Health care reform continues to change the health insurance market and increase employer responsibilities.

The first open enrollment for state health insurance marketplaces in 2015 went more smoothly than the initial launches of most state marketplaces. At this point a significant number of taxpayers have obtained coverage through state marketplaces. Roughly 85 percent of those taxpayers receive subsidies from the federal government.

The “play or pay” requirements will impact most employers in 2015. Employers must offer full-time employees (working 30 or more hours a week) affordable, minimum value coverage to avoid penalties under the employer mandate. “Affordable” means coverage cost less than 9.56 percent of the employee’s household income. “Minimum value” means the plan is expected to pay 60 percent of eligible costs. Employers with between 50 and 99 employees that meet specific requirements will not be subject to penalties until 2016.

As employers become more comfortable with the Affordable Care Act (ACA) requirements, they remain committed to offering health plan benefits. Ninety-nine percent of employers in MMA-MI’s annual survey of mid-market employers indicate they will likely continue to offer health coverage to full-time employees for at least the next two years. Similarly, in Mercer’s 2014 survey, 96 percent of large employers (500 or more employees) will continue offering coverage for the next five years. Both surveys show that the majority of employers see value in providing employer-sponsored health coverage as part of their total compensation package.

Since employers are committed to offering health coverage, they need to focus on cost and coverage benchmarks. The recently completed MMA-MI 2015 Southeast Michigan Mid-Market Group Benefits Survey showed that health plan costs increased just 3 percent after employers made plan changes. This is the lowest percentage increase since the survey began over ten years ago!

Nationally, Mercer reported a health plan cost increase of 3.9 percent after plan changes for 2014 and is forecasting a 7.1 percent increase for
2015. Employers expect to reduce this increase to 4.6 percent with various plan changes.

Some employers have controlled costs successfully. The 25th percentile of MMA-MI’s survey participants saw no cost increase; some even had a cost decrease for 2015.

The economy in southeastern Michigan continues to recover, albeit slowly. Both the unemployment numbers and the housing market are much improved. At the same time, however, the ACA continues to present challenges and potential cost increases for employers.

The ACA continues to influence cost. Some employers have had higher rates of health plan elections as the requirement to obtain coverage or pay a tax penalty has affected employees. Other employers have had to cover more employees because of the change in eligibility rules. These employers used to set the full-time hourly requirement for health plan eligibility at 37 or even 40 hours a week. Now, since the ACA sets full-time as 30 hours a week, they have to cover employees with the lower full-time threshold. Still other employers are concerned about the possible impact of the Cadillac tax in 2018. The IRS has requested stakeholder feedback on the Cadillac tax. Fear of triggering the Cadillac tax may prompt many employers to carve back benefits or limit pre-tax accounts.

Health care cost is a significant burden for most employers. Employers primarily control cost by shifting cost to employees through plan design or increased employee contributions. At some point, employers may also want to consider other strategies to control cost. New tools may soon be available to help. These could include:

- Population health management.
- Payment based on episodes of care or reference-based pricing.
- Alternative care delivery options, with a focus on the least costly venue, such as telemedicine.

Carriers, providers and vendors are all looking for innovative approaches to help manage health plan costs.

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

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

It also reviews the results of MMA-MI’s 2015 Southeast Michigan Mid-Market Group Benefits Survey as compared to our national benchmark, Mercer’s 2014 National Survey of Employer-Sponsored Health Plans. Both sources provide specific data on what employers are currently doing to keep health plan costs in check.

**ISSUES AFFECTING MEDICAL CARE AND COSTS**

Health plan costs are a sizable expense for all organizations. Trend increases have been in the single digits for the last decade. However, employers fear we are overdue for a double-digit spike in health plan cost increases.

Partly because of the struggling economy, costs have been increasing at a lower rate. This trend may continue even as the economy recovers since employers have made changes during tough times. Employees are now becoming more and more involved in the cost of care. Account based health plans are more popular than ever with employees paying significant deductibles. More cost-sharing is being added to HMO and PPO plans. With patients responsible for more of the cost, they tend to use fewer services and look for less expensive treatment options.

New cost control options are currently being tested in the jumbo employer market. These options engage both providers and patients in the cost challenge with a focused effort to pay based on quality and outcomes. New pressures are being placed on members to better manage their health and chronic diseases.

