# CRA Medical Insurance Report

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## Executive Summary

Healthcare spending continues to increase to record levels, and the rate of those increases has exceeded general increases in the cost-of-living. Medical plan enrollees have seen increases in medical plan premiums for themselves and the employer, as well as changes in plan design involving coverage, deductibles, and co-payments. As employers are concerned with cost, risk, and benefits commitments, different strategies of medical insurance are currently being studied. One remedy being favorably evaluated and implemented by employers of various sizes, including large employers, is private medical plan exchanges. Private exchanges are individual market-based health sourcing plans that could offer enrollees more choices in level of coverage, better cost efficiency, and enhance the quality of medical care.

## Introduction

For the first time, annual national health care spending in 2016 will exceed $10,000 per person. The U.S. Department of Health and Human Services (DHS) reports that national health care expenditures will be $3.35 trillion dollars in 2016 (or $10,345 per person), more than 18% of GDP. Moreover, DHS projects that national health care spending will increase at a higher rate than the growth of the national economy over the next decade.

Since the introduction of Medicare and Medicaid in 1966, we have seen many changes in medical insurance plans, and the current economic environment compels us to anticipate more changes in health care delivery.

This Report will analyze current baseline information and emerging trends for medical insurance overall and for retirees specifically.

## Medical Insurance - Current Baseline Information

Listed below is some significant baseline information on medical insurance.

-About 5% of the population accounts for nearly half of healthcare spending, while about 3% have little or no impact on spending.

-Reflecting the impact of Affordable Care Act (ACA), the number of small businesses who offer medical insurance has decreased, but the number of large employers who offer health insurance has held steady. For employers with 1,000 or more employees, about 99% continued to offer insurance from 2004 through 2015. For employers with 100 to 999 employees, 90%+ continued to offer insurance. Between 2004 and 2015, employers with fewer than 10 employees dropped from 36% to 23%, employers with 10 to 24 employees dropped from 66% to 49%, and those

with 25 to 99 employees dropped from 81% to 74%. Small employers, who before ACA often faced higher and volatile cost increases, may have decided that ACA requirements (coverage and affordability regulations, for example) have made medical insurance too expensive and risky.

-Dropping medical insurance could be a benefit for some low income employees (400% of federal poverty level) who are eligible for an ACA subsidy.

-It is estimated that at least 14 million non-elderly Americans will lose their private insurance by 2019.

-Of employers who provided medical coverage, participation rates were 73% and 83% in the private and public sectors, respectively.

-Reflecting the impact of ACA, relatively small percentages of employers with 50 or more FTEs (Full-Time Equivalents) have switched those FTEs to part-time or reduced the number of FTEs to be hired. Also, as a result of ACA, health coverage in rural counties has increased 8% since 2013, and the share of rural Americans unable to afford needed care decreased almost 6%.

-Concerning single/family coverage, employee share of premiums in 2015 were 21%/32% and 13%/29% for the private sector and public sector, respectively.

-Average annual premiums for employer-sponsored health insurance in 2015 were $6,251 for single coverage and $17,545 for family coverage.

-Between 2005 and 2015 for family coverage, average employee contributions increased from $2,713 to $4,955 (up 83%), average employer contributions increased from $8,167 to $12,591 (up 54%), and average total premiums increased from $10,880 to $17,546 (up 61%).

-Between 2000 and 2015, premiums for family coverage increased more than overall inflation (2000-2015: 69% vs. 14%; 2005-2010: 27% vs. 12%; 2010-2115: 27% vs. 9%).

-The CPI for medical care has increased 5.56% per year since 1980. Health care benefit costs for large employers are expected to increase 6% in 2017. These increases in costs are more than the overall CPI (recently below 2%) and salary budget increases (about 3%).

-Approximately 20% of employees are in family coverage with an annual total premium for family coverage of at least $21,054, and approximately 20% of employees were in plans where the family premium is less than $14,036.

-Covered workers contribute on average 18% of the premium for single coverage and 29% of the premium for family coverage; these amounts have not changed much since 2010. Workers in the private sector paid about one-half more on a percentage basis than public sector workers.

