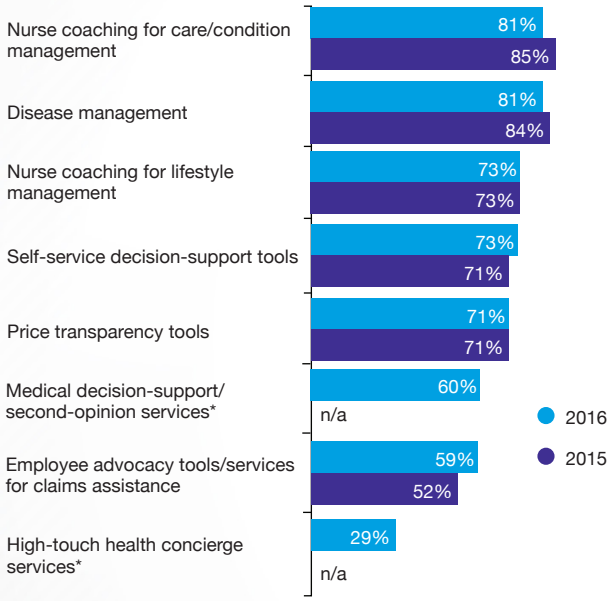
[4] Express Scripts Inc., 2014 Drug Trend Report, March 2015.

# OPTIMIZING THE DELIVERY SYSTEM

For many large employers, they see decades of climbing costs and unresolved quality issues within the system. As a result, employers have been trying to address these concerns on two fronts: the demand side by empowering employees and their families to make smarter health care decisions; and the supply side by helping to change the health care payment and delivery system.

**Tools to Manage Health:** Employers offer a variety of programs and tools to help employees manage their health. These include nurse coaching for care/condition management (81%) and lifestyle management (73%) (Figure 28). Eighty-one percent also have a disease management program in place.

**Figure 28: Employer Tools and Programs**




* Denotes options that were not asked in last year's survey.

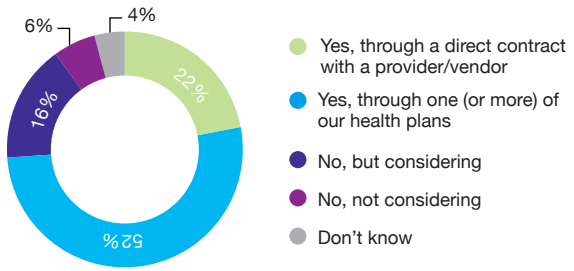
**Consumerism Tools:** Employers are also offering tools and programs to employees to help them make better health care decisions and to navigate the complex health care system. Nearly three-quarters of employers provide employees with self-service decision support tools, often located on their company intranet or online portal. Other tools/programs offered by employers include:

- Price transparency tools (73%);
- Medical decision-support/second-opinion services (60%);
- Employee advocacy tools (59%); and
- High-touch health concierge services (29%).

*Price transparency tools are most likely to be offered by employers offering CDHPs. Compared to employers without CDHPs, full replacement employers are more likely to offer transparency tools for medical procedures (82% compared to 47%), traditional pharmacy (53% compared to 30%) and specialty pharmacy (42% compared to 17%) .*

**Telehealth:** Another service that has been growing quickly among employer plans is the integration of telehealth. In last year's survey, 48% of employers made telehealth options available to employees in states where it was legal.[5] For 2016, 74% of employers will offer telehealth. Some employers will direct contract with a telehealth provider (22%), but most employers are now obtaining the service through their health plans (Figure 29).

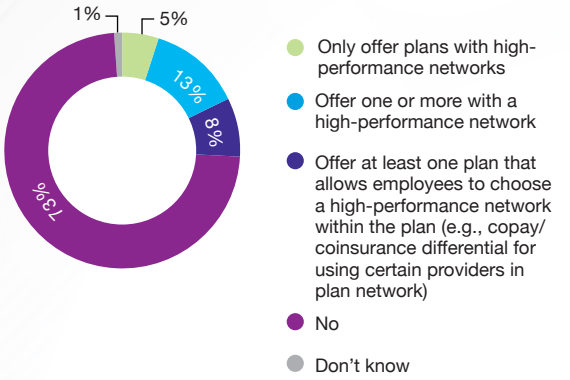
**Figure 29: Large Employers' Use of Telehealth**




[5] States have varying rules relating to telehealth. For more information, see the Business Group's State and Federal Policy Recommendations to Promote Telehealth.

