MERCER

10-minute survey report

large employer health strategies

With bigger health care budgets and more resources to devote to program management, the nation's largest employers tend to be innovators and early adopters of sophisticated health benefit strategies. This 10-Minute Survey was designed to track the strategies used by leading employers.

welcome to brighter

The survey was fielded June through August 2019. Employers with 5,000 or more employees were eligible for the survey. Of the 219 employers that participated in total, 74 have 20,000 or more employees.

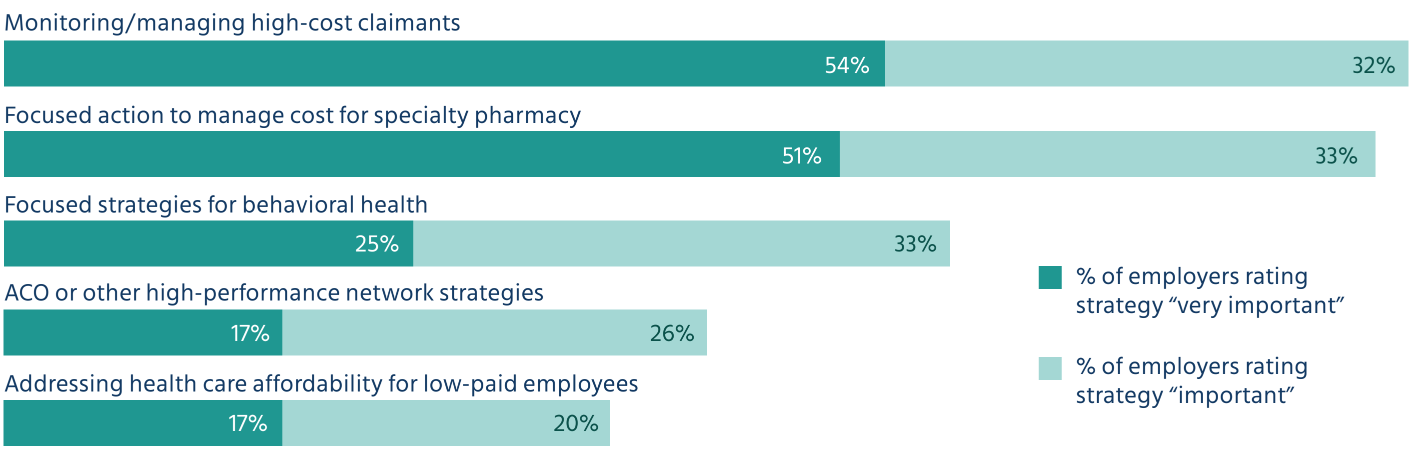
Here is a summary of the survey findings.

01/Introduction

For most large employers, strategic planning for employee health programs today seeks to advance three key objectives: keeping employees healthy and productive, offering health benefits that employees like, and managing this very significant operating expense. At the same time, it must take into account the rapid pace of innovation — in medical science, in the digital technologies that connect people to health care, and in the restructuring of the health care market and the larger US health care system.

All of this is reflected in the strategies employers say will be the most important over the next five years. At the top of the list are managing high-cost claims and addressing specialty drug cost, which continues to grow at a double-digit pace as new therapies reach the market in unprecedented numbers. At the same time, employers are seeking to create a culture of health in their organization and help employees access support for their emotional and behavioral health. Growing concerns about health care affordability have shifted emphasis away from cost-shifting to strategies that seek to manage cost by addressing underlying issues with care delivery — with telemedicine services, Centers of Excellence, specialty drug management, technology-based health resources, enhanced care management, decision-support services and more. These strategies may take more time to reduce plan cost than raising employee cost-sharing, but they seek to fundamentally change – for the better – how plans manage care, how providers are reimbursed and how people support their own health.

