



**DRIVING
INNOVATION
IN EMPLOYER
HEALTH
BENEFIT
DESIGN**



Employment-based benefits drive more than 50 percent of health care in the United States.¹

And large employers, as the biggest segment, are at the wheel. Government officials, insurers, employers, and patients are working to find solutions to contain, or lower, costs. No doubt there are serious issues with affordability, access to care, and perverse financial barriers that don't make sense to beneficiaries. But, unlike what some would want us to believe, the system is not entirely broken. Many things work well and repairs can be made that don't require an entire engine overhaul.

Rather than mandates via regulation or legislation, we should first explore alternative ideas around plan design and incentives for patient engagement and consumer-empowerment. Given the size of the commercial market, and even the self-insured commercial market, employers have a responsibility to show how the marketplace is working for patients and improving health outcomes.

Employers with a stable workforce (low turnover rate) can, and often do, take the long view on health outcomes and budget impact. The health of our workers and our ability to offer quality benefits are too important. There are many natural experiments already occurring in plan design and benefit offerings aimed at reducing overall system costs. Or, more specifically, reduce patient out-of-pocket expenses (cash flow).

Let's ground the debate with a baseline set of information, discuss the issues that are unique to the U.S., consider trade-offs, and figure out practical ways to move good ideas forward.

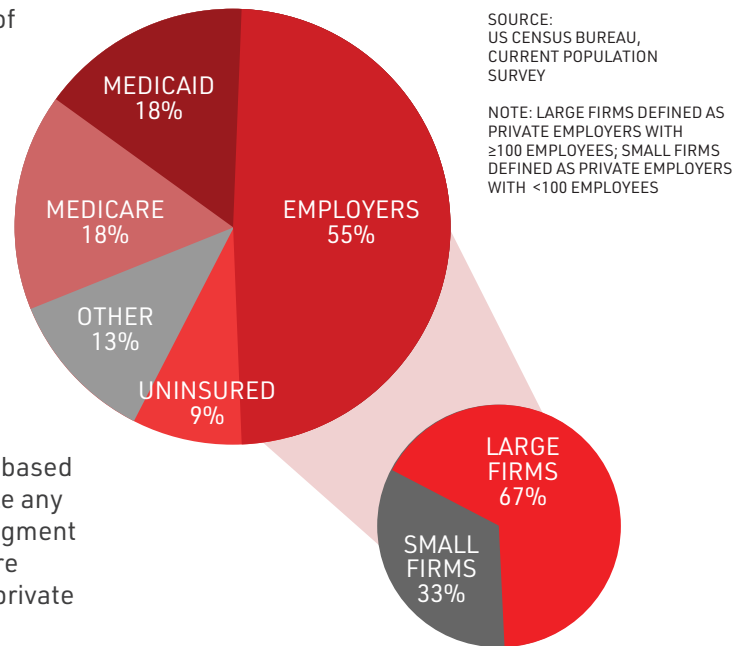
The goal of this report is to drive a discussion about what large employers can do to make the current system work better for their employees. For example, in 2020, our benefit plan will reduce patient out-of-pocket costs to zero for insulins. We'll examine the evolution of our plan design, the recent steps we've taken, and, most importantly, the results. Ultimately, the intent of the analysis and future dialogue is to encourage broader adoption of private market solutions to problems that exist in commercial markets. Employers can show a better way forward for U.S. health care.

Dave Ricks
Chairman and CEO

INTRODUCTION

Health care is an essential benefit for American employees and employers. As of 2018, total health care spending in the United States (U.S.) rose 4.6 percent to \$3.6 trillion, or almost 18 percent of the U.S. gross domestic product.² These rising costs present challenges for many employees, especially when paired with monthly premiums that often exceed the rate of inflation.³ As the largest segment of insurers in the nation, employers address these challenges on the front lines for the employees in their organizations and for the market as a whole. More than 178 million Americans receive employer-based private insurance plans—more than double any other type of plan.¹ The biggest single segment is large employers - those with 100 or more employees - who cover 67 percent of the private workforce.

