High-performance insights — best practices in health care

Six years after Congress passed the Affordable Care Act (ACA), employers’ long-term commitment to providing health care benefits to employees continues to rebound.
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Executive summary

According to findings from our 21st Annual Best Practices in Health Care Employer Survey conducted in the summer of 2016, employers’ confidence that they will offer benefits 10 years from now rose to 54% in 2016 from 44% last year, more than double the lowest confidence levels in 2012 (23%). Even as questions grow about the law’s future, employers continue to focus on controlling costs and adopting solutions to improve the effectiveness of their health care programs.

Employers have good reason to continue their focus on costs: Trend is expected to rise more than last year (5% versus 4%) — and much higher than the general inflation trend. At that rate, total costs (for employer and employee) will approach $13,000 per person by 2017. As in recent years, employers continue to make changes to their plan designs to keep employee cost increases to a minimum. But in this prolonged period of relatively stagnant wage growth, they are increasingly concerned about affordability. By 2018, more than half will make changes specifically designed to lower premium contributions for low-wage workers and out-of-pocket costs at the point of service. Likewise, most offer account-based health plans with tax-advantaged health savings accounts, and many seed these accounts to help cover increased out-of-pocket costs. At the same time, a majority focus their most aggressive cost cutting on minimizing the most expensive and commonly over-used procedures, adopting cost-effective options to manage pharmacy spend (especially for high-cost specialty drugs) and redefining coverage for spouses who can obtain coverage from their own employers.

In addition, more employers are beginning to leverage new sources of higher quality care at lower cost through accountable care organization (ACO) developments, expansion of telemedicine services and increased use of data to drive care management decisions, which are dramatically changing the U.S. health care delivery system. Since where plan members receive medical care has a huge impact on cost — both for companies and employees — employers increasingly encourage the use of telemedicine (over emergency rooms) and centers of excellence (COEs) that have proven quality outcomes for treating expensive back, knee, cardiac and infertility issues. They are
Employers also realize that the healthier and more emotionally and financially secure their employees are, the more productive they are — a critical competitive advantage in a low-inflation world.

also moving to benefit designs that reduce employee costs by requiring or encouraging them to participate in other health-related activities.

With wages and productivity growing at historically low rates over many years, employers realize benefits matter more than ever to the employee value proposition (EVP). To remain competitive and appeal to a multigenerational workforce, they are making changes to position benefits as a core part of the EVP and looking at their health care subsidies in a Total Rewards context. Beginning with the 2017 enrollment season, employees will begin to see expanded choice of core medical and voluntary benefits, greater use of technology for decision support and an enhanced, consumer-style benefit shopping experience.

Employers also realize that the healthier and more emotionally and financially secure their employees are, the more productive they are — a critical competitive advantage in a low-inflation world. As a result, they have come to believe their well-being programs are critical to helping employees be their best at work each day. Three-quarters plan to focus on strategies that encourage healthy behaviors — and not just physical well-being. We also see a growing emphasis on supporting emotional, financial and social well-being as well — all to help employees manage the costs and risks they’ve assumed for their overall well-being. In fact, nearly nine in 10 respondents to our recent Behavioral Health Survey say behavioral health — which includes mental and addiction issues — is an important priority in the next three years. It remains to be seen how many of these employers take the opportunity to step up their actions to meet their high ambitions for a more productive workforce — and how those actions evolve.
Survey highlights

Cost management

Cost pressures — notably for specialty drugs — continue to drive employers to change their benefit programs. Nearly nine in 10 respondents (87%) identify rising pharmacy costs, specifically specialty drug costs, as their top priority over the next three years.

Respondents expect total health care spending (both employer and employee) to increase 5.0% in both 2016 and 2017, up from 4% in 2015. In absolute dollars, total per employee per year (PEPY) costs, including both employee and employer costs, are expected to rise to $12,339 in 2016 and nearly $13,000 in 2017. Although the current rate of cost increases is at an historically low level, it is still well above the rate of general inflation, even after employers make major changes to their programs. Without those changes, it is generally accepted that cost trends would be even higher: 6.0% in 2016 and 2017.

Size matters: In the absence of plan changes, midsize organizations would have faced the largest increases in costs (costs trends before changes ranging from 7% to 8%), and most plan to continue to make changes to their plan designs over the next year.

Industry matters: The energy and utilities industries have faced the most significant cost pressures over the last year (7%) and expect higher-than-average cost trends to persist in the coming year (6.3%). Companies in these sectors are most likely to identify changes in design value (73%) and pharmacy spend (73%) as their top priority over the next year.

Respondents expect total health care spending (both employer and employee) to increase 5.0% in both 2016 and 2017, up from 4% in 2015.
Employers make modest changes to plan design to make coverage more affordable for most employees, especially low-wage employees. In spite of cost pressures, most employers (81%) will continue to make relatively modest changes to their plan designs and subsidy levels to manage the overall efficiency of their programs, so costs are competitive and affordable to participants, especially lower-income workers. More than one-third of companies of all sizes modify plan designs to keep care affordable at the point of service (37%) and modify contributions to achieve affordable premiums for low-wage employees (also 37%). About 16% and 14% more companies, respectively, are planning to do the same over the next two years. With the growth of account-based health plans (ABHPs), 83% of ABHP sponsors seed their employees’ health savings accounts (HSAs) to help them cover the plan’s higher deductibles with average amounts of about $600 per year for single-only coverage and double that amount for employees with family coverage.

Employers refine subsidies to hold the line on costs. Conscious of keeping plans affordable, employers continue to look for ways to optimize plan performance. Their actions include levying surcharges for working spouses who have coverage from their own jobs and requiring employees to take certain actions to get the highest subsidy:

- Redefining spousal subsidies by adopting surcharges (28% today expected to nearly double by 2018)
- Linking contributions to employees taking specific steps (33% now could reach 57% in two years)

In addition, more companies use a defined contribution (DC) strategy than ever before – 25% today (up from 20% last year) with another 23% considering by 2018.

Size matters: Smaller organizations tend to embrace DC arrangements, while larger organizations use a variety of other steps to manage plan costs, including spousal surcharges and linking contributions to employee actions.

Industry matters: The information technology (IT) and telecom sector has embraced DC arrangements, while the health care sector has not. Spousal surcharges are used widely, except in the public sector.
Employers act most aggressively to curb the cost of specialty pharmacy, focusing on its utilization, delivery and rising prices. Escalating costs for specialty drugs continue to be employers’ top health care worry. With the average U.S. plan sponsor’s specialty costs expected to skyrocket, employers are taking note of new U.S. Food and Drug Administration (FDA) approvals of specialty drugs, including the new biologics. In 2015, first-time drug approvals in the U.S. reached a 19-year high with 77% for new specialty drugs, compared with 68% in 2014.