-52% of covered workers in 2015 are in PPO plans, 24% are in a high-deductible plan with a savings options (HDHP/SO), 14% are in HMOs, 10% are in a POS (point-of-service) plan, and 1% are in an indemnity plan.

-Approximately 80% of covered workers have a general annual deductible that must be met before most services are paid for by the plan, besides other costs such as copayments or coinsurance for hospitalizations, outpatient admissions, etc.

-Annual deductibles in 2015 averaged $1,318 for single coverage, up from $1,217 in 2014 and $917 in 2010.

-General annual deductible components of medical plans are more popular and have grown from 55% of plans in 2006, to 70% in 2010, and to 81% in 2015. The average deductible for all covered workers in 2015 is $1,077, up 67% from $646 in 2010, and 255% from $303 in 2006.

-Approximately 70% of covered workers pay a copayment (a fixed dollar amount) for office visits, in addition to any general annual deductible their plan may have.

-Nearly all plans contain some prescription drug coverage. Cost sharing may be based on whether a prescription drug is a generic, a brand-name, a specialty drug, and on the plan's formulary. Plans also have three or more (about 80%) or four or more (about 25%) tiers of cost sharing. Some drug plans have a separate deductible.

-Health risk assessments, biometric screenings, health promotions, and wellness programs are becoming more popular.

-Employers are utilizing Health Reimbursement Accounts (HRA), which are employer-funded, tax-advantaged health benefit plans that reimburse enrollees for out-of-pocket expenses and health care premiums.

-More than 80% of employees at large firms are covered by plans that are self-insured. More than half are covered by partial or fully-funded plans, including those who are covered by stop loss coverage which provide additional coverage for high-cost claims.

-Employer-sponsored insurance covers over half of the non-elderly population (147 million people in total).

-Those who are aged 18 to 34 represent almost half of the uninsured, as many in the group are not overly concerned about a lack of coverage since medical insurance is viewed as too expensive and a poor investment.

-Job-related website CareerBuilder reports that more job candidates say that the quality of employer-provided medical coverage is now a top consideration when evaluating job offers. About 40% of employers report that medical benefits are effective in attracting and retaining workers.

## Retiree Medical Insurance - Current Baseline Information

Listed below is some noteworthy baseline information on retiree medical insurance.

-Since 1988, the number of large firms offering retiree health benefits has declined 38%.

-23% of large firms that offer health benefits in 2015 also offered retiree health benefits, similar to the 25% in 2014.

-92% of those employers who have retiree plans offer medical coverage to those who retire before age 65, and 73% of employers offer Medicare supplement medical plans to those on Medicare.

-In general, retirees do not have enough savings to finance their retirement. For those aged 65, average men and women will need $129,000 and $146,000, respectively, to have a 90% chance of satisfying their health care costs. This is contrasted with the average retirement plan (such as a 401k) balance of $14,500 for those aged 55 to 64.

## Medical Insurance - Emerging Trends

Historically, medical plans have experienced higher premiums, larger deductibles and co-payments, more restrictive case management, capping subsidies, changing benefits for new hires (for example, BP has a different level of retiree medical benefits for those hired April 1, 2014 or later), etc. In the future, we should also expect various creative strategies to be aggressively evaluated. Listed below are some examples that are being considered or implemented.

-Larger employers are more likely to offer tiered networks; however, some of these employers are reducing their network tiers by eliminating provider networks in order to reduce costs. Large employers are also more likely to offer high performance plans, which identify providers who provide better and more efficient care.

-Defined contribution subsidies are increasingly seen as a strategy for employers to gain better control over costs.

-Telemedicine, where the patient and the medical practioner exchange information through webcasts and other electronic means, is being increasingly utilized.