FIGURE 1: 2019 HEALTH INSURANCE COVERAGE OF TOTAL U.S. POPULATION



ORIGINS OF EMPLOYER-BASED HEALTH COVERAGE

Employers have played a central role in shaping health insurance in America as far back as the turn of the 20th century. The industrial revolution, a period of economic growth, brought an influx of jobs at steel mills and factories around the U.S. These jobs often came with a high risk of injury and led, in part, to labor unions and some employers offering sickness protections.

KEY TERMINOLOGY

TERM	DESCRIPTION
First-Dollar Coverage (FDC)	Refers to a policy in which insurance covers health care expenses without first meeting a deductible. ⁵
Zero-Dollar Coverage (ZDC)	Refers to a policy in which there is no patient cost-sharing for select preventive services or medicines, meaning there will be no charge at the pharmacy. ⁵
Health Savings Account (HSA)	A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. ¹³
Health Reimbursement Account (HRA)	A tax-exempt account that can be used to pay for current or future qualified health expenses. ¹³
Rebates	A discount that occurs after drugs are purchased from a pharmaceutical manufacturer and involves the manufacturer returning some of the purchase price to the purchaser. ¹⁴

During World War II, U.S. businesses were prohibited from offering higher salaries in an effort to fight inflation. Determined to recruit and retain talent, employers began offering the earliest iterations of today's employer-sponsored health insurance. This benefit became popular with employees because they did not have to pay income or payroll taxes for it. Tax reforms in 1954 further incentivized the adoption of health plan sponsorship among employers, which in large part laid the foundation for the prevalence of employer-sponsored health plans today.⁴

MODERN EVOLUTION OF HEALTH INSURANCE

The need for affordable and accessible health care brought foundational improvements that helped shape the U.S. health care system into the institution we see today. In the 1950s, many health insurance plans incorporated more coverage options, such as vision and dental benefits. Although employees enjoyed more benefit options, anyone unemployed, including retirees, struggled to afford health insurance. In 1965, the U.S. government created what is now called the Center for Medicare & Medicaid (CMS) to ensure health care for older adults and for low-income workers. Later, in 1997 the U.S. government established the Children's Health Insurance Program (CHIP) to cover children in low-income families.⁴

THE RISE OF HDHPs

As a result of rising health care costs, conventional fee-for-service plans declined in the early 1990s as managed care plans such as HMOs and PPOs grew in popularity. These plans typically featured small deductibles and modest co-pays. They came with some administrative restrictions and financial disincentives for choosing out-of-network providers and non-favored medicines.

But because health care spending continued to rise, many employers turned to high-deductible health plans (HDHPs) to reduce costs and incentivize informed use of coverage. For 2020, the IRS defined an HDHP as any plan with a deductible of at least \$1,400 for an individual or \$2,800 for a family.⁵ Also referred to as consumer-driven health plans (CDHPs), these plans were intended to give employees more control and transparency for their health care decisions. HDHPs also allow employers to maintain lower premiums while shifting some financial responsibility to employees. They may be combined with a tax-advantaged health reimbursement account (HRA) or health savings account (HSA) to help offset out-of-pocket costs for employees.

FOR 2020, THE IRS DEFINES AN HDHP AS ANY PLAN WITH A DEDUCTIBLE OF AT LEAST \$1,400 FOR AN INDIVIDUAL OR \$2,800 FOR A FAMILY⁵

HDHPs began to gain some traction when HSAs were signed into law in 2004 by President George W. Bush. Following the Great Recession of 2008 and enactment of the Affordable Care Act (ACA) in 2010, which expanded health coverage and required individual mandates on health insurance for U.S. taxpayers, the use of HDHPs steadily increased.³ As of 2018, HDHPs covered as much as 46 percent of all Americans with private health insurance (Figure 2).⁶