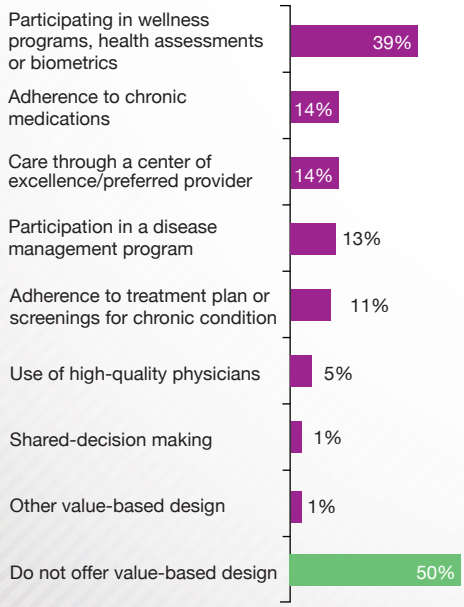
**High-Performance Networks:** About a quarter of employers are now offering high-performance networks in some or all of their plans (Figure 30). High-performance networks typically include narrower networks that encourage enrollees to choose network providers deemed high performing on efficiency and quality measures.

### Figure 30: Large Employers' Use of High-Performance Networks




**Value-Based Benefit Design:** Many employers are also incorporating value-based benefit design features into their plans. Value-based benefit design is where employees receive reduced cost sharing or premium reductions when they take steps to improve their health, manage chronic conditions or obtain higher quality care. The most common example of this is using plan design incentives to encourage employees to participate in wellness programs or "know your numbers" style programs (39%) (Figure 31).

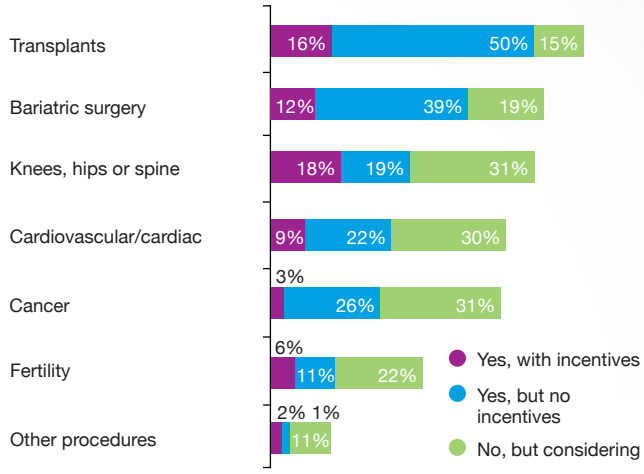
### Figure 31: Value-Based Benefit Design




**Note:** Other responses included: expanded free preventive medications for people with diabetes; and free preventive medications for all employees.

**Centers of Excellence:** Employers have used centers of excellence (COE) programs for specific procedures and conditions for years. COE programs are designed to encourage employees needing complicated and specialized care to visit the highest quality providers. COEs are still most common for transplants (66%), but many employers have COE programs tailored around other conditions or procedures, such as bariatric surgery (51%) or surgical procedures to treat musculoskeletal problems (37%) (Figure 32).

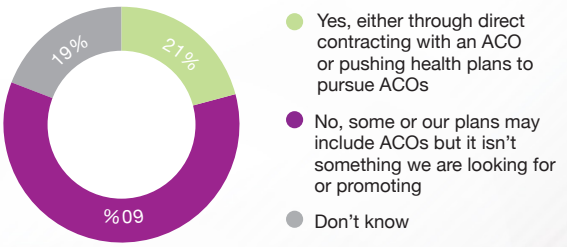
### Figure 32: Centers of Excellence




**Note:** Other centers of excellence programs included: maternity, NICU, sleep apnea, pancreas, cornea, and kidney.

**Accountable Care Organizations:** A growing strategy by health plans is to contract with Accountable Care Organizations (ACOs). ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to provide coordinated care to their patients. While a small number of employers (21%) are actively pursuing a strategy around engaging employees in using ACOs, most rely on their health plans to contract with these ACOs (Figure 33).

### Figure 33: Employers' Strategies Around ACOs

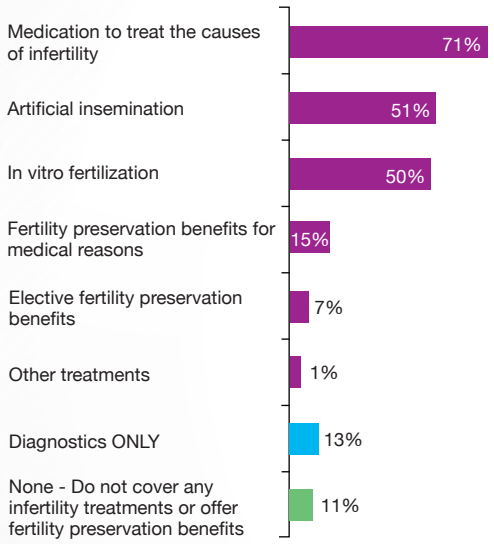


# OTHER PLAN COVERAGE

This year's survey included questions on coverage of treatments for infertility and autism spectrum disorders.

