The changing employer-sponsored group medical plan

Terry Bierman, ASA, MAAA
Sarah Coates, CEBS

Milliman

Over the past 10 years, group medical plans have been evolving. The major economic drivers impacting group healthcare during this time have been the financial crisis that began in 2007 and the passage of healthcare reform in 2010. Additionally, emerging medical technologies and new prescription drugs being released to the market have fueled medical inflation. Healthcare reform and medical inflation will undoubtedly continue to change group healthcare for the foreseeable future.

We conducted an analysis of group medical plans over the past 10 years to follow specific changes that companies are making and examine how they are affecting both the employer and employee. Three notable trends emerged:

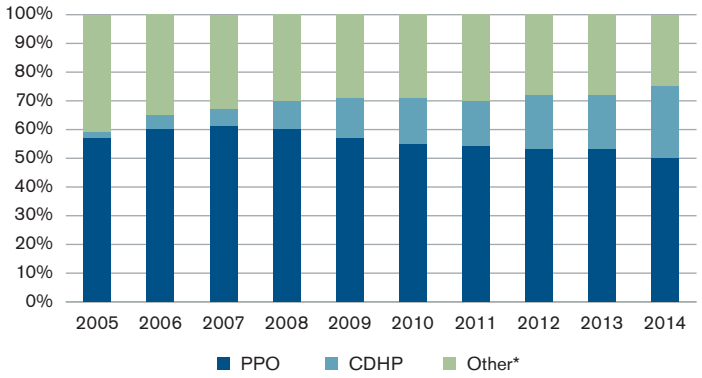
1. Consumer-driven health plans (CDHPs) have become more prevalent.
2. Changes in plan designs have shifted more out-of-pocket expenses to employees.
3. Premiums have outpaced inflation, but the percentage of that premium paid by employees electing single coverage has remained relatively constant.

These results are based on survey responses from an average of 4,300 employers in the "mid-market" category with a median size of 150 employees. Manufacturing; healthcare and social assistance; and professional, scientific, and technical services were consistently the three most prevalent industries represented, comprising approximately half of all respondents.

While employers are still offering plans such as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), and point-of-service (POS) plans, this study focuses on preferred provider organization (PPO) plans and CDHPs. Additionally, we have concentrated on the employee-only or single component of benefits and cost.

The most notable trend we saw is the prevalence of CDHPs. In 2005, CDHPs made up only 2% of the plans offered by the employers in our database. By 2009, CDHPs comprised 14% of medical plans and, by 2014, represented one-quarter of plans offered. (While CDHPs are typically PPO plans with a high deductible, they generally subject most, if not all, services to the deductible and coinsurance and have a corresponding spending account component funded by the employer, employee, or both.)

FIGURE 1: MEDICAL PLAN PREVALENCE



*"Other" includes HMO, EPO, and POS plans

The number of CDHP plans offered doubled between 2007 and 2009, coincident with the timing of the financial crisis—an indication that employers were doing what they could to reduce their share of healthcare costs by putting more ownership, or responsibility for managing these costs, on employees. By requiring employees to share more of the cost burden, the hope is that utilization, and subsequently cost, will go down. Another significant increase in CDHP plan adoption appears in 2014, when many provisions of the Patient Protection and Affordable Care Act (ACA) fully took effect.

Companies continue to look at CDHP plans as a way to offer lower-cost options to limit potential penalties. On average, a typical CDHP plan pays a smaller portion of total allowed claims than a typical PPO plan. This generally leads to lower employee payroll deductions, and, consequently, fewer employees exceeding the ACA affordability threshold.

As the Cadillac tax implementation in 2018 quickly approaches, we expect the prevalence of CDHP plans to continue to increase. Last year, 16% of employers surveyed indicated that they were definitely offering or were considering offering a CDHP in 2015. This would be in addition to the 29% of employers currently offering a CDHP plan. Only 5% of employers responded that they will never offer a CDHP.

The second trend we see is the reduction in plan richness, or cost-shifting, as employees pay more of the cost of their care. Although CDHP plans have grown in popularity, more than 50% of plans offered are still traditional PPO plans with numerous copays and limited services, subject to a deductible and coinsurance.

The numbers in the tables in Figures 2 and 3 represent the employee-only tier, but trends for family coverage are similar. Family deductibles and out-of-pocket maximums have consistently been set at two times the single employee rate during the past 10 years.