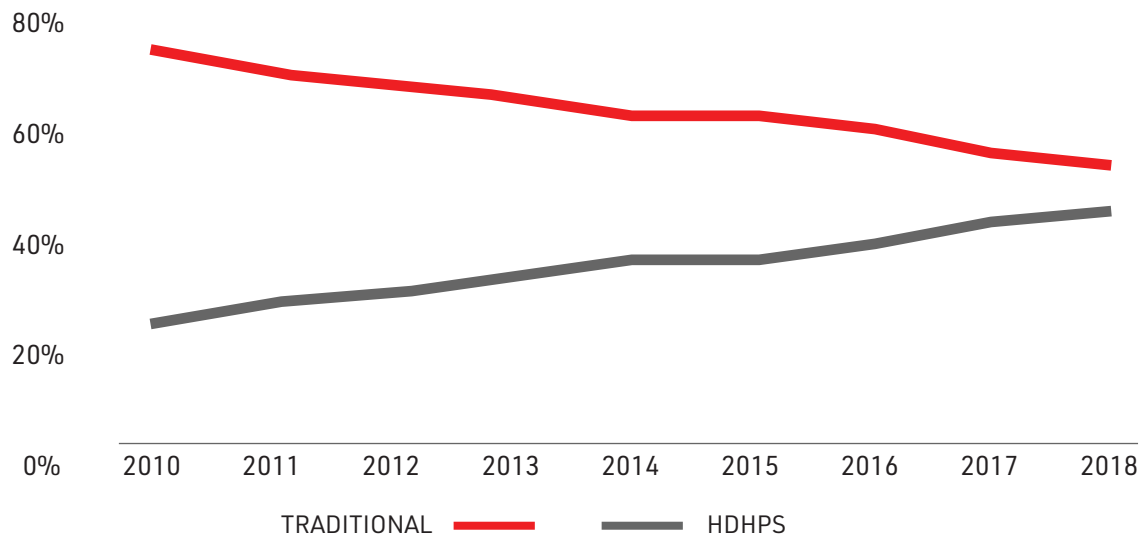


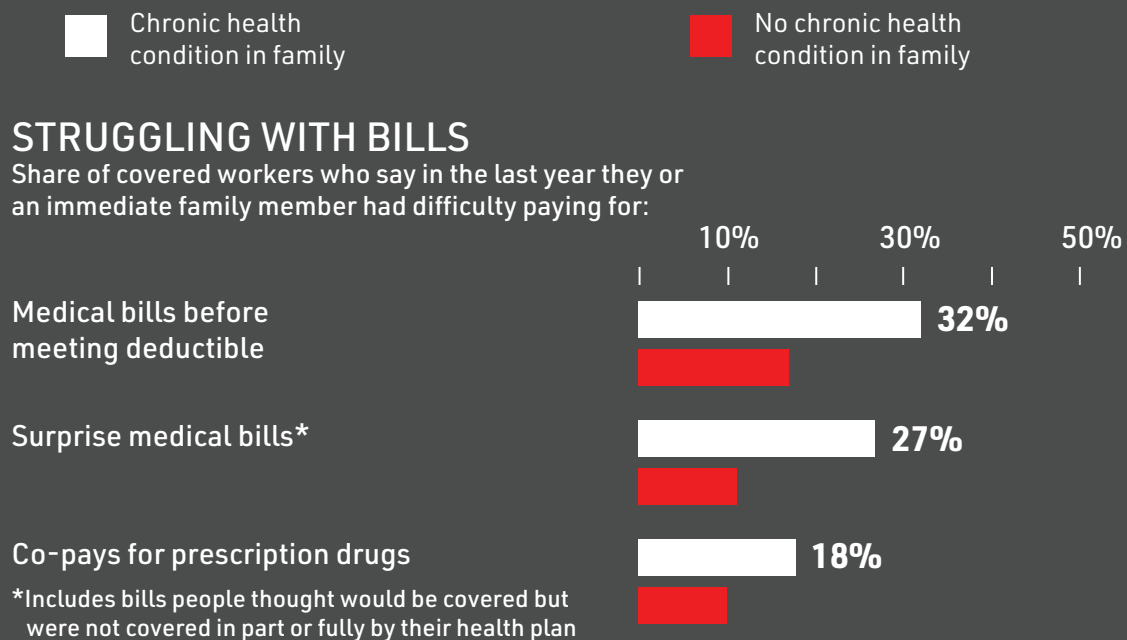
FIGURE 2: PERCENTAGE OF PERSONS UNDER AGE 65 ENROLLED IN PRIVATE HEALTH COVERAGE BY PLAN TYPE: UNITED STATES, 2010-MARCH 2018

