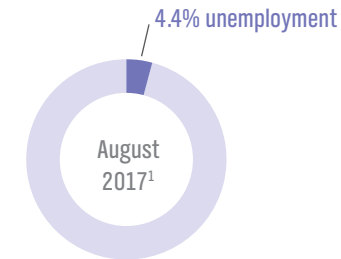


TRENDS IN HEALTH BENEFITS

“THE SECRET OF MY SUCCESS IS THAT WE HAVE GONE TO EXCEPTIONAL LENGTHS TO HIRE THE BEST PEOPLE IN THE WORLD.”

STEVE JOBS

A COMPETITIVE JOB MARKET



As an employer, you know better than anyone what your most valuable assets are: your people. And you know it's becoming harder than ever to hire the best people. One simple reason is there are fewer candidates looking for work. In fact, unemployment dropped from a peak of 10% in October 2009 to just 4.4% in August 2017.¹

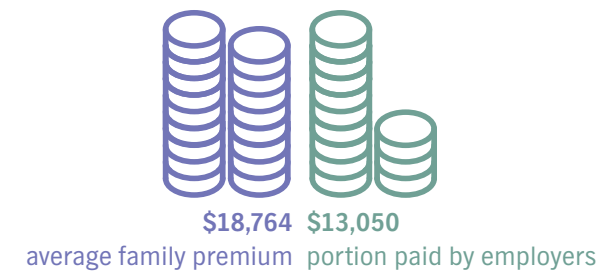
To compete for this shrinking talent pool, you have to pay employees more. Wages are slowly rising, and the cost of benefits continues to grow, too, with employers spending 3% more on health benefits in 2017 than in 2016.²

So how can you hire the best people?

One way to attract employees is to offer a compensation package that matches — or better yet, beats — the competition. Employees in one survey ranked health insurance as the number-one benefit they want — even above vacation/paid time off.³ A good health insurance plan not only attracts employees and provides them a needed benefit, it can also improve how well your company performs. When your employees take care of themselves, they can be more productive at work. It's a virtuous cycle that improves your business in ways you may not even expect.

The **2018 National Health Benefits Statistics & Trends Report** brings you the latest outlook on health benefits, including national health and spending and a snapshot of how other employers are designing their benefit programs. You'll also learn about the most important trends shaping health benefits — from wellness programs to high-deductible plans and specialty pharmacy costs. This report may provide valuable insights as you create a benefits program that attracts the employees you want and positions your company for a bright future.

RISING HEALTH CARE COSTS: 2017



#1 BENEFIT FOR EMPLOYEES



1 U.S. Bureau of Labor Statistics. *Labor Force Statistics from the Current Population Survey* (data extracted on November 28, 2017): data.bls.gov/timeseries/LNS14000000.
2 Kaiser Family Foundation and Health Education & Research Trust. *2017 Employer Health Benefits Survey* (September 19, 2017): [kff.org](https://www.kff.org).
3 Fast Company. *These are the Best Employee Benefits and Perks* (February 3, 2016): [fastcompany.com](https://www.fastcompany.com).

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NATIONAL
CONTEXT

National health snapshot

America's Health Rankings 2016

	State health rank	Smoking rate	Obesity rate	Cardiovascular deaths per 100,000	Cancer deaths per 100,000	Drug deaths per 100,000
UNITED STATES	N/A	17.5%	29.8%	251.7	189.9	14.0
Alaska	33	19.1%	29.8%	214.1	193.3	16.0
Alabama	46	21.4%	35.6%	332.9	211.1	13.1
Arkansas	48	24.9%	34.5%	317.3	218.1	12.1
Arizona	30	14.0%	28.4%	213.7	170.0	18.6
California	16	11.7%	24.2%	229.9	169.9	11.4
Colorado	10	15.6%	20.2%	199.3	161.8	15.9
Connecticut	3	13.5%	25.3%	217.2	173.2	15.1
Delaware	28	17.4%	29.7%	247.5	198.5	18.1
Florida	36	15.8%	26.8%	224.8	182.1	13.2
Georgia	43	17.7%	30.7%	272.9	194.4	11.2
Hawaii	4	14.1%	22.7%	206.6	158.4	11.2
Iowa	19	18.1%	32.1%	245.9	194.4	8.9
Idaho	18	13.8%	28.6%	229.2	177.8	13.1
Illinois	24	15.1%	30.8%	253.8	199.6	12.6
Indiana	37	20.6%	31.3%	277.1	210.5	16.7
Kansas	29	17.7%	34.2%	249.6	192.6	11.7
Kentucky	44	25.9%	34.6%	297.8	232.2	24.1
Louisiana	49	21.9%	36.2%	312.5	218.7	15.6
Massachusetts	1	14.0%	24.3%	205.6	184.8	15.7
Maryland	13	15.1%	28.9%	252.5	189.2	15.3
Maine	20	19.5%	30.0%	220.8	203.1	13.6
Michigan	32	20.7%	31.2%	288.7	201.0	15.7
Minnesota	6	16.2%	26.1%	188.2	179.2	9.3
Missouri	34	22.3%	32.4%	283.6	209.3	17.0
Mississippi	50	22.5%	35.6%	344.8	227.5	11.0
Montana	23	18.9%	23.6%	227.3	179.8	12.8
North Carolina	31	19.0%	30.1%	251.9	196.2	13.3
North Dakota	13	18.7%	31.0%	231.4	176.2	4.0
Nebraska	15	17.1%	31.4%	227.0	186.9	7.1
Nevada	40	17.5%	26.7%	277.8	189.1	20.9
New Hampshire	5	15.9%	26.3%	213.9	188.0	17.9
New Jersey	7	13.5%	25.6%	245.4	183.0	14.0
New Mexico	41	17.5%	28.8%	217.5	168.3	24.7
New York	12	15.2%	25.0%	256.2	179.6	11.1
Ohio	39	21.6%	29.8%	278.7	208.6	21.1
Oklahoma	47	22.2%	33.9%	325.9	215.2	20.9
Oregon	17	17.1%	30.1%	212.4	190.9	12.3
Pennsylvania	25	18.1%	30.0%	259.3	199.8	19.8

America's Health Rankings 2016

	State health rank	Smoking rate	Obesity rate	Cardiovascular deaths per 100,000	Cancer deaths per 100,000	Drug deaths per 100,000
Rhode Island	8	15.5%	26.0%	230.4	195.2	21.4
South Carolina	42	19.7%	31.7%	274.1	202.7	13.4
South Dakota	26	20.1%	30.4%	233.8	185.5	6.6
Tennessee	45	21.9%	33.8%	302.7	215.6	18.3
Texas	35	15.2%	32.4%	256.9	182.2	9.6
Utah	11	9.1%	24.5%	225.0	149.3	22.8
Virginia	21	16.5%	29.2%	239.0	189.2	10.1
Vermont	2	16.0%	25.1%	226.9	190.5	13.1
Washington	9	15.0%	26.4%	213.3	182.0	13.8
Wisconsin	22	17.3%	30.7%	236.8	191.6	14.0
West Virginia	38	25.7%	35.6%	297.9	223.9	32.2
Wyoming	27	19.1%	29.0%	234.4	172.0	17.7

Source: United Health Foundation. *America's Health Rankings® Annual Report 2016*: americashealthrankings.org.

Key health indicators

SMOKING

<1 in 5
people smoke today

41% decrease
in smoking since 1990

CARDIOVASCULAR DEATHS

2016 ended a
26-year drop
in cardiovascular death rates

Deaths increased from
250.8 to 251.7
per 100,000 people

DRUG DEATHS

↑4%
in 2016

↑9%
over the past 5 years

Note: Health rankings are based on access to health care, lifestyle, occupational safety and disability, disease and mortality.

OBESITY

↑157%
in adults since 1990

\$190.2 billion
spent yearly on obesity-related
health issues

That's **21%** of all medical
spending annually

CANCER DEATHS

#2 cause
of death

1.6 million
new cases and

585,000 deaths
every year

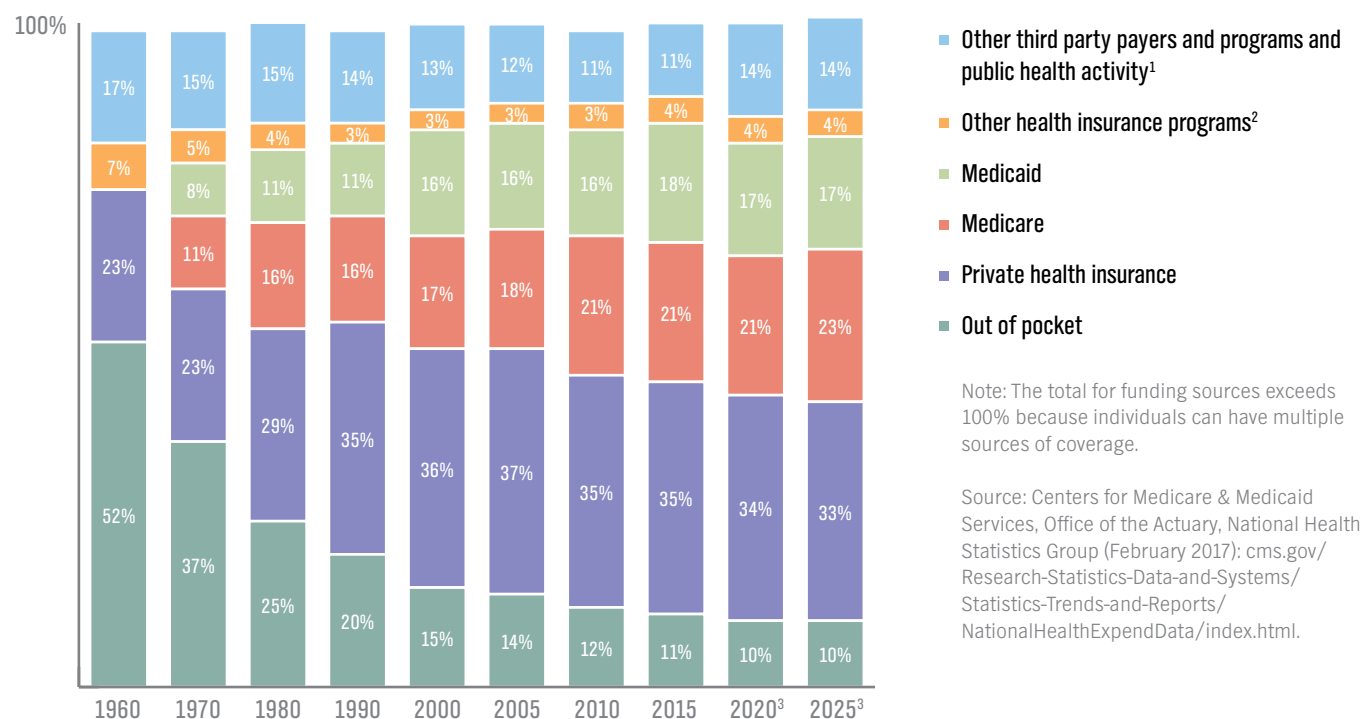
TREND WATCH

Healthy living incentives

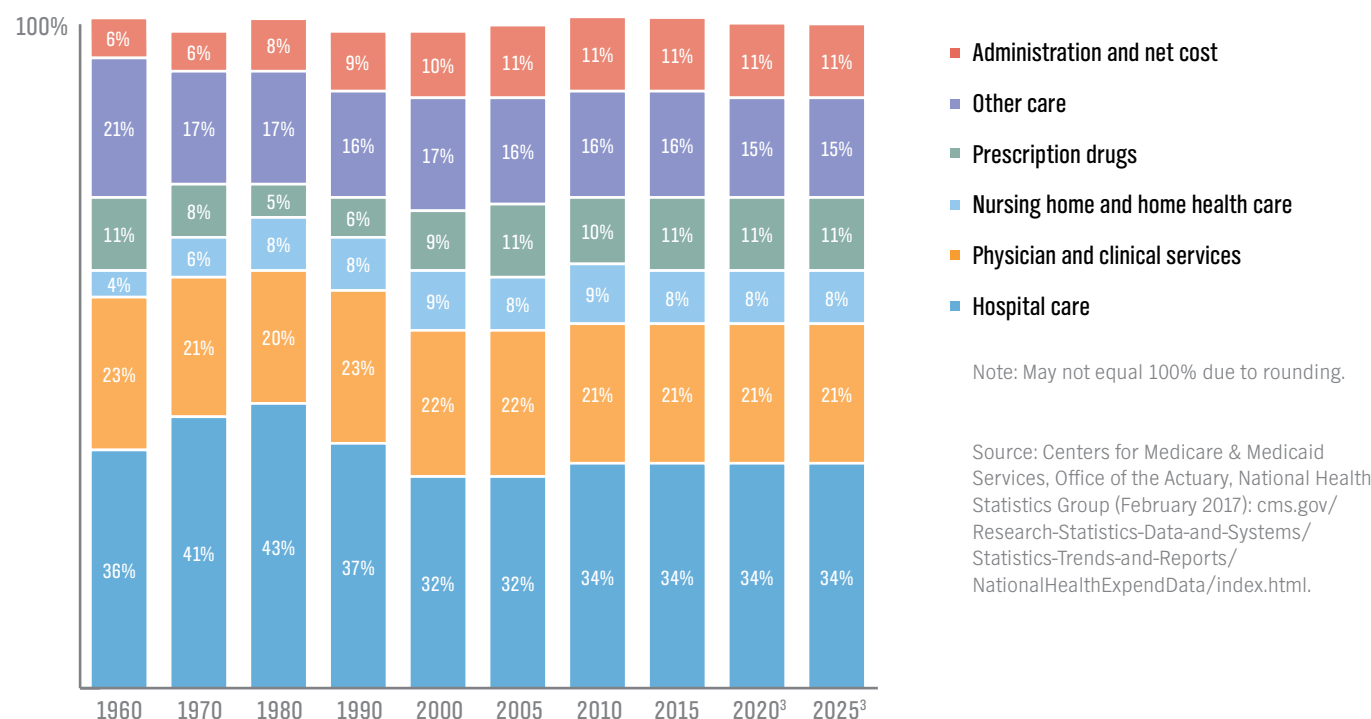
Many employers are adding disease management and healthy living features to their benefit plans. Programs that encourage weight loss, exercise and quitting smoking may help slow down benefit cost increases by helping lower the effects of various health risk factors on benefit costs. They can also help motivate employees to get more engaged in their health. [Learn more about disease management strategies.](#)

The nation's health dollar: trends 1960-2025

Who paid for health care?