As a result, employers responding to our survey have taken or are planning to take a number of steps to control their specialty costs:

- Add new coverage/utilization restrictions: 61% today (up from 53% in 2015 and expected to reach 85% by 2018)
- Evaluate specialty drug costs through the medical benefit (39% today – up from 26% last year – with another 43% expecting to adopt the strategy by 2018)
- Adopt coverage changes to influence site of care (only 19% today but another 43% planning or considering by 2018)
- Establish different copays for specialty drugs to promote the use of less expensive biosimilars (18% today, which could triple in the next two years)

Size matters: The largest organizations are clearly out in front in taking actions on all aspects of their pharmacy spend, particularly specialty pharmacy, through coverage restrictions, evaluating utilization performance through the medical benefit and eliminating subsidies for retail.

Industry matters: Health care organizations are much more likely to evaluate and address specialty drug costs through the medical benefit and use different coverage levels to influence the site of care to less expensive sites.

Escalating costs for specialty drugs continue to be employers’ top health care worry.

With wages finally beginning to inch upward to attract and retain the best people, employers have more reasons than ever to look more closely at the rising cost of health care in a Total Rewards context.

Employers examine health care benefits in a Total Rewards context. The slower health care cost trends of the last few years have not made up for sluggish economic growth and low price inflation. With wages finally beginning to inch upward to attract and retain the best people, employers have more reasons than ever to look more closely at the rising cost of health care in a Total Rewards context – 43% are already doing so and another 37% plan to head in this direction over the next two years. Their goal: to better understand the competiveness of their rewards as health care benefits become a more expensive part of Total Rewards and to connect their health benefits more closely to their EVP.

Size (and industry) matters: There are few differences by industry, but larger organizations are more likely to take on a Total Rewards review of their health care benefits.

Record numbers adopting ABHPs as their only plan drives total increase in employee enrollment to more than 45%. In 2016, nearly 80% of companies across all industries have an account-based health plan, up from 53% in 2011, but the real news is the surge in employee enrollment in these plans from just 20% in 2011 to more than 45% this year. Credit for this uptick belongs to companies that have migrated to ABHPs as their only plan – representing nearly 25% of companies already offering an ABHP, up from 11% in 2012. These so-called total-replacement plans could nearly double (49%) by 2018, if employers follow through with their current plans. Most employers (85% of companies that offer an ABHP) pair their plan with a health savings account and another two-thirds of all companies without an HSA today plan to pair with one by 2018. The vast majority seed their accounts to help close the high-deductible gap with an average $600 for individual coverage and twice that for families.

Size (and industry) matters: ABHP employee enrollment rates are nearly 60% for the largest organizations compared with only 15% for those with less than 1,000 employees. The average of all companies is 45%. There is broad-based adoption of HSAs by all industry sectors.
Best performers use a variety of ways to create highly efficient health plans. Our research shows a great disparity in the total cost of health care across all companies and industries in our database (Figure 5, page 13), ranging from $8,668 to $15,830, with some companies exceeding $18,000 per employee per year. We identify 41 employers that have distinguished their health plans from other large and midsize companies by having more efficient programs and holding the line on health care cost trends to the rate of inflation. These best performers have created a cost advantage of $2,097 PEPY for a total cost of $10,080 in 2016 compared with the national average of $12,177 — an annual savings of $20 million at a company of 10,000 employees. They also maintain a two-year average cost trend of 1.7% after plan changes — roughly 2.8 percentage points lower than the national average (4.5%). While part of their lower trend is derived from plan design changes that shift costs to employees, most of their savings comes from greater efficiency. In fact, best performers maintain a gross trend (before plan design changes) of 3.0 percentage points lower than the national norm (3.0% versus 6.0%).

What's driving the variability? Best performers lead the way in developing high-performing health plans that manage cost through a variety of financial and plan levers and add value through value-based designs, networking strategies and strategies that engage employees in healthier lifestyles. Our research identifies the steps they take more than other employers to create the competitive advantage that sets them apart. We've used their steps to identify the best practices all employers can emulate (see Emerging trends, page 18). These practices focus on seven core areas driven by participation, subsidization and efficiency:

- **Participation**
  - Employee and dependent

- **Subsidization**
  - Program design value and subsidy level

- **Efficiency**
  - Vendor partner strategies
  - Health care delivery
  - Pharmacy management
  - Workforce health
  - Engagement and consumerism

Adding value through value-based payment strategies and designs, technology and member experience

Employers gain momentum in transitioning to value-based payment strategies. Employers have increasingly taken steps to control the overall demand for health care services by maximizing the value they receive from their health plans, contracted insurers and health care providers. Key strategies include:

- **Contracting with their health plan, separate health care provider or carve-out vendor for services at centers of excellence:** Today 45% give employees access to COEs for specialty services (such as back, knee, cardiac and infertility issues), up from 37% last year with another 32% planning it by 2018. Most employers (97%) today work with their health plans in establishing COEs. While only 17% reduce employee cost sharing at a COE today, that could triple to 54% by 2018.

- **Implementing high-performance networks (HPNs):**
  Today 20% offer narrow networks of high-quality, efficient medical service providers that provide affordable care for a defined population, up from 11% last year, with another 39% potentially adding them over the next three years, most through the health plan. Just above 50% of companies that offer a HPN reduce employee cost sharing, a percentage that is expected to expand right along with HPNs over the next two years.

- **Contracting directly with providers:** Few do so today, but nearly 16% of employers are considering this approach to secure improved pricing and greater value on medical services, COE services and accountable care organizations/patient-centered medical homes (ACO/PCMH) services.

- **Size matters:** COEs are largely not used by companies with fewer than 1,000 employees but are very popular among the largest organizations. Likewise, HPNs and direct contracting tend to be used by the largest companies (10,000 or more employees).

- **Industry matters:** HPNs and direct contracting are most popular with companies in the health care industry while COEs have been embraced by companies in the financial services sector and IT/telecom.
Employers place greater emphasis on value-based plan designs. At the same time, a few employers of all sizes and industries also embrace designs that encourage employees to utilize high-value services. Many more plan to move in this direction over the next couple of years.

- Reduce point-of-care costs for the use of high-value services (11% today but could reach 47% by 2018)
- Increase point-of-care costs for the use of commonly overused services (9% today but could reach 41% by 2018)
- Require employees who get certain types of medical procedures to pay a higher cost share if they do not get a second opinion (4% today but could reach 31% by 2018)

**Size (and industry) matters:** There are few differences by size and industry.

Employers embrace telemedicine – near universal adoption by 2018. Nearly 64% of companies of all sizes offer telemedicine services today, compared with only 11% in 2012. If companies follow through with their plans, telemedicine services could reach 92% by 2018. With behavioral health issues on the rise, many employers are also embracing tele-behavioral health and tele-psychiatry services (24% offer today; another 41% could offer by 2018).

**Industry matters more than size:** Companies in the financial services sector and IT/telecom have broadly adopted telemedicine for their workforces, while 41% of IT/telecom companies have already added tele-behavioral health. There are few differences by company size.

