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HEALTH PLAN TRENDS

The COVID-19 pandemic has certainly upended most organizations' plans for 2020. Organizations have had to shut down manufacturing, lay off employees and shift work to remote environments when possible. Many have lost revenue because of the stay home orders in most states. This pandemic has shifted business priorities.

Unfortunately, many layoffs will become permanent. Some employers have frozen their hiring plans. Some are also mandating pay cuts or rescinding merit raises for 2020. Almost overnight employers have shifted their focus from recruiting and retaining talent to controlling costs and surviving the pandemic impacts.

Another troubling aspect is unemployment. For nearly a decade, the unemployment rate hovered around 5 percent. In just a few months, however, the national unemployment rate has risen to 14.7 percent and Michigan's rate was even higher at 22.7 percent through April of 2020.

The recently completed MMA-MI's *2020 Michigan Mid-Market Group Benefits Survey* shows that Michigan health plan costs increased just 3 percent after employers made plan changes in 2020, and increased 3 percent after plan changes in 2019. Nationally, Mercer reported participants expect a 5 percent cost increase in 2020 before changes and reported a 3.4 percent increase after plan changes in 2019.

The MMA MI and Mercer data predates the COVID-19 pandemic. MMA-MI touched base with many of the original survey participants in early May to determine how the pandemic may alter their 2021 health plans. Pre-COVID many had been focusing on condition management and engaging employees in healthy lifestyles and engaging them to find lower cost care options. Post-COVID, employers expect to control cost by reducing plan design and increasing employee contributions. It appears cost-shifting may be the priority next year. Moreover, we are in an election year. Health care will undoubtedly be a key topic for both parties.

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This year the survey data indicates that, in general, employers made very few changes to plan design or employee contributions for health coverage. The PPO median deductible and the office visit copay increased. As with the last several years, employers seem to be concerned about affordability. They are concerned that employees can't afford the cost of coverage or the cost of services if they need to use their coverage. The trend for more Michigan employers to "carve in" pharmacy benefit management with their health plan carrier continues. More employers went back to using their medical carriers to administer pharmacy benefit programs. Medical carriers have negotiated far more aggressively with their internal PBMs and significantly improved their contract provisions. In Michigan, it is generally less expensive to use the medical plan vendor as the pharmacy benefit manager.

Before the pandemic employers had been increasingly considering cost control options that didn't automatically shift costs to employees. These options included encouraging cost-effective treatment venues (programs that reward price shopping), narrow networks, health condition-specific management tools and centers of excellence. However, this trend has pivoted based on our post-pandemic pulse survey. It looks like in 2021, employers will focus on cost shifting as cost-control becomes the priority again.

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

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

It compares the results of MMA-MI's *2020 Michigan Mid-Market Group Benefits Survey* to our national benchmark, Mercer's *2019 National Survey of Employer-Sponsored Health Plans*. Mercer reflects data from employers with 500 or more employees. Both sources provide specific data on what employers are currently doing to control health plan costs.

ISSUES AFFECTING MEDICAL CARE AND COSTS

Every year there are both new and ongoing issues that affect medical needs and the cost of care. This year is going to be interesting. COVID-19 will certainly have an impact, but perhaps not what you would expect. The COVID crisis may affect chronic conditions, sleep disorders, alcohol use and mental health challenges:

- **COVID-19 Claims Impact:** As the pandemic crossed this country in March and April, there was a concern that COVID claims were going to bump up costs significantly for 2020. A close examination of claim dollars shows that not many employers had large amounts of COVID claims and the claims they did have were primarily for testing and emergency room visits. The high number of hospital claims did not affect most employers. Because most states shut down in-person routine care and elective surgeries and treatments over concern about spreading the virus, most health plans have actually had a significant drop in claims since mid-March. The question is, will people feel confident they can now use the health care system without contracting COVID-19? Until a vaccine is available, that concern will remain even as states reopen.

  Some insurance carriers are refunding some insurance premiums because they are concerned about their medical loss ratio calculations for 2020. Employers need to keep an eye on claim utilization for the remainder of 2020. It may bounce back, but perhaps not to projected levels.