SOURCE: ADAPTED FROM NCHS, NATIONAL HEALTH INTERVIEW SURVEY, 2010-2018, FAMILY CORE COMPONENT

HDHPs AND CHRONIC DISEASES

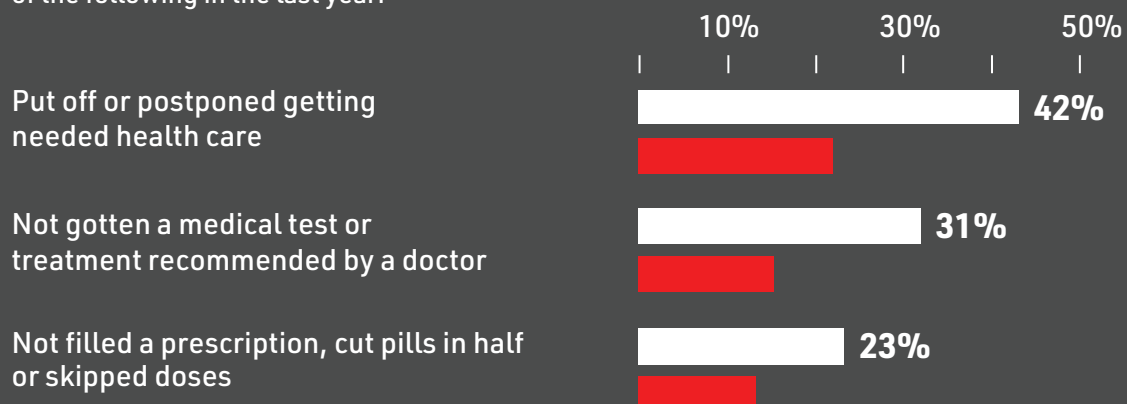
Chronic diseases and their complications are responsible for 90 percent of all health care costs.⁷ But people with chronic diseases have struggled to pay for the frequent medical care they need, especially when covered by HDHPs. Surveys by the Kaiser Family Foundation show that, among employees covered by HDHPs, those with a chronic disease (or a family member with a chronic disease) are about twice as likely to delay needed care or struggle to pay their medical bills (Figure 3). Delaying care for a chronic disease can lead to poorer health for employees and their families, and higher costs for employers down the road.⁸

FIGURE 3: SICK AMERICANS HIT HARDEST BY HEALTH CARE COSTS



DELAYING CARE

Workers or an immediate family member has done each of the following in the last year:



SOURCE: KFF/LA TIMES SURVEY OF ADULTS WITH EMPLOYER-SPONSORED HEALTH INSURANCE, 2018

CASE STUDY: LILLY HEALTH PLAN

Treating her Type 1 diabetes is a constant expense for Angela McDaniel, a mom of three in Indianapolis. She uses medicines, insulin pumping equipment, and blood testing supplies daily that, at list prices, would cost nearly \$1,500 a month.

Angela's job at Eli Lilly and Company gives her an HDHP—where she must pay the first \$3,100 in expenses—and 10 percent after that. This would make the first two months of every year extremely expensive for Angela.

But Angela, 44, uses the \$2,000 she receives from Lilly each January in her health reimbursement account to pay for her diabetes medicines and supplies. Lilly also exempts insulin from its deductible, meaning Angela only ever pays 10 percent of her insulin costs—about \$50 a month instead of \$500.