**Employers have new opportunity to broaden the measurement of health and well-being programs.** The growing number of new technologies and emerging value-based solutions create unprecedented opportunity for employers to access data on all aspects of their employees’ health and well-being, but how they harness that data and apply it in effective ways will be critical to their success in managing their programs now and in the future. Already, with most large companies across all industries realizing a healthy and financially secure employee is a more productive employee, their health and well-being programs are growing in importance and they routinely use medical claim data (75%) to inform decisions about them. Yet, far fewer employers have embraced both financial and nonfinancial metrics (39%) or lost-time metrics (12%). In building the business case for senior management, about two-thirds of organizations use a range of return on investment (ROI) and value on investment (VOI) metrics to support their investment decisions, yet remarkably that leaves one-third of all companies (and nearly half of smaller organizations) using neither ROI nor VOI calculations.

**Size (and industry) matters:** Measurement of all kinds has been embraced more robustly by larger organizations than smaller. There are few differences by industry sector.

**Improving employee experience for a multigenerational workforce**

**Employers connect health and well-being to their EVPs.** Seeking greater productivity and an edge in their hunt to attract and retain critical talent in a multigenerational workforce, the majority of employers (62%) indicate their workforces’ health and well-being is now a core part of their EVP – and not just their physical well-being. Recognizing the complex responsibilities employees – including Gen X and Gen Y (millennials) – face today for their own health and financial security, companies are expanding well-being programs to help employees enhance their emotional, financial and social well-being.

However, less than one-quarter differentiate their well-being programs by key workforce segments in order to improve employee experiences with their health plans – a step that would set them apart as they compete with other organizations for talent and productivity. Apparently, that is about to change.

*If companies follow through with their plans, telemedicine services could reach 92% by 2018.*
While 25% of companies plan to increase their use of incentives over the next three years, two-thirds plan to maintain their current levels and 10% plan to decrease or completely eliminate their use. These may be signs that organizations are rethinking their incentive strategies after many years of mixed success and persistent low engagement.

Four out of five employers (80%) of all sizes and sectors identify employee engagement and consumerism as a top priority over the next three years – managing pharmacy costs, and evaluating health program design value and subsidy levels. And more plan to follow their aspirations with concrete steps by 2018.

As employers align their health and well-being programs with their EVP and Total Rewards strategy, they identify three steps that improve choice and flexibility as critical to enhancing their members’ experience with their health plan:

- Choice in health plan (66%)
- Variety of types of benefits, including voluntary benefits and services (49% rising to 59% by 2018)
- Using technology to create a consumer-centric shopping experience for annual enrollment (24% rising to 38% by 2018)

Some employers are adding capabilities to wellness programs, such as lifestyle coaching and other onsite services, personal financial counseling, or fitness wearables available at low or no cost for tracking exercise activities or nutritional intake. Some use or plan to use mobile apps connected to wellness platforms that automatically send recommendations or reminders to prevent or manage health conditions. Some offer technology-based solutions to help employees evaluate, select, and enroll in and manage benefits — from private benefit exchanges with decision support tools (such as out-of-pocket calculators and recommendation engines that offer a consumer-like shopping experience) to web-based enrollment portals and mobile apps.

Employers rethink the effectiveness of financial incentives. Many organizations continue to use financial incentives as a way to boost participation in programs such as health assessments (73%), biometric screenings (78%) and tobacco cessation (43%). However, while 25% of companies plan to increase their use of incentives over the next three years, two-thirds plan to maintain their current levels and 10% plan to decrease or completely eliminate their use. These may be signs that organizations are rethinking their incentive strategies after many years of mixed success and persistent low engagement. It appears, based on these trends, we may have reached a tipping point.

- Maximum opportunity is $927 per year today compared with $882 last year, but the pace is slowing.
- Use of rewards drops 10 percentage points (from 77% in 2015 to 67% today).
- Use of penalties declines from 27% in 2015 to 18% today.
- There is no growth in the use of biometric outcomes (17% today) and fewer employers are considering it for 2018 compared with previous years (19% today versus 52% in 2013).

Size matters: Large organizations are much more likely to offer financial incentives, particularly tobacco surcharges. While most organizations plan to maintain their current incentives, service sector companies are most likely to increase their use while manufacturing and energy companies are most likely to reduce them.

Industry matters: Manufacturing companies are more likely to use penalties and surcharges for tobacco use.
Beyond incentives: Employers build healthy workplace environments. Three-quarters of companies will increasingly focus on strategies to build the health and well-being of the workplace to encourage healthy behaviors. Organizations are engaged in a range of activities, including those that encourage more physical activity at the workplace (61%) and better nutrition (59%), and those that create excitement by tapping into the social networks in the organization (34%) to promote healthy lifestyles.

Size matters: Large organizations are clearly leading the way in all aspects of building a healthy environment.

Industry matters: IT/telecom and health care emphasize enhancements to the physical environment to encourage healthy behaviors.

Three-quarters of companies will increasingly focus on strategies to build the health and well-being of the workplace to encourage healthy behaviors.
About the survey

The survey was completed by 600 employers, between June and July 2016, and reflects respondents' 2016 health program decisions and strategies and, in some cases, their 2017 and 2018 plans. Respondents collectively employ 12.2 million full-time employees, and operate in all major industry sectors. In this analysis, we focus on the 540 companies that have 1,000 or more employees, but selectively provide additional information about the differences between midsize and large markets and across various industries.

Figure 1. Number of full-time workers employed by respondents

- 200 to 999: 171
- 1,000 to 4,999: 121
- 5,000 to 9,999: 134
- 10,000 to 24,999: 60
- 25,000+: 114

Figure 2. Region where the majority of benefit-eligible workforce is located

- National: 15%
- Northeast region: 11%
- Southeast region: 21%
- North Central region: 21%
- South Central region: 23%
- West region: 9%

Figure 3. Industry groups

- Energy and Utilities: 10%
- Financial Services: 7%
- General Services: 9%
- Health Care: 14%
- IT and Telecom: 9%
- Manufacturing: 28%
- Public Sector and Education: 13%
- Wholesale and Retail: 10%
Costs and experience: keeping plans affordable

While the annual cost increases of employer-sponsored health care are still at historically low levels, employers face the highest trend in three years (Figure 4) as a result of dramatic increases in pharmacy costs, notably for specialty drugs.

Employers expect total health care costs (both employer and employee) to increase 5% in both 2016 and 2017 after plan design changes, a full percentage point over last year’s increase (4%) and a rate much higher than the anticipated inflation rate (about 1.5 to 2.0%). That translates to $12,339 per employee per year in 2016, up from $11,750 in 2015, and $12,954 in 2017. Without plan changes, cost trends would have been 6.0% in each year, which is also up a full percentage point from last year (5%).

This trend rate, plus continual cost shifting to employees over the years, raises concerns about some employees’ ability to afford health care. Employees are paying, on average, 23.2% of total premium costs in 2016. In paycheck deductions, this translates into an average annual employee contribution of $2,862 in premiums in 2016, which could rise to nearly $3,000 per year in 2017 under current plan designs.

To keep their health care plans affordable, employers plan to make only moderate across-the-board changes to cost-sharing provisions in the next year. Instead, they will focus their most aggressive actions on changing coverage provisions for costly services — notably to the highly expensive and fast-growing numbers of specialty drugs — and to imposing surcharges for spouses and, less frequently, dependents.

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have begun to align their HR and Finance functions to look at benefits in a Total Rewards context (43%) are best positioned to assess both the cost and talent implications of future benefit decisions. An additional 37% expect to join these leaders over the next two years.