Employers should be aware of the following influences on health plan costs:

- More people have health insurance today than just four years ago. Your health plan claims are expected to increase if your enrollment has increased either from employees that now have coverage because of the individual mandate or have coverage because they are newly eligible. Those that have been without coverage for a period of time tend to use the plan more heavily at first to catch up on missed care.
- Employees may have difficulty finding a primary care physician. With more people insured, primary care physicians will face new pressures as their patient bases expand. Some employees may gravitate toward urgent care or emergency room care if they are unable to get a primary care
doctor visit. To avoid these more costly venues, employers may want to offer alternatives for basic health care needs, such as coverage for telemedicine or retail health clinics.

- **Employee health directly affects plan costs.** Many employers are struggling with an aging workforce. As employees age, they tend to require more health services.

Health issues are responsible for a sizable portion of health plan costs:

- **Chronic Conditions:** The number of Americans living with one or more chronic diseases increases every year. According to the Centers for Disease Control and Prevention (CDC), about three-fourths of America’s health expenditures and two-thirds of health care spending over the last 25 years have been tied to chronic disease. Chronic conditions lead to additional spending on office visits, diagnostic services and prescription drugs. Further, complications may arise when the conditions are not properly managed. These complications can contribute significantly to cost.

- **Lifestyle choices:** Lifestyle decisions influence health care needs. Smoking, poor nutrition, sleep deprivation and a sedentary lifestyle are all choices that adversely affect a person’s health. These choices can also be a factor in the prevalence of chronic disease. Ultimately, the result is higher health plan costs.

Sleep deprivation is a growing problem with far-reaching consequences. The CDC recommends that adults get between seven and nine hours of sleep each night. Roughly 30 percent of Americans, however, report sleeping six or fewer hours a night. About 70 million Americans suffer from chronic sleep problems. Sleep deprivation is associated with injuries, chronic diseases, mental illnesses, poor quality of life, increased health care costs, and lost productivity. Sleep problems are often a hidden cause of overall poor health, including obesity. Insufficient sleep can also adversely affect metabolism, immune system function, mood and safety.

- **Our complex health care system contributes to health plan cost.** Many people do have primary care doctors for routine services. Others, however, do not; instead they tend to use urgent care centers or the emergency room. In addition, patients with serious health conditions often struggle to receive appropriate treatment when they try to negotiate the system on their own.

As a result, tests are often repeated and patients incur unnecessary medical services because they do not always choose the best path for determining a diagnosis. Patients can usually avoid this problem if they have a relationship with a primary care doctor.

- **Health care providers play a huge role in the cost picture.** Because the ACA affects their business expenses, they need to balance health care reform requirements, potential cuts in Medicare reimbursements, increasing Medicare compliance responsibilities, an increased Medicaid patient load, and care liability issues. With government requirements becoming more onerous, it is difficult for doctors to maintain an independent practice. As a result, many are consolidating their practices or working within the local hospital physician group.

Hospitals are struggling with the administrative complexities as well. Medicare is looking at alternative payment methods. Overall, the Department of Health and Human Services (DHHS) seeks to have 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018. These quality initiatives will further burden hospital systems. Hospital consolidations are expected to continue. Consolidations may reduce competition and thus affect discount negotiations with various PPO networks.

Medicare is not the only entity pushing to change payment rationales. Many payers want to focus on quality, outcomes and effectiveness when they determine payment amounts. Providers will need to adjust to the increasing pressure to structure payments based on these criteria.

The factors influencing health care cost are complex. One of the benefits of the ACA is that these cost challenges are becoming a key focus of the media. As a result, new tactics...
are evolving that should provide a host of options for cost control. Both providers and patients will feel new pressure to maintain health, seek quality care, and make cost-effective treatment decisions.

**STRATEGIES EMPLOYERS ARE USING TO CONTROL HEALTH PLAN COSTS**

Employers must annually review their health plan costs and projected increases. In Southeast Michigan, survey participants reported the lowest increase in over a decade at just 3 percent for 2015. Nationally, the 2014 increase after plan changes was just under 4 percent.

This year employers focused on account based health plans (ABHPs) and wellness initiatives both locally and nationally. Locally, MMA-MI 2015 survey respondents turned to newer options, such as patient advocate programs and telemedicine. Patient advocate programs steer employees and family members through the health care system. They help with handling claims, finding specialists, researching cost and explaining medical tests and screenings. Twenty-seven percent of local employers offered a patient advocate program. Telemedicine allows employees to consult with a physician electronically for routine illness. Typical conditions treated through telemedicine include sinus infections, ear infections, urinary tract infections, and so on. The telephone visit is easy to schedule and convenient to use. It costs roughly half of the usual fee for an office visit to a primary care physician. Twenty percent of local employers offered telemedicine. While private exchanges paired with a defined contribution approach dominated the media, there was very little take up both locally and nationally.