**BEGINNING
JANUARY 1, 2020,
ANGELA WILL FACE
NO COSTS AT ALL
FOR HER INSULIN
— BECAUSE LILLY WILL
REDUCE CO-INSURANCE
ON INSULIN TO \$0.**

In addition, Lilly helps lower patients' costs by passing through rebates from pharmaceutical companies to consumers like Angela at the pharmacy counter. That reduces Angela's out-of-pocket costs for another medicine she takes to control her blood sugar after meals.

Affordable access to the modern medicines and pumps that keep her diabetes under control made it possible for Angela to work full time and have kids. "If I had been born 20 years earlier," she said, "I wouldn't have been able to have this life with children."



PLAN DESCRIPTION

For more than a decade, all employees at Lilly have been enrolled in HDHPs, paired with either a health savings account (HSA) or health reimbursement account (HRA).

Yet Lilly has implemented multiple policies to reduce or even eliminate patients' out-of-pocket costs for essential and chronic medicines.



Lilly pre-funds its members' HSAs and HRAs in January, so they have money to help pay for medicines and other medical care—regardless of whether they need care in December, when their deductible has been met, or in January, when it hasn't.



Lilly exempts a broad list of preventive medicines from the deductibles in its health plans, meaning plan members pay 10 percent or 20 percent of those medicines' prices, but not the full retail price.



Health costs were further reduced in 2018, when Lilly worked with its pharmacy benefit manager, CVS Caremark, to pass through rebates on prescription medicines directly to members at the point of sale.



Beginning in 2020, Lilly will reduce co-insurance to zero for insulins, meaning members will pay nothing at all for insulin.

The cost impacts have been modest. Combined with modest trade-offs in other parts of Lilly's health benefits, Lilly has maintained and even expanded its efforts to reduce patient cost-sharing. Yet premiums in Lilly's health plan over the past five years have grown 3 percent on average—below the trend among all employers.³

Lilly's addition of rebate pass-through in 2018 caused health premiums to rise less than 1 percent. In the first year of that program, more than 11,000 plan members saved nearly \$3 million on their medicines—an average of \$265 per patient.

SURMOUNTING ADMINISTRATIVE HURDLES

Lowering cost-sharing for its employees and their families can require additional time and money for Lilly's self-insured health plan. But Lilly has found the trade-offs worthwhile.

FIRST-DOLLAR COVERAGE

It is fairly easy administratively to exempt preventive medicines from the deductibles of HDHPs—a policy known as first-dollar coverage. Lilly's outside pharmacy benefit manager, CVS Caremark, maintains a preventive drug listing of products that it excludes from deductibles for many employers. Nearly all PBMs do the same.

The costs of exempting preventive medicines is often debated—but rigorous analyses have found minor increases or even savings.

A 2019 Milliman analysis concluded that exempting insulin from the deductibles of HDHPs would increase premiums only 0.43 percent—while saving insulin-users an average of \$1,162 on insulin out-of-pocket costs each year.⁹

And CVS Caremark has found that co-pays of \$0 on a broad list of preventive drugs actually save \$70 annually per person in a health plan, because lower co-pays lead to better adherence and better health.¹⁰

IN 2018



11,000
PLAN MEMBERS

SAVED NEARLY



\$3 MILLION OR
\$265/PATIENT

ON AVERAGE
MEDICINE COSTS

UPFRONT CONTRIBUTIONS

Also easy to administer is making contributions to HSAs and HRAs all at once in January. In fact, it's easier to make a one-time contribution via the regular payroll process than it would be to make those payments with every paycheck.

One challenge can be cash flow. Fewer than half of employees in HDHPs with HSAs receive any contribution from their employers.³ And among employers that do contribute, not all can afford to provide the entire year's contribution at the beginning of the year. But John Scharf, Lilly's senior advisor of health plan strategy and operations, said moving toward more upfront funding improves the experience for employees—who "can't predict if they'll get sick in January or June."

Another challenge can be turnover. If an employer funds its workers' HSAs in January, some of those employees are bound to leave the company before the year ends. Funds in an HSA, unlike those in an HRA, are owned by employees and follow them when they leave a company.