Where did the money go?



Health care spending, 2015

\$3.2 trillion
\$9,990 per person
1/3 of funding from private health insurance
Private funding is up due to higher enrollment and higher benefit spending
Household spending is up 4.7% due to contributions to employer-sponsored private insurance plans

Health care spending, 2018-2019

5.7% growth projected per year due to higher disposable income and higher prescription drug prices
Changes in the Affordable Care Act will impact future projections

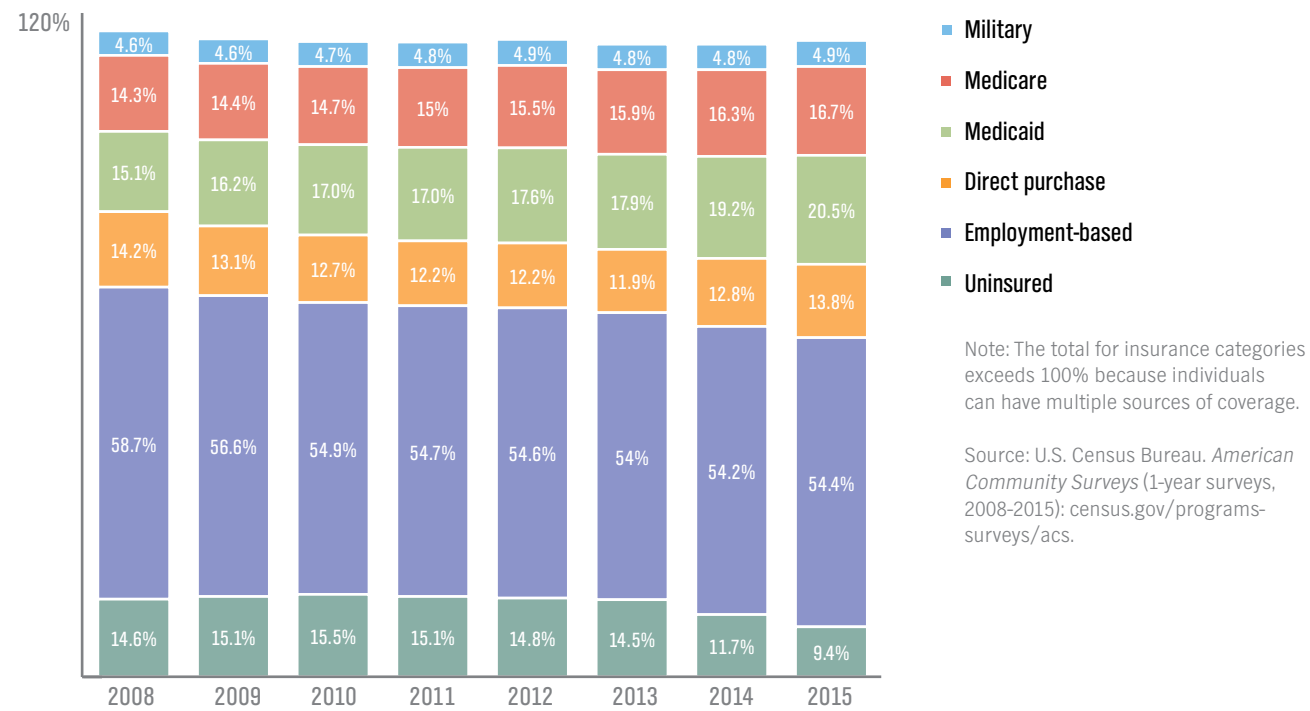
¹ Other third-party payers include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs and school health.

² Other health insurance programs include Children's Health Insurance Program (Titles XIX and XXI), Department of Defense and Department of Veterans Affairs.

³ Projected.

Health insurance coverage

Health insurance coverage by funding source: 2008-2015



Health insurance coverage is increasing

The percentage of people with health insurance coverage for 2015 was **higher than prior years**.

In 2015, private health insurance (direct purchase and employer based) coverage continued to be **more prevalent** than public coverage.

Increases in private health insurance coverage and government coverage contributed to the overall **increase in coverage** between 2014 and 2015.

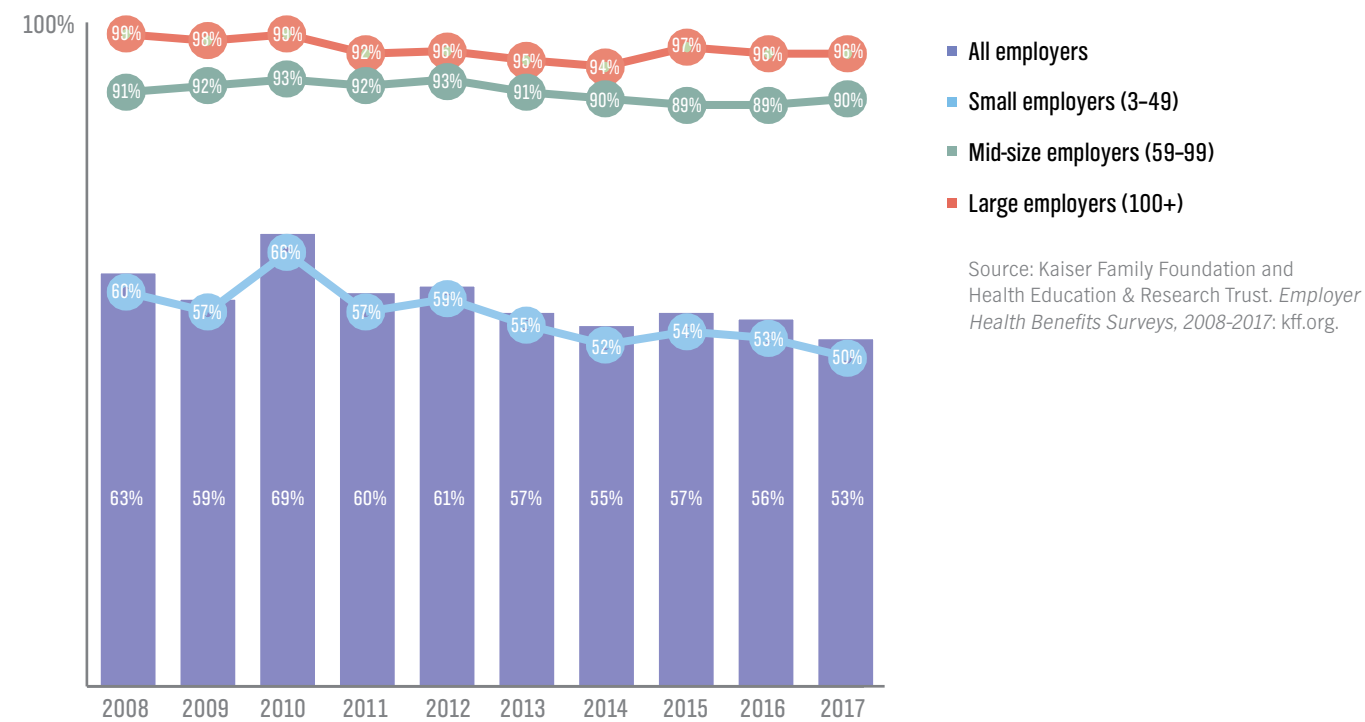
For the second year in a row, the **percentage of people without health insurance dropped** for all ages under 65.



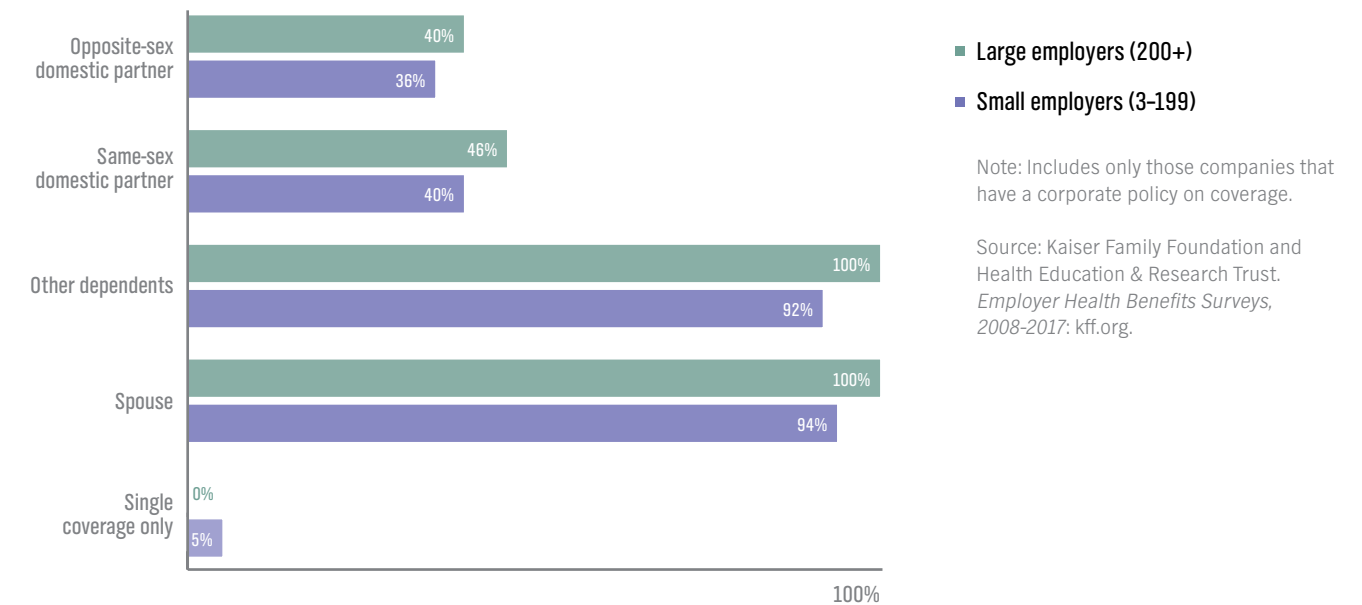
EMPLOYER
SNAPSHOT

Employer-provided coverage

Percentage of employers offering health benefits by company size: 2008-2017



Percentage of employers offering coverage to spouses, dependents and partners: 2017



The percentage of larger employers offering insurance remains **fairly steady**.

Fewer small employers offer health benefits, largely due to rising health care costs.

Most employers (small and large) offer health benefits to **spouses and dependents**.

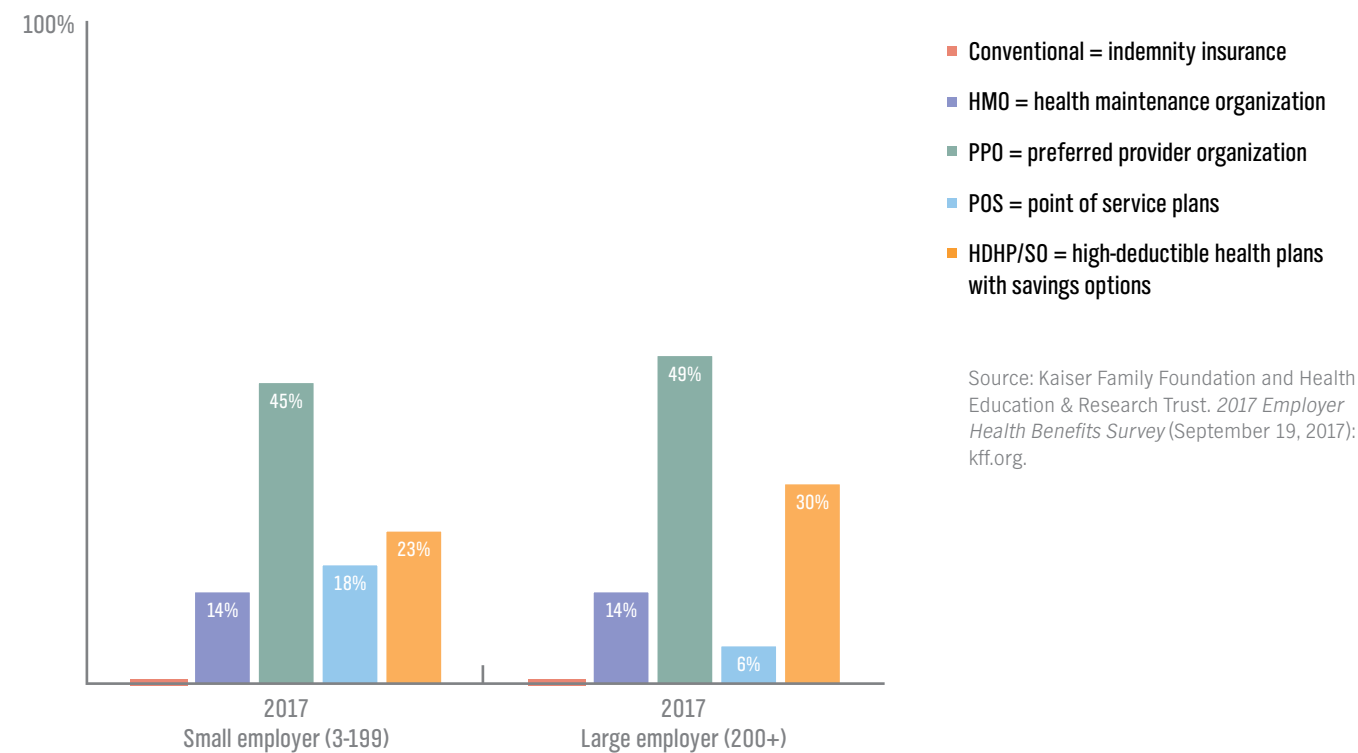
Some employers **pay employees to enroll in their spouse's plan** or not participate in their company health benefits.