-Up to 50% of employers are expected to have considered the use of private exchanges by 2018. Private exchanges, which should not to be confused with public exchanges or the marketplace associated with the ACA, are arrangements designed by medical insurance companies, brokerage firms, and consultants (such as Willis Towers Watson, Aon Hewitt, and Mercer) to provide enrollees different coverages and insurer options. In 2014, three million people had medical insurance on private exchanges, with growth to six million enrollees in 2015 and 40 million expected by 2018. These exchanges provide a variety of benefit packages, including those with higher or lower premiums, co-payments, deductibles, and other coverage options. Enrollees would be able to select the plan that meets their needs from among many competing plans. These plans normally support enrollees with assistance in selecting plans (including personalized, one-on-one guidance with licensed experts) based on cost considerations, preferred doctors, etc. With private exchanges, the employer delegates much of the medical plan design to these private exchanges, so the role of the employers would be simplified and would change the

relationship between the employers and medical plan participants. Thus, these private exchanges are increasingly being viewed as a long-term solution, as well as being applicable to both active and retired employees. For enrollees, available choices and options may be advantageous. So far, these private exchanges have evolved into sophisticated solutions over the last decade with successes in quality coverage. One unanswered question is whether these exchanges will help keep overall medical costs more under control. Also, will participating employers keep their subsidy flat or raise the subsidy as healthcare costs increase over time?

-Professional Employment Organizations (PEO) are being scrutinized as a strategy to reduce benefit costs. In a PEO arrangement, employees are in a co-employment relationship with their employer and the PEO, which handles and administers employee-related issues such as benefits (including medical). PEOs now support between 156,000 to 180,000 small businesses, with about 100,000 businesses currently being added annually.

-Beginning in 2020, the 40% excise tax, mandated under the ACA for medical plans that cost more than $10,200 for single coverage and $27,000 for family coverage, is expected to be a major reason for employers who have these "Cadillac plans" to evaluate retiree medical plans over the next several years. A private exchange may be favorably viewed as the best strategy to minimize or eliminate this tax risk.

-Employers will increasingly offer financial incentives for employees to participate in wellness programs, including, for example, meeting various health-related targets.

-Health insurers are leaving the ACA exchanges. A recent study determined that health insurers providing coverage through ACA exchanges lost $2.7 billion in 2014, and losses in 2015 are continuing. Humana, Aetna, Texas Blue Cross, and United Healthcare are among those with large losses. For example, United Healthcare lost $720 million in ACA exchanges. Accordingly, many insurers, such as United Healthcare, pulled out of many exchange plans in various states. These exchanges have experienced increased costs, as a higher number of older, less healthy people and fewer younger, healthier people participate. Thus, those who must purchase policies on remaining exchanges have rising premiums and more limited choices of doctors and hospitals. The Justice Department has had concerns about mergers of health insurers (such as Anthem-Cigna and Aetna-Humana) as the Department feels these merged firms could have too much power to set rates and limit enrollees' options. Ironically, ACA encourages mergers of hospitals and other providers consistent with ACA's goal to improve efficiency. Also noteworthy is that many doctors feel incented to leave their independent practices for employment elsewhere due to rising costs of their practices. What might be the remedy? Some believe that the best future option may be a government-run health insurance program (similar to the European model of socialized medicine).

-Over the past several years, the overall economic conditions kept consumer spending (including medical care spending) down. Now, it is possible that a somewhat improving economy and economic growth will stimulate health care spending, which could impact premiums and plan designs.

## Retiree Medical Insurance – Emerging Trends

There have been general concerns regarding employee retirement plans: transitions from defined benefit to defined contribution plans, workers not being prepared for retirement, workers retiring earlier than expected, the severe problem of financial illiteracy, etc. Retiree medical costs are also attracting attention by employers, as well as retirees where their medical expenses are a large structural component in their overall retirement financial security. Besides emerging trends in medical insurance overall, the following emerging trends are applicable to retiree medical plans.

-A majority of retirees believe that medical costs increased more than anticipated and that they are concerned about future rising costs. Some report delaying treatment or prescriptions to save money.

-Almost 80% of employers with Medicare-eligible retirees are now using or considering public and private insurance exchanges. As employer confidence in exchanges increases, more employers will favorably consider this change in 2016 and 2017.