- **Our aging workforce and poor lifestyle choices.** Chronic conditions are more common as we age or adopt poor lifestyle habits. In some cases, the COVID-19 pandemic has adversely affected these conditions. People could not see their physicians for routine chronic condition visits. Most physicians renewed prescriptions even if patients could not make routine visits. The concern is that those with chronic conditions struggled with good choices while on lockdown.

  According to the Centers for Disease Control (CDC), chronic diseases are

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defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $3.5 trillion in annual health care costs.

- In the United States, 6 out of 10 adults have a chronic disease; 4 out of 10 have two or more chronic conditions. Chronic diseases include illnesses such as heart disease, cancer, lung disease, stroke, Alzheimer's, diabetes and chronic kidney disease.
- These conditions are the leading drivers of annual health care costs.
- Tobacco use:
    - Cigarette smoking is the leading cause of preventable death and disease in the United States. More than 16 million Americans have at least one disease caused by smoking. Up to $170 billion in direct medical costs could be saved every year if we could prevent teens from starting to smoke and help current smokers quit.
    - About 40 million American adults still smoke cigarettes.
    - Every day about 1,600 young people under age 18 smoke their first cigarette, and more than 300 become daily cigarette smokers.
    - Cigarette smoking causes more than 480,000 deaths annually. It is estimated second hand smoke causes 41,000 of these deaths.
- Excessive alcohol use also contributes to chronic disease and cost:
    - It is responsible for 88,000 deaths in the United States each year, including 1 in 10 total deaths among working-age adults.
    - In 2010, it cost the American economy $249 billion, or $2.05 a drink. Federal, state, and local governments paid about 40 percent of these costs.
    - Binge drinking is responsible for over half the alcohol-related deaths and three-quarters of the cost is due to excessive alcohol use.
    - Pandemic shutdowns may have caused more Americans to use alcohol excessively to cope with the stress of the situation.
- Arthritis is the most common cause of disability. Of the 54 million adults with doctor-diagnosed arthritis, more than 23 million say they have trouble with their usual activities because of arthritis.
- Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults. More than 34.2 million Americans have diabetes and another 88 million adults are prediabetic, which puts them at risk for type 2 diabetes.
- More than 1 in 3 adults (about 92.1 million) have at least one type of cardiovascular disease. About 90 percent of Americans aged two years or older consume too much sodium, which can increase their risk of high blood pressure. Unfortunately, in some patients, COVID-19 tends to cause blood clots that will put more people at risk for strokes.

  These chronic conditions and poor lifestyle choices drive a significant amount of medical spending in the United States. It is expected COVID-19 may have an adverse effect on many of these issues, but the impact will be determined over time.

- **Telemedicine.** Telemedicine has been a popular employee benefit over the

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last few years. This alternative to using a primary care doctor is a cost-effective, virtual way to get routine care. In Michigan, 86 percent of employers offer telemedicine. Nationally, 75 percent of employers offer it. However, in 2019, Mercer reported only about 9 percent of employees used this service. Over the last several years many employers have tried to get employees to take advantage of this benefit; it is more convenient and less expensive than a primary care office visit. Despite these efforts, only a small percentage of employees were using it.

Once the pandemic hit and in-person care became difficult and risky, employees began to embrace telemedicine. Both Blue Cross Blue Shield of MI and Teledoc (a national telemedicine vendor) showed dramatic increases in utilization.

BCBSM

- January 2020 – 5,000 visits
- February 2020 – 5,000 visits
- March 2020 – 130,000 visits
- April 2020 – 140,000 visits

Teledoc

- Visits are up more than 100 percent compared to the first week of March 2020 – averaging 20,000 visits a day
- 9 out of 10 visits are not COVID related
- Q1 2020 usage has grown 90 percent over Q1 2019
- 60 percent of visitors since March 1, 2020, are first time users

It will be interesting to see whether telemedicine use continues once in-person care reopens. Employers should continue to encourage employees to use telemedicine for routine care because it is the least expensive way to handle sinus infections, ear infections, and other common medical maladies.