A small percentage of employers doesn't allow spouses to enroll in their plan if they have coverage available elsewhere. Others allow the spouse to enroll **subject to conditions** or require the employee's spouse to contribute more to the coverage if that spouse is offered coverage from another source.

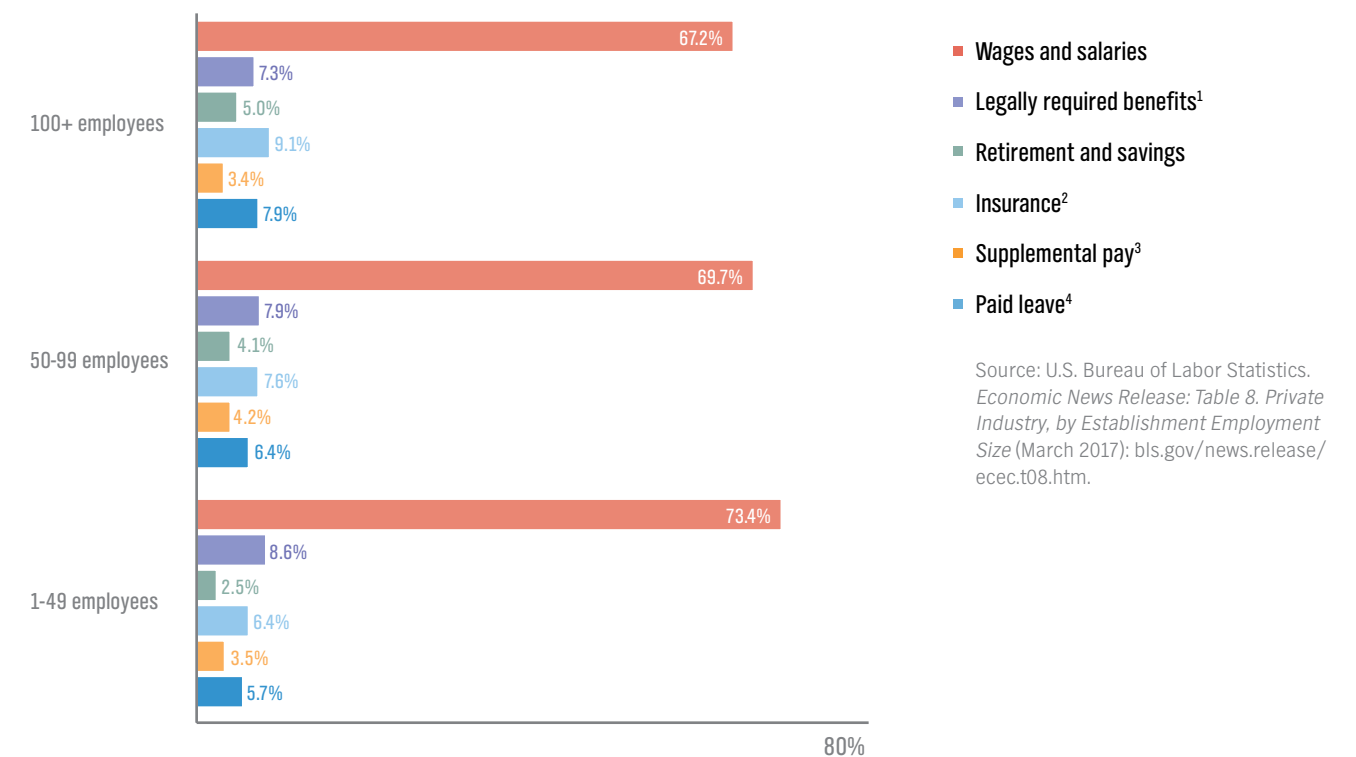


Plan types and cost

Employee enrollment by plan type: 2017



Benefit cost as percent of total compensation: 2016



PPOs continue to be the most popular plan type, enrolling **48%** (combined) of covered employees.

Large employees are more likely to offer **multiple plan types**.

For large employers, **health benefits account for the largest portion** of total compensation other than wages and salaries.

For mid-size and small employers, health benefit costs are **second to legally required benefits**.

TREND WATCH

High-deductible plans

High-deductible plans don't necessarily mean higher overall costs. Employees enrolled in high-deductible health plans with savings options (HDHP/SO) have higher deductibles than those with HMO, PPO or POS plans. But this doesn't mean their out-of-pocket costs are higher. Most employers offering these plans contribute to their employees' savings accounts, which reduces their cost-sharing amount.

¹ Legally required benefits include Social Security, Medicare, unemployment and other legally required benefits.

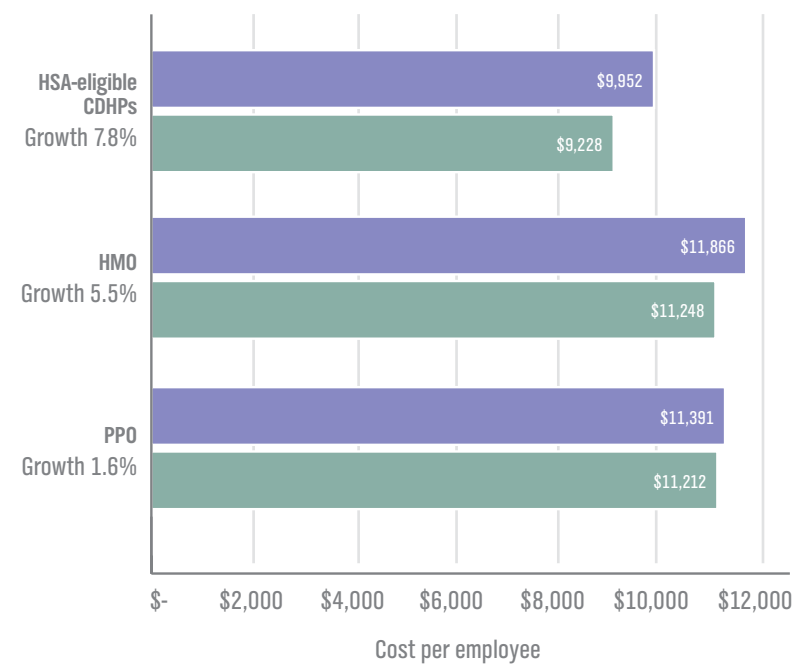
² Insurance includes life insurance, health insurance and short- and long-term disability insurance.

³ Supplemental pay includes overtime, bonuses and other supplemental pay.

⁴ Paid leave includes vacation, holiday, sick and personal time.

Plan and drug costs

Medical plan cost per employee, by plan type

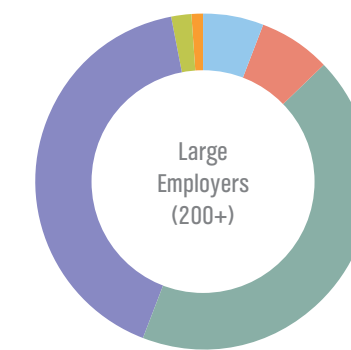
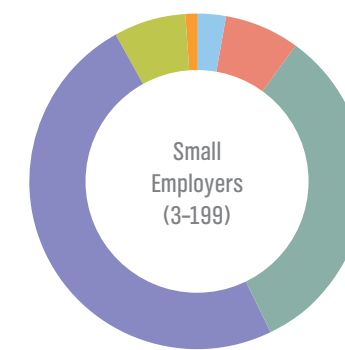


- 2016
- 2015

HSA = health savings account
 CDHP = consumer-driven health plan
 HMO = health maintenance organization
 PPO = preferred provider organization

Source: Mercer. 2016 National Survey of Employer-Sponsored Health Plans Report (October 26, 2016): mercer.com.

Prescription drug coverage and cost sharing



- Single tier
- Two tiers
- Three tiers
- Four or more tiers
- No cost-sharing after deductible met
- Other

Source: Kaiser Family Foundation and Health Education & Research Trust. 2017 Employer Health Benefits Survey (September 19, 2017): kff.org.

*Cost-sharing refers to how prescription drug costs are shared between employers and employees. Health plans typically use a preferred drug list that classifies drugs into categories (tiers) that are subject to different cost-sharing or management.



HMO and PPO costs in 2016 were very similar, but with a higher increase, HMOs are becoming the most expensive plan type.

While per-employee costs for CDHPs grew at a higher rate from 2015 to 2016 (7.8%), they're still considered the least expensive plan type.

Almost all covered employees have **prescription drug coverage**.

Some plans require employees to meet a deductible for prescription drugs instead of, or in addition to, a general deductible.

Most employers offer a multi-tier prescription drug cost-sharing formula.

Employees enrolled in high-deductible health plans with spending accounts (HDHP/SAs) are more likely to be in a plan with the same cost-sharing arrangement, **regardless of drug type**.

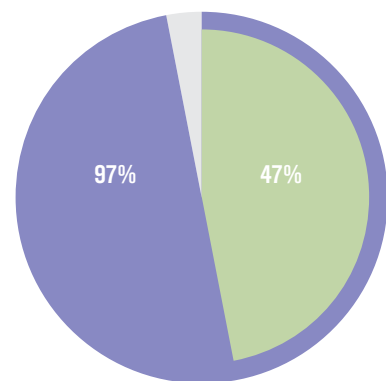


TREND WATCH
CDHP growth continues

The growth in offerings of CDHPs slowed in 2016, but enrollment has increased steadily – indicating that employees are moving away from the traditional PPOs and HMOs.

Drug coverage

Large employer (200+) specialty drug coverage: 2017

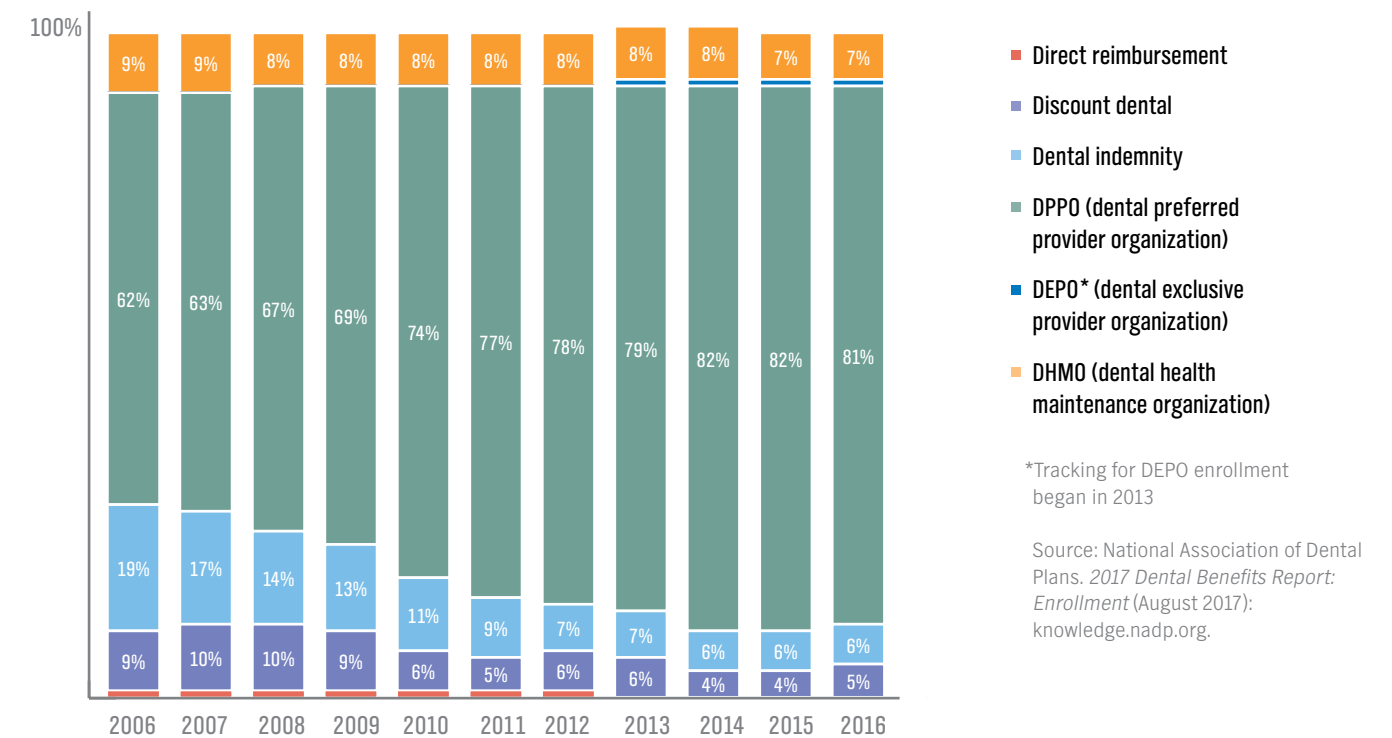


- Covered employees whose plan includes specialty drug coverage
- Of those, coverage includes a separate tier for specialty drugs

Source: Kaiser Family Foundation and Health Education & Research Trust. *2017 Employer Health Benefits Survey* (September 19, 2017): kff.org.