Median PPO deductibles for employee-only coverage have more than tripled since 2005, increasing from $300 to $1,000 in 2014. Interestingly, based on our survey results, the median deductible stayed constant at $500 for eight years, just recently experiencing a $250 annual increase in both 2013 and 2014. Out-of-pocket maximums have also increased, although not as drastically—moving slowly over time from $2,000 in 2005 to $3,000 by 2014. Primary care physician copays have increased slightly over the past 10 years, going from $20 to $25 in 2013; however, specialist copays have seen a much more significant increase, from a starting point of $20 in 2005 to the current $40. Some parts of the PPO plans have changed very little over the years, including coinsurance, which has held constant at 80% since 2006. Prescription drug copays have also remained relatively constant, with the biggest change seen in the area of specialty copays. We didn't begin to track this copay until 2010 when we noticed employers adding a fourth tier to their prescription drug benefits.

Combining these basic plan elements, we used Milliman's Health Cost Guidelines™ to calculate a relative value for each year based on the expected cost to the employer, with 2005 set at 1.000.

PPO plan values have consistently decreased each year, with the median PPO in 2014 approximately 5% less rich than the median plan offered 10 years ago. In terms of the ACA and metallic-tier plan designs, the median PPO plan in 2005 was close to a platinum plan, with an actuarial value (AV) of 0.879 and has decreased to a gold plan in 2014 with an AV of 0.817. In an effort to control their healthcare budgets, employers are continuing to place more ownership for healthcare costs on employees. Higher deductibles, copays, and out-of-pocket maximums have cost employees significantly more money at the time they receive medical care.

CDHP plan designs have also seen a significant shift in deductible and out-of-pocket maximums over the past 10 years; however, as with PPO plans, employer coinsurance has changed little. Deductibles for single coverage have increased from a median of $1,500 in 2005 to $2,500 in 2014—a 67% increase. Out-of-pocket maximums have followed suit and have doubled from $2,000 in 2005 to $4,000 by 2014.

In addition to plan designs changing, the funding mechanism has also changed. In 2005, the number of companies offering a health savings account (HSA) in conjunction with a CDHP plan versus a health reimbursement arrangement (HRA) was split nearly evenly (51% of the employer-sponsored accounts were HSAs and 49% were HRAs). Since then, there has been a significant shift toward HSA arrangements. In 2014, 69% of employer-sponsored

FIGURE 2: PPO PLAN DESIGNS (IN-NETWORK, EMPLOYEE-ONLY)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Deductible	$300	$500	$500	$500	$500	$500	$500	$500	$750	$1,000
Employer Coinsurance	85%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Out-of-pocket Maximum	$2,000	$2,200	$2,250	$2,350	$2,500	$2,500	$2,850	$3,000	$3,000	$3,000
Office Visit Copays (PCP/Specialist)	$20/$20	$20/$20	$20/$25	$20/$25	$20/$25	$20/$30	$20/$30	$20/$30	$25/$35	$25/$40
Rx Copays, Retail (Generic/Brand Formulary/Brand Non-Formulary/Specialty)	$10/$25/$40	$10/$25/$40	$10/$25/$45	$10/$30/$50	$10/$30/$50	$10/$30/$50/$60	$10/$30/$50/$60	$10/$30/$50/$60	$10/$30/$50/$60	$10/$30/$50/$80
Relative Value	1.000	0.983	0.981	0.978	0.975	0.974	0.968	0.965	0.958	0.952
Actuarial Value	0.879	0.860	0.857	0.852	0.850	0.849	0.842	0.840	0.827	0.817

*Specialty Rx copays not tracked prior to 2010

FIGURE 3: CDHP MEDICAL PLAN DESIGNS (IN-NETWORK, EMPLOYEE-ONLY)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Deductible	$1,500	$1,575	$2,000	$2,000	$2,000	$2,000	$2,250	$2,250	$2,500	$2,500
Employer Coinsurance	90%	90%	100%	100%	100%	90%	93%	93%	90%	90%
Out-of-pocket Maximum	$3,000	$3,650	$4,000	$4,250	$4,500	$4,500	$5,000	$5,000	$4,000	$4,000
% HRA	49%	42%	38%	35%	33%	33%	34%	33%	32%	31%
% HSA	51%	58%	62%	65%	67%	67%	66%	67%	68%	69%
Fund, EE	$500	$500	$500	$500	$500	$563	$600	$600	$600	$600
Relative Value, incl. Fund	0.976	0.966	0.988	0.988	0.987	0.946	0.945	0.945	0.938	0.938
Actuarial Value	0.851	0.839	0.794	0.791	0.788	0.811	0.810	0.810	0.791	0.791

arrangements were HSAs while 31% were HRAs. It is likely that the risk associated with offering an HSA (money must be transferred to participant accounts whether it is used or not) is outweighed by the greater potential for long-term savings from reduced utilization.

