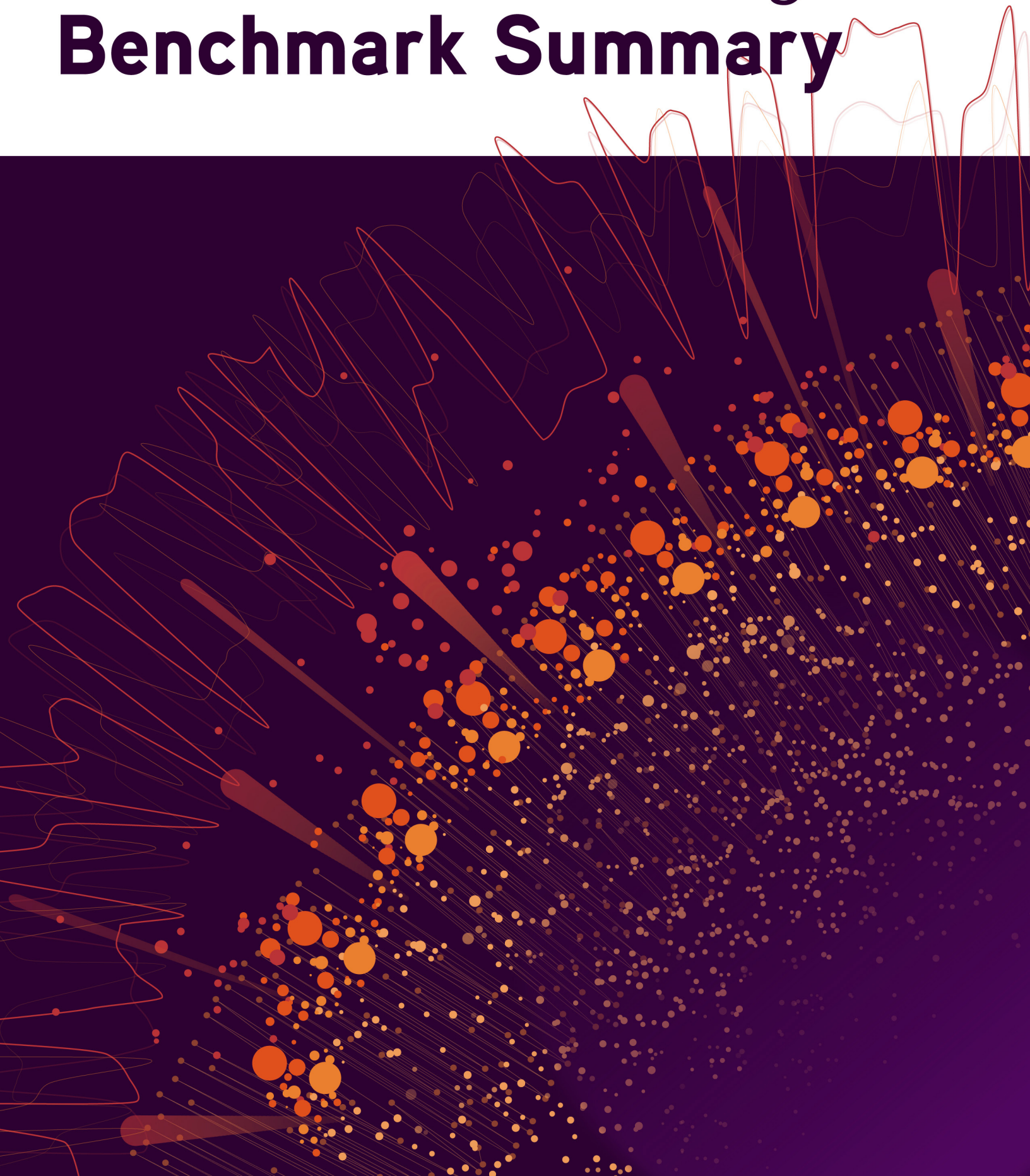
2016 Health Plan Design
Benchmark Summary