Dental, vision, life and disability coverage

Dental benefits by plan type



97% of covered employees work for employers whose largest health plan provides specialty drug coverage

47% are in a plan with at least one cost-sharing tier specific to specialty drugs

PPOs are preferred over HMOs because HMO networks are typically more limited.

64% of group policies include employee/employer cost share

29.9% of dental plans are voluntary, paid 100% by employees

Only **6.4%** of dental plans are **100%** employer-paid

About **3%** of dental benefits are integrated with medical policies

Self-insured group dental benefits continue to be popular, representing **48%** of all commercial group enrollment

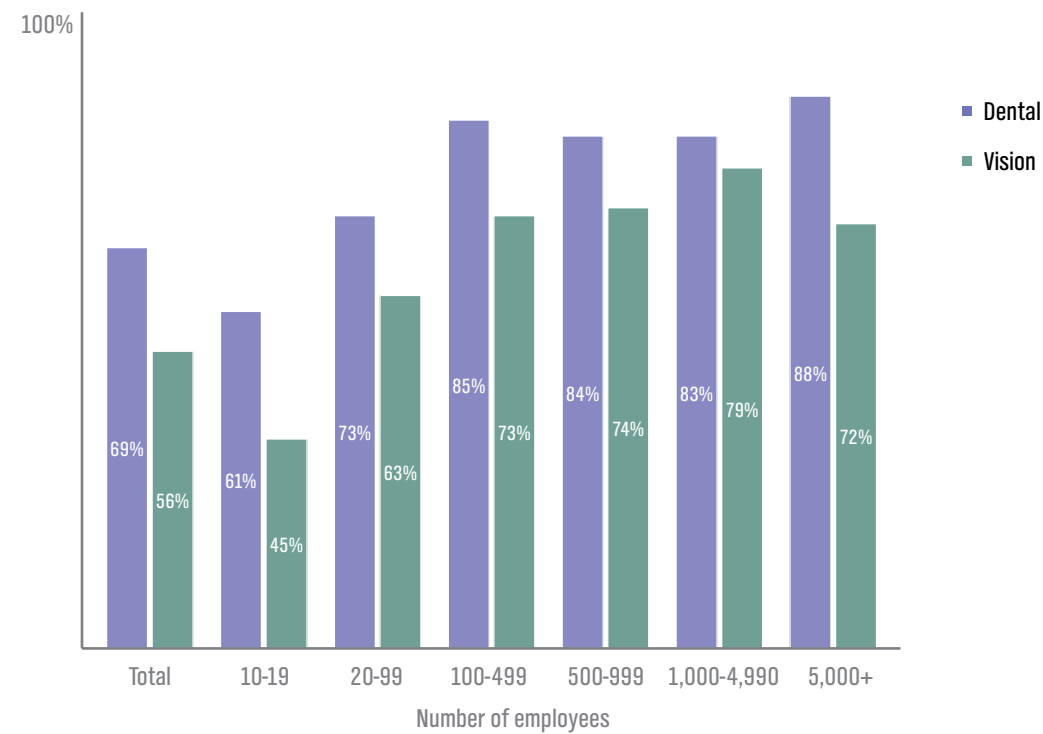
TREND WATCH

Specialty drugs

Specialty drugs require strategic management. Specialty drugs are used to treat health problems that are challenging to manage, and can be extremely expensive. In addition, unlike traditional prescription drugs, specialty drugs are often covered under the pharmacy benefit and the medical benefit. Because of this, employers are using a variety of strategies to help contain costs and maximize health outcomes. These include focused and/or tiered drug lists, prior authorization, quantity limits, dose optimization, split fills and management strategies that cross both benefits. Cost sharing for specialty drugs usually includes either copays or coinsurance. [Learn more about specialty drugs.](#)

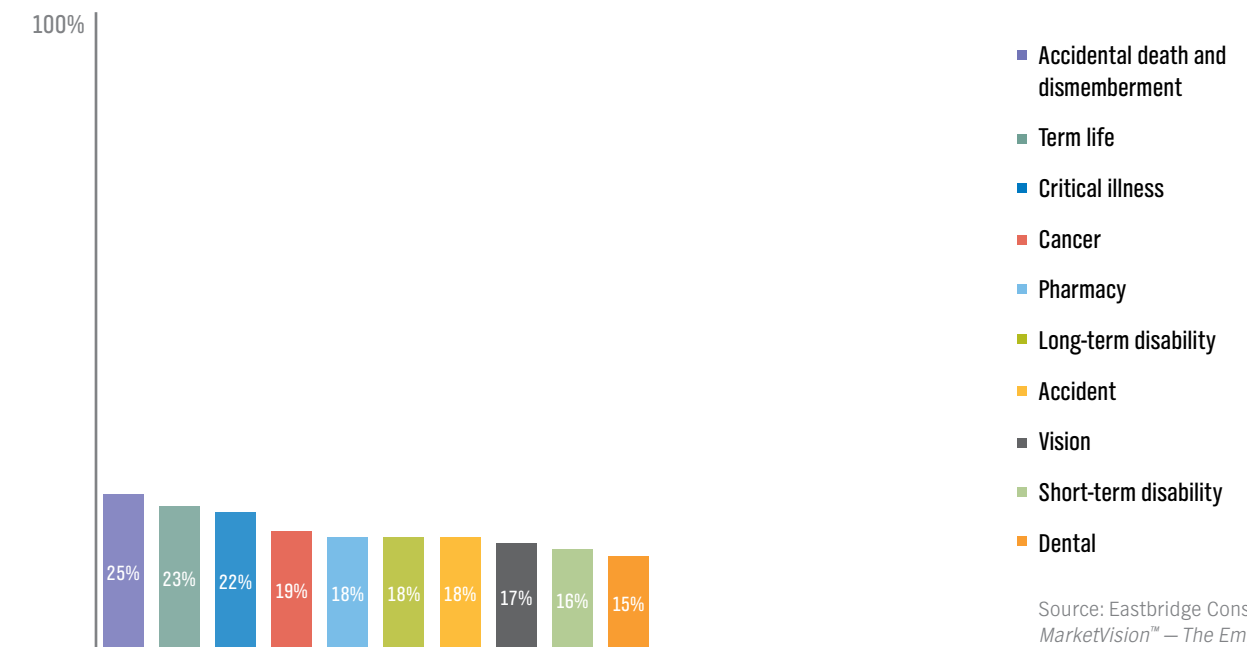
Dental, vision and ancillary coverage

Percentage of employers offering dental and vision coverage



Voluntary coverage

Percentage of employers who offer the product



Source: Eastbridge Consulting Group. *MarketVision™ – The Employer Viewpoint* (accessed November 29, 2017); eastbridge.com.

Percentage of employers offering other ancillary products

	NUMBER OF EMPLOYEES						
	Total	10-19	20-99	100-499	500-999	1,000-4,990	5,000+
BASIC LIFE	53%	42%	61%	77%	72%	71%	84%
LONG-TERM DISABILITY	45%	34%	50%	67%	65%	79%	72%
SHORT-TERM DISABILITY	44%	31%	52%	66%	65%	72%	76%
ACCIDENTAL DEATH & DISMEMBERMENT	36%	25%	45%	51%	58%	57%	70%
ADDITIONAL/SUPPLEMENTAL LIFE	24%	13%	31%	47%	56%	53%	64%

Source: LIMRA. 2016 LIMRA Employer Study: Benefit Communication and Enrollment (June 27, 2016); limra.com.

TREND WATCH

The power of integrating voluntary benefits

Benefits are increasingly important to potential and current employees. Offering voluntary products — those that employees pay for — can help companies recruit and retain employees, and help fill gaps in their benefit portfolios without added costs.

While larger employers are historically more likely to use separate carriers to provide different voluntary products, there are clear benefits to integrating health plans with voluntary products using a single carrier. Integrated plans allow employers to offer their employees a personalized enrollment experience based on age, gender or life stage. And a single platform (preferred by 60% of employers) provides a simpler, streamlined experience for employees and less administration for employers.

[Learn more about integrated health plans.](#)

Source: Eastbridge Consulting Group. *MarketVision™ – The Employer Viewpoint* (accessed November 29, 2017); eastbridge.com.

Dental benefits are the ancillary product offered most often by all employer sizes.

Larger employers are more likely to offer ancillary services, but most employers offer vision and life.



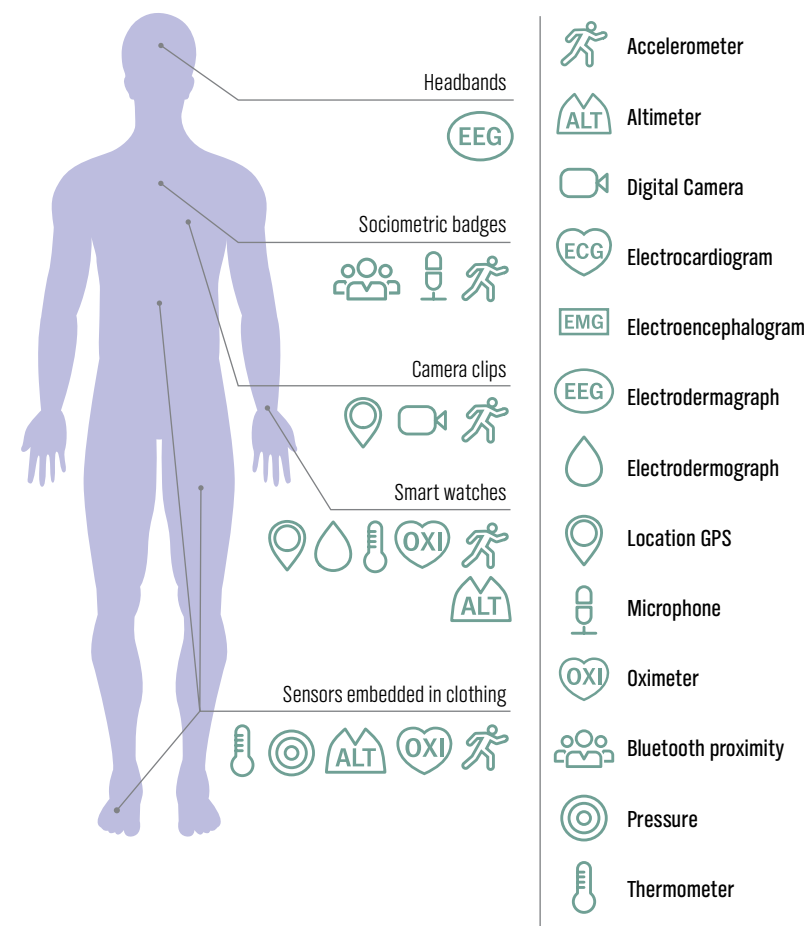
EMERGING TRENDS

Wearables

Wearable devices

The line between consumer health wearables and medical devices is beginning to blur, and now wearable devices can monitor many different types of risk factors. These new wearables can give individuals access to data and analytics that can promote well-being, help manage chronic illnesses and make a big impact on their health.

Stationary computerized solutions like web-based services, electronic self-reports and email feedback already help create positive behavior change in people who have health issues such as obesity, anxiety, panic disorders, post-traumatic stress disorder (PTSD) and asthma. Wearables can also provide a platform to manage long-term chronic conditions at home. For example, many wearable devices can automatically upload tracking information, making them helpful tools for weight management and control of obesity-related conditions such as type 2 diabetes.



Source: Piwek L, Ellis D, Andrews S, Joinson A. *The Rise of Consumer Wearables: Promises and Barriers* (February 2, 2016): ncbi.nlm.nih.gov/pmc/articles/PMC4737495/.

Wearable technology

Wearables can also be a valuable addition to employer wellness programs. Consider weaving them into workplace challenges and investigate online tools your health benefits provider may offer. These tools can track employees' healthy habits over time and may help encourage them to invest in their health. Wearables can provide an easy metric for interoffice competitions and fuel a "fitness is fun" culture at work.



1 in 6 Americans
use wearable devices regularly to monitor factors like sleep, activity and heart rate

Source: Piwek L, Ellis D, Andrews S, Joinson A. *The Rise of Consumer Wearables: Promises and Barriers* (February 2, 2016): ncbi.nlm.nih.gov/pmc/articles/PMC4737495/.



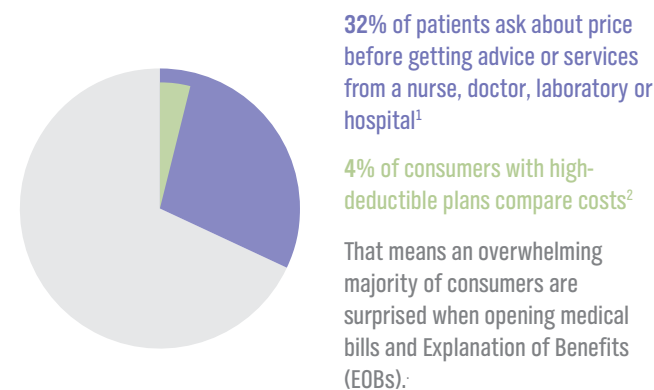
\$11.2 billion industry
by 2020



Transparency tools

In today's information age, answers are literally at our fingertips 24/7. Yet when it comes to health care price and quality information, we're barely getting out of the Dark Ages. Without clear details around price and quality, it's difficult for consumers to make sound health care decisions.