Strategies rated as important / very important for the next five years

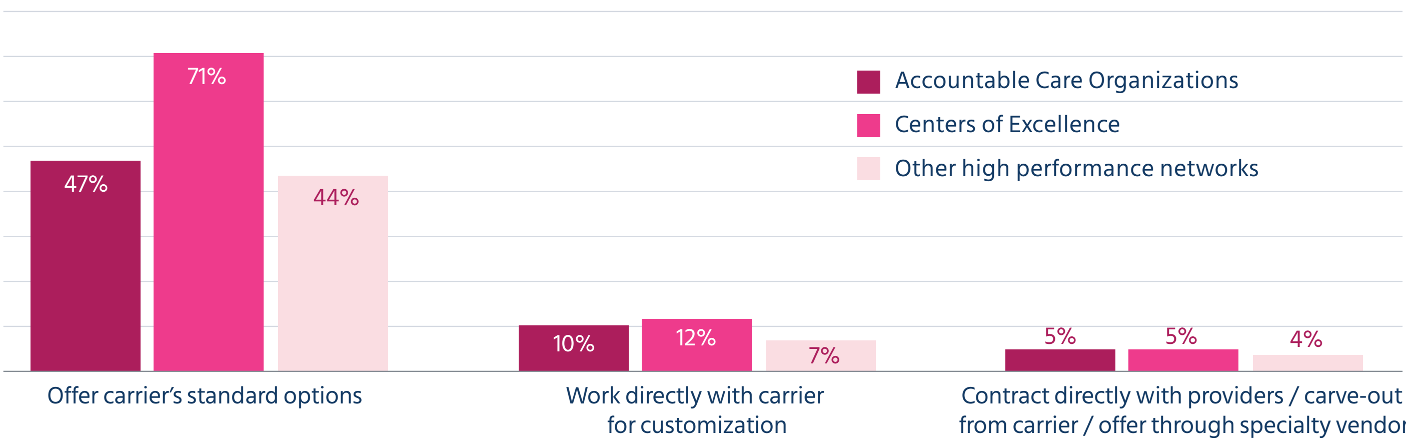


Source: Mercer’s National Survey of Employer-Sponsored Health Plans

02/Seeking value

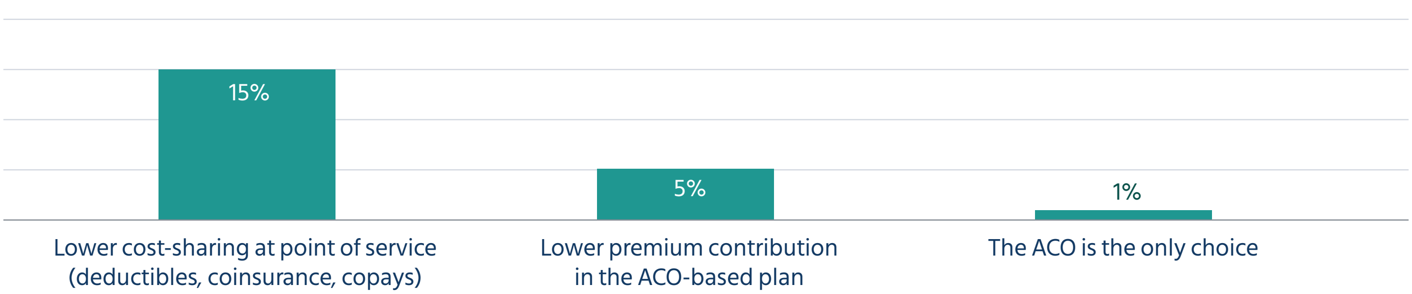
Accountable care organizations, centers of excellence and other network strategies

About half of respondents (47%) say that their employees can access an accountable care organization (ACO) that their carrier offers as a standard option. One in ten have worked directly with their carrier to customize the ACO option, and a few – 5% – utilize a carve-out vendor.



To encourage employees to use ACO providers, 15% of respondents offer lower cost-sharing at the point of service (lower deductibles, coinsurance, copays) and 5% offer a lower premium contribution to elect an ACO-based plan option. The majority of respondents, however, do not use plan design to steer members to ACOs (83%).

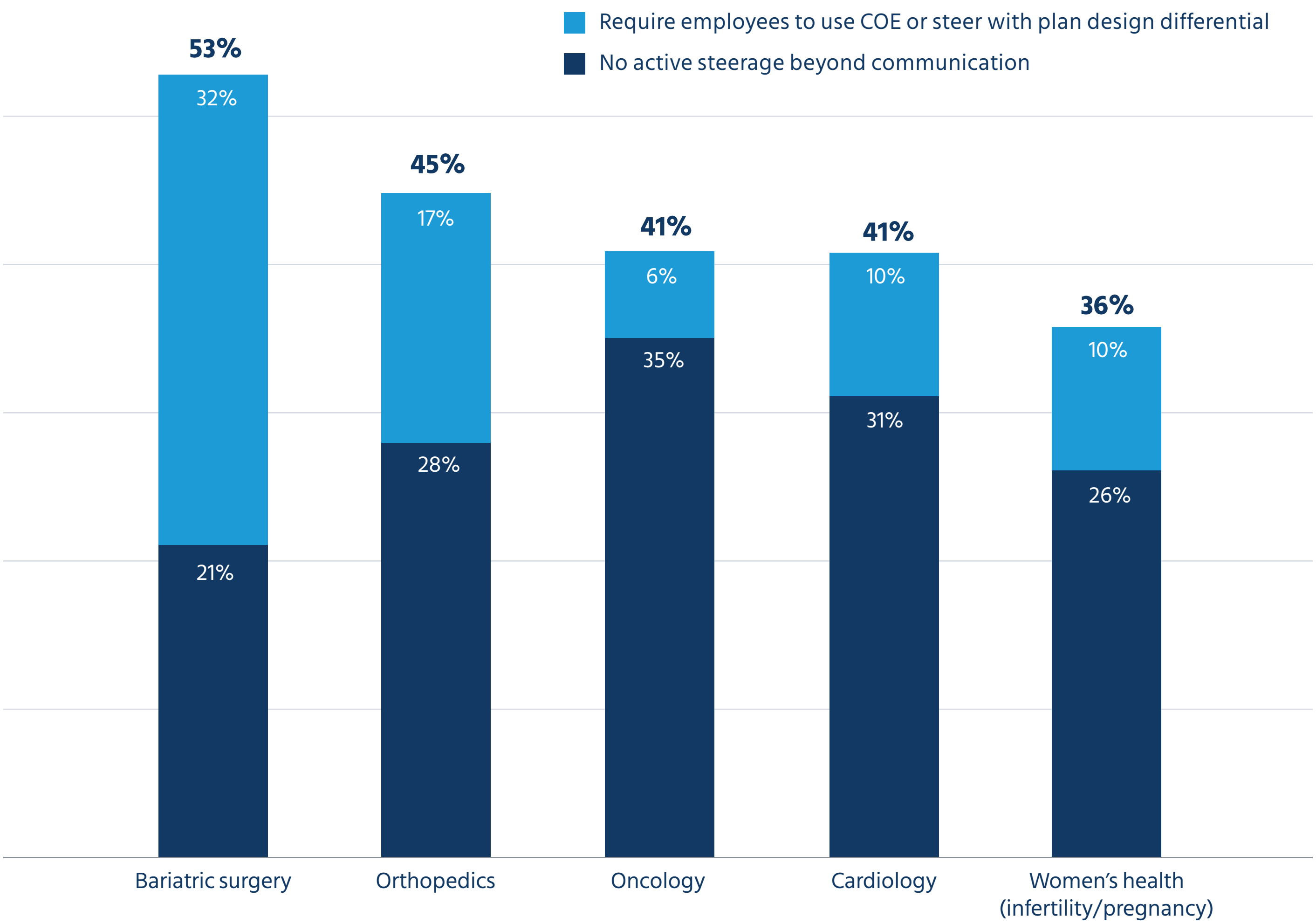
Methods used to encourage employees to select an ACO provider (beyond communication)