MMA-MI’s annual Southeast Michigan Mid-Market Group Benefits Survey reviews benchmark data for plan design, cost, contributions and cost-control strategies. A review of the 2015 data compared to 2014 national benchmarks will provide employers a host of options to consider for the 2016 plan year.

**Consumer-Driven Health Plans (CDHPs) or Account Based Health Plans (ABHPs)**

ABHPs increase participants’ out-of-pocket costs for services. Most employers offer a qualifying high-deductible health plan (HDHP) paired with a health savings account (HSA). HSAs are individually owned, tax-favored trust accounts that employers and employees can fund. The IRS rules for HSAs require the account holder to be enrolled in a qualifying high-deductible health plan. A number of criteria determine whether a high-deductible health plan is qualified.

The theory is that ABHPs control costs because members will make more cost-effective treatment decisions when they pay a greater share of the cost. Independent studies support this theory, indicating that ABHPs can result in savings ranging between 5 and 14 percent.

The MMA-MI survey indicates that 43 percent of employers offered an ABHP in 2015. This is up from 38 percent in 2014. In addition, 7 percent of employers make an ABHP the only health plan option. The employer may offer more than one plan, but all are ABHPs. GM adopted this aggressive strategy for its salaried workforce several years ago.

Nationally, the prevalence of ABHPs has increased among large employers. For employers with 500 or more employees, 48 percent offered an ABHP in 2014. This was up from 39 percent in 2013. In addition, 11 percent of employers offered ABHPs as their only plan option.

Locally, costs for ABHPs increased by roughly 5 percent in 2015. Nationally, costs for ABHPs with an HSA increased by just over 3 percent. ABHPs paired with an HSA are the least expensive plan option nationally. The annual cost for each employee covered by an ABHP with an HSA is more than $2,000 less than the “benchmark” PPO and HMO plans.

ABHP designs remain remarkably similar on both the local and national levels. The median deductibles held steady at $1,500 for single coverage and $3,000 for family coverage. HSAs are the tax-favored account of choice. Nationally, employers tend to fund the HSA at a higher level, with 71 percent of large employers funding a portion of the HSA. Locally, 55 percent of employers fund the HSA. Funding amounts were the same locally and nationally, with employers generally funding $500 for single coverage and $1,000 for family coverage.

Employers that fund part of the HSA have an additional cost-control strategy in their arsenals. They can choose to adjust HSA funding levels annually in response to cost increases, economic realities, wellness activities or business performance. A component of their plan costs can be modified independently from the ABHP benefit levels or employee

Continued on Page 5
contributions. In addition, employers may choose to stop funding them after the plan has been in place a number of years and employees have had an opportunity to build up their HSA account balances.

Two forces may be driving the increased popularity of ABHPs. First, employers are wary about the Cadillac tax. The Cadillac tax will hit employers in 2018 which is only two and a half years from now. Second, many employers have had to expand the number of employees they cover as a result of the employer mandate. Employers wanting to limit their financial exposure chose to offer their employees a low cost, minimum value ABHP.

**Employee Wellbeing**

Wellness plans have remained a strong strategy nationally and in Michigan. In 2015, 80 percent of MMA-MI’s survey participants offered some type of wellness program. Twenty-five percent of local employers offered a full-fledged wellness program. These programs typically include biometric screenings, health assessments and coaching to help improve health and lifestyle choices. Employers can offer these wellness programs using either health insurer resources or vendors specializing in wellness programs.

Nationally, 43 percent of large employers in 2014 worked with a vendor to provide comprehensive wellness services. Another 27 percent purchased additional wellness services through their health insurance carrier.

More and more employers are including spouses in wellness activities. Offering wellness activities to spouses is a best practice for wellness plan design. Locally, 45 percent of employers offer the wellness plan to both employees and their spouses. Fifty-six percent of employers nationally extend eligibility to key aspects of the wellness program to spouses.

Incentives are a critical piece of the wellness picture. Locally, our survey data shows incentives encourage employees to participate in wellness. For the 65 percent of employers offering incentives, the employee participation rate is between 75 and 99 percent. The 35 percent of employers that do not offer incentives achieved less than a 25 percent participation rate.