- **Sleep Disorders.** Inadequate sleep is a national issue. It contributes to and exacerbates many chronic conditions. According to thegoodbody.com, 35 percent of Americans don't get the recommended seven hours of sleep each night. Roughly 20 percent of Americans have a sleep disorder. Ninety-seven percent of teenagers get less than the recommended amount of sleep. Sleep deprivation costs Americans $411 billion annually. It is not only linked to obesity but also strongly linked to depression. Nearly 20 percent of serious car accidents are associated with driver sleepiness.

The COVID-19 pandemic has increased sleep struggles for many Americans. During this national time of crisis, employees need to take good care of themselves. Sleep is critical. It empowers an effective immune system. Sleep also enhances mood and improves mental health.

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

Hospital systems are also actively purchasing primary care physician practices for slightly different reasons. If they own the entry point, all specialty care will be referred to their facilities. This practice, however, often increases cost.

The pandemic has adversely affected health systems. For a time, COVID-19 patients filled many hospital beds. Because all elective health care was shut down to prevent spreading the virus, hospital systems across the country had to lay off employees. Many of the shut down services had been generating significant revenue. Some health care systems may have to file for bankruptcy if they can't recover from the shutdown

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and may not be able to buy more entry points to the health care system, but you may see more mergers and acquisitions of health care systems in this environment.

- **Childhood Immunizations.** The COVID-19 pandemic has had a significant impact on childhood immunizations. Because routine care was shut down to prevent spreading the virus, the number of routine pediatric vaccinations declined. American children and their communities might now face outbreaks of preventable diseases. Parents canceling check-ups for fear of possibly exposing their children to COVID-19 during well child visits might be contributing to this decline. As a result, the United States may see an uptick in childhood diseases, such as the measles.

- **Mental Health Concerns.** Employers are concerned about the mental health impact the pandemic will have on families. Everyone's world was stopped on a dime. Children missed milestone events, sports participation, and interaction with friends. Some adults lost their jobs and took on new responsibilities at home, helping kids with virtual learning. Others kept their jobs but had to work from home. Still others were on the frontlines of this pandemic, working and engaging with the public in essential businesses. Our health care workers saw the devastation of this virus up close. Family members of health care workers worry daily about their loved ones' safety.

  People may need mental health support to deal with the effects of the pandemic. These effects may hit them at different points. Employers may see an uptick in mental health claims as employees try to cope with the fallout from this pandemic.

It has been said many times in the past, but this year has been truly unprecedented, especially in terms of the factors that contribute to health plan cost increases. If a COVID-19 vaccine is approved in 2020 or early 2021, health plans will be required to cover it at 100 percent and that may influence cost in 2021.

STRATEGIES EMPLOYERS USE TO CONTROL HEALTH PLAN COSTS

Every year, employers monitor health plan costs, project increases and determine health plan budgets. If projected costs exceed their budgets, employers make changes. Some employers try to reduce the need for health care. For example, they may offer programs to help employees manage conditions such as diabetes. Managing a disease properly can prevent common complications and reduce excessive costs. Over the last 10 years in a tight labor market, employers have weighed health plan actions against their organization's priorities. They had to consider the potential impact on recruiting and retaining talent when they devised their health plan strategies.

The COVID-19 pandemic may have changed that focus. The unemployment rate in Michigan shot up to almost 23 percent as of the end of April. Many organizations have frozen hiring and some layoffs will likely be permanent. Cost control is now the primary focus of most organizations given the significant disruption of business and supply chains. It will likely impact health plan cost decisions for 2021.

It is also critical to understand how your projected rates will be developed for 2021. Several months in the experience period will have artificially low claim activity because of the months where routine and elective care was not accessible.

In Southeast Michigan, survey participants reported a 3 percent cost increase after plan changes in 2020. Nationally, the 2019 increase after plan changes was 3.4 percent.