Centers of Excellence

For complex medical issues, getting treatment from the most experienced, best-qualified doctors can make a significant difference in both outcomes and cost, and employers are providing members with access to Centers of Excellence (COE) for a growing number of services. Typically, COEs are provided by the carrier as a standard option (71% of respondents), but 12% of respondents have worked directly with their carrier to customize COE offerings, and 5% utilize a carve-out vendor.

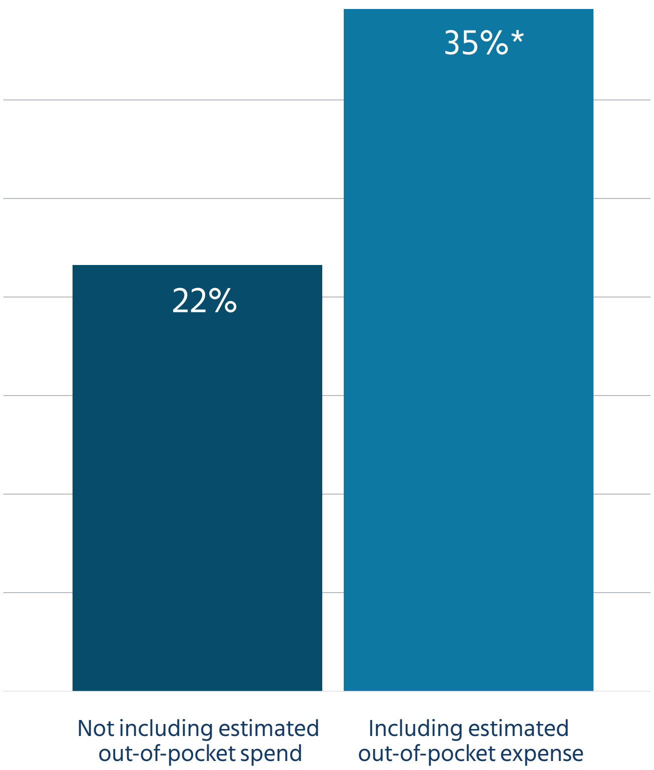
Employers are increasingly willing to steer employees to COEs – particularly for bariatric surgery. About half of respondents (53%) offer a COE for bariatric surgery and 32% steer members to it either with cost-sharing differentials or by requiring its use. COEs for orthopedic services are offered by 45% of respondents and 17% actively steer members to it. Other common COEs include oncology (offered by 41%), cardiology (41%), and women's health (36%), but employers are less likely to steer members to them.



03/Medical plan management

Affordability strategies

Employees bear a significant portion of health plan cost. Overall, the average percentage of total medical plan cost across all plans and coverage tiers paid by employees through paycheck deductions in 2019 is 22%. When including estimated out-of-pocket expenses, employees pay for 35%* of medical plan costs on average.



*Estimated percentage using respondent-provided employee premium contribution data and actuarial values derived from respondent-provided plan design information and Mercer's proprietary plan pricing tool, MedPrice.