Introduction

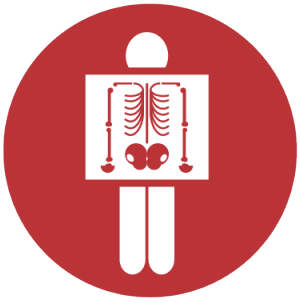
The Zywave Health Plan Design Benchmark Summary is based on data gathered from the largest database in the country, consisting of nearly 60,000 employer-offered health plans. The data analyzed in this summary provides benchmarking information on six key plan design measures:

1. Individual out-of-pocket maximum

2. Individual deductible

3. Emergency room copay

4. Office visit copay



5. Specialty office visit copay

6. Prescription drug deductible

To help employers compare their plan design offerings against similar organizations and plans, the data is broken down by group size and plan type.

This is a summary document analyzing the data set as a whole and comparing it against previous years' data. To view a report of how your specific plan design measures up in comparison to employers of your size, in your region or in your industry, speak with your broker.

Executive Summary of Findings

The 2016 Health Plan Design Benchmark Summary is the result of an analysis that was performed on Zywave's proprietary database of nearly 60,000 employer-offered plans. This analysis focused on the trends that emerged from the aggregate data over the past five years, what differences occurred in plan designs between small and large employer plans, and how plan types responded to economic and regulatory conditions.

It is important to note that the data used to compile this summary was from the 2016 calendar year, meaning that the vast majority of plans were set prior to the 2016 presidential election. As the Trump administration's agenda includes significant alterations to the changes made to the health care system under former President Barack Obama, we anticipate seeing shifts in plan design in the coming years.

The following pages contain details and charts exploring how health plans have shifted over the years. Below is a summary of some of the key findings.

- **The broad shift in plan components seems to be driven by increasing health care costs.** In most of the plan components analyzed, we see broad shifts away from levels that are less expensive for employees toward levels that expose employees to additional costs. These shifts started occurring before many of the Affordable Care Act (ACA) provisions took effect and were gradual and broad enough to suggest that these movements were in reaction to the increasing costs of health care—a trend that has been ongoing for more than a decade.
- **ACA requirements seem to have had a major impact on some plan components.** While there continues to be a somewhat gradual reaction to the increasing costs of health care within most plan components, in some components, we see this accelerated dramatically by the ACA's requirements. In components like the individual out-of-pocket maximum (OOPM), we see a dramatic shift that occurs from 2013 to 2014, which is likely a result of the cost-sharing limits that became effective at this time. In these instances, employers seemed to use the OOPM limit as a benchmark for what is acceptable and rapidly adopted plans near this limit.

  If the ACA is ultimately repealed, or if any replacement legislation removes these limits, we would likely not see a significant reduction in the average OOPM. Instead, we would expect to see a continued increase in the average OOPM. Because employers have already moved toward higher OOPM levels, it would be a significant expense to reduce those levels. A decrease would likely only occur if necessitated by a dramatically increased level of competition for talented employees.
- **Healthy employees seem to be more insulated from increasing costs than unhealthy employees.** The average amount for plan components like the emergency room (ER) copay and the OOPM have seen more dramatic increases than the averages for components like office visit copays or individual deductibles. We believe this is the result of employers' attempts to shield the average employee from feeling the increasing cost of coverage. Only a handful of employees on any given plan may have to pay the full OOPM or ER copay amount, while many employees will likely hit a deductible limit, and nearly all employees will have to pay an office visit copay. While this protects the average healthy