For example, just:



Employers are in a unique position to not only empower their employees by providing health care price and quality information, but also engage them and drive behaviors that will help them better manage their health and related expenses.

Encourage educated choices

Consumer-driven health plans like health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending accounts (FSAs) contain funds employees can use toward health care services. By offering employees the tools and support they need to effectively manage these funds, employers empower them to become better health care consumers.

When people become educated consumers, they tend to do a better job of managing their own health care dollars and making informed choices. And as employees make better choices for their own wallet and health, overall health care costs for employers can also be reduced.

Empower employees with information

Partner with a health plan that will help employees truly understand their benefits. The health plan should provide tools and resources that help your employees and their dependents feel comfortable asking questions about medications and/or treatment plans selected by their doctor.

Evaluate transparency tools

The trend toward transparency is growing, and many organizations offer these types of tools. So how do you know which tools are best or will be the most helpful for your employees and their dependents? Here are a few things to consider:

- Does the cost shown reflect the user's specific plan design (deductible, copay and/or coinsurance)?
- Does the tool tell if doctors and facilities are in-network for the user's plan?
- Does the cost shown reflect the user's insurance carrier's negotiated price?
- Does the tool translate complex clinical information in a way that is intuitive and actionable?³
- Does the tool include patient comments on their experience with doctors and facilities?
- Is the tool easy to navigate and understand?
- Does the experience work well on a mobile device? Is it easy for users to find relevant information they may need when they're in the doctor's office or need to find care quickly?

¹ Altarum Institute. *Altarum Institute Survey of Consumer Health Care Opinions* (January 8, 2014): altarum.org.

² Sinaiko D, Mehrotra MD, Sood N. *Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care: Enrollees with Skin in the Game*. *JAMA Internal Medicine* 2016;176:395-7: jamanetwork.com.

³ National Business Group on Health. *Selecting Vendor Partners in the CDHP Era* (accessed November 29, 2017): businessgrouphealth.org.

Health care apps

The use of mobile apps for health care increased from 16% in 2014 to 33% in 2016.¹ Meanwhile, wearable health device use more than doubled from 9% in 2014 to 21% in 2016.² People are using health apps for a variety of health and wellness activities, including fitness, diet and nutrition, symptom management and accessing health care websites. Of those who use a health app, 40% have shared its data with their doctor in the past year.²

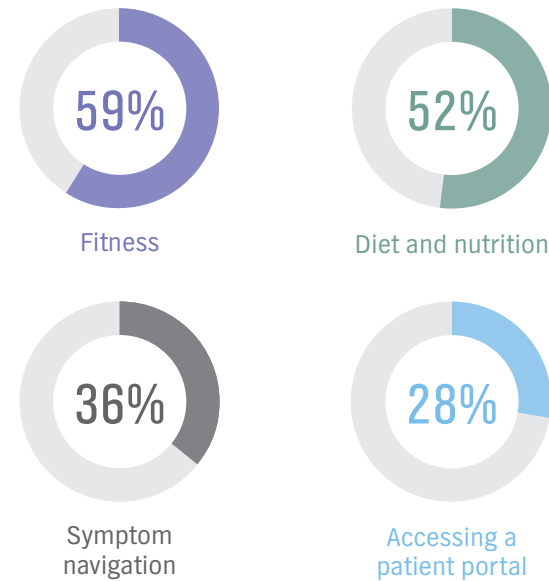
Health care app growth



- Number of mobile health apps in the stores
- Number of mobile health publishers

Source: research2guidance. *mHealth App Developer Economics 2016* (October 2016): research2guidance.com.

HEALTH CARE APP USE²



Employers are increasingly driving mobile health adoption among employees to:

- Help employees become better health care consumers.
- Improve workforce health.
- Reduce health care costs.

More than half of large employers offer mobile health apps to employees (56%), and nearly as many are also encouraging spouses/domestic partners to use them, too (55%).³

Encouraging employees to use health care apps

To encourage use of these apps, employers are using the following strategies:⁴

- Incentives for purchasing and/or using wearable fitness trackers
- Contests and competitions among employee groups for “bragging rights”
- Personalized and targeted messaging based on demographics, attitudes, behaviors and other available data

However, using an app doesn’t necessarily help consumers get the health guidance they’re looking for. Only 23% of apps react appropriately when users enter data that indicates a serious health issue, such as a high blood pressure reading or other symptoms.⁵

1 research2guidance. *mHealth App Developer Economics 2016* (October 2016): research2guidance.com.

2 Accenture Consulting. *Accenture 2016 Consumer Survey on Patient Engagement* (June 29, 2016): accenture.com.

3 National Business Group on Health. *Employers Invest in Technology to Promote Employee Wellbeing, though Measuring Effectiveness Proves Challenging* (March 2016): businessgrouphealth.org.

4 National Business Group on Health. *Financial Incentives for Healthy Lifestyles: Who’s Doing It, What’s Legal and Where’s the Evidence?* businessgrouphealth.org.

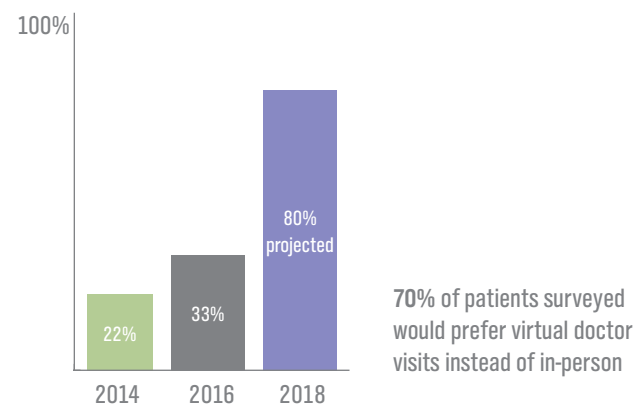
5 Singh K, Krouin K, Newmark LP, Lee J, Faxvaag A, Rozenblum R, et al. *Many Mobile Health Apps Target High-Need, High-Cost Populations, but Gaps Remain*. Health Affairs (December 2016): healthaffairs.org.

Telehealth

Telehealth is the use of telecommunication and information technology to provide health care from a distance. Telehealth programs are used to:

- Allow users to speak with doctors, psychologists or psychiatrists or other health care providers through live video.
- Send health records electronically.
- Monitor patients remotely using devices that collect and send health and medical data.
- Send health-related information to users through cellphones, tablets or other computers.

PERCENTAGE OF EMPLOYERS THAT OFFER TELEHEALTH³



The benefits of telehealth¹

Reduces medical costs

- The average telehealth visit costs \$40.
- The average in-office visit costs \$140.
- An emergency room (ER) visit for a minor issue can reach more than \$750.
- Telehealth saves an average of \$100 per visit. Some studies estimate the savings are as high as \$126 per visit.²

Improves access to care

- The supply of primary care doctors has not grown at the same rate as the demand for their services.
- Instead of waiting days or weeks for an in-office visit with a doctor, employees can see one on-demand and at their convenience.

Saves employees time

- Between scheduling, travel and waiting to see a doctor, employees spend a lot of time on in-office doctor visits.
- The average total time spent for a typical in-office medical visit is 121 minutes, with only 20 minutes spent face-to-face with a doctor.
- Telehealth gives employees back their time, improving their quality of life and making them happier.³

Improves employee productivity and can help attract new talent

- Telehealth removes the stress and distraction of scheduling and traveling to medical appointments.
- Traditional health care visits can only be scheduled during work hours, but telehealth is usually available 24/7 and can be accessed at the employee's convenience.
- A telehealth benefit positions an employer as forward-thinking and modern – an important aspect of recruitment as the Boomer generation retires and Millennials increasingly populate the workforce.
- When considering new career opportunities, job candidates don't just look at their potential salary – but also their benefits package.⁴

Encouraging the use of telehealth

Consistent communication about the benefits of telehealth is key to its use, so:

- Integrate telehealth registration in your open enrollment to help drive registration.
- Opt in to any health plan-initiated communications around telehealth. This should typically include emails and postcards at a minimum.
- Execute year-long campaigns promoting telehealth, but pay particular attention to seasonal peak times for ER usage, such as:
 - Spring allergies and sports injuries
 - Summer vacation
 - Cold/flu season

Many health insurers are adding telehealth services to their benefits in addition to having a 24/7 nurse information line. These types of services give employees options for care at lower costs and in a setting they prefer. They can also help lower costs for employers.

¹ National Business Group on Health. *Financial Incentives for Healthy Lifestyles: Who's Doing It, What's Legal and Where's the Evidence?*. businessgrouphealth.org.

² Singh K, Krouin K, Newmark LP, Lee J, Faxvaag A, Rozenblum R, et al. *Many Mobile Health Apps Target High-Need, High-Cost Populations, but Gaps Remain*. Health Affairs (December 2016): healthaffairs.org.

³ American Well. *Telehealth Index: 2016 Employer Benchmark Survey*. americanwell.com.

⁴ Alliance for Connected Care. *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services* (December 2014): connectwithcare.org.

The opioid impact

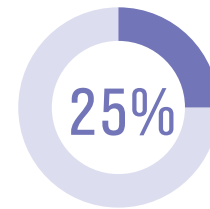
Opioids are a class of drugs commonly prescribed to relieve pain. They include prescription drugs such as morphine and codeine (categorized as natural opioids); hydrocodone and oxycodone (semi-synthetic forms); synthetic drugs such as methadone and fentanyl; and heroin, an illegally-made opioid synthesized from morphine.

When properly administered, opioids can be an effective treatment for acute pain syndromes and painful conditions. But they carry significant risks when misused. Opioid misuse, substance use disorders and substance use-related conditions are often chronic conditions, best managed through an integrative approach to care and services and requiring evidence-based treatment to maintain stability and recovery.

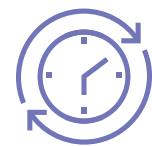
Opioid misuse is a growing national epidemic and a public health emergency. Addiction, overdose and deaths involving non-medical prescription drug use and illicit drug use have risen dramatically during the last decade, quadrupling since 1999.¹

33,091 deaths

FROM OPIOID OVERDOSES IN 2015
(4x increase from 1999)¹



2015 DRUG DEATHS INVOLVING
HEROIN
(3x increase from 2010)²



EVERY 25 MINUTES

a baby is born suffering from opioid withdrawal
(5x increase since 2000)³

Challenges

Effectively battling the opioid epidemic demands intense collaboration among health care stakeholders, including patients, providers, payers, the pharmaceutical industry and state and federal government. Many challenges remain, including:

- An inadequate number of qualified substance use treatment providers and licensed health care professionals trained to support people with substance use disorders.
- A lack of pain medicine specialists, leaving non-specialists and primary care providers to manage some of the most complex patients with chronic pain and painful conditions.
- The need for increased access to naloxone, a medication used to reduce opioid overdose death.
- The need for greater resources dedicated to researching and understanding misuse, substance use disorders and related conditions.

Addressing the national opioid epidemic must meet some basic objectives:

- Prescription opioid management
- Prevention, early identification and treatment of opioid addiction
- Strategies to address non-pharmacologic chronic pain management
- Fraud, diversion and abuse of opioids prevention

Addressing opioids in your workplace

While many of these challenges are larger national issues, employers can do several things to address the use of opioids:

- **Educate your team.** Distribute materials at work about opioid misuse and foster an open dialogue about treating opioid abuse.
- **Know where to get help.** Use health plan resources such as an employee assistance program (EAP), talk to a doctor and become more familiar with the condition by using expert resources like the [American Society of Addiction Medicine](#) and the [U.S. Substance Abuse and Mental Health Services Administration](#).
- **Be compassionate.** If you have reason to think someone may be abusing opioids or has a family member struggling with this issue, talk with them. Ask a human resources (HR) professional or a qualified third party to sit with you while you have a private conversation with the employee.
- **Exercise confidentiality and discretion.** Assure your employees that their communications with HR and health care providers will be kept private.

¹ Centers for Disease Control and Prevention. *Drug Overdose Death Data* (December 2016): cdc.gov/drugoverdose/data/statedeaths.html.