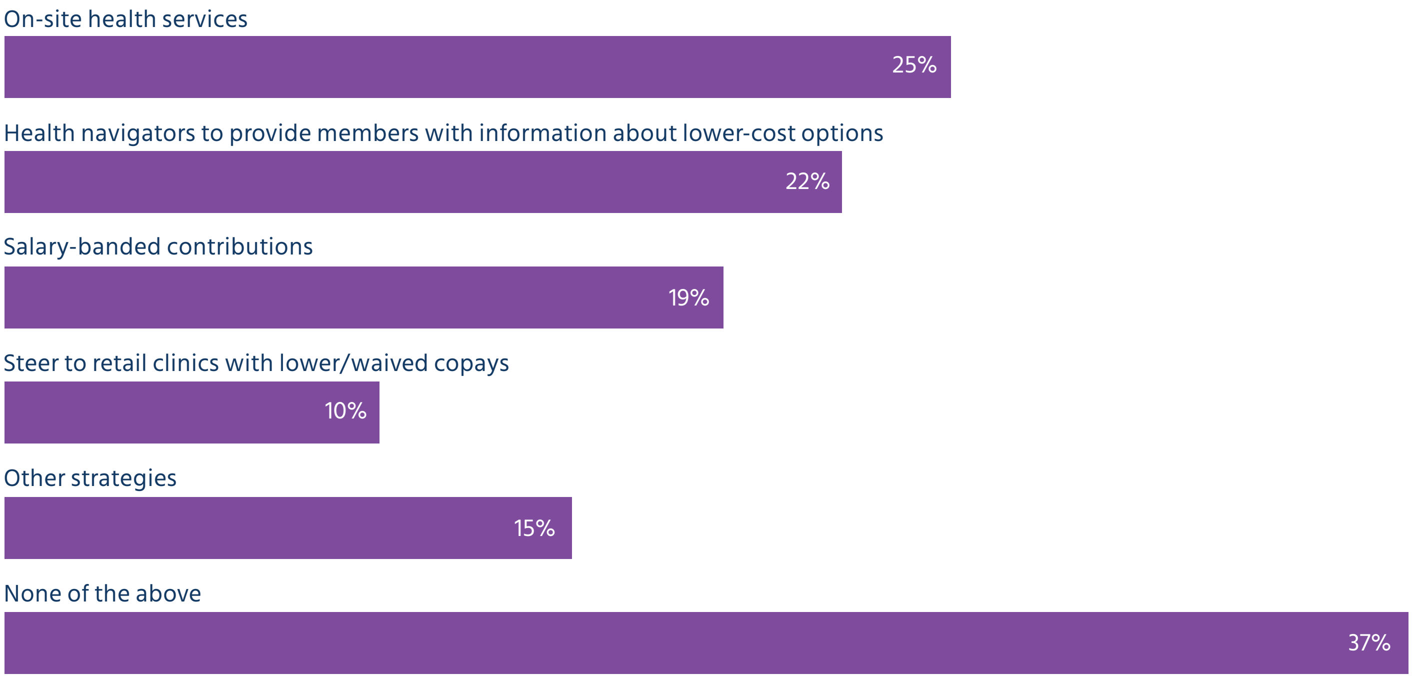
While health care is a manageable expense for many employees, very large employers typically have a diverse workforce with employees at many different wage levels. When asked about actions taken specifically to assist low-wage workers to afford the health care they need, a quarter of employers indicated that they provide onsite health services. This is one of the most direct ways an employer can make primary care and, increasingly, other medical services available to employees at low or no cost. In addition, the convenience of an onsite or near-site location saves employees travel time and expense. Shared near-site clinics make it possible for more employers to provide this benefit even if they don't have the space or the critical mass of employees for an onsite clinic.

Lack of price transparency makes it difficult for plan members to seek lower-cost providers. More than a fifth of respondents (22%) offer their employees the services of a health navigator to provide them with information about options that could save them money. Some (10%) will encourage employees to use retail clinics with lower or waived copays.

These strategies all focus on reducing out-of-pocket cost. Some employers free up more of their lower-wage employees' paycheck with salary-banded contributions (19%).

As more employers focus on the issue of health care affordability, new, creative approaches are emerging. Telehealth, teletherapy and other virtual solutions offer low-cost, convenient alternatives to office visits. We're seeing more initiatives to support financial well-being, such as emergency funds and tuition assistance or other education-focused programs to improve skill levels (and thus earnings). The most progressive employers are addressing social determinants of health; for example, by sending mobile health vans into geographies with poor access to health care, and teaming with organizations like churches and local Ys that help support communities.

Strategies implemented to assist low-wage workers to afford health care

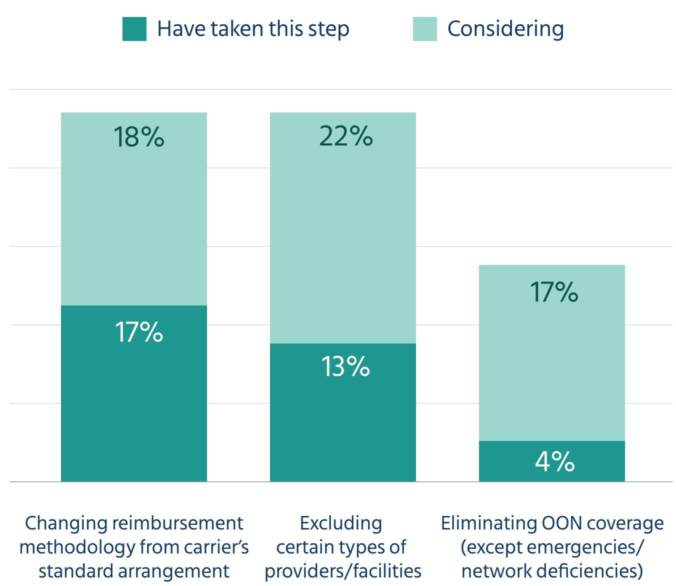


Out-of-network reimbursement

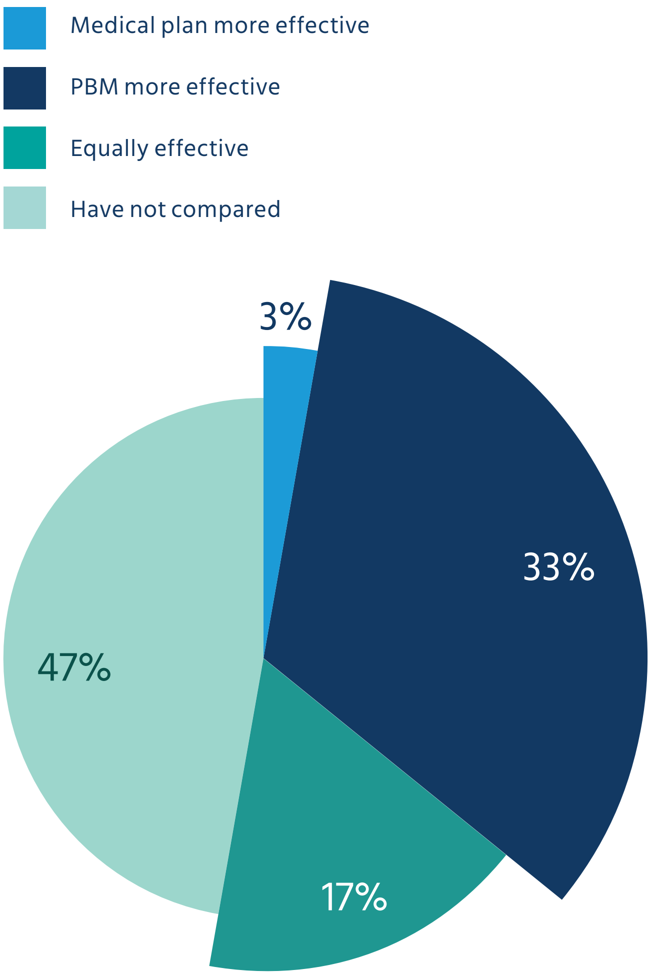
Surprise medical billing has been in the spotlight this year, with bipartisan efforts underway in Washington to protect people from large, unexpected bills that can arise after the patient's health plan pays benefits under the terms of the plan and an out-of-network provider seeks the rest of their billed charges from the patient. Employers are backing legislation that would set benchmark payment rates for out-of-network services based on the median in-network rate in the area, while medical provider groups are pushing proposals to use arbitration to settle payment disputes.