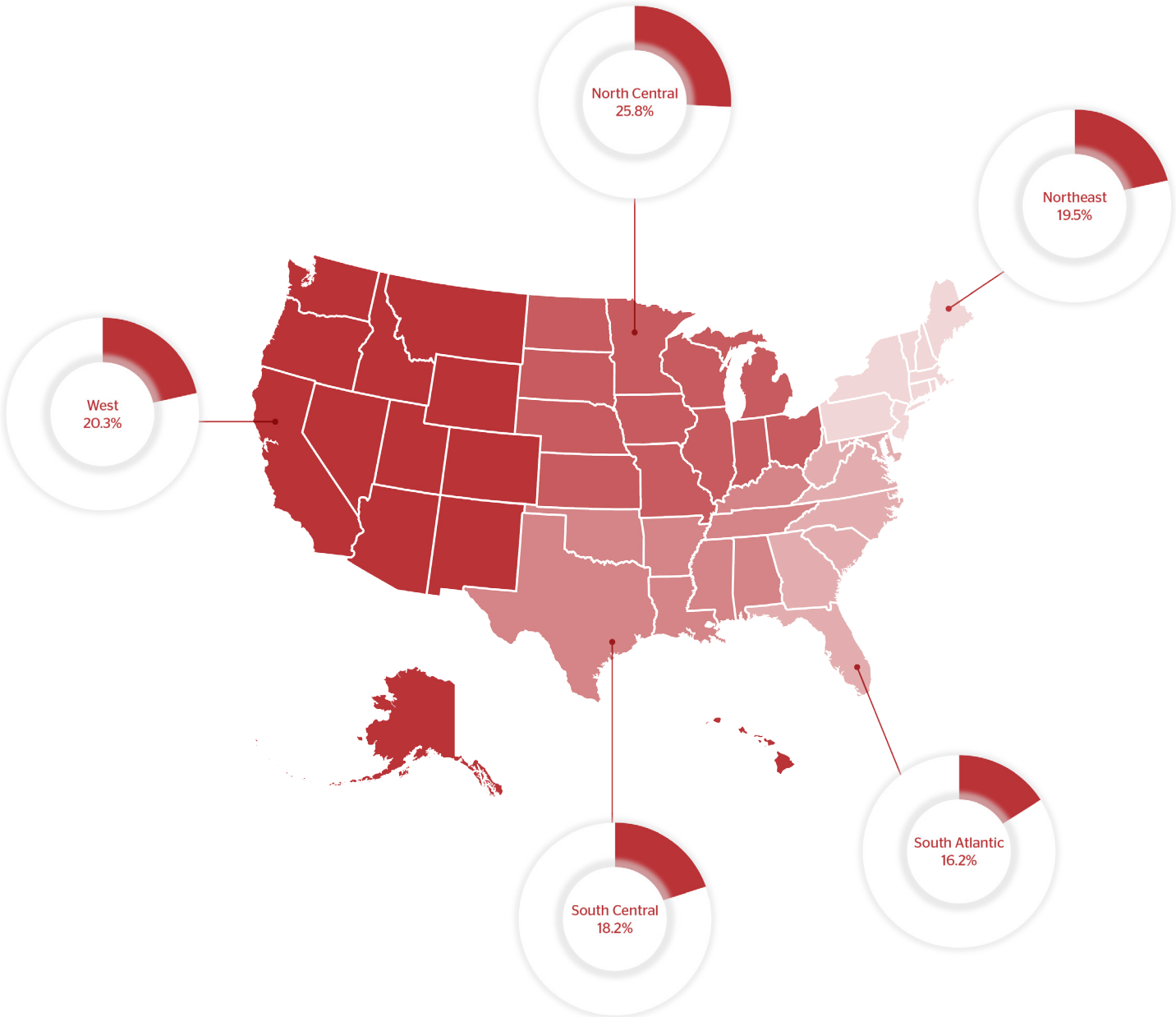
employee from realizing the full cost increase, this has the unintended consequence of exposing unhealthy employees to a larger share of the cost increase.

- **Large employer and small employer plans are becoming increasingly similar.** Over the past five years, the differences between large and small employer plans have narrowed. For most plan components, the differences between the percent of small employer plans (50 or fewer employees) in a given segment and the percent of large employer plans in that segment decreased. The differences that do still exist are typically the result of large employers offering more generous plan designs than small employers. This is likely due to large employers' increased emphasis on attracting top talent and relatively lower price sensitivity.
- **Different plan types react similarly to regulatory and economic conditions.** After analyzing the six most represented plan types in the data set, we found that, on average, each plan type reacted in a similar way to changing market conditions. So while different plan types migrated to less generous plan components at different rates over the years, the change between plan types in each pricing segment was effectively zero. This trend indicates that generally all plan types reacted similarly to market conditions in a manner consistent with the inherent strategy of each plan type.