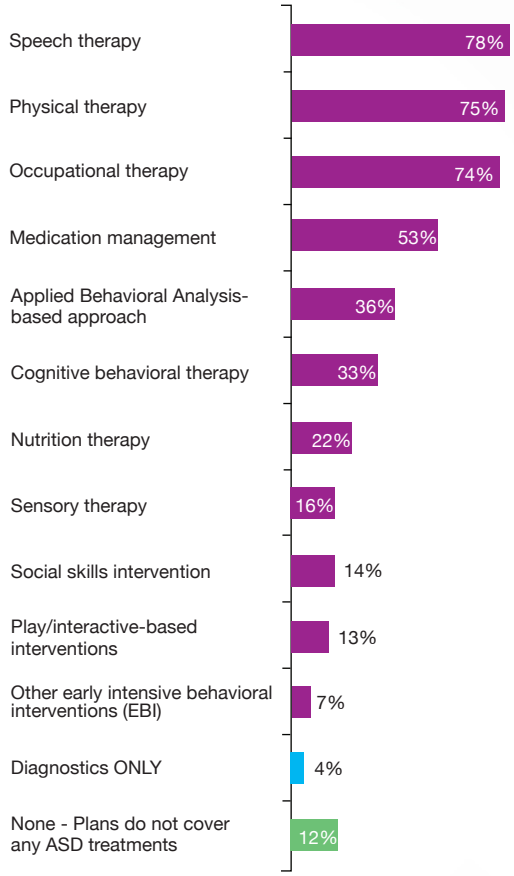
For infertility, most large employers include some level of coverage to help employees having trouble conceiving. Seventy-one percent of employers cover medication to treat the causes of infertility (Figure 34). Roughly half of respondents also include coverage for artificial insemination or in vitro fertilization. A few employers also offer fertilization preservation benefits (e.g., egg/embryo freezing) for when a treatment or condition is likely to result in infertility (15%), and a few employers extend fertility preservation to employees who do not have an underlying medical condition.

### Figure 34: Coverage of Infertility Treatments




In addition, most large employers include coverage for helping children diagnosed with autism spectrum disorders (ASD). Most plans include coverage for speech therapy (78%), physical therapy (75%) and occupational therapy (74%) for children with ASD (Figure 35). In 2016, 36% of employers will offer some level of coverage for Applied Behavioral Analysis-based approaches.

### Figure 35: Coverage of Autism Spectrum Disorder (ASD) Treatments

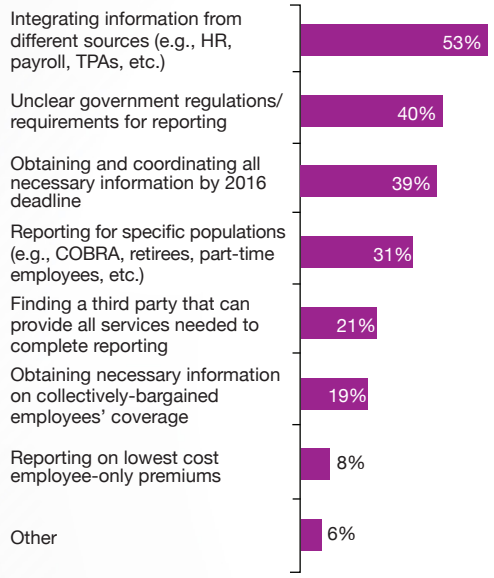


# OTHER POLICY IMPLICATIONS

Since the ACA was passed, employers have been asked about the changes they would be making to their health plans to comply with new regulations coming into effect in the upcoming year. The most immediate, set of regulations that employers are in the midst of trying to comply with involve reporting requirements effective January 1, 2016.

Employers have been preparing for the new reporting requirements for the last few years, but have hit numerous barriers in their efforts to meet the deadline (Figure 36).

### Figure 36: Largest Barriers in Meeting Reporting Deadline

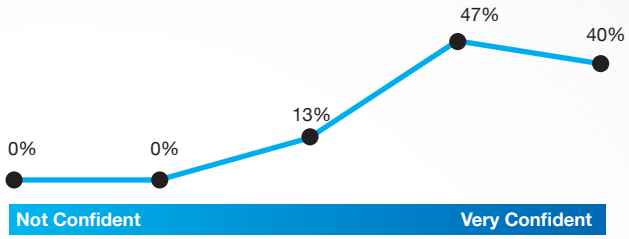



**Note:** Other responses included: The cost of tracking and reporting; overseeing third-party partners; ensuring accuracy of information gathered.