While CDHP deductibles have been increasing, employer-funded accounts have remained relatively flat, with the median employee-only fund increasing just 20%, from $500 to $600. This covers only a quarter of the deductible. With HSA funds most prevalent now, employers are hesitant to give too much money away up front, encouraging employees to save their own dollars and make more conscientious healthcare purchasing decisions. Employers need to remember that the more of the deductible that is funded, the more the plan moves toward paying 100% of medical costs.

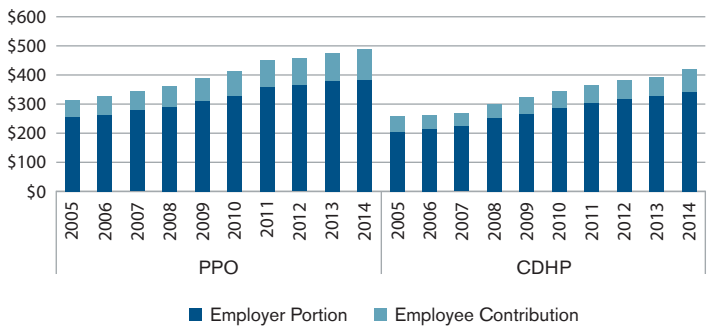
As with the PPOs, we calculated a relative value for each year and compared that with the 2005 PPO. CDHP plan values (including the fund amount) have decreased, with the median CDHP in 2014 approximately 4% lower than the median plan offered 10 years ago. On average, CDHPs (including the fund amount) are only 1% less rich than PPOs. Without considering employer-sponsored fund dollars, CDHPs are valued at 6% less than PPOs, indicating that the average fund amount is worth approximately five points on our relative value scale. Thinking of the ACA again, the median CDHP plan in 2005 was between a platinum and a gold plan with an AV of 0.851 and has decreased to a gold plan in 2014 with an AV of 0.791. Both of these values include the HSA fund.

The third observation is in the area of premiums and contributions. While plans have become less rich, premiums and, consequently, payroll deductions have increased. According to our survey, employee-only premiums for PPO and CDHP plans have increased, on average annually 5% and 5.6%, respectively. Annual increases at the beginning of the 10-year measurement period were slightly higher than most recent increases. And while employees continue to have higher payroll deductions for access to their employer's medical plans, the percentage of premium that the employee is paying to cover only himself or herself has changed relatively little. For PPOs, a single employee contribution has increased from a median of $56 per employee per month (PEPM) in 2005 to $105 in 2014; however, the percentage contribution has only increased from 19.5% to 21.8%.

Single payroll deductions for CDHPs have increased from $54 PEPM to $79 PEPM over the past 10 years. The average percentage contribution is currently 2.8% lower than PPOs at 19.0%, although there has been greater fluctuation year over year, with contributions ranging from 16.7% to 20.0% of total plan premium.

It is important to stress that this is based solely on the payroll deductions for an employee electing single coverage. It does not take into consideration the frequently higher family contributions or cost-sharing associated with out-of-pocket expenses such as deductibles and copays.

FIGURE 4: MEDICAL PLAN PREMIUMS AND CONTRIBUTIONS



What the future holds for employer-sponsored medical plans will largely be driven by medical inflation as well as further healthcare reform, likely determined by the upcoming presidential election and decisions made by Congress. We expect that employers will keep reducing the value of medical benefits offered, continuing to shift toward CDHP plans over the next few years. The percentage of total premium that employees will pay for self only coverage in contributions will likely hold steady in order to limit exposure to the ACA's affordability threshold. Rather than simply making reactionary changes through cost-sharing and cost-shifting, though, employers will need to be more proactive about the health of their employees. Internally, this could mean creating wellness incentives and penalties for unwanted behaviors, educating employees to be more prudent consumers of healthcare. Externally, employers will need to be more aggressive with their carriers, if they want to affect long-term changes, by establishing performance measures that help them move toward improved quality and pricing.

Terry Bierman, ASA, MAAA, is a senior actuarial consultant with the Omaha, Nebraska, office of Milliman. Contact him at terry.bierman@milliman.com.

Sarah Coates, CEBS, is a senior benefits consultant with the Omaha, Nebraska, office of Milliman. Contact her at sarah.coates@milliman.com.

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE

Visit our reform library at www.milliman.com/hcr
Visit our blog at www.healthcaretownhall.com
Or follow us on Twitter at www.twitter.com/millimanhealth