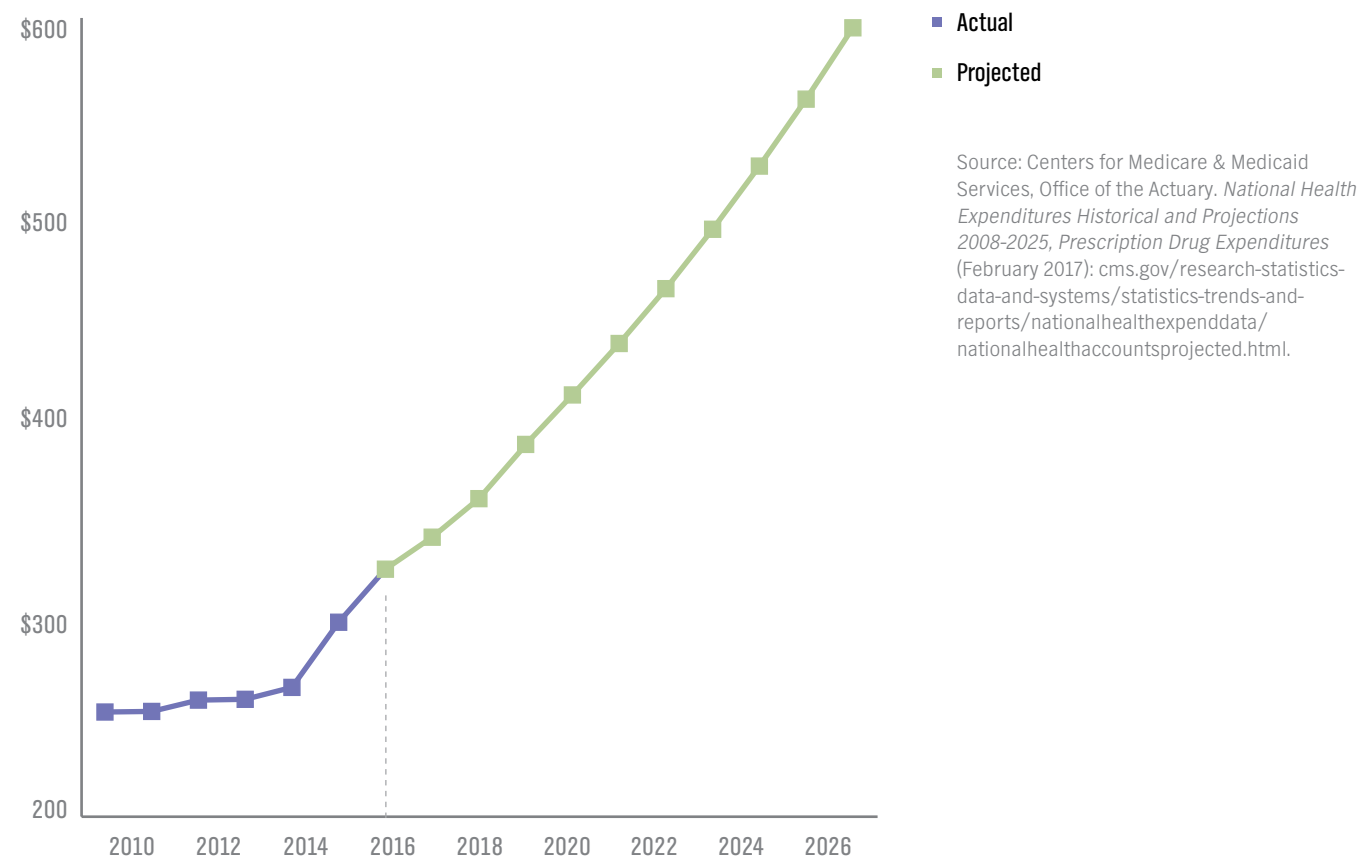
² Centers for Disease Control and Prevention, National Center for Health Statistics. *Drug Overdose Deaths in the United States, 1999-2015* (February 24, 2017): cdc.gov/nchs/products/databriefs/db273.htm.

³ National Institute on Drug Abuse. *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome* (September 2015): drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome.

Prescription drug costs

Rising drug costs continue to dominate the news. U.S. prescription drug spending totaled \$341 billion in 2016.¹ Total spending is predicted to reach \$597 billion by 2025.¹

U.S. annual and projected drug expenditures: 2008-2025 (in billions)



Specialty drug costs

The ever-increasing costs of specialty pharmaceuticals pose the greatest challenge to employers offering prescription drug benefits. Specialty drugs are used to treat diseases that are challenging to manage. Specialty drugs may require special storage and handling, and can be extremely expensive.

Nationally, specialty drug spending reached \$151 billion in 2015.² Specialty drugs grew from 22% of total drug spending in 2007 to 40% in 2016. Many employer groups are seeing a similar trend in their specialty drug spend.³

Multiple factors are driving the rising costs of specialty medications:

- **Inflation is rising.** Average drug prices are increasing as a result of more higher-cost drugs being prescribed and drug price increases are exceeding general, economy-wide inflation. However, growing public pressure has encouraged some drug manufacturers to voluntarily limit drug prices and increases.
- **More specialty drugs than traditional drugs are getting approved.** In 2012, 59% of new drugs approved by the U.S. Food & Drug Administration (FDA) were specialty drugs. By 2016, 73% of new FDA-approved drugs were considered specialty medications.⁴

- **Existing specialty drugs are receiving FDA approval to treat more health conditions.** Pharmaceutical companies can increase their market share by finding other conditions that existing medications can treat. In addition, a drug's price tends to increase following FDA approval for additional indications.
- **Specialty drugs are increasingly used to treat chronic, lifelong health conditions.** Patients will require ongoing treatment to keep these types of conditions in check, which creates a long-term market for the specialty drugs used to treat those conditions. Examples include drugs used to treat rheumatoid arthritis, psoriasis, multiple sclerosis and high cholesterol.
- **"Orphan" drugs that treat rare conditions are extremely costly.** Orphan drugs are designed to treat very rare health conditions, typically affecting less than 200,000 people in the U.S.⁵ The small patient population means pharmaceutical companies must charge more to recoup their drug development investment. For example, Radicava was approved in May 2017 for the treatment of amyotrophic lateral sclerosis (ALS), which affects 14,000 to 15,000 people in the U.S., and has a pre-discount price of \$145,000 per year.^{6,7}

FDA DRUG APPROVALS BY TYPE			
YEAR	NME APPROVED*	TRADITIONAL DRUGS	SPECIALTY DRUGS
2012	39	16	23
2013	27	11	16
2014	41	14	27
2015	45	12	33
2016	22	6	16
2017	46	18	28

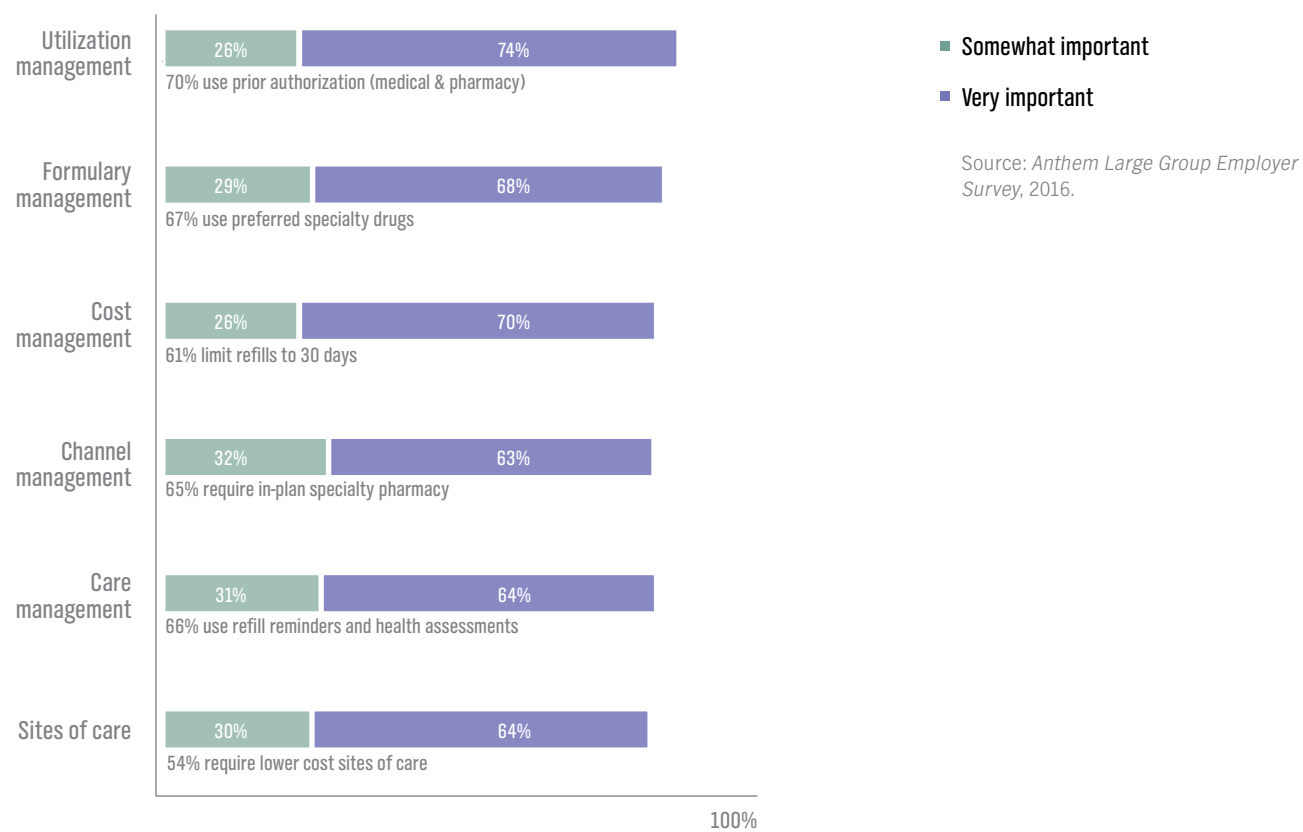
*NME = new molecular entity. An NME is a drug that has not undergone the investigation, trials or approval process.

Source: U.S. Food & Drug Administration. *Drug Approvals and Databases* (modified February 1, 2018): [fda.gov/Drugs/InformationOnDrugs/default.htm](https://www.fda.gov/Drugs/InformationOnDrugs/default.htm).

How employers manage specialty drug costs

Employers are using a variety of methods in efforts to manage specialty drug spending. A survey of 303 large employers in 14 states found that while employers rate all management techniques as important, utilization management tops the list.⁸ Utilization management programs encourage the use of clinically effective, lower cost drugs by reviewing prescribed medications against approval criteria for appropriate and cost-effective use.

Importance of technique/tool in managing specialty drugs



Better ways to manage growing pharmacy costs

Pharmacy cost management strategies should align with employer priorities and employee needs. Consider these ideas when making pharmacy benefit decisions:

- Focused drug list.** A focused drug list (also called a formulary) includes preferred drugs that are clinically effective and cost less. It excludes brand-name drugs that have over-the-counter or lower-cost alternatives. This can help drive utilization to drugs that are cost-effective and have strong, well-documented health outcomes.
- Specialty drug list tiers.** Specialty drug use and cost can be better managed by including two specialty drug tiers in a plan. Specialty tier 1 includes preferred generic and brand-name specialty drugs. These drugs are effective and generally cost less. Specialty tier 2 includes non-preferred specialty drugs that typically have generic or preferred lower-cost alternatives available on lower drug list tiers.
- Management requirements.** Prior authorization, quantity limits and dose optimization programs are very common for drugs covered under a pharmacy benefit. These management tools can be applied to specialty drugs through the pharmacy and medical benefit to promote appropriate use and savings.
- Specialty drug split fills.** Many people new to a specialty drug stop taking it within 30 days due to side effects. A split fill program provides two 15-day supplies of medication at a pro-rated copay for one month to determine if the drug can be well tolerated. This reduces waste and saves employees copays if a medication change is needed.



1 Centers for Medicare & Medicaid Services. *National Health Expenditures Projections 2016-2025* (modified November 21, 2017): [cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html](https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html).
 2 IQVIA Institute. *IMS Health Study: U.S. Drug Spending Growth Reaches 8.5 Percent in 2015* (April 2016): [iqvia.com](https://www.iqvia.com).
 3 IQVIA Institute. *Medicines Use and Spending in the U.S.: A Review of 2016 and Outlook to 2021* (May 4, 2017): [iqvia.com](https://www.iqvia.com).
 4 U.S. Food & Drug Administration. *Drug Approvals and Databases* (modified October 5, 2017): [fda.gov/Drugs/InformationOnDrugs/default.htm](https://www.fda.gov/Drugs/InformationOnDrugs/default.htm).
 5 U.S. Food & Drug Administration. *Developing Products for Rare Diseases & Conditions* (updated November 30, 2017): [fda.gov/forindustry/developingproductsforrareconditions/default.htm](https://www.fda.gov/forindustry/developingproductsforrareconditions/default.htm).
 6 National Institute for Neurological Disorders and Stroke. *Amyotrophic Lateral Sclerosis (ALS) Fact Sheet* (accessed September 25, 2017): [ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet](https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet).
 7 Fierce Pharma. *Mitsubishi's Radicava, First ALS Med in Decades, Beats all Comers to FDA Approval* (May 8, 2017): [fiercepharma.com](https://www.fiercepharma.com).
 8 Anthem Large Group Employer Survey, 2016.



BENEFIT
STRATEGIES

Incentivizing healthy behavior

Incentives can be a strong motivator for people to complete specific tasks or take the first steps toward a healthier lifestyle. Employers are trying to figure out which incentives motivate employees the most without breaking the bank.

Typical incentives for completing wellness programs include lower premium contributions or cost sharing; cash, contributions to health-related savings accounts or merchandise.¹

Incentives on the rise

	2016	2017
Employees offering incentives	72%	74%
Incentives for spouses/dependents (62% offer same incentive to spouse)	52%	69%
Average annual incentive value (67% offer at least one non-financial incentive)	\$651	\$742

Some employers offer incentives that reward employees for a specific outcome — like maintaining or achieving a certain body mass index (BMI)/weight or blood glucose metric. This approach encourages employees to focus on their health throughout the year instead of participating in a “one-and-done” activity like a well visit or biometric screening.

While most employers use incentives to encourage desired behaviors, some use penalties for undesired behaviors. About 28% penalize employees for tobacco use through a premium surcharge, and 6% penalize employees who choose not to participate in biometric screenings or health assessments.²

Financial incentives by program or behavior

	% of employers offering financial incentive		Median employee incentive value	Average employee participation rate
	Reward	Penalty		
Health assessment	81%	6%	\$140	53%
Biometric screenings	87%	8%	\$130	46%
Tobacco cessation program	58%	10%	\$250	10%
Physical activity programs/challenges	78%	0%	\$150	29%
Weight management programs	64%	0%	\$100	10%
Disease/care management programs	41%	0%	\$175	12%
Lifestyle management programs	65%	0%	\$100	10%
Stress management programs	48%	0%	Not available	5%
Resiliency training	27%	0%	Not available	3%
Mindfulness classes/training	20%	0%	Not available	3%
Happiness programs	19%	0%	Not available	1%
Financial seminars/lunch-n-learns	23%	0%	Not available	8%
Financial health challenges	20%	0%	Not available	7%

Source: Fidelity Investments and the National Business Group on Health. *Moving from Wellness to Wellbeing: Seventh Annual Employer-Sponsored Health and Wellbeing Survey* (March 17, 2016): businessgrouphealth.org.