In Lilly's case, the loss of funds from its low turnover rates was negligible, but companies with higher turnover rates could see a bigger impact.

REBATES AT THE POINT OF SALE

Lilly had the most administrative work to set up rebates at the point of sale.

Lilly's PBM, CVS Caremark, estimates the size of each rebate a patient should receive at the pharmacy counter (or on a pharmacy mail order). Then, once a quarter, Lilly's benefits staff reviews data from CVS to determine if a "true up" is necessary.

"There is a fee for the service, and you are adding some work," Scharf said. But it is feasible, he said, as most PBMs now have the technology to provide rebates at the point of sale.

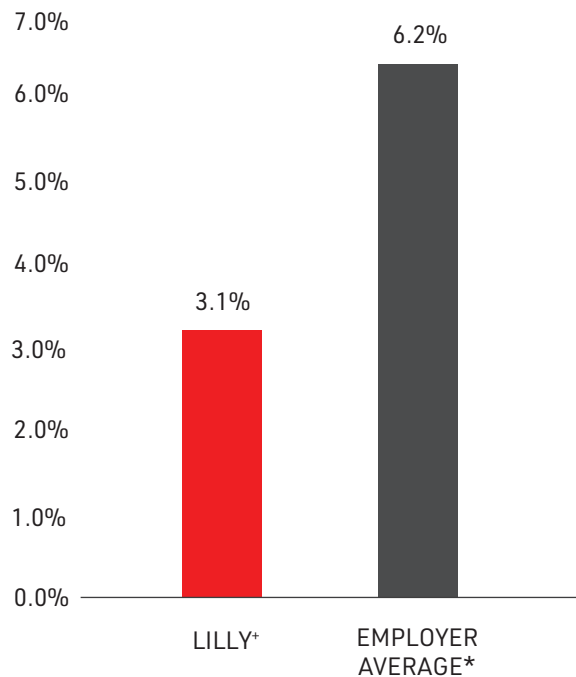
Lilly's change in premiums was smaller than it would be at many other employers—because the Lilly plan had already been using the rebates its health plan received to lower both the company's and its employees' share of premiums.

By contrast, two-thirds of employers do not use rebates from prescription drugs to reduce employees' premiums or costs, according to a 2018 survey by the Pharmacy Benefit Management Institute. At those employers, instituting a program of rebates at the point-of-sale would impact premiums more.¹¹

Still, the overall impact appears modest. A 2017 analysis by Milliman estimated that passing through rebates to patients would, for an HDHP with co-insurance, **raise premiums by less than \$1 per member per month**.¹²

While the above programs do require some incremental cost and effort to implement, Lilly's leadership regards these as worthwhile investments to control the long-term costs of the health plan while helping employees and their families remain healthy.

ANNUAL HEALTH SPENDING GROWTH
2014-2018



*COMPOUND ANNUAL GROWTH RATE PER PARTICIPANT IN LILLY EMPLOYEE HEALTH PLAN

*PWC MEDICAL COST TREND: BEHIND THE NUMBERS 2019

LOOKING AHEAD: FROM CONSUMER DRIVEN TO CONSUMER EMPOWERED

As we enter the 2020s, Lilly is just one of many employers making efforts to shift from consumer-driven health plans into consumer-empowered benefits. More employers are offering lower cost-sharing for key medical therapies known to be high-value—improving employees' health and saving employers money. And they're taking into account employees' ability to shoulder the financial responsibility of high deductibles. We hope these experiments continue—and catch on.

To make that happen, CEOs and CFOs throughout corporate America need to get more engaged. Benefits are not a core competency for most employers, and most leaders have understandably tried to outsource or delegate the task. But that approach isn't working. The financial costs of health benefits are higher than ever. Yet employee satisfaction is tepid – which in today's tight labor market is a recipe for losing talented workers. Also, with calls to replace the private health insurance market, the task of preserving a flexible, innovative free market that allows choice now requires active leadership from the C-suite. Executives can make the long-term decisions and trade-offs needed to do health benefits differently – and better.

