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# WITH THE EXCISE TAX IN THEIR SIGHTS, EMPLOYERS HOLD HEALTH BENEFITS COST GROWTH TO 3.8% IN 2015

New York, January 12, 2016

- **Mercer survey finds average total health benefit cost per employee rose 3.8% in 2015, following a 3.9% increase in 2014**
- **23% of large employers are at risk of hitting excise tax cost threshold in 2018 based on their current premiums – and 45% are at risk for 2022**
- **2016 costs predicted to rise by 4.3% after employers make changes to plans**

The business imperative to control health benefit cost growth has taken on a new urgency with the fast-approaching implementation of the excise or "Cadillac" tax, one of the Affordable Care Act's (ACA's) final provisions. Employer actions to reduce their exposure to the 40% excise tax, which goes into effect in 2018, helped hold growth in health benefits cost per employee to just 3.8% in 2015, for a third straight year of increases below 4% (see Figure 1).

According to the *National Survey of Employer-Sponsored Health Plans*, conducted annually by Mercer (with 2,486 participants in 2015), total health benefits cost averaged $11,635 per employee in 2015. This cost includes both employer and employee contributions for medical, dental and other health coverage, for all covered employees and dependents. Small employers were hit with higher increases than large employers. Cost rose by 5.9% on average among employers with 10-499 employees but by just 2.9% among those with 500 or more (see Figure 2).

Employers predict that in 2016 their health benefits cost per employee will rise by 4.3% on average. This increase reflects changes they will make to reduce cost; if they made no changes to their current plans, they estimate that cost would rise by an average of 6.3%. But about half of all employers indicated that they would make changes in 2016.

"Employers are moving on several fronts to hold down health cost growth," said Julio A. Portalatin, President and CEO of Mercer. "In the best scenarios, they're addressing workforce health, restructuring provider reimbursement to reward value, and putting the consumer front and center by providing more options and more support. In other cases, the pressure to avoid the excise tax is leading to some cost-shifting, plain and simple."

Helping to hold down cost growth for large employers was a jump in enrollment in high-deductible consumer-driven health plans (CDHP) as they continued to implement new plans in 2015. Among small employers, use of these plans has grown more slowly. Where enrollment has nearly doubled among large employers over the past three years – from 15% to 28% of covered employees -- among small employers it has risen from 17% to just 19%. Overall, CDHP enrollment reached 25% in 2015 (see Figure 3).

**Excise tax a challenge for employers with high-cost plans that are not "Cadillac"**

A plan's actuarial value – the percentage of a member's health care expenses it can be expected to cover – is not the only factor that can drive up cost above the excise tax threshold. Health plan costs vary significantly by geographic region, the degree of competition in the provider market, and workforce demographics. Based on their current premiums, Mercer estimates that 23% of large employers have at least one plan with cost that will exceed the excise tax threshold in 2018 if they make no changes between now and then (see Figure 4). That's down from 33% last year, because employers continued to make changes to slow cost growth. However, due to the way the excise tax threshold is indexed, the percentage of employers at risk will rise every year that medical inflation exceeds the general CPI. By 2022, 45% of employers are estimated to be liable for the tax unless they make changes.

It will be harder for some employers to avoid the tax than others. Those with very rich plans have room to maneuver. But among large employers, only 44% of the plans expected to reach the excise tax cost threshold in 2018 have an actuarial value (AV) of 90% or higher, which is the definition of a Platinum plan, the most expensive plan on the public exchanges. Another 45% have an AV of 80%-89% and would be considered Gold-level plans, like a typical employer-sponsored plan today. But more than one in 10 would be considered just Silver-level plans, or even Bronze-level – the lowest-value plan on the exchange (see Figure 5).

"For employers that want to maintain current benefit levels for their employees, there are a range of strategies to explore that can help control cost over the long term," said Tracy Watts, Mercer's national leader for health reform. "But for employers with high-cost plans that aren't what most would consider 'Cadillac', that 2018 deadline is a tough challenge."

**Turning the corner on consumerism**

High-deductible consumer-directed health plans remain a key tactic for minimizing excise tax exposure. Fully one-fourth of all covered employees are now enrolled in CDHPs, which include an employee account -- either health savings account (HSA), the most common type, or a health reimbursement account. The largest employers have moved the fastest to add CDHPs – 73% of employers with 20,000 or more employees now offer a CDHP (see Figure 6), and 30% of their covered employees are enrolled.