Employers have been grappling with the issue of out-of-network medical plan charges by trying to reduce OON utilization as far as possible. The most common step taken has been to change reimbursement methodology from the carrier's standard arrangement – 17% of respondents have done so, up from 14% in 2018. In addition, 13% of respondents now exclude certain types of providers/facilities for out-of-network coverage (up from 10%). However, the more draconian step of eliminating all out-of-network coverage except for emergencies and network deficiencies has been taken by just 4% of respondents, unchanged from 2018.

Employers taking steps to reduce OON spend



Specialty drug management: Medical plan vs. PBM



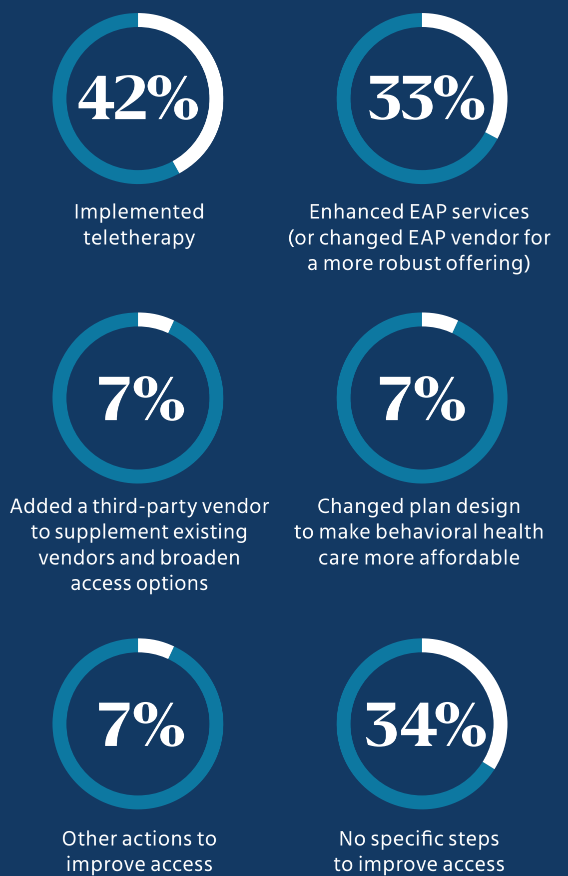
Specialty pharmacy

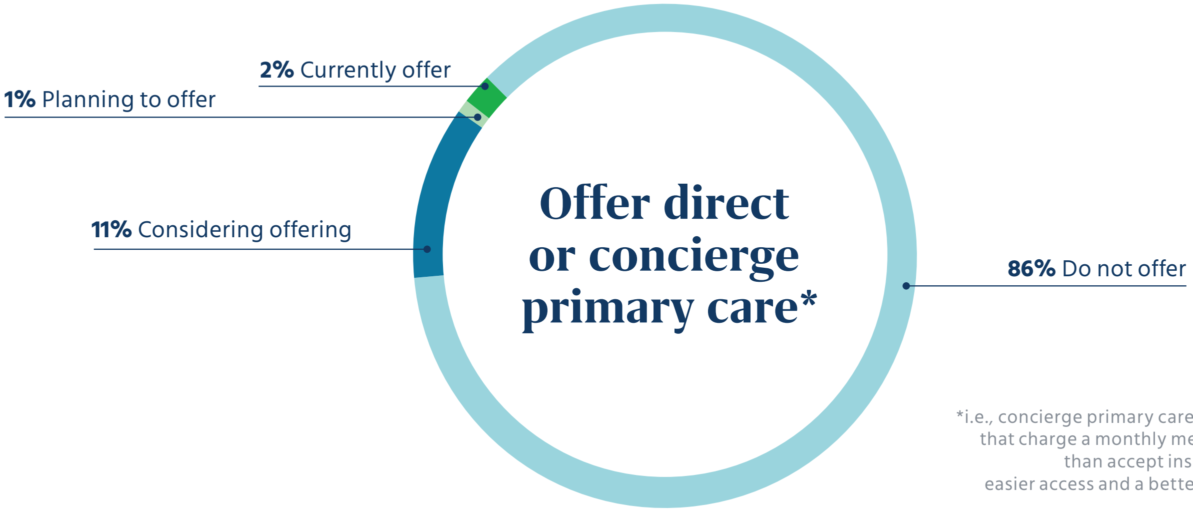
While growth in spending on specialty drugs has slowed somewhat over the past few years, it was still above 10% in 2019, making management of these very expensive drugs a priority for virtually all large employers. Just over half of respondents have compared how well specialty drugs are managed by the medical plan vs. the PBM. Most believe their PBM does a better job (33%) and 17% say they seem equally effective. Only 3% believes that the medical plan is generally more effective.