Southeast Michigan provides significant incentives for wellness. Where the incentive is a reduced premium, the dollar amounts average $384 a year for single coverage and $723 for family coverage. Nationally, incentive amounts were reported by activity. Fifty-six percent of employers provide a median incentive amount of $150 to complete a health assessment. Forty-two percent of employers offer a median incentive amount of $240 to complete a biometric screening. Thirty-five percent of employers offer a median incentive amount of $175 to participate in a lifestyle management program.

Eighty-four percent of southeastern Michigan employers represent the incentive as a “carrot” rather than a “stick.” Incentives used in a positive light, rather than as a penalty seem to be more successful.

Tobacco surcharges remained steady in southeastern Michigan. In 2015, 12 percent of employers required smokers to pay a surcharge. Nationally, tobacco surcharges continue to become more prevalent. In 2014, 21 percent of employers required it, which was up from 17 percent in 2013.

As employers try to encourage employees to make better lifestyle choices, tobacco surcharges may become more common.

The ACA treats tobacco surcharges favorably. Under the employer mandate, at least one plan option must be affordable and meet the minimum value to avoid penalties. A plan is affordable if the premium for single coverage does not exceed 9.56 percent of the employee’s household income. Tobacco surcharges are not included when testing affordability. This means employers can use non-smoker contributions to test for affordability.

The next step for many employer wellness programs is to tie incentives to a targeted health goal. These types of programs are typically called outcomes-based wellness programs. They continue to be popular even when employers must comply with specific requirements. Thirty-one percent of local employers tie incentives to achieving a health goal. According to Mercer, 23 percent of large employers nationally do the same. There is growing interest in structuring programs to make members take responsibility for their poor lifestyle or health decisions.

Some employers have moved to outcomes-based wellness plans and want to enhance these plans even further. These employers may consider instituting a population health management program. Population health programs collect medical claim, prescription plan and biometric data from a number of different sources including the wellness vendor and health assessments. With access to all the data, vendors have a more complete picture of a member’s current health and potential risks. They can then target efforts to improve each member’s health based on the member’s current health needs. For example, if a prescription for a chronic condition goes unfilled, the vendor may contact the member or physician directly to make sure there are no lapses in taking a necessary medication. Similarly, a review of the claims data may indicate a member failed to have a routine mammogram. An outreach call may again be in order.

Population health management is a more precise, data-driven approach to wellness and health management. Vendors can help with health and lifestyle issues at the member level through a detailed check of the database. They can then target communications to inform members of health risks and better lifestyle choices. Population health management is popular with employers who want to dig deeper into the data to improve employee health.

### Plan Design

Southeast Michigan showed minor changes in median PPO plan design. The key plan provisions for 2014 and 2015 are as shown in the table on page 6.

<table>
<thead>
<tr>
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<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Deductible</td>
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<td>$500</td>
</tr>
<tr>
<td>In-Network Coinsurance</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Single Out-of-Pocket Max (includes deductible, coinsurance and copayments)</td>
<td>$2,850</td>
<td>$5,100</td>
</tr>
<tr>
<td>Office Visit Copay</td>
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<tr>
<td>Urgent Care Copay</td>
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</tr>
<tr>
<td>Emergency Room Copay</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Rx Copays</td>
<td>$10 generic/ $35 preferred brand/ $60 non-preferred brand</td>
<td>$10 generic/ $40 preferred brand/ $70 non-preferred brand</td>
</tr>
</tbody>
</table>

Moved beyond the standard $500 deductible to even higher amounts.

The maximum out-of-pocket limit increased substantially. This increase is probably because the ACA sets limits on out-of-pocket maximums and requires all out-of-pocket costs to accumulate toward that maximum. The 2015 statutory single out-of-pocket maximum limit is $6,600. Not all employers set their out-of-pocket limit at the maximum allowed.

Nationally, the median PPO plan for 2014 is remarkably similar to southeast Michigan’s median plan. National plans, however, have a few differences:

- Slightly lower prescription drug copays ($10/$30/$50)
- Slightly lower emergency room copay ($125)
- Lower out-of-pocket maximums ($2,600)

The median HMO plan in southeast Michigan showed some plan design changes in 2015. Southeast Michigan’s HMOs differ from typical national HMOs in several ways:

