

Special points of interest:

- **EMPLOYER HEALTH BENEFITS COSTS ROSE 6.1% IN 2005**

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The following is an excerpt from Spencer's Research Reports:

In 2005, the increase in the average annual per-employee cost of employee health benefits continued to drop and at 6.1% was the lowest since 1999 (\$7,089) according to a survey conducted by employee benefits consultant William M. Mercer. HMO cost rose at a slightly higher rate (6.6% compared with 11.8% in 2004) than preferred provider organization (PPO) cost (6.3%), and prescription drug trend continued to level off at 11.5% (from 14.3% in 2004). In 2005, enrollment in HMOs fell from 27% to 25% of employees, point-of-service (POS) plan enrollment remained at 10%, while PPOs continued to gain, from 58% to 61%, at the expense of HMOs and indemnity plans.

The survey is based on responses from 2,999 employers that have at least ten employees and that sponsor health insurance plans. The survey participants include organizations of all sizes, industries, and levels of government.

This report summarizes the findings of Mercer's National Survey of Employer-Sponsored Health Plans 2005. A copy of the 52-page survey results, including information on flexible benefits and retiree medical, may be purchased for \$500 from Tara Lewis, William M. Mercer, 1166 Avenue of the Americas, 28th Floor, New York, NY 10036; telephone (212) 345-2451, e-mail: tara.lewis@mercer.com. A copy of the report with related data tables is available for \$1,000.

Health Care Costs

The survey revealed the following trends on health care costs to employers and employees:

Average costs generally. The average per-employee cost of employee health benefits in 2005 was \$7,089, a 6.1% increase from \$6,679 in 2004. Average cost changes were as follows: for large employers (those with 500 or more employees), up 6.7% to \$7,379; for small employers (those with between ten

and 499 employees), up 4.9% to \$6,670 (compared with an 18.1% increase in 2002). Furthermore, employers predict the cost increase trend will be slightly higher in 2006 at an average of 6.7%.

The top two strategies for cost management are care management (wellness and disease management programs, 62% of large employers rate it as "the future of cost management") and consumerism (plan participants making wise health care decisions, (55% of large employers), survey respondents said. "While there is a growing conviction that health management and consumerism address key health benefit cost drivers in a way that managed care, ultimately, did not, there is no sense of the complacency of the mid-1990.s" noted Blaine J. Bos, a Mercer Worldwide Partner based in Minneapolis and the study's author, in the introduction to the 2005 report.

"Employers are keeping all hands on deck as they push ahead into the future of health care cost management." Mr. Bos concluded. He suggests that future strategies will include adoption of an old strategy, collective purchasing of health care; transparency with data to compare efficiency and outcomes of individual providers to assist informed decision-making; and decision management strategies to determine what new treatments and techniques the plan will cover, under what conditions, and how much to pay.

And employers are beginning to introduce consumer-oriented plan designs, including so-called consumer-directed health plans with either a health reimbursement or health savings account supported with Web-based information tools. Employers also are focusing on improving medical system performance through case management, collective purchasing, and transparency in costs and quality.

Managed care enrollment. Managed care plans are now the most common type of health insurance, offered by most employers. But, more than half (61%) of covered employees elected to enroll in a PPO (continuing to rise from 58% in 2004, compared with 25% in HMOs and 10% in POS plans). Over the past seven years, PPO growth has strongly outpaced HMO growth. In fact, nationally, PPO enrollment has doubled in the past ten years. PPO enrollment has sur-

passed that of HMOs, even in the West (52% versus 33%), which typically has had high HMO enrollment, and in the South and Midwest (67% each versus 22% in the South and 20% in the Midwest). Two regions with the highest enrollment in PPOs.

The average cost per active employee increased for all types of medical plans, which were offered by employers, as follows: by 6.6% for HMO plans to \$6,210; by 6.3% to \$6,480 for PPOs; and by 5.6% to \$6,444 for point-of-service (POS) plans.

- Regional variations in the annual cost per employee ranged from a low of \$6,434 in the South to a high of \$7,694 in the Northeast.
- Employers with fewer than 500 employees had the lowest average cost per employee, \$6,670, while employers with 500 or more employees had the highest cost, \$7,379. And small employers experienced smaller cost increases (4.9%) than large employers (6.7%).