Demographics

REGION

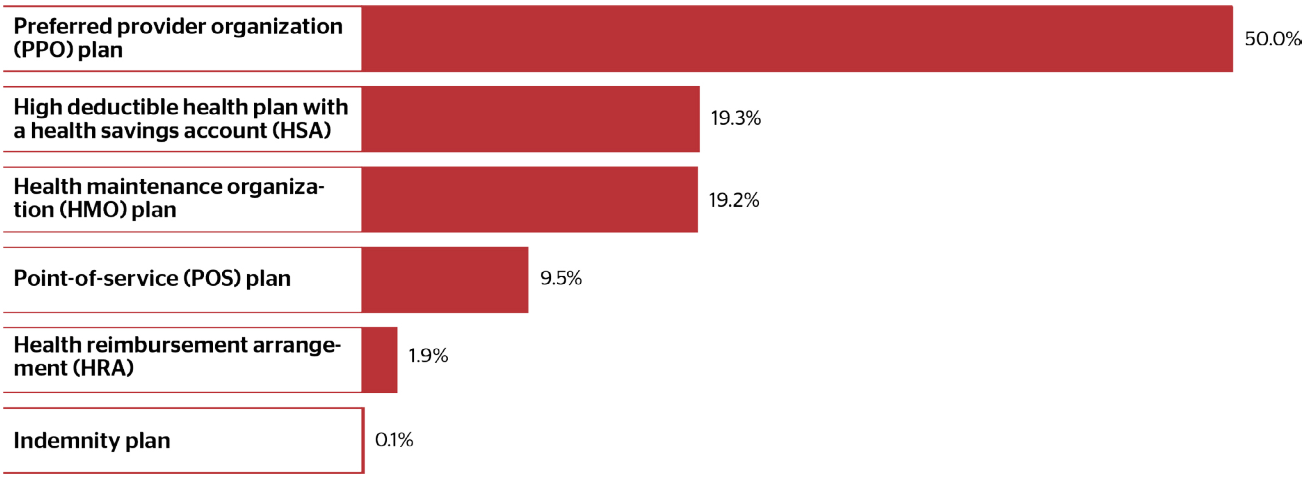
This is how each region in the United States[1] was represented in the 2016 data, with the five main regions showing similar representation.



[1] Puerto Rico and the Bahamas were also surveyed, but make up less than 1 percent of the data.