Most of the growth in enrollment is the result of employers adding plans. Because most employers offer a CDHP alongside other medical plan choices, building CDHP enrollment over time is an ongoing challenge. An HSA-eligible CDHP costs about 18% less, on average, than a traditional PPO, and it's typically the lowest-cost option for employees in terms of their paycheck deduction (see Figure 7). However, when they are offered as an option, even among large employers that have offered the plan for at least three years only 29% of employees, on average, elect to enroll.

"Employers have learned that the higher deductible can be a real deterrent for employees without enough savings to comfortably handle a major medical expense," said Ms. Watts. "When CDHPs were first introduced, the concept made intuitive sense but we didn't have the tools we have now to help employees actually become better health care consumers. I think we're finally turning the corner." A key difference is that more consumers now have real, and financially substantive, "shopping" choices. "You can pay $40 for a telemedicine visit, $70 to stop in at a retail clinic, or $125 for an office visit," said Ms. Watts.

Employers are moving quickly to implement telemedicine services -- telephonic or video access to providers -- as a low-cost, convenient alternative to an office visit for some types of non-acute care. Offerings of telemedicine services jumped from 18% to 30% of all large employers (see Figure 8).

The ability to compare prices for higher-cost services is becoming a reality as well. More large employers contracted with a specialty vendor to provide their employees with a "transparency tool" – an online resource to help them compare provider price and quality (among employers with 20,000 or more employees, 24% provided transparency tools in 2015, up from just 15% last year). When employees can comparison shop, employers can give incentives to avoid the most expensive providers – in turn giving those providers a reason to adjust their prices. With "reference-based pricing," for example, employers set a limit on how much they will cover for a specific service in a specific area, and the patient is responsible for the cost above that amount. Use of reference-based pricing rose from 11% to 13% among large employers in 2015.

Employers are also getting more creative in how they support workforce health -- the most desirable route to long-term cost management. About one-fourth of large employers (24%) encourage employees to track their physical activity with a "wearable" device, while 30% use mobile apps designed to engage employees in caring for their health (see Figure 9). They are broadening the focus of workforce health and wellness programs to include other elements of well-being, offering programs to address sleep disorders (39%, up from 32% last year), improve resiliency (42%), and provide help in managing finances (69%).

**Sharp drop in small employers considering terminating their plans**

While Mercer's surveys have consistently shown that large employers remain committed to offering health coverage, in the early days of the health reform debate sizable numbers of small employers thought it was likely that they would drop their plans and send employees to the public exchange. In 2013, 21% of employers with 50-499 employees said they were likely to drop their plans within the next five years; this number fell to 15% in 2014 and to just 7% this year. Among employers with 500 or more employees, just 5% say they are likely to drop their plans, essentially unchanged from 4% last year (see Figure 10).

"Employers know that health benefits really influence how employees feel about where they work," said Beth Umland, Mercer's director of research for health and benefits. "They want to continue to offer coverage, and with cost growth holding below 4% they're gaining confidence that they'll be able to afford it."

**Other findings**

- **Private exchanges** are gaining momentum fast: 6% of large employers already use a private exchange for active employees or will by next year's open enrollment, a 50% increase in just one year. Significantly, an additional 27% of large employers are considering switching to an exchange within five years.
- **Egg freezing** is covered by 5% of all large employers (11% of those in the Northeast). In vitro fertilization is covered by 24%; this number has remained essentially the same over the past 15 years.
- **Gender reassignment surgery** is covered by 11% of all large employers (up from 8% in 2014) and by 29% of employers with 20,000 or more employees (up from 25%).

- **Tobacco-use surcharges** 29% of large employers (up from 26% in 2014) vary the employee contribution amount based on tobacco-use status or provide other incentives to encourage employees not to use tobacco. Among those reducing the premium for non-tobacco use, the median reduction is $400. The majority of employers (59%) include e-cigarettes in their definition of tobacco.
- **Domestic partner coverage** There was a big jump in the prevalence of employers that include same-sex domestic partners as eligible dependents, from 55% to 64% of all employers, and from 76% to 81% of jumbo employers. While there was growth nationally, there is still significant regional variation, from 80% of all employers in the West to 47% in the South.
- **Spousal surcharges and exclusions** There was no growth among large employers in the use of provisions excluding spouses with other coverage available (8%), but the use of spousal surcharges rose from 9% to 12% of all large employers. Among jumbo employers, 26% require a surcharge, essentially unchanged from last year. The median surcharge is $100 monthly.