Specific Coverages

Dental benefits. Dental care plans continued to be popular in 2005 among large employers, 96% offered a plan, most with comprehensive coverage. Fewer than one-fifth (17%) of the dental care plans are offered through the medical plans. Managed care is being applied to dental benefits, with 61% (compared with 58% in 2003) of large employers that sponsor dental benefits offering them through a preferred provider plan and 20% (up from 16% in 2004) offering them through a dental HMO. The average per active employee cost remained relatively flat in 2005 at \$600. Average per employee costs were highest in the West at \$713 and lowest in the South at \$504.

EAPs. Employee assistance programs (EAPs) were offered by 77% of employers in 2005, up from 74% in 2004. Most EAPs provide short-term, face-to-face counseling, of up to six sessions, on average.

Mental health care/Substance abuse. As a result of the 1996 Mental Health Parity Act, which as of 1998 requires employers to apply the same annual or lifetime dollar maximum benefits for coverage of mental ailments as for physical ailments, health plans have modified plan design to comply. Now, nearly all (98%) large employers' health plans continue to provide coverage for mental health and substance abuse. Most employers provide the coverage through their medical plans; freestanding mental health and substance abuse programs are used by 22% of the largest employers (those with at least 20,000 employees), up from 13% from 2004. Nearly one-fifth of plan sponsors (17%) limit such coverage to in-network providers.

Prevention/Wellness.

Employers continued to offer their employees a wide range of preventive health and wellness benefits outside of and through their medical plans.

Care management. Care management involves not only disease management, but also health risk assessments and behavior modification programs (smoking cessation, weight management). In 2005, the number of employers using at least one disease management program grew substantially, from 32% of employers in 2004 to 41%, as did the number using behavior modification programs (from 9% in 2004 to 16%). This trend supports employers' assertions that care management will be a key strategy in the next five years, Mercer noted. Two thirds of large employers (500 or more employees) now offer at least one disease management program (67%, compared with 58% in 2004). And nearly half of large employers use health risk assessments. Many more large employers have implemented nurse advice lines (64%), health Web sites (72%), and case management for catastrophic or complex (65%) cases.

Disease management involves coordinating all the care and prevention efforts, including self-management, for individuals with high risk, expensive chronic diseases such as asthma, diabetes, and heart disease. When an employer provides a disease management program, it is generally through a medical plan (76%) and the larger the employer the greater the likelihood that it will contract with a specialized vendor for the care management services (two-fifths of the largest employers with at least 20,000 employees). Adoption of disease management strategies has ballooned in the past couple of years. Disease management programs most commonly target diabetes (62% of employers), heart disease/hypertension (57%), and asthma (52%). Disease management programs are increasingly targeting obesity (31%). The majority of the largest employers (those with at least 20,000 employees) have either attempted to measure the return on investment (45%, up from 41% in 2004) and among employers who attempted to measure results, 44% reported positive ROI.

Alternative medicine. Health plan coverage for these types of practices has stabilized or risen slowly. By far the most widely covered alternative medicine is chiropractic care, covered by a majority of plans (84%), a substantial jump from 61% in 1998. Types of alternative medicine practice recording modest gains in coverage acceptance were acupuncture/acupressure (covered by 30% of employers' largest plans), massage therapy covered by 18%, homeopathy and biofeedback covered by 10% and 9%, respectively. Nearly half of all large employers cover bariatric surgery to reduce stomach size, and half of those require behavior modification efforts first.

Prescription Drugs

Nearly all large employers provide some benefit for outpatient prescription drugs, the majority both through mail order (91% of employers) and retail card (71%) plans. Seventeen percent of plan sponsors (up from 13% in 2004) medical plan sponsors offer the drug benefit separately (or "carve-out") from the medical plan and contract directly with separate pharmacy benefit managers (PBMs) to provide services, Mercer observes. With the

advent of high deductible health plans with a health reimbursement arrangement (HRA) or health savings account (HSA), the number of large employers moving to coinsurance requirements for prescription drugs rose to 14% in 2005 from 11% in 2004.

Mail order plans typically require employees to pay a set dollar amount per 90-day prescription formulary in the now most prevalent (69% of plans for card plans and 65% of mail-order plans) three-tier drug plans. The number of large employers who implemented three-tiered copayments in 2005 rose from 64% of employers in 2004 to 69%. Copayments average \$10 for generic drugs and \$23 for brand name drugs in the plan's formulary, and \$41 for brands not on the formulary, for card plans; and \$17 for generics, \$39 for brands in the formulary, and \$69 for brands not on the formulary for mail-order plans. The rate of drug plans with coinsurance also rose from 11% to 14% for card plans and from 8% to 9% for mail-order plans.