While obtaining all of the data necessary to comply with the reporting requirements has proven a challenge for many (39%), the top barrier cited by respondents was integrating all of that disparate information obtained from various internal and external sources (53%). Unclear and confusing regulations/ requirements confounded these issues for many employers.

Despite those – and other – challenges, employers are relatively confident that they will meet the reporting deadline. No respondent indicated that they were not confident that they would be able to meet the January 1, 2016 deadline, and 40% were very confident (Figure 37). While employers only received the final regulations for this requirement in March 2014,[6] employers have been preparing and planning for this requirement for much longer.

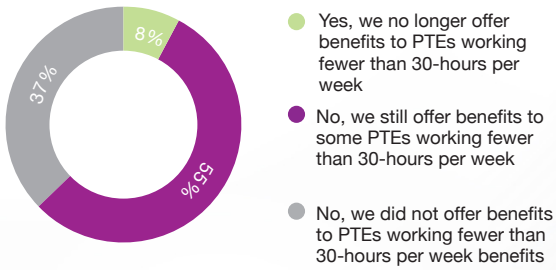
### Figure 37: Confidence in Meeting Reporting Deadline




Beginning in 2015, large employers were required to offer coverage to part-time employees working at least 30-hours per week. Given that many employers already offered coverage to part-time employees working fewer than 30-hours per week, respondents were asked whether they changed their eligibility restrictions to follow the ACA regulations.

The majority of employers (55%) will continue to offer benefits to at least some of their employees working fewer than 30 hours per week. While a few employers offer benefits to all employees (regardless of hours worked), most employers offering coverage to any employees working fewer than 30-hours per week have an eligibility criteria of 20-hours per week. A small number of employers (8%) decided to change their eligibility requirements to match the criteria laid out by the ACA (Figure 38).

### Figure 38: Benefits for Employees Working Fewer than 30-Hours per Week




[6] National Business Group on Health, IRS Issues Final Regulations on Employer Reporting Requirements under ACA, *Public Policy Alert*, March 2014.

# EMPLOYERS' FOCUS GOING INTO THE FUTURE

As the effective date of the excise tax approaches, employers continue to look for ways to avoid the tax while still providing their employees with access to quality health care. However, faced with medical inflation far outpacing general inflation as well as drastically increasing pharmacy costs due to specialty pharmacy pricing, employers are challenged with how to provide quality health benefits to employees.

As a result, much of the focus going forward by employers centers around engaging employees to be better consumers as well as improving many of the lifestyle behaviors that impact employee health. When asked which three behaviors were employers top focus areas for 2016, 58% of respondents reported that they were focusing on helping employees to become more engaged in health care decision-making, and 37% reported that it was their top focus area (Figure 39). Employers are also focused on:

- Increasing physical activity/ decreasing sedentary behavior,
- Weight management,
- Tobacco cessation,
- Stress reduction, and
- Improving financial wellness.

**Figure 39: Top Behaviors Employers are Focusing on in 2016**


**Note:** Other responses included: chronic disease management; getting employees to be aware of their health risks; and reducing emergency room utilization.

# OTHER RESOURCES FOR BUSINESS GROUP MEMBERS

For other sources of information relating to changes in plan design, see the following National Business Group on Health resources.

- Large Employers' 2015 Health Plan Design Survey, *Survey Report*, August 2014.
- Top Ways Employers Can Work with their Health Plans to Transform Health Care, *Issue Brief*, March 2015.
- Health Reform (Patient Protection and Affordable Care Act) Implementation and Communications Toolkit, *Toolkit*, updated June 2015.
- Private Health Insurance Exchanges: A Toolkit for Employers, *Toolkit*, updated April 2015.
- Communicating Consumerism and Consumer-Directed Health Plans (CDHPs): Eight Years of Best Practices, *Issue Brief*, September 2014.
- Spousal Coverage Options: Strategies for Communicating Changes to Employees, *Issue Brief*, January 2015.
- Supporting Low-Wage Employees in a Consumerism World, *Issue Brief*, October 2014.
- Right Care, Right Place, Right Health Professional: Site of Care Benefit Manager Guide, *Benefit Manager Guide*, February 2015.
- FDA-Approved Drugs to Treat Chronic Hepatitis C, *Employer Alert*, updated July 2015.
- State and Federal Policy Recommendations to Promote Telehealth, *Policy Brief*, June 2015.
- Employer Perspectives On Accountable Care: ACO Definitions, Key Considerations, and Recommendations, *Issue Brief*, May 2015.
- Evidence-based Infertility Treatments, *Benefit Manager Guide*, January 2015.
- Therapies for Children with Autism Spectrum Disorders, *Benefit Manager Guide*, updated October 2014.

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