**Survey methodology**

The Mercer *National Survey of Employer-Sponsored Health Plans* is conducted using a national probability sample of public and private employers with at least 10 employees; 2,486 employers completed the survey in 2015. The survey was conducted during the late summer, when most employers have a good fix on their costs for the current year. Results represent about 600,000 employers and nearly 100 million full- and part-time employees. The error range is +/–3%.

The full report on the Mercer survey, including a separate appendix of tables of responses broken out by employer size, region and industry, will be published in April 2016. For more information, visit www.mercer.com/ushealthplansurvey.

**About Mercer**

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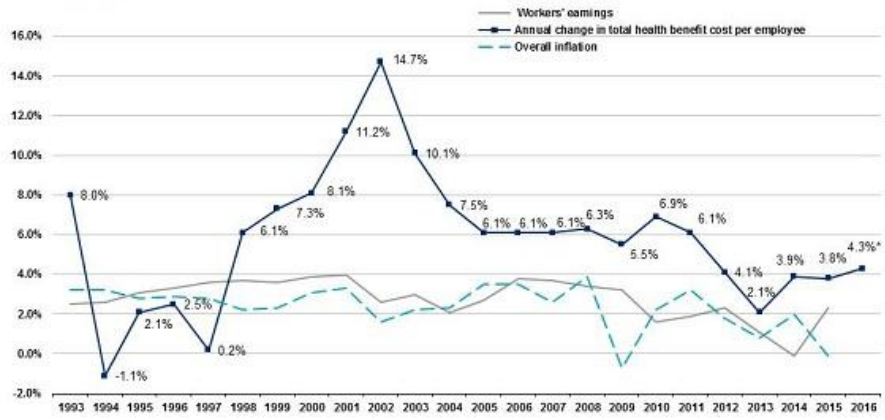
FIGURE 1

## Employers hold growth in the average total health benefit cost per employee to 3.8% in 2015



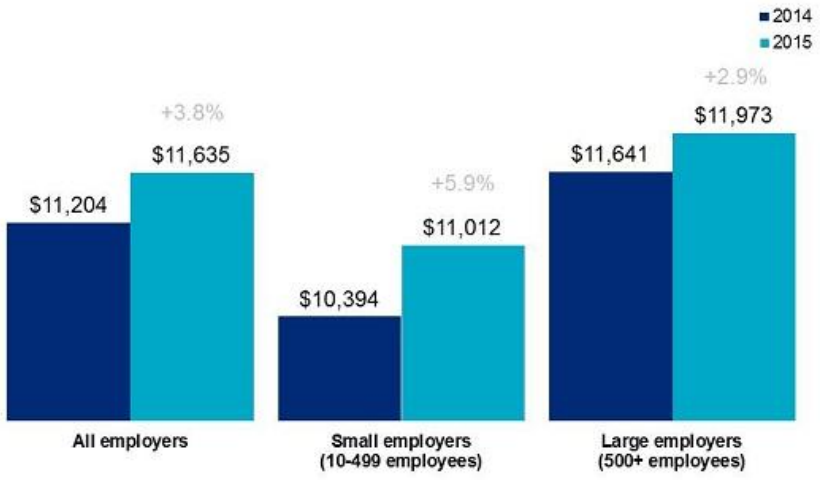

*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1993-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1993-2015.

SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 2

## Cost rose more sharply among small employers

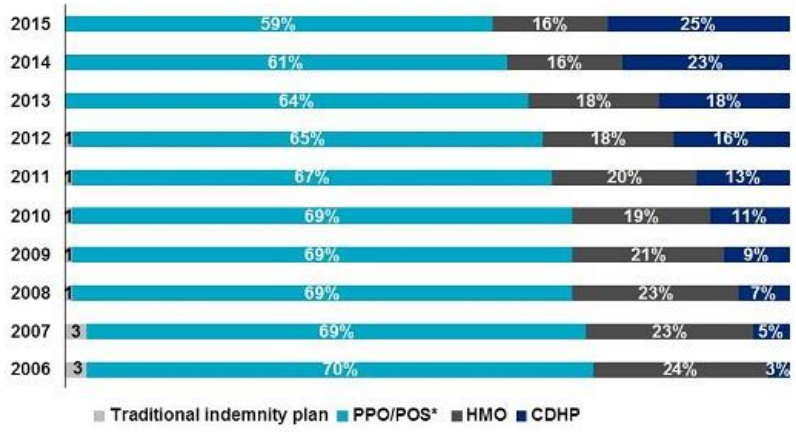



SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 3

**CDHP enrollment reaches new milestone of 25% of all covered employees as many large employers add plans**

Percentage of all covered employees enrolled in each plan type



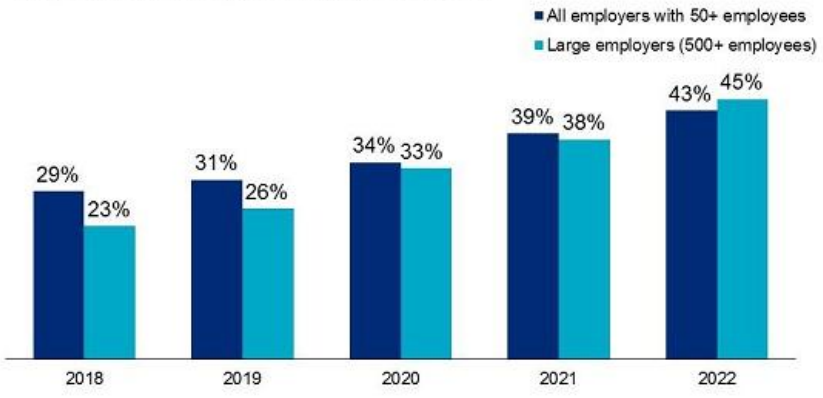

*Includes traditional indemnity plans beginning in 2013.

SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 4

**Over one-fourth of employers estimated to hit excise tax threshold in 2018**

Percentage of employers that will be subject to tax by the specified year if they make no changes to their current plans




Estimates based on data from Mercer's National Survey of Employer-Sponsored Health Plans 2015; premium trended at 6%, tax threshold trended at 3.7% for 2019 and 2.7% for future years

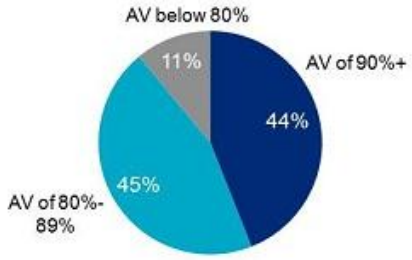
SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 5

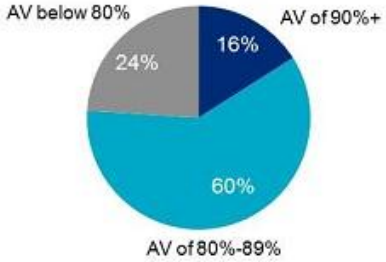
## More than one in ten of the plans estimated to hit the excise tax cost threshold in 2018 currently have actuarial values of less than 80%

Among large employers (500 or more employees)

Distribution of actuarial values of plans that will exceed tax threshold by 2018




Distribution of actuarial values of plans that will not exceed tax threshold by 2018




23% of large employers are estimated to have plans that will exceed excise tax threshold in 2018 (based on their 2015 medical plan premiums for the employer's highest-cost or only plan, trended forward at 6%; with the excise tax threshold trended at 3.7% for 2019 and 2.7% thereafter)

SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 6

## Big jump in CDHP offerings among large employers in 2015

Percent of employers offering/likely to offer CDHP, by employer size

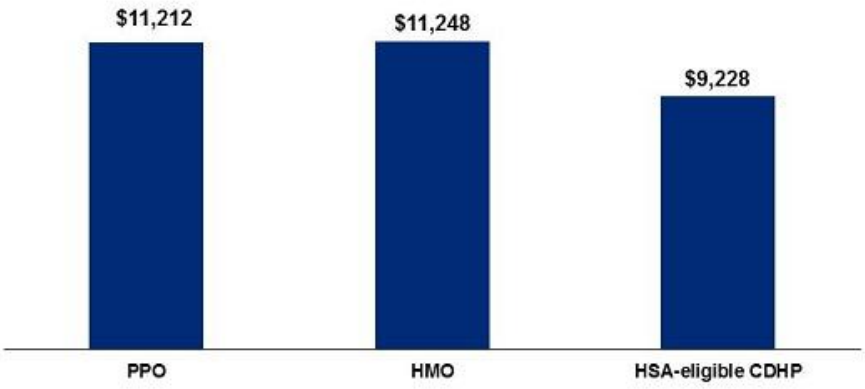
| Number of employees | 2011 | 2012 | 2013 | 2014 | 2015 | Expect to offer in 2018 |
|---|---|---|---|---|---|---|
| All employers (10+ employees) | 20% | 22% | 23% | 27% | 29% | 40% |
| All large employers (500+ employees) | 32% | 36% | 39% | 48% | 59% | 75% |
| Jumbo employers (20,000+ employees) | 48% | 59% | 63% | 72% | 73% | 85% |

SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 7

**How HSA-based CDHPs reduce excise tax exposure: They cost about 18% less than PPOs and HMOs in 2015**

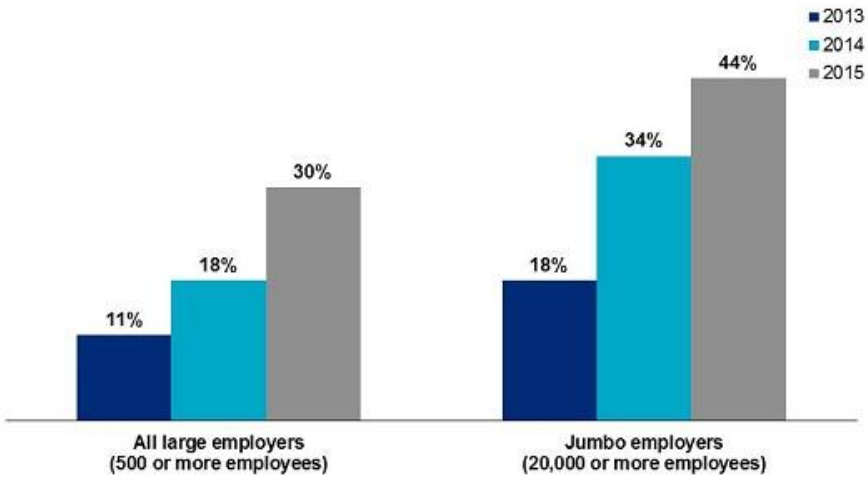
Medical plan cost per employee (includes employer contributions to HSA accounts)




SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 8

**Employers adding telemedicine services**




SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 9

**Broad range of programs support employee well-being**

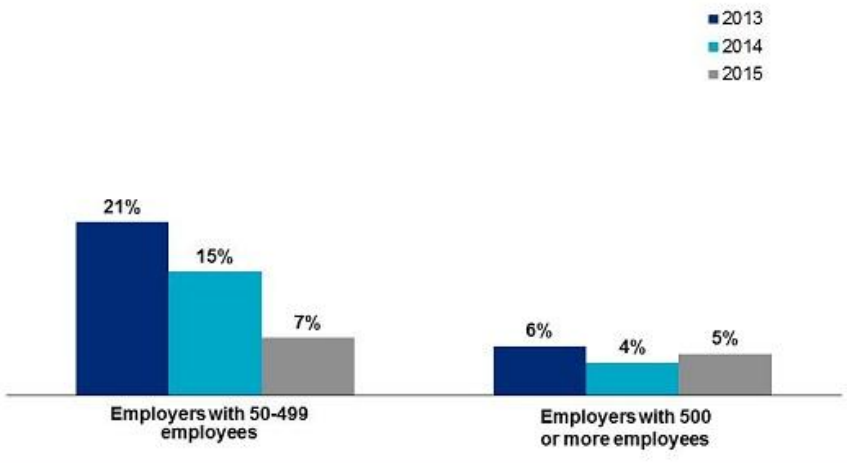
| | All large employers (500 or more employees) | Jumbo employers (20,000 or more employees) |
|---|---|---|
| "Wearables" to track physical activity | 24% | 38% |
| Health engagement mobile apps | 30% | 44% |
| Sleep disorder programs | 39% | 34% |
| Resiliency/stress management programs | 42% | 46% |
| Financial well-being programs | 69% | 86% |

SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

FIGURE 10

**Small employers changing their minds about dropping coverage**

Percent of employers that say they are "very likely" or "likely" to terminate plans within the next five years




SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans

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