Industry and company size: Do they matter?

Major differences exist between low- and high-cost industries and between the smallest and largest companies (Figure 5). For instance, energy and utility companies saw increases of 7% in 2016 and expect 6.3% in 2017 versus the average of 5%. Without changes, companies with fewer than 5,000 employees would have increased from 7% to 8% versus the average of 6%. See other noteworthy size and industry differences throughout the report.
Figure 4. **Health care cost increases before and after plan design changes**

- Health care trend after plan changes (total plan costs)
- Health care trend before plan changes
- Consumer Price Index for all urban consumers (CPI-U)

Sample: Based on respondents with at least 1,000 employees.
Notes: Median trends for medical and drug claims for active employees, including both employer and employee contributions but excluding employee out-of-pocket costs; CPI-U extracted from the Department of Labor, Bureau of Labor Statistics
*Expected

Figure 5. **Wide variance of costs across industries**

$20,000
$15,000
$10,000
$5,000

**Retail/Wholesale**
- 10th percentile: $7,782
- 25th percentile: $9,566
- Average: $10,532
- 75th percentile: $12,047
- 90th percentile: $15,830

**Manufacturing**
- 10th percentile: $7,004
- 25th percentile: $9,362
- Average: $10,651
- 75th percentile: $11,824
- 90th percentile: $13,990

**Financial Services**
- 10th percentile: $8,700
- 25th percentile: $9,232
- Average: $10,612
- 75th percentile: $11,062
- 90th percentile: $12,339

**Health Services**
- 10th percentile: $9,283
- 25th percentile: $9,362
- Average: $10,651
- 75th percentile: $11,824
- 90th percentile: $13,448

**Technology**
- 10th percentile: $4,2
- 25th percentile: $5,5
- Average: $6,4
- 75th percentile: $6,8
- 90th percentile: $14,574

**Energy/Utilities**
- 10th percentile: $4
- 25th percentile: $5
- Average: $5
- 75th percentile: $5
- 90th percentile: $15,937

**Pharmaceuticals**
- 10th percentile: $5
- 25th percentile: $5
- Average: $6
- 75th percentile: $5
- 90th percentile: $15,937

**Total database**
- 10th percentile: $4
- 25th percentile: $5
- Average: $6
- 75th percentile: $5
- 90th percentile: $15,937

Sample: Companies with at least 500 employees
Source: High-Performance Insights — Best Practices in Health Care: 2016 Health Care financial benchmark survey
Employers continue to show dramatic differences in their abilities to manage their health care cost trends. Our research identified 41 companies that qualify as best performers based on their abilities to manage cost trends and efficiency.

Best-performing companies must exhibit the following two characteristics:

- **Efficiency:** Two-year average efficiency (2015 to 2016) that is 5% or greater (roughly 60th percentile and above) (additional explanation below)
- **Cost trend:** Two-year average trend after plan changes (2014/5 and 2015/6) that is below the national norm (5% in 2016) and two-year average trend before plan changes (2014/5 and 2015/6) that is below the national norm (6% in 2016)

We selected best performers from the 252 companies with at least 1,000 employees that completed the last two years of the Willis Towers Watson Financial Benchmark Survey and this year’s Best Practices Survey. The 41 best performers represent 16% of eligible companies reporting both favorable efficiency and cost trends before and after plan changes at or below the national average. We project best performers will pay $2,097 PEPY less than other companies in our national survey ($10,080 in 2016 compared with the national average of $12,177 — an annual savings of $20 million at a company of 10,000 employees). They also maintain a two-year average cost trend after plan changes of 1.7% — roughly 2.8 percentage points lower than the national average (4.5%). While plan design changes have helped to mitigate their cost increases, best performers also maintain a two-year average gross trend (before plan design changes) of 2.2 percentage points lower than the national norm (3.3% versus 5.5%).

**About efficiency**

The national benchmark is adjusted to reflect differences between the PEPY costs of an organization and the database for each of these four key criteria:

- **Age/Gender:** The age/gender profile of the population (Cost is directly correlated with age. The impact of gender on expected cost varies with age.)
- **Family size:** The estimated number of members covered per employee, expressed in terms of adult cost equivalents (Larger-than-average family size usually increases costs per employee.)
- **Geography:** The underlying cost for basic health care services in an area (Provider competition and more prevalent managed care plans may reduce costs in some areas. More enrollments in higher cost areas usually increase costs.)
- **Plan value:** The level of benefits covered under your medical plan (Plans reimbursing a higher percentage of medical expenses than the database average usually increase costs.)
The result of these adjustments is a benchmark that is customized to each company's population. The custom benchmark is the database cost if the database looked like that company’s population with its plan designs. Efficiency represents the percentage that a company's PEPY costs are above or below the custom benchmark with the most efficient plans reporting costs significantly below the adjusted national norm.

What can we learn from best performers?
Best-performing companies lead the way in developing high-performing health programs that manage costs and add value, in part by implementing superior network and provider strategies. Throughout the rest of this report, we identify specific tactics that best-performing companies are doing much more than the national average or other organizations — best practices focused on our seven core areas:

- **Participation**
  - Employee and dependent
- **Subsidization**
  - Program design value and subsidy level

- **Efficiency**
  - Vendor partner strategies
  - Health care delivery
  - Pharmacy management
  - Workforce health
  - Engagement and consumerism

While many factors can explain the reasons for best performers holding the line on costs, these activities are likely an important part of their recent success, and many are emerging trends that could position them — and those who emulate them — for success in the future. While best performers are leading the way, there is plenty of opportunity for all companies to take actions to rein in costs and improve the performance of their health care programs.

Measuring total plan costs: Where do we get our data?
For the second year, total plan costs for this study are being based on Willis Towers Watson's annual Financial Benchmark Survey, which includes detailed medical plan cost values on 1,142 companies with more than 9.2 million enrollees and total costs of over $108.5 billion. By incorporating the use of this deep and broad database in our annual Willis Towers Watson Best Practices in Health Care Survey, we enhance our ability to provide detailed annual plan costs for over 20 industry groups. These cost data are adjusted for demographic, geographic and design factors, and as a result, help us evaluate how efficiently companies' health plans are performing. This significant change enables participating employers to gain a richer understanding of how well their plans are performing compared with those of others at a level of detail that is unmatched by any other survey data source in the marketplace. For fully insured medical and pharmacy plans, the costs presented reflect premium rates. For self-insured plans, the costs reflect premium equivalencies, which include company contributions to medical accounts such as HRAs and HSAs, health management program costs and program participation incentives paid by the plan, and administration costs. In total, nearly 74% of respondents to the Willis Towers Watson Best Practices in Health Care Survey participated in the Willis Towers Watson Financial Benchmark Survey.
In order to cover the country’s millions of uninsured prior to its enactment, the ACA set out to improve the cost, quality and effectiveness of health care in the U.S. By the time it became law in 2010, early in the financial crisis recovery, employers’ confidence that they would still be able to offer the benefit over the long term had already begun its precipitous decline from a high of 73% in 2008 to a low of 23% in 2012, 26% in 2013 and 25% in 2014 (Figure 6). Last year, following the Supreme Court ruling on the law’s constitutionality, we saw the first confident step up — to 44%. This year, despite employers’ well-founded concern about cost, 54% say they will offer health care in 10 years, more than double the lowest confidence levels. In a clear sign that they understand the importance of benefits in recruitment and retention, employers continue to turn their sights to more aggressive cost controls and solutions to improve the effectiveness of their health care programs. They are confident their actions can pay off even as questions grow about the law’s future.
Specialty pharma in the crosshairs

Employers’ top priority for the next three years is managing pharmacy costs, specifically specialty drugs (88%) (Figure 7). It’s no wonder, given that spending on specialty drugs is expected to skyrocket, becoming the fastest growing health care cost. Employers are taking note of new FDA approvals of specialty drugs, including the new biologics. In 2015, first-time drug approvals in the U.S. reached a 19-year high with 77% for new specialty drugs, compared with 68% in 2014.