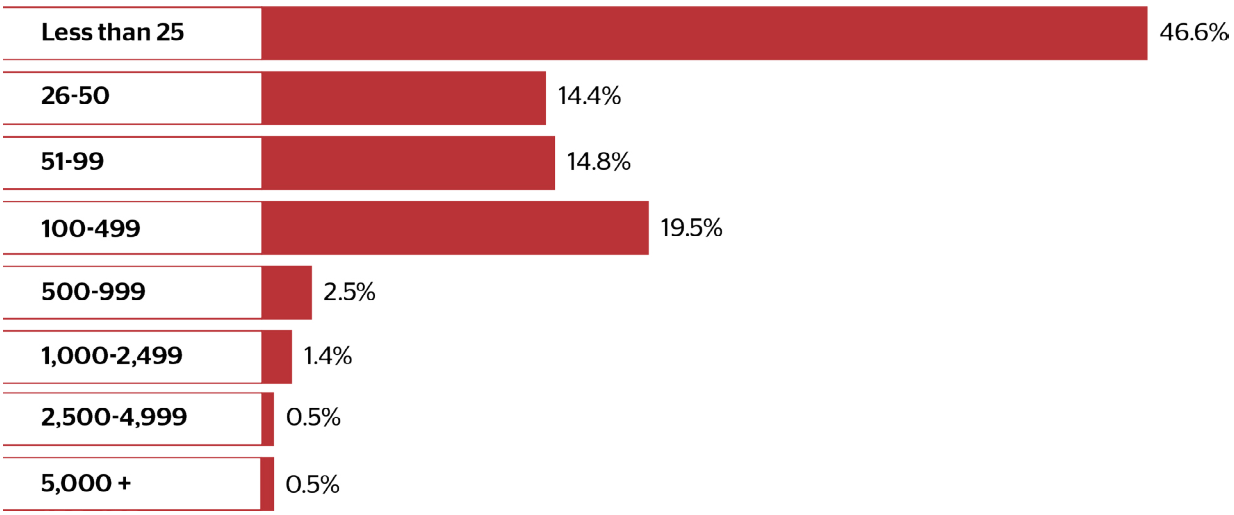
PLAN TYPE

In 2016, preferred provider organization (PPO) plans continued to be the most represented plan type within the data set. Plans with a health savings account (HSA) continued to grow in popularity, and for the first time, represented the second most frequently offered plan by employers. HSA plans are expected to become increasingly prevalent in the years to come as more emphasis is placed on health care consumerism both by employers as a way to combat their benefits-related expenses and by the Trump administration as a favored vehicle to drive down overall health care spending.



GROUP SIZE

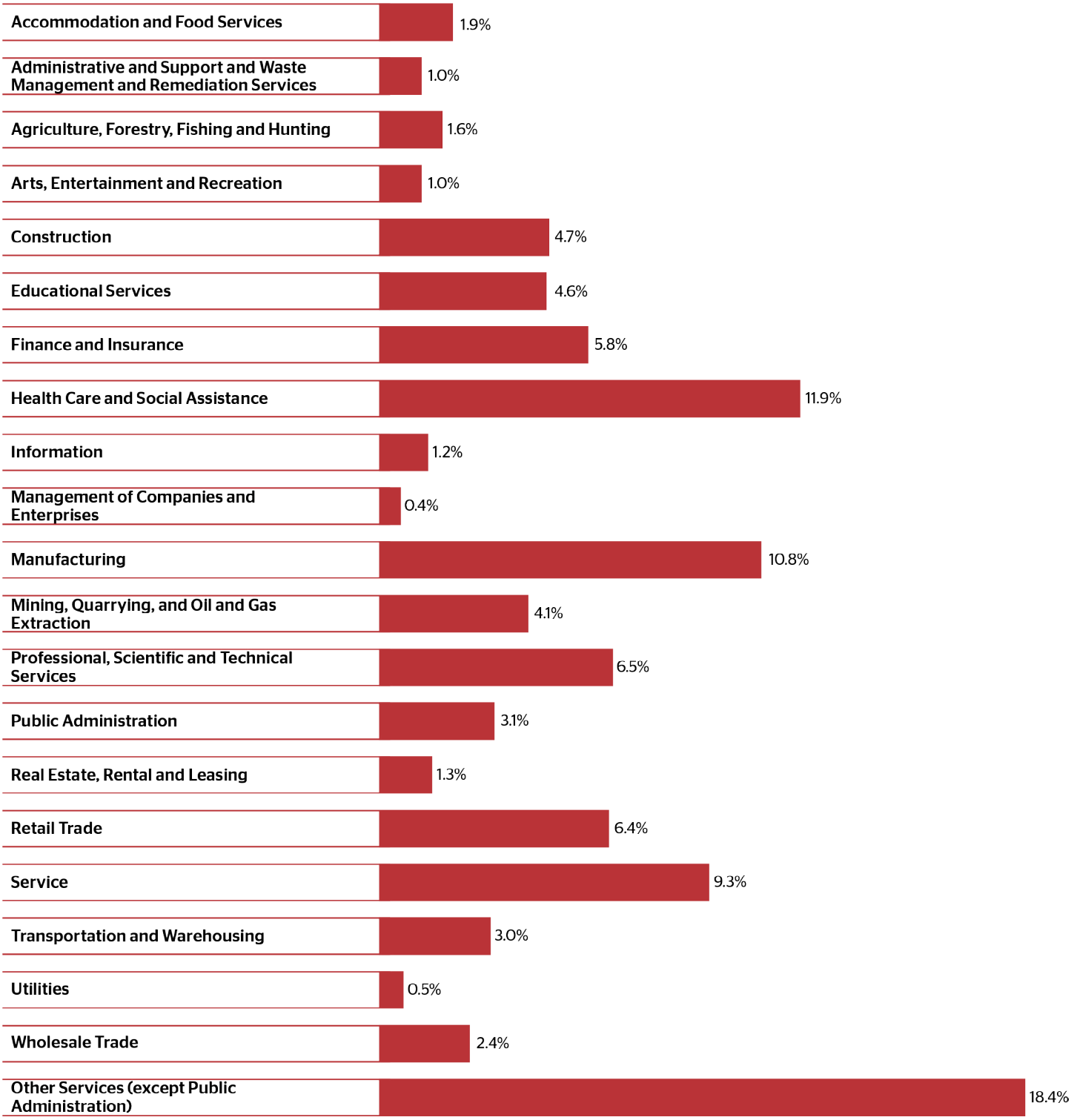
The chart below shows how group sizes were represented in the 2016 data. Consistent with prior years' data, groups with fewer than 25 employees once again represented nearly half of all health plans and small groups with 50 or fewer employees made up over 60 percent of the plans analyzed.[2]