After several years of cost escalation, the drug benefit cost increase continued to moderate in 2005 (at 11.5%, down from 14.3% in 2004 and from a peak of 18.3% in 2000), mainly due to design changes and more pharmacy benefit management techniques, as well as higher employee cost share. Plan sponsors have implemented additional prescription drug cost management strategies including providing financial incentives to encourage use of generics, requiring step-therapy (try preferred drugs first), and restricting coverage of "lifestyle drugs" such as for weight loss or smoking cessation. Employers have also begun to join together to buy PBM services: 11%, up from 7% in 2004, of the largest employers (those with at least 20,000 employees) have done so.

Indemnity Plans

Prevalence. Offers of and enrollment in traditional indemnity plans of large employers continued to drop from 15% in 2004 to 12% and from 3% to 2%, respectively. The average annual per employee cost for indemnity plans rose slightly from \$6,383 in 2004 to \$6,680.

The "typical" indemnity plan offered by large employers is a comprehensive major medical plan with deductibles and coinsurance for all covered charges. The South and West regions had the lowest indemnity plan offer rates (10% each), while employers in the Northeast and the Midwest had the highest offer rates, at 17% and 13%, respectively. Most employers (81% for individual coverage and 92% for family) required employee contributions, averaging 24% of premium for individual and 37% of premium for family coverage. For individual coverage the median deductible was \$300 and out-of-pocket limit was \$1,500.

Health Maintenance Organizations

Prevalence. The proportion of large employers offering HMOs (44%, down from 46%) continued to drop since

1998, and the proportion offering open-access HMOs (which allow direct access to specialists) grew from 32% to 38% in 2005. However, the average number of HMOs employers offer dropped, with the largest employers dropping from 18 HMOs to 12. Overall HMO enrollment also dropped from 30% to 27%. HMOs continued to be most popular in the West where enrollment rates dropped from 41% of employees to 38%. About half (49%, down from 53% in 2004) of employers required HMOs to be accredited by accreditation agencies such as the JCAHO or the NCQA.

Employer costs. The average HMO premium that large employers paid for active employees continued to rise by 10.49%, to \$6,658. The average HMO cost in 2005 was higher than the PPO cost, but the differences vary among regions, for example, \$54 lower for PPOs than HMOs in the South, but nearly \$500 in the West.

Employee costs. Most (85%, compared with 87% in 2004) of large employers offering an HMO require contributions for employee-only HMO coverage, and 95% require contributions for family HMO coverage. The chart titled "Employee Contributions For 2005" provided in this report, profiles employee contributions.

Rating type. In 2005, the proportion of large employers with HMOs that were community-rated was slightly higher (43%) than the proportion of employers that experience-rated their HMOs (41%), while 16% (down from 18%) self-funded at least one of their plans.

Preferred Provider Organizations

Prevalence. Although the percentage of large employers offering PPOs to their employees in 2005 was stable at 86%, average PPO enrollment continued to rise from 55% to 58% of covered employees with the largest increase in the South (from 59% to 63% of employees).

Employer costs. The per-active-employee cost for PPO coverage in 2005 averaged \$6,518 up 5.5% from \$6,181. There was little variation in costs among three of the regions, but in the South costs continued to be significantly lower at \$5,995.

Employee costs. The proportion of large employers requiring employee contributions toward coverage was relatively stable at 87% for employee-only and 95% for family coverage. The average share of the employee's monthly contribution has remained relatively stable since 1995, at 23% of the premium, or \$78 (up from \$72), for single coverage but up to 33% from 31%, or \$290 (up from \$258), for family coverage.

Most large employers. PPO plans required different employee cost-sharing amounts for in-network and out-of-network service: Seventy-nine percent of employers required a deductible for in-network services and 94% required one for out-of-network services. For inpatient hospital services, 87%, up from 83%, of employers required patient contributions, 70% of them required coinsurance

(up from 66%), a median of 20% in-network and 30% out-of-network (among the 92% of employer PPOs that required it). The same coinsurance amounts applied for physician office visits. Although most (78%, down from 82%) PPO sponsors require a fixed dollar copayment (most often \$20, up from \$15) for in-network physician office visits, 22% now require a coinsurance amount, averaging 20%, and one-quarter (up from 18%) now require a higher copayment for specialists' visits.