Behavioral health care

According to Mercer's 10-Minute Survey on Behavioral Health Care, about three-quarters of survey respondents with 5,000 or more employees are concerned about employee access to behavioral health services at some or all locations – and 20% say it's a concern at all locations. Within the past two years, 42% of respondents have implemented teletherapy to improve employees' access to behavioral health services. A third have enhanced EAP services or changed EAP vendor for a more robust offering. Less common steps include adding a third-party vendor to supplement existing vendors and broaden access options (7%), and changing plan design to make behavioral health care more affordable (7%).

Efforts to improve employees' access to behavioral health within past 2 years





*i.e., concierge primary care: physician practices that charge a monthly membership fee rather than accept insurance, and promise easier access and a better patient experience

New focus on primary care

Primary care is by far the most significant variable related to better health status, correlated with lower mortality, fewer deaths from heart disease and cancer, and a host of other beneficial outcomes. However, adequate access to primary care is a growing concern. According to a study published in JAMA, the density of primary care physicians declined by 11% between 2005 and 2015, falling from 47 to 41 PCPs per 100,000 people.

Given that the number of primary care physicians is likely to continue to decline, employers are looking at strategies to increase access and utilization of high quality primary care. Several primary care models have emerged, such as direct primary care, which charges a periodic membership fee covering all or most services and does not bill on a fee-for-service basis, and concierge primary care, which charges a periodic fee for enhanced access while continuing to bill on a fee-for-service basis. Just 2% of respondents offer direct or concierge primary care, although another 11% are considering it.

Another model, called "advanced primary care," also provides comprehensive, patient-centric primary care, but with a strong focus on coordinating care for patients with complex needs.

*Other than in traditional HMO plans

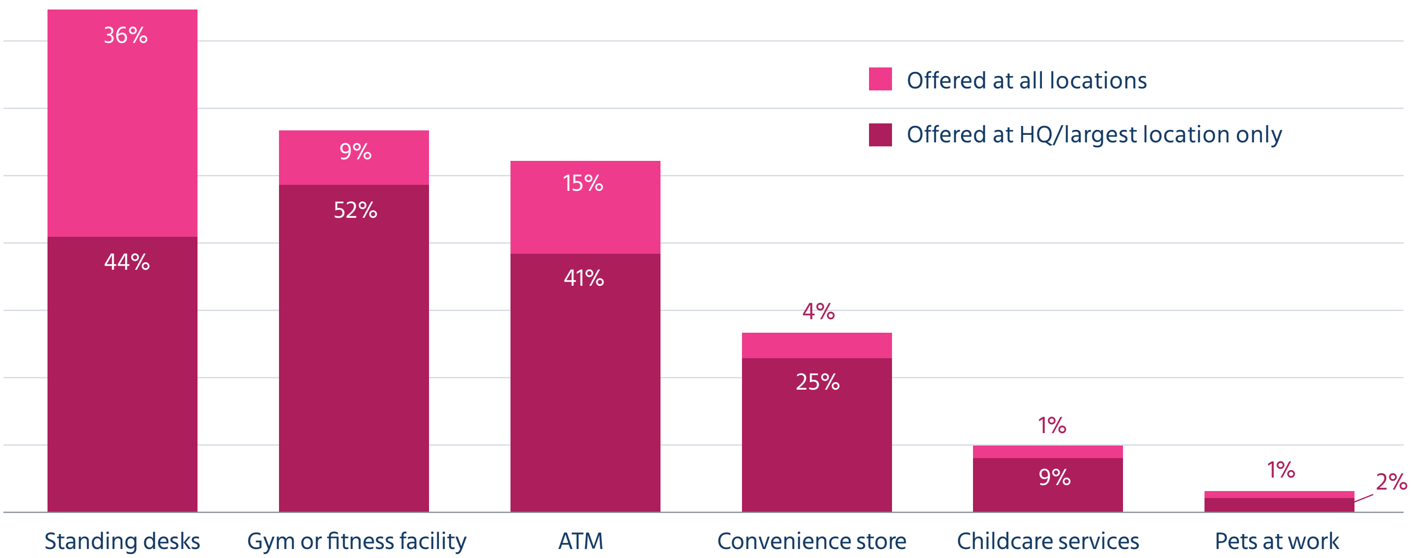
A simpler way for employers to underscore the importance of primary care is to require employees to select a PCP. While this is a common feature of traditional HMO plans, 6% of respondents offer a plan option other than an HMO in which the employee is required to select a PCP.

Promoting health and well-being at work

Over half of respondents (52%) offer a gym or fitness facility at their headquarters or largest location and an additional 9% offer these services at all locations. Standing desks have become a standard offering, with 44% of respondents providing them at the company HQ/largest location and another 36% providing them at all locations.

Onsite ATMs and convenience stores can make life easier for employees, and are offered by 56% and 29% of respondents, respectively. One in 10 respondents provide onsite childcare services, a very meaningful family-friendly benefit.

While "pets at work" policies receive considerable attention in the press, only 3% of respondents offer this benefit.