So we encourage our employer peers to take an increasingly assertive role in health benefits. If we all do that, we can drive greater value in health care and empower our most valuable asset—our people—to keep themselves and their families as healthy and productive as possible.

EXAMPLES OF EMPOWERMENT

Cummins Engine Company recently created a two-tier structure for its contributions to employees' health savings account. For workers making less than \$50,000, Cummins deposits \$400 more into their HSAs than it does for higher-paid workers.

The University of Michigan Center for Value-Based Insurance Design (V-BID) has worked with multiple private and public employers to implement benefit plan designs that create easier access or lower cost-sharing (or both) for health care services with strong evidence for being a good value for their cost. But for therapies shown to be low-value, V-BID reduces access or raises cost-sharing (or both).

Huntington Ingalls Industries, America's largest military shipbuilding company, offers a telemedicine benefit for \$10 per session. This benefit gives employees low-cost, 24-hour access to medical care for such things as sinus and ear infections, flu and skin conditions. It also provides dermatology care and behavioral health support.

CVS Health shared a percentage of the rebates its health plan received from pharmaceutical manufacturers to reduce out-of-pocket costs for its employees and their dependents. By reducing their costs, CVS Health saw adherence rates rise by 6 percent—meaning more of its health plan members were taking the medicines they had been prescribed.

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KEY TERMINOLOGY

TERM	DESCRIPTION
Centers for Medicare & Medicaid Services (CMS)	Formerly known as the Health Care Financing Administration, CMS is a federal agency within HHS responsible for Medicare, Medicaid, and State Children's Health Insurance Program. ¹⁴
Children's Health Insurance Program (CHIP)	Enacted in 1997, CHIP is a federal-state program that provides health care coverage for children in low-income families that are not eligible for Medicaid. ¹³
Chronic Care	Health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. ¹³
Coinsurance	A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met. ¹³
Copayment	A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. ¹³
Cost-sharing	A feature of health plans where beneficiaries are required to pay a portion of the costs of their care (e.g. copayments, coinsurance, annual deductibles). ¹³
Deductible	A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount before insurance begins to pay for health care services. ¹³
Fee-for-Service (FFS)	A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. ¹³
Health Maintenance Organization (HMO)	An entity that provides, offers, or arranges for coverage of designated health services generally within network needed by members for a fixed, prepaid premium. ¹⁴
High-deductible health plan (for 2019)	The IRS defines a high-deductible health plan as any plan with a deductible of at least \$1,350 for an individual or \$2,700 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than \$6,750 for an individual or \$13,500 for a family. (This limit doesn't apply to out-of-network services.) ¹⁵
High-deductible health plan (for 2020)	The IRS defines a high-deductible health plan as any plan with a deductible of at least \$1,400 for an individual or \$2,800 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than \$6,900 for an individual or \$13,800 for a family. (This limit doesn't apply to out-of-network services.) ¹⁵

TERM	DESCRIPTION
Individual Mandate	An ACA requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. ¹³
Medicaid	Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. ¹³
Medicare	Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older. ¹³
Out-of-Pocket (OOP) Costs	Health care costs, such as deductibles, copayments, and coinsurance that are not covered by insurance. Out-of-pocket costs do not include premium costs. ¹³
Out-of-Pocket (OOP) Max	A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost. ¹³
Pharmacy Benefit Managers (PBMs)	Organizations that manage pharmacy benefits for managed care organizations, other medical providers, or employers. ¹⁴
Preferred Provider Organization (PPO)	A managed care delivery model consisting of preferred networks of providers with some out-of-network coverage. ¹⁴
Premium	The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers and individuals. ¹³
Preventive-care benefits	A list of items or services, including those with specified chronic conditions described in IRS Notice 2019-45, that may be provided without satisfying the applicable deductible for an HDP. ⁵
Self-insured Health Plan	A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. ¹³

Lilly