[2] Any plans that did not fall into one of the most common plan type categories listed above were omitted from the total number of plans; therefore, they are not factored into the listed percentages for given plan types.

INDUSTRY

The 2016 data included the following industry breakdown, with a wide variety of industries represented.



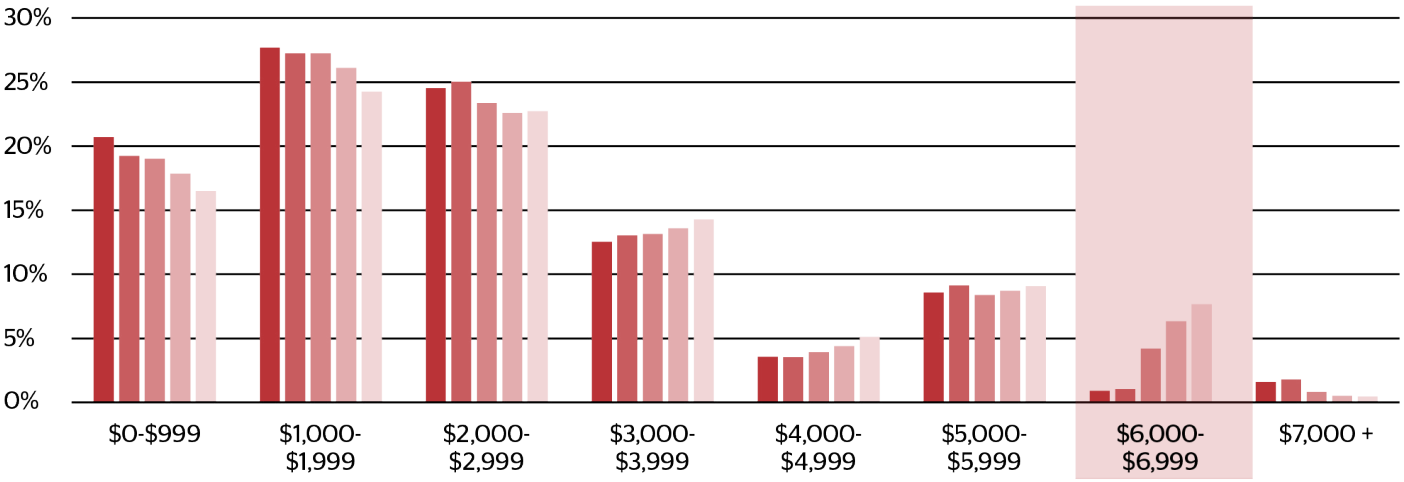
Individual Deductible

Overall, the trends that have been prevalent over the past four years continued in 2016. While they still make up a majority of plans offered, the prevalence of plans with an individual deductible lower than $3,000 has been decreasing consistently since 2012. Reflecting the broader theme of employers grappling with increasing health care costs, we see plans with higher individual deductibles growing in popularity. Most prominently, plans with an individual deductible between $6,000 and $6,999 have grown by more than 750 percent since 2012 and now make up nearly one-thirteenth of all plans (highlighted below). While this is still a relatively small portion of the total plans, most of the decreases in lower deductible plans appear to be captured by this segment.