In addition to changes in design and specialty drug management, look for employers to focus on engagement and consumerism with actions to increase participant engagement in health and well-being (80%), workforce health (71%), vendor partner strategy (68%) and health care delivery (63%).

What are Biologics? How do they differ from Biosimilars?

Biologics are medicines made from living organisms. In recent years, some have transformed the quality of life for patients afflicted with many chronic conditions, such as rheumatoid arthritis, psoriasis and cancer. However, many of these drugs are among the most costly therapies available today.

Biosimilars are the more affordable versions of biologics. As more biosimilar products are approved by the FDA and enter the market, the hope is that increased competition will help drive down costs and provide greater patient access to these life-saving drugs in the way that generics have.

Yet unlike generics, biosimilars are not exact copies of the originator biologics they mimic. They are approved based on a determination of clinical similarity to the medicines they reference when it comes to safety and effectiveness. Physician and patient confidence that biosimilars will work as well as the originator products they reference will play a significant role in the kind of traction biosimilars will have in the U.S.

As the majority of employers become much more aggressive about strategies to control costs and improve program effectiveness, a number of emerging trends continue to evolve in the areas that make up the Willis Towers Watson framework (above) for best practices for a high-performing health plan.

By looking at the strategies and tactics our best performers leverage (see Best performers win big, page 14) to achieve a per person annual cost advantage of over $2,000, we have identified best practices in each of these emerging trends. Employers can look closely at these practices to learn how best performers lead all other companies in developing a high-performing health plan. In almost every case, the companies that pay the highest for employee health care (average $15,800) trail both the best performers ($10,080) and national average companies ($12,177) significantly in their use of best practices to lower cost and raise the efficiency of their plans — putting themselves at a distinct competitive disadvantage.

**Emerging trends**

*Willis Towers Watson framework for best practices for a high-performing health plan*

- **Vendor partner strategy**
  Determine entities best positioned to help you deliver on your strategy

- **Health care delivery**
  Maximize purchasing value of health care services

- **Workforce health**
  Identify and effectively manage population health risks

- **Engagement and consumerism**
  Increase participant engagement through shared accountability

- **Pharmacy**
  Manage specialty drug costs and leverage cost-effective options

**Employee and dependent participation**

Single most significant predictor of per employee health costs

**Program design value and subsidy level**

Define financial commitments based on overall program value

Employers can look closely at these practices to learn how best performers lead all other companies in developing a high-performing health plan.
Participation: Employee and dependent

More employers than ever address their affordability concerns by charging more to families, especially spouses with coverage from their own jobs, than they do for single coverage (Figure 8). To avoid across-the-board increases to all employees, more than 60% charge more to cover spouses, rising from 56% last year. More than half charge more to cover children, up from 46% last year. Over the next two years, those numbers are set to increase with 80% charging more to cover spouses and 62% planning to charge more to cover children by 2018. In addition, nearly a third of employers use spousal surcharges when other coverage is available from the spouse’s own job, with almost twice as many planning to do so by 2018. Only employees who cover other family members pay contributions in tiers, along with the spousal surcharge.

The amount of surcharge varies across industries, ranging from a high of $1,500 for energy and utility companies to a low of $600 for public sector and education; the most common for all sizes of companies across all industries is $1,200.

Best practices: Participation

Spousal surcharge (when other coverage is available)
- 37% of best performers
- 28% of national average = best performers lead by 9%
- 21% of high-cost companies = best performers lead by 16%

Structure contributions on a per-dependent-covered basis
- 7% of best performers
- 5% of national average = best performers lead by 2%
- 2% of high-cost companies = best performers lead by 5%

More employers than ever address their affordability concerns by charging more to families, especially spouses with coverage from their own jobs, than they do for single coverage.
The trend to ABHPs as employers’ only plan

Eighty-two percent of employers plan to offer ABHPs in 2017, up from 53% five years ago (Figure 9). And now that 24% offer them as their only plan (up from 11% in 2012), employee enrollment — a key metric of these plans’ success — is also surging. Median employee enrollment hit 45% in 2016, compared with 20% five years ago.

The majority of companies that offer ABHPs also offer alternative plans, but many tip the scales in favor of their employees choosing their ABHP. Over half that offer both will subsidize employee premiums in 2017 at a higher level than other plan options, rising to 61% in 2018. With the growth of ABHPs and members’ higher exposure to point-of-care costs, almost all employers that offer ABHPs in 2017 will also include an HSA (91%), the dominant account model — up from 70% five years ago — and the vast majority (83%) will seed their employees’ HSAs to help them close the high-deductible gap. Average seed amounts are about $600 per year for single-only coverage and double that amount for employees with family coverage.

In addition, 41% promote the value of ABHPs with a year-round communication strategy, jumping to 68% in 2017 and 80% in 2018. Moreover, as more and more of their workforces age into a retirement mindset, 50% of employers will incorporate education on the benefits of HSAs into their retirement planning tools next year, compared with only 28% in 2016.

At the same time, in an effort to better understand the long-term effects of these plans on employee behavior and workforce health, many employers are interested increasingly in using data to inform their strategy. They have begun to evaluate behavior against objectives (e.g., costs and utilization metrics, program participation), rising from just 37% in 2015 to 57% that plan to do it in 2017 and 72% in 2018.
Subsidization: Program design value and subsidy level

With the economy growing more slowly than health care costs, employers continue their struggle to balance changing plan design to control company costs and keeping health care affordable for employees. More than one-third (37%) of companies of all sizes are taking steps to modify their plan designs to achieve affordable care at the point of service and to modify contributions to achieve affordable premiums for low-wage employees, jumping to over 50% in the next two years (Figure 10).

Importantly, 43% of employers now review health care benefits in a Total Rewards context to understand their ability to attract and retain the best employees in an increasingly competitive marketplace, which is expected to double within two years based on those that are planning or considering it. About a third offer lower costs to employees who take specific steps (33%), such as completing a health assessment, with nearly twice that many planning to by 2018. Just a quarter use a DC arrangement, but that could nearly double by 2018 (48%) based on those that are planning or considering it.