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

Consumer-Driven Health Plans (CDHPs)

Most employers now commonly offer CDHPs. Locally in 2015, only 43 percent of employers offered CDHPs. By 2020, 58 percent offered them. Nationally, in 2014, 41 percent of employers offered CDHPs. By 2019, 66 percent offered them.

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

HSAs have triple tax benefits. First, contributions are tax-free, second, earnings in the accounts are tax-free, and third, distributions from the accounts used for qualified medical expenses are tax-free.

The hope is that CDHPs will encourage people to save for health care expenses and become wiser consumers. Vendor transparency tools can help them make informed decisions and choose less expensive treatments. Independent studies support this theory, suggesting CDHPs can save around 5 percent because of consumer shopping.

The MMA-MI survey indicates that 58 percent of employers offered a CDHP in 2020, up from 55 percent in 2019. Only 8 percent of employers, however, make a CDHP their only health plan, which is up from 4 percent in 2019. Offering a CDHP as the only option is aggressive. Many employers realize that this is not the right fit for some employees, so offering another choice is important.

Nationally, the number of CDHPs decreased slightly in 2019 among all employers. Among employers with 500 or more employees, 66 percent offered a CDHP in 2019, down from 68 percent in 2018. Only 13 percent of national employers offer CDHPs as the only type of health plan option, up from 11 percent in 2018. The 2019 survey data shows a decrease in the prevalence of CDHPs for the first time since they were introduced in the early 2000s.

Nationally, CDHPs paired with HSAs are the lowest cost plan. They cost roughly 25 percent less than PPO plans. That is a difference of $2,710 per employee. CDHPs have historically trended at a rate slightly lower than PPOs nationally. This year, however, cost did not follow that trend. They trended at roughly the same rate as PPOs nationally.

Locally, HMO plans are the lowest cost plans in both the single and family tiers this year. PPO plans are the highest cost plans in both tiers.

Nationally, we saw minor changes in the median plan designs for CDHPs. Last year the median single deductible was $2,000; in 2018 it was $1,950. The 2019 family deductible remained at $4,000. The number of large employers contributing to HSAs decreased. Nationally, 78 percent of large employers contributed to employees' HSAs. The employer median HSA contribution for single coverage decreased to $500 and for family coverage the contribution stayed steady at $1,000.

The potential employee liability after employer contributions to the HSA is $1,500 single and $3,000 family.

Local plans showed no change in plan design between 2019 and 2020. Our median single deductible is $2,000 and the family deductible is $4,000. Only 61 percent of local employers contribute to employees' HSAs. The median contribution to the HSA has stayed steady at $500 single and $1,000 family. The employee liability after employer contributions to the HSA is $1,500 single and $3,000 family.

Employers that fund part of the HSA have another cost-control strategy in their arsenals. They can adjust HSA funding levels annually in response to cost increases, economic realities, wellbeing activities or business performance. A component of their plan costs can be modified independently from the CDHP design or employee contributions. Employers may also stop funding HSAs after the plan has been in place a number of years and employees have built up their account balances.

CDHPs have become more common in the last five years. Not only are more employers offering them, but also more employees are choosing them. Nationally, in 2019, 39 percent of employees chose CDHPs. Locally, in 2020, 31 percent of employees chose them.

Employee Wellbeing

Wellbeing programs continue to evolve. Employers consider all six pillars of wellbeing, not just physical health. The percentage of Michigan employers that offer

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programs to bolster those six aspects is show in the table at the top of page 7.

Six Pillars of Wellbeing	2020	2019
Physical	88%	92%
Mental/Emotional	83%	83%
Financial	78%	71%
Social	48%	43%
Community	48%	49%
Professional Growth/Development	45%	36%

The shifts this year have been interesting. COVID-19 and legislative activity will likely affect changes. The number of employers with physical wellbeing strategies dropped. The EEOC is expected to offer guidance on the Americans with Disability Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) incentives for biometrics, annual doctor visits, or health assessments. The proposed regulations have not been released and it will likely take some time to finalize them, but employers need to start thinking about these incentives. The proposed regulations may allow only *de-minimis* incentives, which is contrary to the up to 30 percent of premium incentives many employers have adopted. COVID-19 has shifted some organizations' wellbeing focus. In a pulse survey of MMA MI's survey respondents collected in April 2020, 55 percent of employers said they would shift some focus of their wellbeing strategy because of COVID-19. Priorities post-COVID have shifted as well. The top priorities in descending order are physical, emotional, professional, financial, social and community.