The proportion of employers self-funding their PPO plans remained the same at 68%, with 94% of the largest employers doing so. The proportion of self-funded employers administering their own PPO plans was stable at 3%. The responsibility for administering the majority of self-funded PPO plans went to insurers and Blue Cross and Blue Shield plans (62%) and third party administrators (35%).

Plan Accreditation. Few employers are requiring their PPOs to be accredited by one of three organizations (JCAHO, URAC, or NCQA); in 2005, 41% of large employers required such accreditation.

Point-Of-Service Plans

Prevalence. The proportion of large employers offering a POS, or "open-ended" HMO, was 15%, down from 20% in 2004, and the number of employees enrolled in such plans was stable at 11%. POS plan enrollment dropped considerably in the Northeast (from 33% to 22%) where the POS plan prevalence was the highest.

Employer costs. POS plans cost 3.6% more in 2005, averaging \$6,709 per active employee.

Employee costs. A POS plan basically functions as an HMO that offers the option of obtaining care from non-network providers by paying a higher coinsurance or copayment than that required for network providers: The majority of plans (67%, down from 72%) still do not require a deductible for in-network care; the median deductible rose to \$350 from \$250 for an individual, but most do for out-of-network care, with a median of \$500 (up from \$400) for individual and \$1,000 (up from \$900) for families.

The median copayment for in-network physician office visits remained \$15 and more plan sponsors (34%, up from 29%) required coinsurance (doubled from 10% of eligible charges) for in-network hospital stays. The number of POS plans in the median implementing an out-of-pocket maximum for in-network services rose from 54% to 66%, with an average of \$1,500 per individual. Most POS plans (88%) also have an out-of-pocket maximum for out-of-network services, an average of \$3,000, up from \$2,500. (See Employee Contribution table.)

Retiree Health Care

The percentage of large employers offering retiree health benefits continued its downward spiral in 2005.

Twenty-nine percent of employers offered retiree health coverage to retirees younger than age 65 and another 8% offered them to a closed group (that is, new employees are not eligible), and 21% offered them to Medicare-eligible retirees, with another 6% offering them only to a closed group. The prevalence of retiree health benefits increases with the employer size but the percentage of employees working for an employer that sponsored a retiree medical plan dropped by 20% from 2004 to 2005. The prevalence of retiree coverage (including employers offering those benefits only to a closed group) ranges from 34% of employers with 500-999 employees to 64% of those with at least 20,000 employees. More employers are now limiting retiree medical coverage to current employees (ranging from 6% of employers with 500 to 999 employees up to 17% of the largest employers). Government employers are most likely to offer retiree medical benefits (82%), as are industries with highly unionized work forces such as transportation, communications, and utilities (47%).

The most common type of plan offered to early retirees is a PPO (81%, up from 73%), followed by an HMO (44%), a traditional indemnity plan (19% down from 24%, in 2004), and a POS plan (14% down from 19%) and 3% offered a consumer-directed health plan. PPOs also were the most common coverage option for Medicare-age retirees (63%, up from 56%), followed by traditional indemnity plans (34%, down from 41%), and HMOs (34%).

For the 226 sponsors providing 2005 cost data, the pre-Medicare-eligible retiree cost averaged \$8,717, up 6.6% from 2003. For the 203 sponsors providing cost data for Medicare-eligible retirees in 2005, cost averaged \$3,851 (an 8.7% increase from 2003).

Plan sponsors continue to shift the financial responsibility for retiree medical to retirees. The proportion of employers requiring early retirees to pay the full cost of health coverage was 38% for retiree only, while 48% (up from 44%) share the cost with beneficiaries and 14% paid the whole cost. For Medicare-age retirees the results are similar. More than one-fourth of employers (28%), adjust early retirees' contributions based on age and years of service (13%), by years of service only (10%), or by age only (5%).

Most employers providing retiree medical coverage include prescription drugs for their early and age-65 retirees (84% and 80%, respectively). At least in the short-term, the effect of the new Medicare Part D prescription drug benefit on retiree medical plan drug benefits will be minimal, Mercer found. Only 2% of retiree plan sponsors indicated that they were likely to terminate all retiree coverage for Medicare eligible retirees, another 3% said they were likely to terminate retiree drug coverage only, and 22% said the new Medicare benefit will enhance their ability to provide retiree medical benefits. Some 44% of large employers, but 67% of the largest employers, said they would keep their retiree plans and apply for the subsidy. Plan sponsors largely have chosen the status quo and retiree drug subsidy due to delayed information on the

Medicare prescription drug plans. "It is likely that many employers will revisit their Medicare Part D strategy for 2007," the Mercer report said.