While the increase in plans with higher deductibles is likely the result of employers trying to manage increasing health care costs, the fact that the $6,000 to $6,999 segment has grown so rapidly is almost certainly driven by regulation. Under the ACA, cost sharing (including deductibles) for non-grandfathered plans is capped at a plan's OOPM, and the highest OOPM falls in the $6,000 to $6,999 segment.

We would expect to see this segment continue to grow in the future if the Trump administration leaves this rule in place and as high deductible health plans (HDHPs) become more common. However, if the limit on individual deductibles is removed, we would expect to see more plans feature individual deductibles in excess of $7,000.

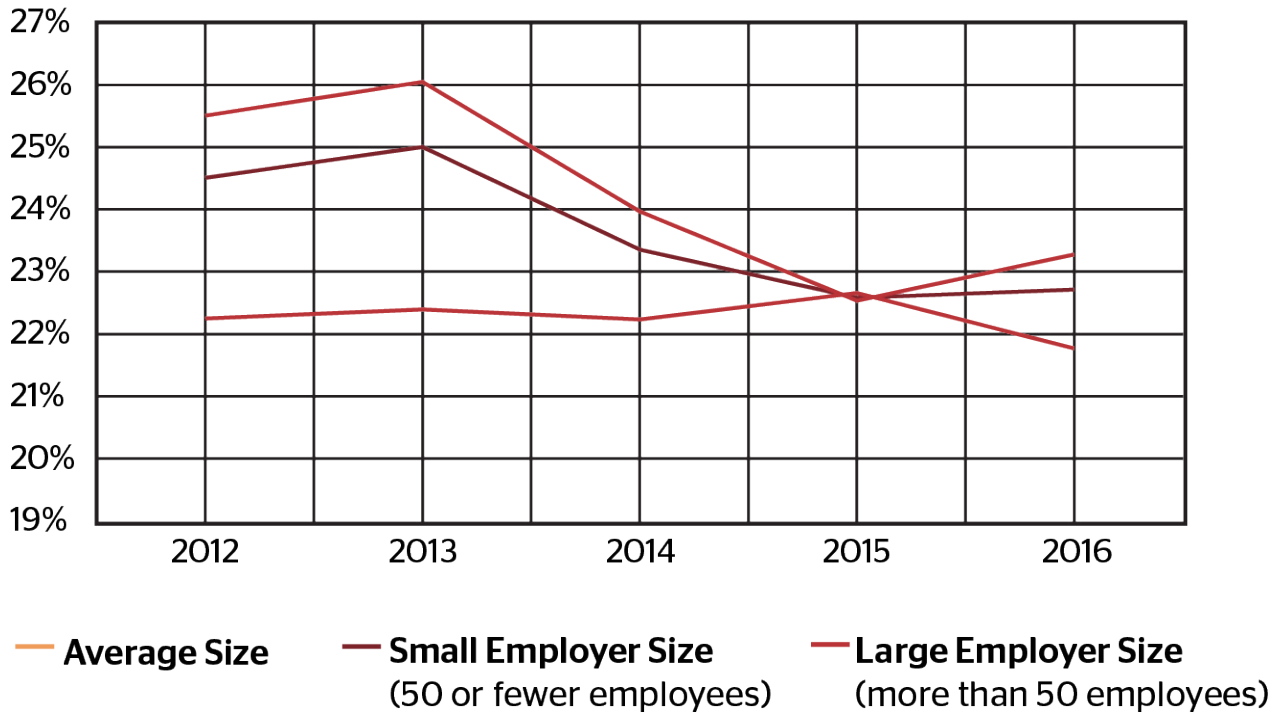
Percent of Plans with an Individual Deductible in Each Segment



EMPLOYER SIZE ANALYSIS

Small and large employers generally have similar distributions within individual deductible segments and have become more similar over the past five years. The average gap between small and large employers for each segment narrowed from 2.62 percent in 2012 to 1.87 percent in 2016—a 29 percent decrease. The most extreme example of this is the wide gap that existed between the percent of large and small employer plans in the $2,000 to $2,999 segment—this gap shrank from 3.26 percent in 2012 to 0.95 percent in 2016. See below for a chart comparing small employer plans, large employer plans and the weighted average of the two. This drop indicates that small and large employers have increasingly similar preferences when it comes to individual deductibles.[3]

Percent of Plans with a Deductible Between $2,000 and $2,999, by Employer Size



[3] The weighted average in this summary is calculated based on the prevalence of plans within the data set. For example, when comparing large and small employers, the weighted average is calculated using the equation below.