Key reasons Michigan employers devoted time and effort to employee wellbeing is shown in the table at the bottom of page 7.

Reasons for Investing in Wellbeing	2020	2019
Improved Health and Wellbeing	92%	91%
Improved Employee Engagement	79%	84%
It's the Right Thing to Do	85%	78%
Positive Impact on Medical Trend	69%	69%
Improved Productivity	53%	57%
Improved Attraction and Retention	53%	52%
Reduced Absenteeism	53%	48%
Employee Feedback Survey	33%	34%
Industry Recognition Awards	13%	16%

Many employers are creating a wellbeing strategy. A robust strategy could help alleviate these challenges:

- Absenteeism
- Turnover
- Tobacco utilization
- Chronic conditions
- Safety scores
- 401(k) participation
- Employee engagement

Employers have typically offered incentives to participate in various wellbeing activities. In 2020, however, the MMA survey showed fewer employers offered them. In 2019, 47 percent of employers offered a reduced health plan contribution for wellbeing participation, and in 2020, only 38 percent of employers did. In 2020, the average contribution incentive increased slightly to $437 for single coverage and decreased slightly to $805 for family coverage.

The current thinking is incentives are highly effective for one-time participation, but not very effective in changing long-term behavior.

Tobacco surcharges remained fairly steady in Michigan. In 2020, 16 percent of employers required smokers to pay a median surcharge of $50 a month.

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

Employers have been increasingly focused on the impact of broad-ranged employee wellbeing programs. The COVID-19 pandemic is likely to increase the range of wellbeing activities. Employers that laid off employees for a period time had a stark and difficult reminder that nearly half their employees don't have emergency savings for unexpected financial challenges. Employers may spend more time this year focusing on financial wellbeing. Many employees may benefit from information on budgeting and saving for the unexpected.

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Median PPO Plan Design	2020	2019
Single Deductible	$1,000	$750
In-Network Coinsurance	80%	80%
Single Out-of-Pocket Max (includes deductible, coinsurance and copayments)	$6,350 (includes an embedded coinsurance maximum of $2,500)	$6,350 (includes an embedded coinsurance maximum of $2,500)
Office Visit Copay	$30	$25
Urgent Care Copay	$40	$40
Emergency Room Copay	$150	$150
Rx Copays	$15 generic/$40 preferred brand/$80 non-preferred brand	$10 generic/$40 preferred brand/$80 non-preferred brand

Plan Design

Michigan showed a couple of changes in median PPO plan design in 2020. The key plan provisions for 2019 and 2020 are as shown in the table at the top of page 8.

The MMA-MI survey shows average deductibles increased by almost 14 percent in 2020. In 2019 the average single deductible was just $1,030; in 2020 it rose to $1,173.

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

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

Nationally, the median PPO plan did not change in 2019. It still has a $750 single deductible and a $25 office visit copay; all other parameters align with the Michigan median plan design.

Southeast Michigan's median HMO plan showed little change in 2020, but local HMO benefit levels are dramatically different from national HMO benefit levels (see table at top of page 9).

HMO plans have taken two different paths both locally and nationally and neither path resembles the HMOs of a decade ago. In the past, most HMO plans required a physician gatekeeper and included 100 percent coverage with a number of copays. HMO benefits were traditionally far better than PPO benefits. Now, nationally, HMO and PPO median plan designs are similar. With the changes to PPO plans locally, the HMO plan design aligns closely with the PPO plan. The differences appear in the cost of these plans. Nationally, HMOs cost slightly less than PPO plans. Locally, HMOs are the lowest cost plan option.