Pre-Medicare age retirees are more likely to have access to dental and vision coverage (52% and 39%, respectively, of large employers), than are Medicare-age retirees (46% and 38%, respectively, in 2005).

Consumer-Directed Initiatives

The largest employers lead in offering the latest health benefit option: so called consumer-directed (or defined contribution) health plans (CDHPs). These plans typically offer high deductible coverage accompanied by an employer-paid health reimbursement account (HRA) to cover a large part of the deductible expenses and thanks to HIPAA, a new health savings account (HSA) that belongs to the employee and to which both the employer and employee may contribute. Typically, any HRA or HSA funds unused at the end of the plan year may be rolled over to the next plan year and combined with the contribution for that year. However, while individuals' HRA fund amounts are always within the employers' control, HSA funds belong to and are controlled by the employee participant. Therefore, an HRA sponsor may limit the rollover of HRA funds to active employees or retirees, unless a terminating employee elects COBRA coverage.

While just 2% of small employers with ten to 499 employees offered CDHPs in 2005, 22% (up from 12% in 2004) of employers with at least 20,000 employees offered these plans. Among the largest employers, 29% said they were likely to implement a CDHP in 2006 and 31% thought they likely would implement one in 2007. Surprisingly, small employers have been slow to adopt CDHPs.

The information following was provided by 106 employers (compared with 88 in 2004) with at least 500 employees offering a CDHP. The respondents cited "promoting health care consumerism" and "lowering our organization's health benefit cost over time" as the top objectives for implement-

ing CDHPs and more than half (58%) thought these objectives had been reached. Fewer than one-fifth of employers offered the CDHP as the only health insurance option.

Where employees had a choice of options, on average 16% of employees enrolled in the consumer-directed plan. Nearly one-fourth of employers (23%) waived employee-only contributions to encourage enrollment and employees. monthly premium contribution was lower than for HMO or PPO (\$57 versus \$67 and \$78 for employee-only coverage), though only significantly so for family coverage (\$206 versus \$266 for HMO and \$290 for PPO).

Employer cost for the consumer-directed health plan with an HRA or HSA was \$5,714, compared with \$6,518 for a PPO without the high deductible requirement. Nevertheless, CDHPs are not a particularly attractive option for employees; on average, only 2% have enrolled. The Mercer study found that a much lower proportion of CDHP sponsors contribute to employees' HSAs (62%) than to HRAs (100%).

The HRA funds may be used *only* to reimburse for any qualified medical expense under Section 213 of the Internal Revenue Code, while the HSA may be used to pay for expenses other than medical, but then the amounts used for non-medical expenses are subject to a 10% tax.

The median amount employers provided to the HRA in 2004 was \$700 for employee-only coverage and the median deductible is \$1,250; for family coverage those figures respectively are \$1,200 and \$3,000. However, preventive care typically is covered at 100% through the health insurance coverage at 74% of the employers.

According to respondents, enrollees are positive about their consumer-directed plans: 13% of plan sponsors say the response has been "strongly positive," 50% said it had been more positive than negative, while another 30% say it has been evenly split.

Employee Contributions For 2005

| | HMO Individ./Fam. | PPO Individ./Fam | POS Individ./Fam | Indemnity Individ./Fam |
|------------------------------|----------------------|---------------------|---------------------|---------------------------|
| % of employers requiring | 85%/95% | 87%/95% | 92%/96% | 81%/92% |
| Average, as a % of premium | 23%/33% | 23%/33% | 22%/33% | 24%/37% |
| Average monthly amount | \$67/\$266 | \$78/\$290 | \$89/\$311 | \$85/\$283 |
| Median Deductible | | | | |
| physician copayment | \$16 | | | |
| hospital deductible | \$250 | | \$350 | \$300 |
| In-network | N/A | \$300/\$750 | N/A | N/A |
| Out-of-network | N/A | \$500/\$1,000 | \$500/\$1,000 | N/A |
| Median Out-of-pocket maximum | N/A | | | \$1,500 |
| In-network | N/A | \$1,960/- | \$1,500/- | N/A |
| Out-of-network | N/A | \$3,000/- | \$3,000/- | N/A |