When creating an incentive strategy, consider these best practices:

1. Make sure the incentive design is simple and easy for employees to understand.
2. Communicate the incentive design clearly and give ample notice to employees on changes that relate to premiums and health status.
3. Consider your employee population's greatest health risks and design incentives to motivate health behaviors to combat the risks.
4. Design incentives to promote sustained behavior change by offering them midway through the program and again upon completion.

¹ Kaiser Family Foundation and Health Education & Research Trust. *2016 Employer Health Benefits Survey* (September 14, 2016): kff.org.

² Fidelity Investments and the National Business Group on Health. *Moving from Wellness to Wellbeing: Seventh Annual Employer-Sponsored Health and Wellbeing Survey* (March 17, 2016): businessgrouphealth.org.

Consumer-driven health plans

Consumer-driven health plans (CDHPs) are about more than just high deductibles. They're increasingly popular because they encourage people to be more actively involved in decisions about their health care spending — and 90% of consumers say they want to do a better job managing their own health care and medical spending.¹

With CDHPs, consumers bear the cost for claims until they meet their high deductible. They use a designated spending account to pay for out-of-pocket costs. Preventive care is typically covered at 100%.

Anatomy of a CDHP



LOW
PREMIUMS



SAVINGS
ACCOUNTS



HIGH-DEDUCTIBLE
MEDICAL COVERAGE



100% PREVENTIVE
CARE COVERAGE



ACCESS TO
EDUCATIONAL TOOLS

CDHPs are increasingly available to Americans. By 2012, 59% of large employers offered at least one CDHP.² And these plans offer savings and advantages to employers *and* their employees:

- *CDHPs reduce health care costs.* Plans with a deductible of at least \$1,000 per person and an associated health account are associated with 17% to 21% reductions in health care costs.²
- *CDHPs create better health outcomes.* Almost all CDHPs exempt preventive care such as physicals, mammograms and colonoscopies from the deductible requirement. If you educate your employees about these benefits, you can help them get and stay healthy. And employees may become more conscious of their own health and decisions once they become more responsible for associated costs.

CDHP spending accounts



HSA

Health savings account (HSA)

- Bank account in employee's name
- Accumulates interest tax-free
- Employees can withdraw money for medical expenses
- Money withdrawn for non-medical expenses is taxed
- Contributions come from employee, employer or both
- If employee-funded, typically comes from each paycheck (pre-tax)
- Government sets annual limits on contributions
- Funds roll over yearly and stay with employees even if they leave the company



HRA

Health reimbursement account (HRA)

- Employer sets aside specified amount of money to pay for employee's medical expenses
- Employer establishes whether money remaining in the account at end of year is carried over or forfeited
- When an employee leaves the company, any remaining balance is forfeited



FSA

Flexible spending account (FSA)

- Employees set aside money from each paycheck on a pre-tax basis
- Accumulated money can be withdrawn tax-free to pay for covered medical expenses
- Any unused funds at end of year are forfeited and cannot roll over into next year (some companies do offer a grace period for using the funds after the end of the year)

¹ Alegeus. 2017 Alegeus Healthcare State of Denial. allegeus.com.

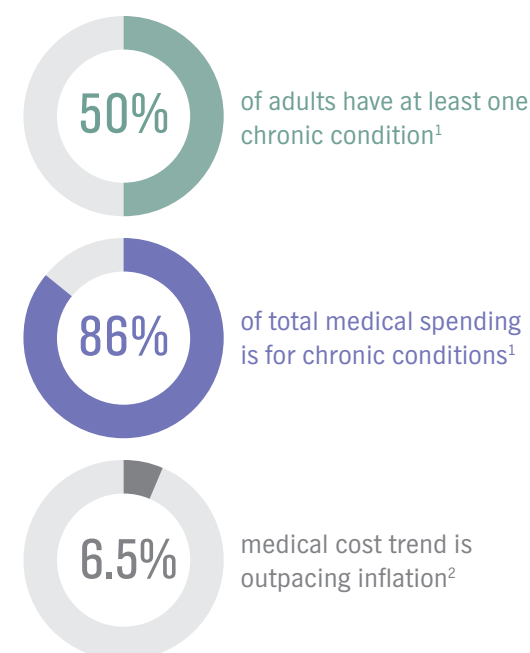
² Rand Corporation website. *Consumer-Directed Plans and Health Care Costs* (accessed December 14, 2017): rand.org.

The integrated health care opportunity

Integrated health care (IHC) — connecting dental, vision, pharmacy and disability plans with medical plans — is an increasingly common strategy for engaging employees in their health and potentially improving health outcomes.

Why? Chronic disease is driving U.S. health care spending, and an unhealthy workforce costs employees. Sharing health data among medical and ancillary plans can help detect chronic disease early, including diabetes, cardiovascular disease, chronic obstructive pulmonary (lung) disease, asthma, cancer and arthritis. It can also help identify people who may be at risk and manage chronic conditions.

THE CHALLENGE



How integrated care works



PHARMACY

Complex chronic conditions like cancer, multiple sclerosis and inflammatory conditions are covered under medical and pharmacy benefits. These conditions are better managed when all employee health benefits are closely aligned.



DENTAL

Certain medical conditions, like diabetes and pregnancy, are better managed with good oral care.³ IHC allows care managers to identify these conditions and provide at-risk employees with useful oral care information. Some insurance carriers provide extra dental cleanings and send employees condition-specific notifications when a gap in care is identified through claims analysis.



VISION

Eye doctors can detect early signs of some conditions and diseases by looking at the retina and blood vessels in the eye.⁴ With IHC, an employee's electronic health profile can be shared with an eye doctor so they can provide more informed care. A routine eye exam claim can trigger a proactive care management program referral, helping employees get the care they need.



DISABILITY

Typically, 5% to 10% of employees (those with a disability claim), represent 50% of employee medical costs.⁵ With IHC, care managers and disability case managers can work together more effectively to help employees develop stay-at-work or return-to-work goals.

Integration strategies

When surveyed, 89% of employers said they're already integrating ancillary plans with their medical plans, or considering it. Most believe integrating all ancillary benefits — pharmacy, vision, dental and disability — is critical to achieving the best results.⁶

While it's possible to implement IHC using multiple carriers, a single carrier model simplifies implementation because it eliminates the need to transfer data between carriers.

Improved health and productivity outcomes, along with cost-savings, are clearly driving IHC adoption. But employee use of integrated benefits is key to realizing those objectives.

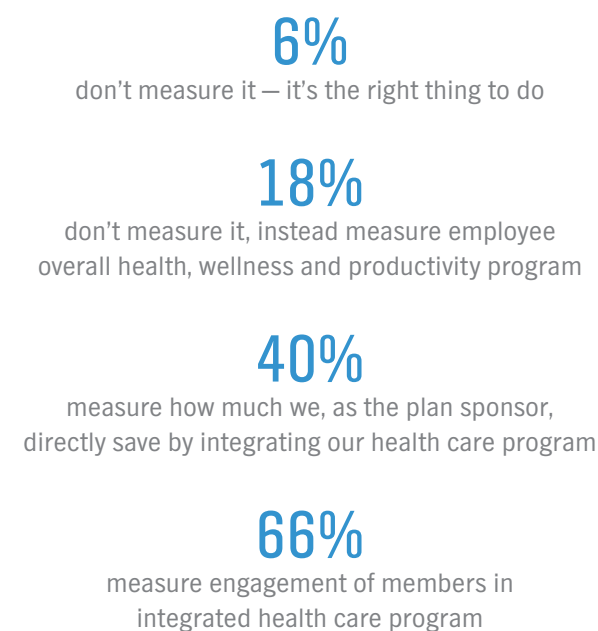
THE VALUE OF INTEGRATED HEALTH CARE⁶

89%
of employers are integrating, considering it or likely to integrate within 5 years

85%
agree dollars invested in integration are saved in employee well-being

83%
agree integrating benefits is cost-effective

OVERALL MEASURED SUCCESS OF AN IHC PROGRAM (among those implementing IHC)



When asked which benefit types are important for integration, almost all employers rate each benefit type as important, very important or critical. Integrating data from each type of benefit helps to better inform integrated health care efforts and improve outcomes.

99%
Pharmacy

97%
Dental

98%
Vision

96%
Disability

1 Centers for Disease Control and Prevention. *Chronic Disease Overview* (June 28, 2017): cdc.gov/chronicdisease/overview/index.htm.

2 PwC. *Medical Cost Trend: Behind the Numbers 2018* (June 2017): pwc.com.

3 Jeffcoat MK, Jeffcoat RL, Gladowski PA, Bramson JB, Blum JJ. *Impact of Periodontal Therapy on General Health*, *American Journal of Preventive Medicine* (August 2014): ajpmonline.org.

4 American Optometric Association: *Evidence-based Clinical Practice Guideline: Comprehensive Adult Eye and Vision Examination* (2015): aoa.org.

5 Council for Disability Awareness. *Chances of a Disability* (July 3, 2013): disabilitycanhappen.org.

6 Anthem *Integrated Health Care Report* (2017), Edition 2.

Choosing a vision carrier

Did you know people are three times more likely to get an annual eye exam than an annual physical? That means eye doctors are a critical first line of defense when it comes to early detection of chronic conditions, such as high blood pressure, diabetes and other conditions.¹



EYE DOCTORS
are often the first health care professionals to detect high blood pressure through a comprehensive eye exam²



More than
39 MILLION AMERICANS
have low vision or an eye disorder that can lead to a reduced quality of life³



Combined, these impairments cost
\$68 BILLION ANNUALLY
in direct health care costs and lost productivity³

How can you make sure you're choosing the right vision plan?

Vision plan checklist

✓ Coordinated care

- Does the vision plan integrate with your health plan's disease and care management program?
- Does it allow for communication among employees, their eye doctors and their other doctors and health care providers?

✓ Pricing options to help you stay on budget

- Does it give you options such as employee-paid (voluntary) funding?
- Defined contribution (private exchange)?
- A portfolio of plans with different cost shares (copays and maximums) to choose from?

✓ Accessible network

- Does the vision plan offer your employees the convenience and savings of a large network?
- A wide choice of private practitioners and popular retail locations?

✓ Service

- Does it offer employees the convenience of live customer service seven days a week?
- Online service 24/7?
- Mobile solutions?

✓ Savings

- Does the vision plan offer network savings and discounts on popular lens options?
- Additional pairs of glasses and contact lenses?
- Lasik surgery and more?

¹ VSP Vision Care. *Human Capital Management Services (HCMS) study on behalf of VSP* (2010): visionbenefits.vsp.com.

² Ong YT, Wong TY, Klein R, Klein BE, Mitchell P, Sharrett AR, et al. *Hypertensive Retinopathy and Risk of Stroke* (October 2013): Hypertension 2013 Oct;62:706-11: ncbi.nlm.nih.gov/pubmed/23940194.

³ The Vision Council. *Vision Loss in America: Aging and Low Vision* (2015): thevisioncouncil.org.

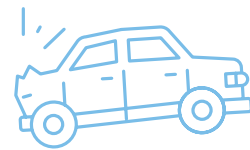

Choosing a disability carrier

No one wants their employees to get hurt or ill, but if it happens, you want a disability plan that actively helps your employees get back to good health and their work as quickly as possible.



What's the
NUMBER ONE CAUSE
of disabilities?

Most people think it's an
ACCIDENT

The truth is **90%** of disabilities
are caused by an
ILLNESS*



Typically, the
5-10% OF EMPLOYEES
who file disability claims represent
50% OF EMPLOYEE MEDICAL COSTS.*

How can you make sure you're choosing the right disability plan?

Disability plan checklist

✓ Financial stability

- Financial security is important, but disability coverage is more than writing a check. Does your carrier provide support programs like financial and emotional counseling to keep your employees healthy?

✓ Claims accuracy and turnaround time

- Does your carrier turn around claims quickly and accurately so your employees can return to health faster?

✓ Customer service

- Not all providers deliver the same level of service. Does your carrier provide disability case managers so your employees have the same contact throughout their case?

✓ Extra member programs

- Does your carrier provide support services such as counseling and referrals?

✓ Integrated benefits

- Every disability claim is also a medical or behavioral event. So it makes sense that your disability coverage should be connected with your medical coverage. Integration streamlines the process for employees and employers.
- Is your disability plan integrated with your medical plan?
- Does it facilitate case managers, doctors, specialists and other providers working together to get your employees back to health and work sooner?