- In 2015, 88 percent of local HMO plans included coinsurance, a significant increase from the 57 percent last year. Of those with coinsurance, the median amount was 90 percent coverage after the employee paid any applicable deductibles and copays. This was up from 80 percent last year and likely due to the influx of new plans including coinsurance. Mercer has now started reporting on coinsurance. In 2014, 20 percent of HMO plans included coinsurance nationally.
- A deductible applies in 68 percent of local HMO plans, with median deductibles of $500 for single coverage and $1,000 for family coverage. Nationally, 33 percent of plans have an overall deductible and median deductibles are the same as the local ones. In addition, 18 percent of local plans report having an inpatient hospital deductible or copay. Nationally, 59 percent of HMO plans have an inpatient hospital deductible. Both nationally and in southeast Michigan, the median inpatient hospital deductible is $250.
- Office visit copays are a standard feature of HMO plans. Both locally and nationally, the office visit copay is $20.
- Split copays are a plan design feature where copays to see a specialist are higher. Nationally, 59 percent of HMO plans have higher copays for specialist visits;
the median is $35. In southeast Michigan 53 percent of HMO plans have this design feature; the median copay amounts are $25 for primary care visits and $40 for specialist visits.

- Both locally and nationally, HMO plans include an emergency room copay of $100.

The HMO market in southeast Michigan is vastly different from the national market. Nationally, HMO plans remain the most expensive plan option, but in southeast Michigan they are one of the most affordable choices. They continue to be a cost-effective option locally because of strong competition and innovative plan designs. Locally, the median HMO plan design is very similar to the median PPO plan design.

**Contribution Strategies**

Employee contributions in southeast Michigan, in monthly dollars and as a percentage of the premium, are as shown in the table below.

For 2015, we excluded HSA funding from the calculation of the percentage of premium.

As the table shows, dollar amount increases were fairly low or in some cases flat. Single coverage contributions are close to national contribution benchmarks. Family contributions are fairly close to national on PPO plans. HMO contributions for family are significantly lower locally. HMO plans are far less expensive locally than nationally. Family contributions for ABHPs are slightly lower locally than nationally.

ACA requirements may have prompted employers to consider new contribution strategies.

When employers who cover dependent children were required to cover these children to age 26, employers investigated requiring contributions for each dependent child. Only 3 percent of employers locally charge for each dependent child.

Employers also considered income-based contributions as the employer mandate took effect in 2015. Since the affordability test is based on household income, employers could use income-based contributions to pass the affordability test. Income-based contributions have not taken off even with the affordability test.

Only 7 percent of employers locally use an income-based contributions strategy. Nationally, 11 percent of employers use an income-based strategy. Income-based contributions sound good but can cause problems. They multiply the number of possible contributions you need to track in your HRIS system depending on the number of salary bands you use. They also can be difficult for employees. If an employee gets a raise, the employee might jump a salary band and see an increase in employee contributions. The result of the raise would be a lower take home pay.

**Prescription Drugs**

The prescription drug market presented some challenges this year. In December 2013, Sovaldi entered the market. Sovaldi is a specialty medication that is the first treatment for Hepatitis C. One course of Sovaldi costs approximately $80,000. Patients completing the whole course of Sovaldi treatment have an exceptionally high cure rate. Some employers were hit with several Sovaldi claims which affected prescription costs in 2014. A newer Hepatitis C drug is available called Harvoni. This medication can cost more than Sovaldi if maximum treatment regime is needed.

\[\text{Continued on Page 8}\]
Specialty medications will continue to be an issue. Most medications in the pipeline are considered specialty medications and are likely to carry heavy price tags. They are often injectable and require special administration or handling. These drugs treat complex or life-threatening conditions. In many cases, they are biologics that work in limited circumstances for certain patients. They can profoundly affect the quality of life for patients with serious health conditions. Employers can take a variety of approaches to controlling pharmacy cost, with some approaches targeting these specialty medications.

Employers are driving cost-effective use through copay structures. Nationally, 64 percent of plans (and locally, 68 percent of PPO plans) have a three-tier prescription drug copay structure. More and more employers are adopting additional copay tiers. Nationally, 24 percent of drug plans have a fourth or fifth copay tier. Locally, 23 percent of PPO prescription plans have a fourth prescription drug tier. Another 14 percent of plans have added a fifth tier. If there are five tiers, the employer has a list of preferred specialty medications available in the fourth tier. The fifth tier is reserved for non-preferred specialty medications.

Nationally, copays have not changed significantly over the last three years. National median prescription drug plan copays are $10 for generics, $30 for formulary brands and $50 for non-formulary brands. Local median prescription drug plan copays are slightly higher at $10 for generics, $40 for formulary brands and $70 for non-formulary brands.

Another approach to controlling specialty medications is to eliminate coverage for specific specialty medications. This is a very aggressive approach. Only 6 percent of local employers have taken this route. This approach needs to be considered carefully; these specialty medications have meaningful impact on the lives of people with serious health conditions.