CONTRIBUTION STRATEGIES

The chart shown at the bottom of page 9 shows monthly employee contributions in Michigan for 2019 and 2020 as a percentage of the premium.

Since affordability depends on household income, employers could use income-based contributions to pass the affordability test. Some employers have considered using them to pass that test more easily. Locally, we saw a decent bump in the number of employers moving to income-based contributions, with 7 percent adopting them in 2020 down from 9 percent in 2019. Nationally, however, income-based contributions are more popular. Fifteen percent of large employers based their contributions on income in 2019.

These contributions can be difficult to implement. They increase the number of possible contributions you need to track in your HRIS system depending on the number of salary bands you use and plan options you offer. They also can be difficult for employees. If they get a raise, they might jump a salary band and might

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have to increase their contributions. Ironically, a raise may result in lower take home pay. During the COVID pandemic, some employers encountered a situation they had not anticipated. Some employers implemented pay cuts that resulted in employees dropping to lower salary bands. Most employer policies had not considered how salary cuts might affect income-based contributions.

Plan Provision	2019 Mercer National	2020 MMA MI
% plans and overall deductible	47%	88%
Plan deductible	$500/$1,000	$1,000/$2,000
% of plans with coinsurance	40%	71%
Coinsurance	20%	20%
% of plans with inpatient deductible or copay	39%	17%
Inpatient deductible/copay amount	$250	$150
Office visit copay	$20	$20
% plans with split office visit copay	64%	86%
Split copay amount	$20/$40	$20/$40
Urgent care copay	Not reported	$50
Emergency room copay	$125	$150

PRESCRIPTION DRUGS

Employers must continue to watch prescription drug prices carefully. This cost can change dramatically based on specialty medication use, the provisions of pharmacy contracts and the mix of medications. This year's top story in pharmacy was Michigan's increase in carve-ins, but nationally, more employers are carving out pharmacy benefit management. The cost of specialty medications continues to be a concern.

Many employers self-fund their pharmacy plans and use pharmacy benefit managers (PBMs), instead of using their medical plan vendors. This arrangement allows them to take advantage of better contract terms standalone PBMs offer. As a result, insurance carriers have lost pharmacy business. To counteract this trend, many insurance carriers have significantly improved their contract terms to be more competitive with PBMs. Many employers have now gone back to using their carriers for pharmacy benefits. In 2018, 26 percent of Michigan survey respondents used PBMs. In 2019, that dropped to 18 percent. In 2020, it dropped even further to just 16 percent.

National organizations are following an opposite trend. In 2018, 27 percent of large national employers used PBMs. In 2019, that number increased to 34 percent.

Specialty medications will be an issue for many years to come. Although few people use them, these drugs represent a substantial percentage of drug costs. The BCBSM book of business claim data illustrates this challenge. In 2011, only 0.7 percent of prescriptions were for specialty medications. In 2011, even with this very low dispensing rate, these medications represented 19.4 percent of dollars paid for prescriptions. In 2019, prescriptions for specialty medications increased slightly to 1.2 percent of prescriptions dispensed but represented almost 48 percent of total dollars paid for prescriptions.

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

One method is to structure copays in tiers. These tiers encourage effective drug use. Nationally, Mercer did not report copay structure in its 2019 report. Locally,

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	PPO		HMO		CDHP	
	$ Amount	% of Premium	$ Amount	% of Premium	$ Amount	% of Premium
2020 Single	$151	26%	$104	24%	$98	20%
2019 Single	$141	25%	$112	24%	$87	19%
2020 Family	$492	29%	$387	29%	$322	22%
2019 Family	$475	29%	$399	30%	$283	21%

51 percent of PPO plans had a three-tier copay. More and more employers are now adding copay tiers. Locally, 45 percent of PPO prescription plans have a separate fourth or fifth tier. If there are five tiers, typically the employer has a list of preferred specialty medications available in the fourth tier. The fifth tier is reserved for non-preferred specialty medications.