-31% of employers are now using an individual market solution for retiree health care. 70% of employers have chosen a private exchange, with options of a range of health plans with advisory services to ensure enrollees select the best appropriate coverages. Chrysler, General Motors, and Ford adopted this strategy for salaried former employees. Alcoa, IBM, AT&T, and Time Warner are now moving retirees to private exchanges. General Electric disclosed that it will save $3.3 billion by using private exchanges for retirees effective 2016. Private administrative platforms or exchanges (with various service options) could be implemented first for Medicare eligible retirees and later implemented for pre-Medicare retirees. Employers with a significant number of retirees across the U.S. may favorably consider market-based multi-carrier exchanges.

-Concerning prescription drugs for retirees, many employers have already moved to Medicare Part D, and the majority of remaining employers are considering moving, from the Retiree Drug Subsidy (RDS) strategy to Medicare Part D Employer Group Waiver Plan (EGWP) to leverage ACA's additional funding sources for Medicare Part D. RDS tax-favored status was eliminated in 2013, and Medicare Part D was improved (phase-out of coverage gap or 'donut hole' by 2020 and drug discounts for those in the gap beginning 2011).

-Applicable employers are considering splitting active and retiree legal plan structures.

-Some employers are investigating new group-based Medicare Advantage strategies for retirees to provide both medical and prescription drug coverage for Medicare-eligible retirees. However, since these national programs are locally focused with many vendors, local reimbursements have not kept pace with inflation and premiums have increased. Thus, this strategy may not be a long-term solution to manage costs.

-We should expect Medicare to have long-term financial challenges. Medicare will probably be shifting more costs to Medicare supplemental plans. So, employers, in anticipating that cost-shifting, will need to make plan design changes that mitigate that future financial impact.

-Employer-sponsored Health Reimbursement Accounts (HRA) seem to be within the definition of a required employee-sponsored Minimum Essential Coverage (MEC). However, HRAs preclude retirees from receiving a federal subsidy on a state exchange, so employers who offer HRAs may have to carve out those who desire coverage on a state exchange.

-As they did with retirement plans to reduce risk, employers are considering purchasing life annuities administered by trusts to support current and future retirees, possibly through a private exchange. In these cases, no further funding would be made, so benefits may have to be adjusted if trust assets are insufficient.

-Medicare may be authorized to negotiate prescription drug prices.

-Employers could terminate retiree medical plans and offer retirees information about coverage in exchanges.

## Conclusion

The goal of many employers regarding medical care is to achieve corporate cost and risk management objectives while continuing to support benefits commitments.

Directionally, medical plan consumers should be prepared to pay a higher share of costs, as spending someone else's money in a system dominated by third-party payers contributes to increased costs and spending. Otherwise, shortages of available medical care could result in rationing.

With anticipated financial challenges in Medicare (as well as other U.S. social welfare programs), future political and legislative activity, and general medical cost issues, many employers are making or considering changes in plan design now or in the near future. This strategy is considered financially prudent and provides time for both enrollees and employers to understand and prepare for additional pending changes.

It appears that individual market-based health care sourcing strategies are being favorably assessed, with their ability to deal with cost issues and to remove employers from being positioned in an intermediary role between retirees and Medicare. These private market plans could deliver more value through greater plan choice and diversification, better savings potential, and enhanced service and decision support.

Various strategies described here will be problematic, but future medical plan changes may indeed provide superior medical care that is more cost efficient.

Sources of information include the following:
-Aon Hewitt

-CareerBuilder
-Deloitte
-Forbes
-"Health Economics and Policy" by James W. Henderson
-"Insurance Journal"
-Kaiser Foundation
-Society of Human Resource Management
-U.S. Department of Health and Human Services, including "Medicare & You – 2016" Publication
-U.S. Department of Labor, including the Bureau of Labor Statistics, the ERISA Advisory Council, and Employee Benefits Security Administration
-U.S. Social Security Administration
-Willis Towers Watson

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