Finding the right dental plan

Dental insurance is the most frequently offered employee benefit, with 95% of employers including some level of dental coverage in their benefit packages.¹ Employees place a high value on it — saying it's the second most important benefit following health insurance.¹

Since 90% of the body's diseases show signs and symptoms in the mouth, it's easy to see how a healthy mouth is connected to overall health.² So it's important that your dental and medical plans work together for your employees. For example:

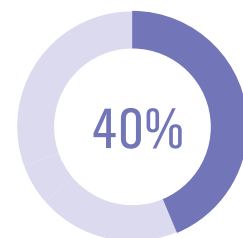
- Screening for chronic conditions in dental offices could reduce U.S. health care costs by up to \$102.6 million per year or up to \$32.72 per person.³
- Medical costs and hospitalizations for patients with chronic disease or pregnancy can be lowered by up to 74% if their periodontal disease is treated.⁴



164 MILLION WORK HOURS LOST
each year to oral health problems
or dental visits²



51 MILLION SCHOOL HOURS LOST
each year to dental-related illness³



Almost 40% of Americans
age 18 to 64 don't get regular oral care.¹

WHAT DOES THAT MEAN FOR YOUR BUSINESS?

How can you make sure you're choosing the right dental plan?

Dental plan checklist

✓ Focus on your employees' overall health

- Do your medical and dental plans work together to provide better care to your employees and help reduce your overall costs?
- Does your dental plan offer an extra cleaning or periodontal procedure to members with certain conditions who could benefit from them the most?

✓ Flexible or custom benefits

- Does your dental plan allow you to choose between different product features like annual maximum, coinsurance, network discount, maximum carryover, composite fillings, dental implants and orthodontia?

✓ Large local, national and international networks

- Does your plan offer a large network that gives employees access to a large number of dentists, including the one they prefer?
- Does it include "effective discounts" to gauge how many members are actually taking advantage of the network and the discounts it delivers?

✓ Powerful tools, technology and reporting

- Does your plan give employees tools that can help them determine the health of their teeth and gums, and even their risk for oral cancer?
- Do your employees have access to experts who can quickly and privately answer their questions?
- Can they get estimates for dental services before they get the services?

¹ Society of Human Resource Management. *2014 Employee Benefits: An Overview of Employee Benefits Offerings in the U.S.* (2015): shrm.org

² Centers for Disease Control and Prevention, National Center for Health Statistics. *Oral and Dental Health* (updated May 3, 2017): cdc.gov/nchs/fastats/dental.htm.

³ Nasseh K, Greenberg B, Vujcic M, Glick M. *The Effect of Chairside Chronic Disease Screenings by Oral Health Professionals on Health Care Dollars.* American Journal of Public Health (April 2014): aphaublications.org.

⁴ Jeffcoat MK, Jeffcoat RL, Gladowski PA, Bramson JB, Blum JJ. *Impact of Periodontal Therapy on General Health.* American Journal of Preventive Medicine (August 2014): ajpmonline.org.

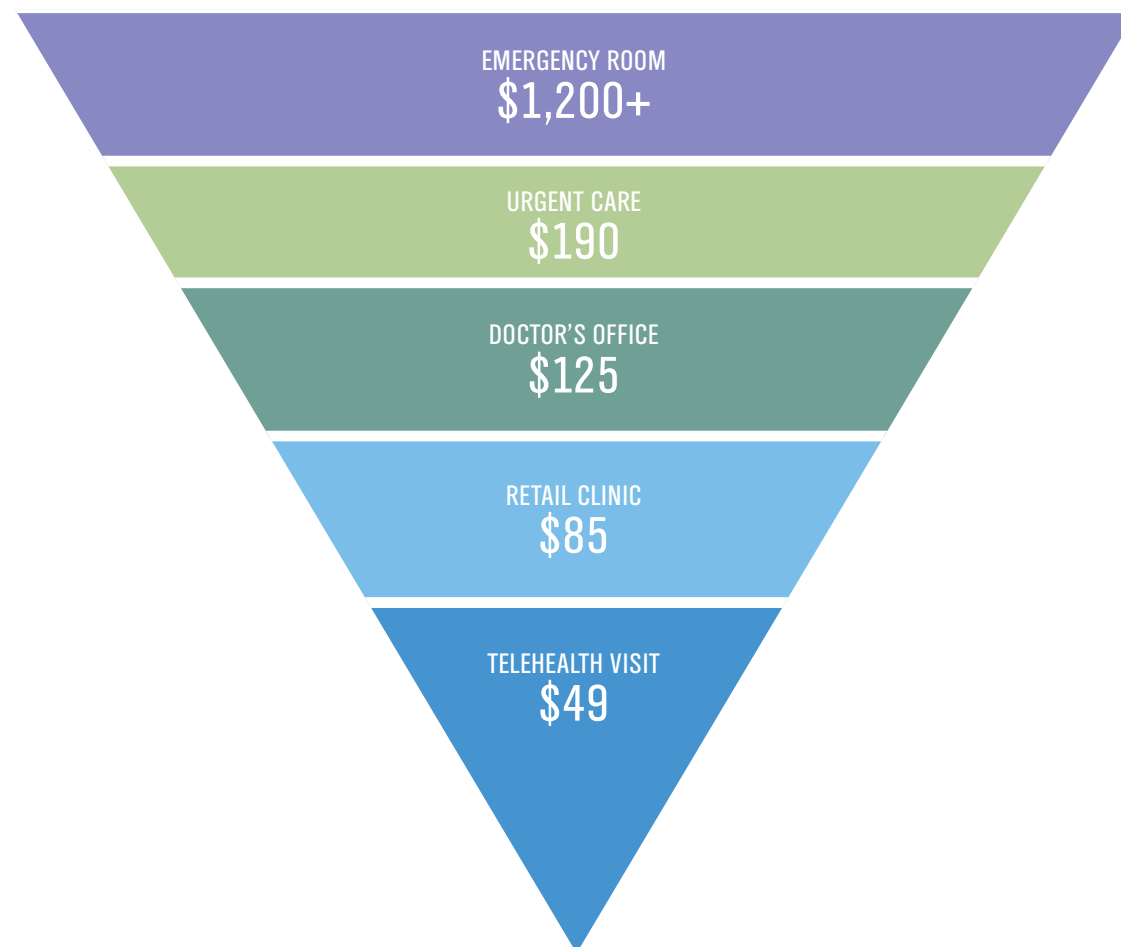
ER education

Studies show that up to 66% of emergency room (ER) visits could have been safely treated in another health care setting.¹ If your employees are aware of their health care options, they can save money, time and frustration.

The U.S. Centers for Disease Control estimates that one in five Americans goes to the ER at least once a year, adding up to 131 million visits a year.¹ Now consider the possibilities if 66% of those visits were treated in a more appropriate care setting such as an urgent care, doctor's office, telemedicine or retail clinic. The savings to our health system would add up to billions.

Think about the savings for you and your employees. If 20% of your employees go to the ER at least once a year and 66% of those visits could have been handled in a less expensive health care setting, that adds up to a lot of your employees' and your company's money being wasted!¹

Average costs per visit²



¹ Anthem internal survey. *Voice of the Customer Quick Care Alternatives Communication Survey* (2014).

² National averages of the total cost, not what members paid based on Anthem members' paid claims from January 1, 2015 through December 31, 2015.

Here are some ideas on how to educate your employees about where to go for care in different medical situations:

- **Ask your health benefits company or broker.**

They should be able to give you materials to jumpstart a campaign to help educate employees on the best health care setting for their needs.

- **Promote your health plan's nurse line.**

Nearly all offer a free 24/7 nurse line that can help triage any health concern.

- **Promote your health plan's preferred telehealth provider.**

Mobile device-based care is just an app away, lightning fast, inexpensive and very effective for non-emergency care day or night.

- **Make sure to reinforce that some situations do require emergency rooms or a call to 911.**

Your health plan should be able to provide you with materials to clearly explain when to seek emergency care and when to consider other options.

- **Give them a handy reference chart.**

Ask your healthcare provider for an easy-to-read chart that shows which care options work best based on your employees' medical needs, time availability and cost.

As with most things, a little advance planning goes a long way. Make sure your employees know the answer when that "what now/where to" moment occurs.



Comparing administrators for a self-funded health plan

Instead of purchasing fully insured health plans, some companies are choosing an alternative: self-funding and paying an insurance carrier to administer the plan. Essentially, these companies are paying for the specific health care services their employees and covered dependents receive, plus an administrative services fee. This is often called an administrative services only (ASO) arrangement.

The ASO fee usually includes the use of the insurance carrier's network of doctors and hospitals at the discounted rate that the company has negotiated. The fee may also include claims processing services, customer service and programs to help manage the cost of health care.

When you're shopping for an administrator, you can only get a true comparison by looking at total cost of care, not just fixed fees. This includes factors like network discounts, the percentage of claims that are in network and wellness programs.

Not all ASO arrangements are the same. Look beyond fixed fees and ask questions to get a better picture of every carrier's total cost of care. Ask your broker to put together a spreadsheet addressing these variables and comparing total rates.

How can you make sure you're choosing the right ASO plan?

ASO administrator checklist

✓ Deep network discounts

- What kind of discounts has the carrier negotiated with hospitals and doctors?
 - Similar to other businesses, volume matters when negotiating prices for health care services. So bigger carriers generally get better deals. And the better the deal, the more savings that get passed on to you.

✓ Broad networks

- Can your employees continue seeing their preferred local doctors and visiting their preferred hospitals?
- What percentage of claims are usually paid as in-network and what percentage are out-of-network for the carriers you're considering?
 - A cheaper ASO fee may mean fewer doctors and hospitals in the network, which can lead to more out-of-network claims that do not get a discount. These claims cost you and your employees more.
 - Also look at geoaccess and disruption reports when comparing carriers. Geoaccess reports tell you how many in-network doctors match your employees' ZIP codes. Disruption reports reveal what percentage of employees' doctors are in network with each carrier. The closer to 100%, the better.

✓ Health and wellness programs

- Healthy employees spend less every year on health care. Ask these questions:
 - Does the carrier have programs for chronic conditions like diabetes?
 - Are there intervention programs, such as helping with weight loss or smoking cessation?
 - Can programs be customized to match the demographics of your employees?
 - Does the carrier give incentives for healthy living?
 - Does the carrier offer turnkey promotional tools rather than relying on your HR resources?
 - Does the carrier have statistics on how well the programs have worked in the past?

✓ Experience

- Sometimes, the larger and more experienced a carrier is, the better.
 - How much experience do they have administering self-funded plans?
 - How much experience do they have transitioning employers to new plans?
 - Do they have referrals from happy customers?

✓ Fixed fees aren't the same

- Are there additional charges in addition to the fixed fees?

These may include fees for auditing claims or fees for negotiating one-time discounts on out-of-network claims and other services.

Comparing carriers: network considerations

One of the key factors in how many people select health plans is whether their doctor is in network for the plans they're considering.¹ As you consider which health plan to offer your employees, the network is also key. The network landscape has evolved over the past several years, so there are new factors to consider when you're comparing carriers and their networks.



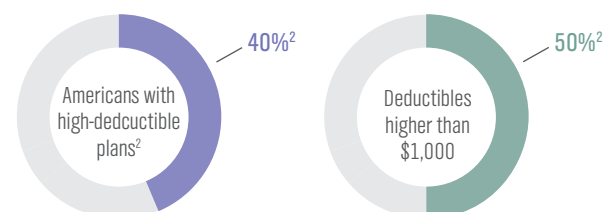
BROAD NETWORKS

- ✓ When you're shopping for a new insurance arrangement, you want your employees to be able to continue seeing their local doctors and hospitals.
- ✓ If there are fewer doctors and hospitals in the network, more of your employees may see out-of-network doctors, which can be significantly more expensive for them.
- ✓ If you have employees in rural areas, the doctors and hospitals there may only work with a few insurance companies, so be sure the carriers you're considering will have in-network options for them.



DEEP NETWORK DISCOUNTS

- ✓ Similar to other businesses, volume matters when negotiating prices for health care services. So bigger carriers generally get better deals.
- ✓ The value of the discounts that the carrier has negotiated with hospitals and doctors makes a direct difference in your employees' pocketbooks. Here's why:



- ✓ So more people are paying the "full price" for more of their care before they meet their deductible.³ And the better the deal, the better the savings passed on to you, the employer.



HIGH-QUALITY HOSPITALS

- ✓ Many organizations evaluate hospitals and doctors on various quality indicators. Some of those include the Centers for Medicare and Medicaid Services (CMS), The Leapfrog Group, the Blue Cross and Blue Shield Association and the Consumer Reports Hospital Quality Institute.
- ✓ When employees and their dependents get care at hospitals that deliver high-quality care, they're less likely to end up back in the hospital and may have fewer complications.
- ✓ Look at how many high-quality hospitals are in network with the carriers you're considering. It may vary more than you'd expect.



VALUE-BASED PAYMENT ARRANGEMENTS

- ✓ For decades, most health care that people get has been paid for at a "per procedure price," also known as fee for service. For example, when you get an MRI, the doctor gets paid a certain amount. The more services the doctor or hospital provide, the more they get paid.

More recently, insurance companies have worked with doctors and hospitals on different payment arrangements that reward doctors for the value the treatment provides, rather than the volume. The doctors and hospitals get paid based on quality of care, effectively managing costs and overall patient satisfaction. These arrangements go by different names, depending on how they're structured: accountable care organization, patient-centered medical homes, pay-for-performance and others.
- ✓ Many insurance companies are expanding the number of these arrangements as the concept catches on. Check with the ones you're considering to see if they offer them in the areas where your employees seek care.

1 FAIR Health. *Healthcare and Health Insurance Choices: How Consumers Decide* (October 2016): fairhealth.org.

2 Cohen RA, Zammitti EP. *High-Deductible Health Plans and Financial Barriers to Health Care: Early Release of Estimates from the National Health Interview Survey*, 2016. National Center for Health Statistics (2017): cdc.gov/nchs/nhis/releases.htm.

3 Kaiser Family Foundation and Health Education & Research Trust. *2016 Employer Health Benefits Survey* (September 14, 2016): kff.org.



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