Size matters: Companies of all sizes are examining affordability within their plan designs. Smaller organizations tend to embrace DC arrangements, while larger organizations use a variety of other steps to manage plan costs, including spousal surcharges and linking contributions to employee actions.

Industry matters: Companies in the health care sector are most focused on modifying contributions for low-wage employees and ensuring point-of-care costs are affordable. The IT and telecom sector has embraced DC arrangements, while the health care sector has not. Spousal surcharges are used widely except in the public sector.

Figure 10. Changes in contribution strategies to keep health care affordable

<table>
<thead>
<tr>
<th>Action taken/ Tactic used</th>
<th>Planning for 2017</th>
<th>Considering for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review health care benefits in a Total Rewards context</td>
<td>43%</td>
<td>12%</td>
</tr>
<tr>
<td>Structure employee contributions based on employees taking specific steps (e.g., completing a health assessment, biometric screening or physical activity requirements)</td>
<td>33%</td>
<td>4%</td>
</tr>
<tr>
<td>Modify plan designs to achieve affordable care at point of service (i.e., out-of-pocket costs)</td>
<td>37%</td>
<td>4%</td>
</tr>
<tr>
<td>Modify contributions to achieve affordable premiums for low-wage employees</td>
<td>37%</td>
<td>4%</td>
</tr>
<tr>
<td>Use a defined contribution arrangement (i.e., employer’s share of premiums are the same for all plans in a common tier)</td>
<td>25%</td>
<td>4%</td>
</tr>
<tr>
<td>Structure employee contributions based on employee compensation levels</td>
<td>24%</td>
<td>4%</td>
</tr>
<tr>
<td>Offer a skinny or minimum-value plan (also referred to as a minimum essential coverage, or MEC, plan)</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>Use a “pure” defined contribution strategy (i.e., flat dollar amount that is the same for all employees regardless of plan type or tier)</td>
<td>4%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Sample: Companies with 1,000-plus employees

Best practices: Subsidization

Modify contributions to achieve affordable premiums for low-wage employees
- 41% of best performers
- 37% of national average = best performers lead by 4%
- 28% of high-cost companies = best performers lead by 13%

Use a DC arrangement (i.e., employer’s premium share is same for all plans)
- 27% of best performers
- 25% of national average = best performers lead by 2%
- 16% of high-cost companies = best performers lead by 11%

Structure employee contributions based on compensation levels
- 27% of best performers
- 24% of national average = best performers lead by 3%
- 16% of high-cost companies = best performers lead by 11%
Efficiency: Vendor partner strategies

Employers continue to aggressively monitor their many health care vendor partners offering a variety of services — from telemedicine to centers of excellence. They are focused on performance guarantees; health management programs; and requiring vendors to share data for employee outreach, integrated reporting and strategic planning to improve collaboration.

Not surprisingly, employers are laser-focused on choosing the right vendors to begin with. They consider much more than just the best competitive discounts, which nearly every company considers extremely important today (90%) — even the outliers that pay the most for health care (84%) (Figure 11). Today most also look seriously at a much wider range of criteria, including the vendor’s total cost of care (91%), ability to lower cost of care through health and medical management programs (84%), availability of performance guarantees to monitor vendor outcomes (75%), reimbursement based on quality, improved efficiency and better outcomes (68%), willingness to partner with a third party (65%), upgraded reporting (64%) and availability of COEs (55%).

Figure 11. Factors in selecting a health plan vendor

<table>
<thead>
<tr>
<th>Category</th>
<th>Extremely important</th>
<th>Somewhat important</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competitiveness of the vendor’s total cost of care (e.g., discounts, health management, gaps in care, member engagement)</td>
<td>91%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Competitiveness of the negotiated provider discounts</td>
<td>90%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Vendor’s ability to lower the cost of care through health management and medical management programs</td>
<td>84%</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Availability of performance guarantees to monitor vendor outcomes</td>
<td>75%</td>
<td>21%</td>
<td>4%</td>
</tr>
<tr>
<td>Vendor’s emphasis on adopting reimbursement methodology based on cost, quality, improved efficiency and better outcomes</td>
<td>68%</td>
<td>28%</td>
<td>4%</td>
</tr>
<tr>
<td>Willingness to partner with third parties (e.g., price transparency, high-performance networks, health management vendors)</td>
<td>65%</td>
<td>26%</td>
<td>8%</td>
</tr>
<tr>
<td>Employer reporting demonstrating results/effectiveness of new contracting strategies</td>
<td>64%</td>
<td>29%</td>
<td>7%</td>
</tr>
<tr>
<td>Availability of centers of excellence (COEs)</td>
<td>55%</td>
<td>34%</td>
<td>11%</td>
</tr>
<tr>
<td>Availability of telemedicine solutions integrated with health plan</td>
<td>48%</td>
<td>31%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Best practices:
Vendor partner strategies

Competitiveness of negotiated provider discounts
- 95% of best performers
- 90% of national average = best performers lead by 5%
- 84% of high-cost companies = best performers lead by 11%

Availability of performance guarantees
- 83% of best performers
- 75% of national average = best performers lead by 8%
- 77% of high-cost companies = best performers lead by 4%

Willingness to partner with third parties
- 68% of best performers
- 65% of national average = best performers lead by 3%
- 60% of high-cost companies = best performers lead by 8%

Offer high-performance networks
- 22% of best performers
- 20% of national average = best performers lead by 2%
- 14% of high-cost companies = best performers lead by 8%
Dramatic changes in health care delivery — including the development of ACOs, increased technology use, telemedicine, more data collection and correlation with care, and more self-service opportunities for patients — continue to impact employer plans significantly. A growing number of employers seeking to achieve better health outcomes for employees at a lower cost implement value-based reimbursement and payment arrangements with their health insurers and health care providers. As employers grapple with how to lower the cost of health care without lowering quality, they are increasingly looking to pay health care providers for health outcomes instead of the services they provide. Today, these strategies are more common in geographies where employers have large concentrations of employees or where cost-efficient providers are available and willing to engage in emerging reimbursement models. But this is just the start of a much larger transition — a move from a health care delivery system based on fees for services to a more patient-centric system based on fees for value or outcomes.

Nearly half (45%) use centers of excellence, up from just 37% last year, with another 32% considering it by 2018. Most work with their health plan in establishing a COE (97%). While only 17% reduce employee cost sharing at a COE today, that could triple by 2018 (54%) (Figure 12). Similarly, employers expect their use of high-performance networks to grow significantly along with reducing employee cost sharing for use of an HPN. Only 20% offer HPNs today, but that's nearly twice last year’s amount (11%), and it could grow to nearly 60% by 2018.

Few (8%) are contracting directly with providers today, but nearly 16% of employers are considering it to secure improved pricing and greater value on medical services, and services from COEs and ACOs/PCMHs.