Medical director

As we have seen, some of the most ambitious strategies pursued by employer health plan sponsors today involve working directly with health care providers. Having a medical director on staff can help employers take on quality initiatives, direct contracting, onsite medical clinics and many other projects with more confidence. Medical directors – typically doctors – can also help sponsors simply make more informed decisions about health plans coverages and employee well-being initiatives. Still, hiring a medical director represents a considerable investment, and only 15% of survey respondents currently have one on staff, with another 2% considering it.

04/Beyond the health plan

Supporting the whole person

Family friendly benefits

Parental leave and other family-friendly benefits are no longer considered a “nice to have” for organizations that want to be an employer of choice. Not only do they help demonstrate a commitment to employee well-being, but making it easier for parents to take time off when they need it and supporting their return to work can help retain valued staff. Half of survey respondents offer paid maternity leave (beyond paid disability) and half offer paid paternity leave. Just under half offer paid adoption leave (46%) and a quarter provide paid leave for employees bringing a foster child into their home. Only 9% provide paid surrogacy leave; most require surrogate mothers to use PTO or unpaid medical leave while they recover from childbirth.

Elder care/caregiver paid leave is still relatively rare, offered by just 7% of respondents. However, 34% of respondents offer elder care/caregiver referrals/consultations and 15% offer access to backup elder care services.

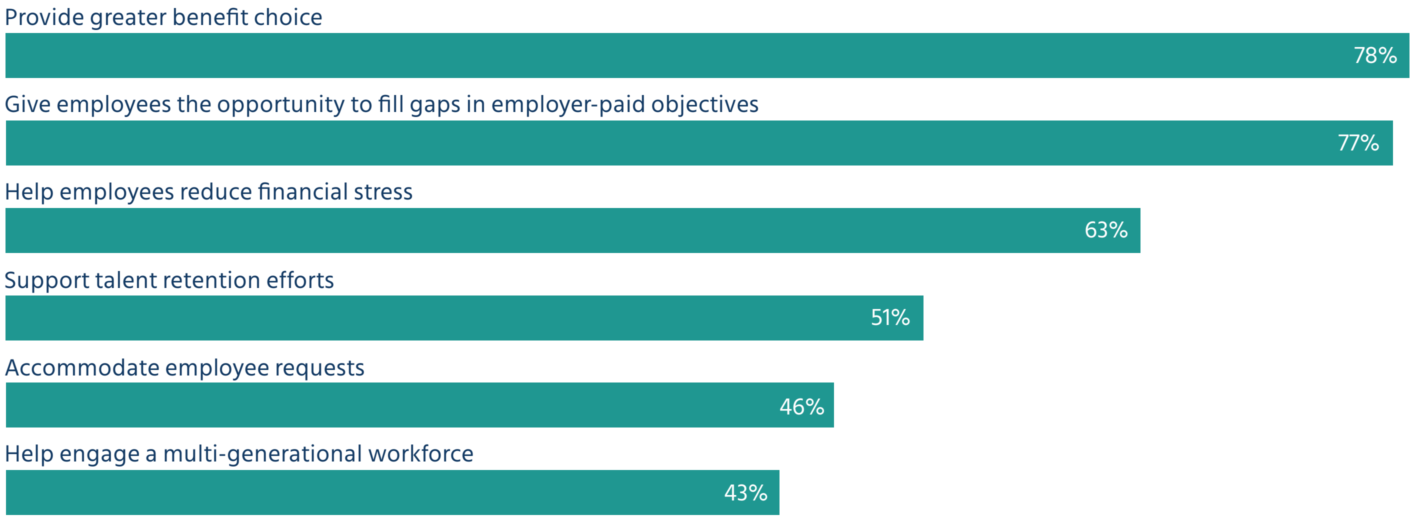
Parental benefits/leave:	
Paid maternity leave (beyond paid disability)	50%
Paid paternity leave	50%
Paid adoption leave	46%
Paid foster child leave	25%
Paid surrogacy leave	9%
Fertility treatment coverage for LGBTQ+ or single individuals	22%
Adoption assistance	52%
Foster care assistance	8%
Phased back-to-work programs for new parents	6%
Working mother benefits:	
Onsite lactation room	79%
Breast milk shipping services for business travel	12%

Child care assistance:	
Child care referral/consultations	33%
Subsidized child care services	10%
Access to backup child care services	19%
Elder care assistance:	
Elder care/caregiver referral/ consultations	34%
Access to backup elder care services	15%
Elder care/caregiver leave	7%

Voluntary benefits

The most important objectives cited for offering voluntary benefits are to provide employees with greater benefit choice (78%) and to give employees the opportunity to fill gaps in employer-paid benefits (77%). Nearly two-thirds of respondents (63%) said they offer voluntary benefits to help employees reduce financial stress and 51% do so to support talent retention efforts.