Nationally, median prescription drug plan copays in 2019 were $10 for generics, $30 for formulary brands and $50 for non-formulary brands. If the employer has a fourth tier, the copay for specialty drugs is $100. Local median prescription drug plan copays stayed steady in 2020. The copays are $15 for generics, $40 for formulary brands and $80 for non-formulary brands.

Employers can take a number of steps to help control pharmacy costs. Options can include:

- Prior authorizations
- Mandatory generics
- First fill limits on specialty medications of 14 days or less

Employers that self-fund their health plans need to keep a close eye on drug costs. As pharmacy costs become a larger percentage of expense, employers should consider adding them under stop loss protection. In 2020, 88 percent of local employers covered prescription drugs under their stop loss policies. Mercer does not report this metric on the national level.

Employers have aggressively used medical management programs and incentives to drive down their prescription drug costs. This diligence has been effective. For the last five years, they have been controlling costs using medical management programs rather than raising copays. As a result, prescription drug copays, both locally and nationally, have changed very little.

ELIGIBILITY STRATEGIES

Employers use various eligibility strategies to keep health plan costs in check. Some offer above benchmark medical plans at below benchmark contributions; however, these plans become the plan of choice. In other words, when both spouses work, they will turn to your plan for coverage. If your organization has a reputation for having excellent benefits, your employees may opt for your benefits without even checking their spouses' benefits. The MMA MI survey shows 59 percent of employees elected dependent coverage in 2020. Nationally, Mercer data shows 52 percent of employees elected dependent coverage in 2019. If your dependent coverage elections are significantly higher than the benchmark, your plan is likely a plan of choice.

Locally, employers use two tactics to discourage employees from enrolling spouses in their plans: force-outs and surcharges. In 2020, 9 percent of survey respondents have a spousal force-out. Under this provision, spouses with coverage available through their own employers are not eligible for coverage under your health plan. Spousal force-outs are **not** popular with employees, because they can force the family to deal with different plans, deductibles and out-of-pocket maximums.

Twenty-four percent of local employers use a surcharge. With this strategy, employees pay an extra premium to cover their spouses on your plan, if their spouses could have obtained coverage through their own employers. The median monthly surcharge in 2020 is $100.

These strategies are not as popular nationally. In 2019, only 13 percent of large employers had a spousal force-out and 12 percent applied a spousal surcharge. The median monthly surcharge is $100.

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

CONCLUDING THOUGHTS

The MMA Michigan Mid-Market Group Benefits Survey showed health plan costs increasing at 3 percent after plan changes in 2020. Nationally, health plan cost increased 3.4 percent after plan changes in 2019.

Health plans have become a sizable expense for many organizations over the last several decades. For the last 10 years, most employers were focused on recruiting and retaining employees and used the health plan to help in those endeavors. The COVID-19 pandemic has seemed to change that focus overnight. The shutdowns and stay at home orders have deeply affected most

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businesses. It appears that cost control in all aspects of business, especially health plans, will be a priority in 2021.

Our survey and national surveys show that employers most successful in controlling health plan cost use a variety of strategies. Although employers should not lose sight of those strategies, they need to remember that health care is expensive and cost-shifting may make it difficult for employees to afford.

More and more innovative options are being introduced locally and nationally to solve this problem. Employers should look for cost control strategies that prompt members to consider cost, steer them to cost effective venues, inform them of cost/transparency tools and engage them in their health. Options to consider include:

- High performance or narrow networks
- Centers of excellence
- Reference-based pricing
- Price shopping rewards programs
- Population health management
- Spousal surcharges
- Consumer driven health plans
- Telemedicine or coverage for retail clinics
- Expanded copay tiers in prescription drug program
- Competitive PBM discount/ rebate arrangements
- Health assessments/ biometric screenings
- Health coaching
- Activity challenges
- Healthier options in cafeteria/company meetings
- Financial wellbeing programs
- Focused communication strategies
- Year-round communication efforts
- Carrier provided transparency systems
- External transparency systems
- Expert medical opinions

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

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

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