As health care delivery transforms, nearly 64% of companies of all sizes and industries offer telemedicine services today (Figure 13), compared with only 11% in 2012. If companies follow through with their plans, telemedicine services could reach 92% by 2018. With behavioral health issues on the rise, many employers, notably in IT/telecom (41%), are also embracing tele-behavioral health and tele-psychiatry services (24% offer today; another 41% could offer by 2018).
In addition, employers are beginning to change design to drive plan value by encouraging employees to use higher-quality, more efficient and lower-cost services. (Figure 14). For instance, nearly one-third (32%) require employees to participate in health-related activities, which 25% more are planning or considering by 2018. Few are using other value-based design changes, but we see that changing based on the growth of those that are planning or considering them by 2018. The plan design features expected to grow in usage include:

- **Reducing point-of-care costs for the use of high-value services:** 11% of employers do this today, but the number could reach 47% by 2018.
- **Increasing point-of-care costs for the use of commonly overused services:** 9% do so today, but the number could grow to 41% by 2018.
- **Requiring employees who get certain types of medical procedures to pay a higher cost share if they do not get a second opinion:** 4% do so today, but the number could reach 31% by 2018.

**Best practices:**

**Health care delivery**

*Health care delivery is a top priority of health care actions*

- 41% of best performers
- 26% of national average = best performers lead by 15%
- 24% of high-cost companies = best performers lead by 17%

**Value-based designs in medical plan that reduce point-of-care costs for high-value services**

- 12% of best performers
- 11% of national average = best performers lead by 1%
- 7% of high-cost companies = best performers lead by 5%

**Require employees to pay higher cost share for certain medical procedures**

- 7% of best performers
- 4% of national average = best performers lead by 3%
- 0% of high-cost companies = best performers lead by 7%

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**Figure 14. Value-based designs in the medical plan**

<table>
<thead>
<tr>
<th>Action taken/ Tactic used for 2016</th>
<th>Planning for 2017</th>
<th>Considering for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require employees to participate in other health-related activities (e.g., complete a biometric screening or participate in a lifestyle management program) to receive reduced employee cost sharing through the benefit design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use value-based designs in the medical plan that reduce point-of-care costs for use of high-value services supported by evidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use value-based designs in the medical plan that increase point-of-care costs for use of specific services that are commonly overused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require employees who get certain types of medical procedures to pay a higher cost share if they do not first seek additional input (e.g., second-opinion services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use reference-based pricing in the medical plan (e.g., consumer pays cost over a preset limit)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sample: Companies with 1,000-plus employees
Efficiency: Pharmacy

Employers are taking more aggressive action to stem the rapid growth in pharmacy trend. Today 63% of employers evaluate their pharmacy benefit contract terms, up from 60% last year – growth that is poised to jump to 94% by 2018. More than half exclude compound drugs, preventing pharmacies from charging high costs to customize prescriptions unnecessarily, up from just 39% last year, and set to jump to 65% by 2018 (Figure 15). Large employers have felt the pain of the practice more than others and they lead the way with 65% excluding compounds versus only 15% of small employers. Similarly, 74% of large companies evaluate their benefit contract terms versus only 34% of small companies.

While only 15% of employers currently invest in employee education and partner with vendors to stem the tide of opioid use, its disastrous effects on nearly every community will drive nearly half to do so by 2018.

Value-based health care strategies on the rise

Value-based health care strategies include both design and reimbursement strategies.

Value-based design describes a member benefit that charges members lower out-of-pocket costs for services proven to be valuable to their long-term health. For instance, health plans are mandated under the ACA to offer full coverage for preventive care because it is considered to be of substantially higher value than other services and, therefore, is covered more generously.

Value-based contracting describes how providers are reimbursed. It is a health plan reimbursement approach that pays health care providers based on the value they deliver to patients under their care, rather than the volume of services they deliver. Value is increasingly defined as the quality of the service and the results, or outcome, actually achieved. For instance, providers who have lower surgical complication rates might get higher reimbursements because their outcomes are better. To genuinely improve the care of their patients, value-based providers or health systems need to support sophisticated technology and to align value incentives for all key stakeholders: providers and health systems, and patients and payers.

Notably, employers are also turning their attention to developing strategies to control the spiraling costs of specialty drugs, which are expected to skyrocket. Many have taken or are planning to take a number of steps to control their specialty costs (Figure 16):

- Add new coverage/utilization restrictions (61% today – up from 53% in 2015 and expected to reach 85% by 2018)
- Evaluate specialty drug costs through the medical benefit (39% today – up from 26% last year – and expected to reach 82% by 2018)
- Adopt coverage changes to influence site of care (19% today and expected to reach 62% by 2018)
- Establish different copays for specialty drugs to promote the use of biosimilars (18% today, which could triple in the next two years)

**Size matters:** Smaller organizations tend to promote use of biosimilars through different copays; otherwise, the largest organizations are clearly out in front in taking actions on specialty pharmacy through coverage restrictions and eliminating subsidies for retail.

**Industry matters:** Health care organizations are much more likely to evaluate and address specialty drug costs through the medical benefit and use coverage changes to influence the site of care at less expensive sites.

### Best practices: Pharmacy

**Evaluate your pharmacy benefit contract terms**
- 73% of best performers
- 63% of national average = best performers lead by 10%
- 60% of high-cost companies = best performers lead by 13%

**Offer narrow retail network**
- 17% of best performers
- 14% of national average = best performers lead by 3%
- 5% high-cost companies = best performers lead by 12%

---

**Figure 16. Specialty pharmacy strategies**

<table>
<thead>
<tr>
<th>Tactic used in 2016</th>
<th>Planning for 2017</th>
<th>Considering for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt new coverage or utilization restrictions as part of your specialty pharmacy strategy (e.g., require prior authorization or quantity limits based on clinical evidence)</td>
<td>61%</td>
<td>10%</td>
</tr>
<tr>
<td>Evaluate and address specialty drug costs and utilization performance through the medical benefit</td>
<td>39%</td>
<td>22%</td>
</tr>
<tr>
<td>Implement coverage changes to influence site of care for specialty pharmacy through your medical benefit</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>Establish different copays for specialty drugs to promote use of biosimilars</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Eliminate subsidy or don’t cover specialty pharmacy through retail</td>
<td>25%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Sample: Companies with 1,000-plus employees
Three-quarters of companies increasingly focus on strategies to build the health and well-being of the workplace to encourage healthy behaviors (Figure 17), involving a wide range of investments, including manager involvement, communication, social norming, affinity groups to building and contracting with onsite health centers. A majority of companies (62%) indicate health and well-being is a core part of their EVPs. Employers of all sizes and sectors have high aspirations for focusing on health care engagement and consumerism but need to follow it up with action (see Engagement and consumerism, page 29). Less than one-quarter take the steps needed to set them apart as they compete with other organizations for talent. The good news is they are committed to change. Over half (53%) say boosting employee engagement in health and well-being is one of the top priorities over the next year — just behind managing medical plan and pharmacy costs. Also, 80% identify employee engagement and consumerism as a top priority over the next three years (see Figure 7, page 17).

Driving the commitment is the realization that the healthier and more financially secure their employees are, the more productive they are — a critical competitive advantage in a low inflation world. While physical well-being has been a priority of organizations for many years (61%), there is a growing emphasis on supporting the emotional (36%), financial (28%) and even social (24%) well-being of employees (Figure 18).
Emotional support programs include adding coaching and wellness to employee assistance programs (54% with another 16% planning or considering it by 2018), flexible working options (60% with another 9% planning or considering it by 2018), manager training and coaching targeted to reducing stress (24% with another 29% adding it by 2018), companywide stress or mental health strategy or action plan (18% rising to more than half [51%] by 2018), and resilience training (20% more than doubling by 2018).