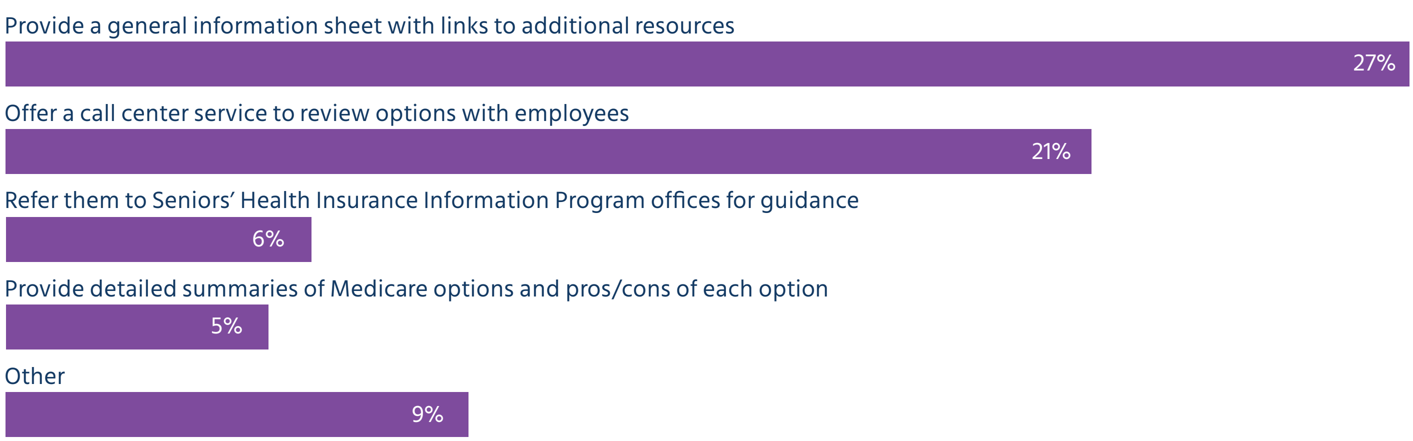
Most important objectives for voluntary benefits program



Medicare offerings and services

Over a quarter of respondents provide a generational information sheet with links to additional resources to assist employees with the selection of Medicare benefits upon their retirement. Just over a fifth of respondents offer a call center service to review options with employees. However, 42% don't provide any assistance with Medicare selection, but 12% are considering it.

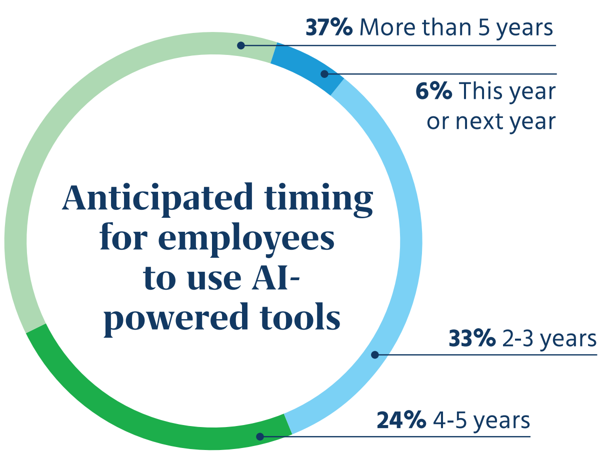
Supporting employees in selection of Medicare benefits

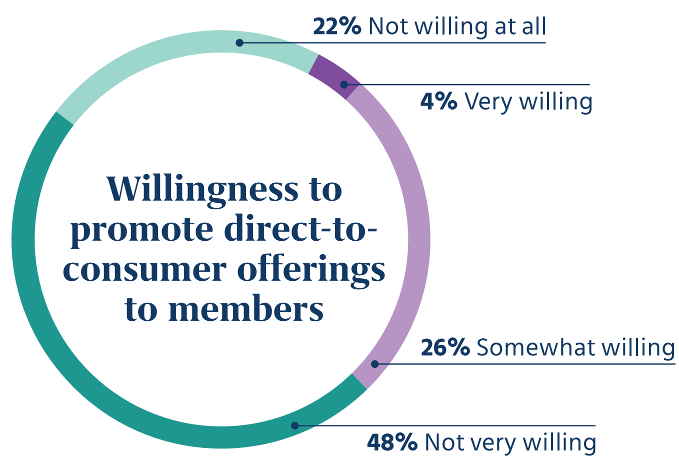


05/Digital health solutions

Consumer-facing health tools will increasingly incorporate artificial intelligence (AI). While only 6% of respondents expect to offer their employees AI-powered tools like chat bots and symptom checkers by next year, the majority expect to do so within the next five years.

Direct-to-consumer health solutions, such as 98point6, GoodRx and 23andMe, market their services to individuals outside of employer-sponsored health plans. They may be free or consumers may pay for them out of pocket. Close to a third (30%) of respondents said that they would be very or somewhat willing to promote certain direct-to-consumer offerings to their plan members. About half (48%) said they were not very willing and 22% were not willing at all to promote these solutions.

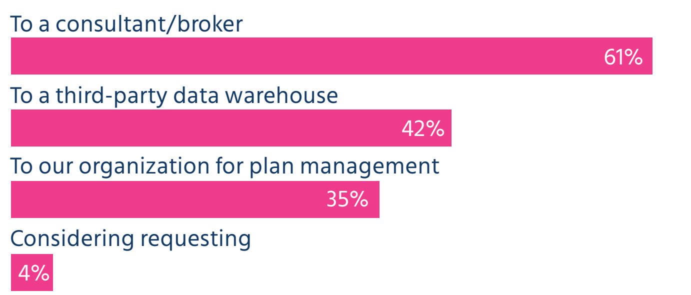




Requiring vendors to provide claims data

Sophisticated data analysis, such as predictive analytics, requires access to comprehensive databases on plan members. Although employers can encounter resistance from carriers to sharing claims data with other vendor partners, 61% of respondents say that they require their vendor partners to provide all claims data, including complete financial and clinical information, to their consultant or broker, and 42% require vendors to send it to a third-party data warehouse. Just over a third require this information from their vendors to go to their own organization for plan management (35%).

Requirement of vendors to provide all claims data



For more data and insights from our National Survey of Employer-Sponsored Health Plans, visit Mercer.us/NationalSurvey