Medical management programs are also important. Some programs require prior authorization. In these cases a physician must authorize the use of a specific medication. Others use step therapy to ensure that the patient is first trying less costly medications, before moving on to more costly options. Locally 56 percent of employers use step therapy and prior authorization. Nationally, 51 percent of employers use these approaches.

Mandatory generics also help control cost. A plan with mandatory generics covers only generics if they are available. Fifty one percent of local employers use mandatory generic requirements. Thirty three percent of national employers use mandatory generics.

In some cases, specialty medications are prescribed for very specific situations and will not work for all patients. The side effects may be so harsh that the patient cannot continue therapy. Because of this, many plans will limit the first fill of certain drugs to a two-week supply.

Employers have aggressively managed drug programs to drive down their prescription drug costs. This diligence has been effective. In fact, employers are now using medical management programs instead of continually raising copays. As a result, prescription drug copays, both locally and nationally, have changed very little in the last five years.

**Eligibility Strategies**

Employers rely on a variety of eligibility strategies to keep health plan costs in check. Locally, employers have used two tactics to discourage employees from enrolling their spouses. Fourteen percent have a somewhat aggressive spousal force-out. Under this provision, if spouses have coverage available through their employers, they are not eligible for coverage under your health plan. Spousal force-outs are not popular with employees, because they can force the family to deal with different plans, deductibles and out-of-pocket maximums.

The other way to limit spousal enrollment is through a surcharge, which 22 percent of local employers use. With this strategy, employees pay an extra premium to cover their spouses on your plan, if their spouses are eligible for coverage sponsored by their own employers. The median monthly surcharge in 2015 is $100.

These strategies are not as popular nationally. Only 9 percent of large employers have a spousal force-out and 9 percent apply a spousal surcharge. Nationally, large employers tend to charge more for family coverage overall, rather than limiting spousal coverage.

The “play or pay” rules will require employers to cover full-time employees and their dependent children or potentially pay a penalty. Employers are not, however, required to cover...
spouses as part of the "play or pay" rules. As a result, a third, very aggressive option may be considered. Employers could choose to exclude all spouses from coverage. (Kroger adopted this aggressive stance at the beginning of 2014.) An ineligible spouse may purchase coverage through the Health Insurance Marketplace. The spouse may be eligible for premium subsidies in the Marketplace based on household income.

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

**CONCLUDING THOUGHTS**

The MMA-MI Southeast Michigan Mid-Market Group Benefits Survey showed health plan costs increasing at the lowest rate in over ten years.

The leading local and national strategies to keep costs in check were ABHPs and wellness initiatives. Employers are considering ABHPs for several reasons. They are a low-cost, minimum value plan option that avoids potential penalties under the employer mandate. Employers want to minimize potential cost increases whether they are due to the individual mandate or a 30-hour full-time threshold. Employers are concerned about the Cadillac tax coming in 2018. These ACA forces are pushing employers to adopt cost-effective ABHPs.

Wellness is also a lead strategy. Employers with aging workforces need to maximize health to keep medical costs for chronic conditions in check. Growing evidence suggests sedentary work environments are just as harmful to health as smoking. Wellness initiatives encourage employees to move. Improved health also increases productivity and lowers absenteeism rates. The last few years have brought a shift in how employers view wellness. The focus is on employee well-being with the core components of physical health, mental health and financial security. Upper management seems to understand the value of wellness initiatives. Management now focuses less on return on investment and more on improving health metrics, nutrition and activity levels.

Health plan vendors are also considering new options to control cost, such as new payment models. In the coming years, carriers will determine eligible reimbursements based on quality, outcomes and effectiveness. Reference-based pricing may also become a vendor focus in Southeastern Michigan. This approach sets a fee for certain services based on the fee determined for quality care. Some providers will accept the reference-based price. If a member selects a provider that charges more than the reference-based price, then the member pays the difference.

Employers should also encourage members to choose cost-effective treatments. For example, an employer may offer telemedicine with either a low copay or no copay at all. A telephonic doctor visit is less expensive than a primary care office visit, an urgent care visit or emergency room treatment. Often people with non-emergent conditions use urgent care or even the emergency room when they can’t immediately see their physician. Telephone consultations are a quicker, less costly option. Some employers are structuring cost-sharing to steer members to outpatient facilities, stand-alone imaging centers and other less costly treatment alternatives.

If you have any questions about health plan trends, please contact your MMA-MI Account Director.