Employers show considerable interest in financial well-being programs with 40% of employers including it as a key part of their overall well-being strategy and another 35% planning or considering by 2018. Programs range from third-party counselors who promote financial well-being (e.g., debt management, wise spending) and student loan counseling and repayment assistance to comprehensive tools, seminars and education. However, in spite of robust vendor activity, employer take-up of these programs is off to a slow start. Standing in the way of aggressive action is an immature vendor market with many inexperienced companies jumping into it. Having been burned by missteps in the early days of the physical wellness market, employers are being careful about choosing their partners. They want to get it right the first time in this arena.

Best practices:
Workforce health

Provide flexible working options (e.g., flex hours, work from home, summer sabbaticals)
- 73% of best performers
- 60% of national average = best performers lead by 13%
- 56% of high-cost companies = best performers lead by 17%

Ban use of tobacco on entire campus
- 51% of best performers
- 48% of national average = best performers lead by 2%
- 40% of high-cost companies = best performers lead by 11%

Offer/incent use of stress or resilience management
- 20% of best performers
- 15% of national average = best performers lead by 5%
- 18% of high-cost companies = best performers lead by 2%

Use data for targeted outreach on health and well-being programs or gaps in care
- 44% of best performers
- 37% of national average = best performers lead by 7%
- 32% of high-cost companies = best performers lead by 6%

Offer weight management programs
- 76% of best performers
- 72% of national average = best performers lead by 4%
- 70% of high-cost companies = best performers lead by 6%
Efficiency: Engagement and consumerism

With wages and productivity growing at historically low rates over many years, employers realize benefits matter more than ever in order to remain competitive and appeal to a multigenerational workforce. As a result, they are aligning their health and well-being programs with their EVPs and their Total Rewards strategies and taking steps that improve choice and flexibility and enhance their members’ experiences with their health plan. Beginning with the 2017 enrollment season, employees will begin to see (Figure 19):

- Expanded choice in health plan (66%)
- Expanded choice in voluntary benefits and services (49% rising to 59% by 2018)
- Enhanced, consumer-style benefit shopping experience (24% rising to 38% by 2018)
- Greater use of technology for decision support

Some employers are adding capabilities to wellness programs, such as lifestyle coaching or fitness wearables available at low or no cost for tracking exercise activities or nutritional intake. Some use or plan to use mobile apps connected to wellness platforms that automatically send recommendations or reminders to prevent or manage health conditions (Figure 20). Some offer technology-based solutions to help employees evaluate, select, enroll in and manage benefits – from private benefit exchanges with decision support tools (such as out-of-pocket calculators and recommendation engines that offer a consumer-like shopping experience) to web-based enrollment portals and mobile apps (Figure 21). While few employers have moved to a private exchange to enroll active employees in health benefits, nearly 17% are planning or considering it by 2018, and some are adopting aspects of private exchanges to their self-managed programs.


Employers realize benefits matter more than ever in order to remain competitive and appeal to a multigenerational workforce.
Figure 20. Mobile apps for health and well-being

<table>
<thead>
<tr>
<th>Mobile applications for condition management or reducing health risks</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action taken/ Tactic used in 2016</td>
<td>29</td>
<td>15</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action taken/ Planning for 2017</td>
<td>31</td>
<td>6</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action taken/ Considering for 2018</td>
<td>26</td>
<td>9</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sample: Companies with 1,000-plus employees

Figure 21. Decision support

<table>
<thead>
<tr>
<th>Support for enrollment decisions (e.g., plan cost calculations, algorithm-driven recommendations)</th>
<th>0%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action taken/ Tactic used in 2016</td>
<td>53</td>
<td>11</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action taken/ Planning for 2017</td>
<td>23</td>
<td>8</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sample: Companies with 1,000-plus employees

Best practices:

**Engagement and consumerism**

- **Support for enrollment decisions**
  - 61% of best performers
  - 53% of national average = best performers lead by 7%
  - 45% of high-cost companies = best performers lead by 16%

- **Well-being program focused on physical health**
  - 68% of best performers
  - 61% of national average = best performers lead by 7%
  - 53% of high-cost companies = best performers lead by 16%

- **Offer choice in health plan options**
  - 78% of best performers
  - 66% of national average = best performers lead by 12%
  - 64% of high-cost companies = best performers lead by 14%

- **Reward or penalize smokers**
  - 66% of best performers
  - 46% of national average = best performers lead by 20%
  - 55% of high-cost companies = best performers lead by 10%
Use data to achieve high-performing health plans

A growing number of new technologies and emerging value-based solutions are creating unprecedented access to data on all aspects of employees’ health and well-being. In fact, companies of all sizes and across all industries could do more with medical claim data to achieve high-performing health plans. Less than half (44%) have articulated a measurement strategy, but that seems destined to change quickly — with an additional 32% either planning or considering to have one by 2018 (Figure 22).

Driving their interest may be growing recognition that a healthy and financially secure workforce drives productivity, making employer-sponsored health and well-being programs even more important in today's slow-growth economy. As companies continue to invest more in these programs, they will take greater advantage of data to learn what works and what doesn't.

Most companies (75%) routinely use data to inform decisions about their health and well-being programs. Yet, they leave out an effective component when they don’t embrace nonfinancial metrics (only 39% use both financial and nonfinancial) or lost-time metrics (only 12%) (Figure 23).

About two-thirds of organizations, mostly the largest, share a range of ROI and VOI metrics with senior management to build a business case for their investment decision. Nearly half of smaller organizations don’t use either.

Companies of all sizes and across all industries could do more with medical claim data to achieve high-performing health plans.
Next steps for employers: Learn from the best performers

- **Examine health care benefits in a Total Rewards context**: Make changes to plan design and account contributions that consider affordability for low-wage employees.

- **Understand your population health**: Use growing opportunities to measure and analyze your health care data in ways critical to forming the right health care strategies and selecting programs that will support your health care goals. Broaden measurement to include nonfinancial metrics.

- **Take action to curb the cost of specialty pharmacy**: Focus on price, utilization and delivery/site of care.

- **Improve employee engagement** by reviewing program structure, vendor partners and incentive strategy.

- **Consider care extenders**, such as telemedicine and onsite/near-site clinics, to enhance employee access, productivity and convenience in a cost-effective manner for both medical and behavioral health conditions.

- **Place greater emphasis on value-based arrangements** through plan designs that encourage employees to utilize high-value services (quality and cost effectiveness) to maximize the value they receive from their health care benefit.

- **Improve employee behavioral health** through enhanced navigation support, integrating behavioral health with medical and disability conditions and effective support for complex behavioral health issues.

- **Put employees at the center** of the health care strategy:
  - Enhance the member experience through more choice with decision support.
  - Expand well-being programs to address financial issues alongside physical, emotional and social.
  - Adapt the workplace environment to encourage good health habits.
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