Weighted Size Average = (p) * SegmentSmall + (1 – p) * SegmentLarge

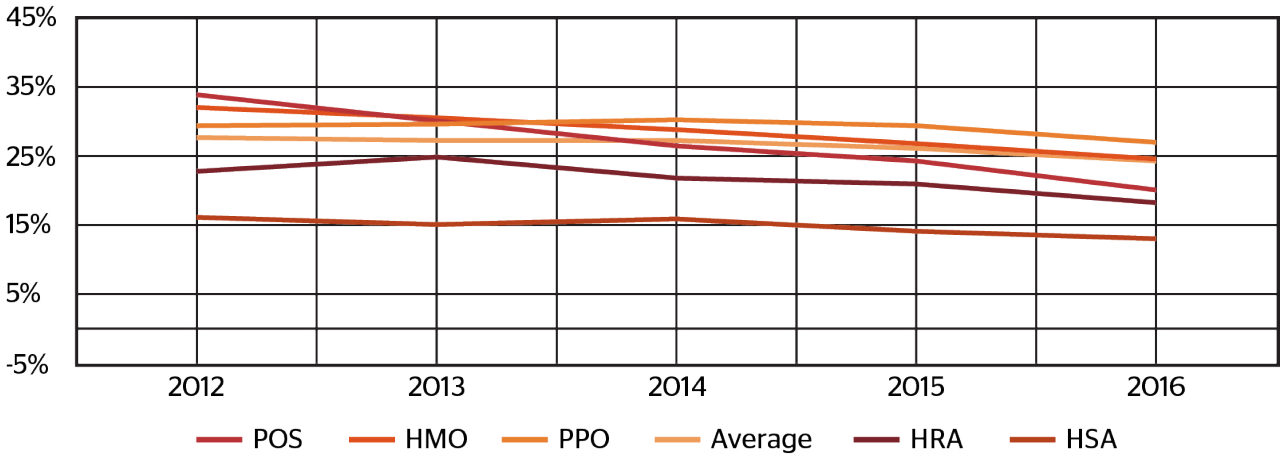
In the equation above, p is the percent of small employer plans in the data set, SegmentSmall represents the percent of small employer plans that are contained in a given segment and SegmentLarge represents the percent of large employer plans that are contained in that segment. Because there are more small employer plans contained in this data set, the weighted size average will more closely track the small employer numbers.

PLAN TYPE ANALYSIS

The differences between plan designs[4] in terms of individual deductibles are largely inherent due to the strategy of each plan type. For example, while 26 percent of HMO plans had an individual deductible in the $0 to $999 segment, HSAs weren't represented in this segment. Conversely, a higher percent of HSA plans had a deductible between $3,000 and $4,999, while a relatively small percent of HMO plans had a deductible in this range.

The standard deviation[5] between the plans averaged across all segments remained effectively unchanged from 2012 to 2016, showing that, on average, employers reacted in a similar way to market and regulatory forces. A good example of this is the $1,000 to $1,999 segment, in which we see plans generally move in the same direction.

Percent of Plans with a Deductible Between $1,000 and $1,999, by Plan Type



[4] For this and subsequent sections discussing differences between plan designs, analysis was conducted on the five most represented plans in the data set. Analyzed plan types include HMOs, HRAs, HSAs, PPOs and POS plans.

[5] Standard deviation measures how dispersed a set of data is from its average. We use this measurement in the plan type analysis as it tells us how large of a difference plan type makes when deciding on a plan component level. A large standard deviation would indicate that plan type matters a great deal, while a small standard deviation would indicate that plan type is not a large factor. Comparing standard deviation across time is particularly useful as it can indicate whether plan types are becoming more similar or different.

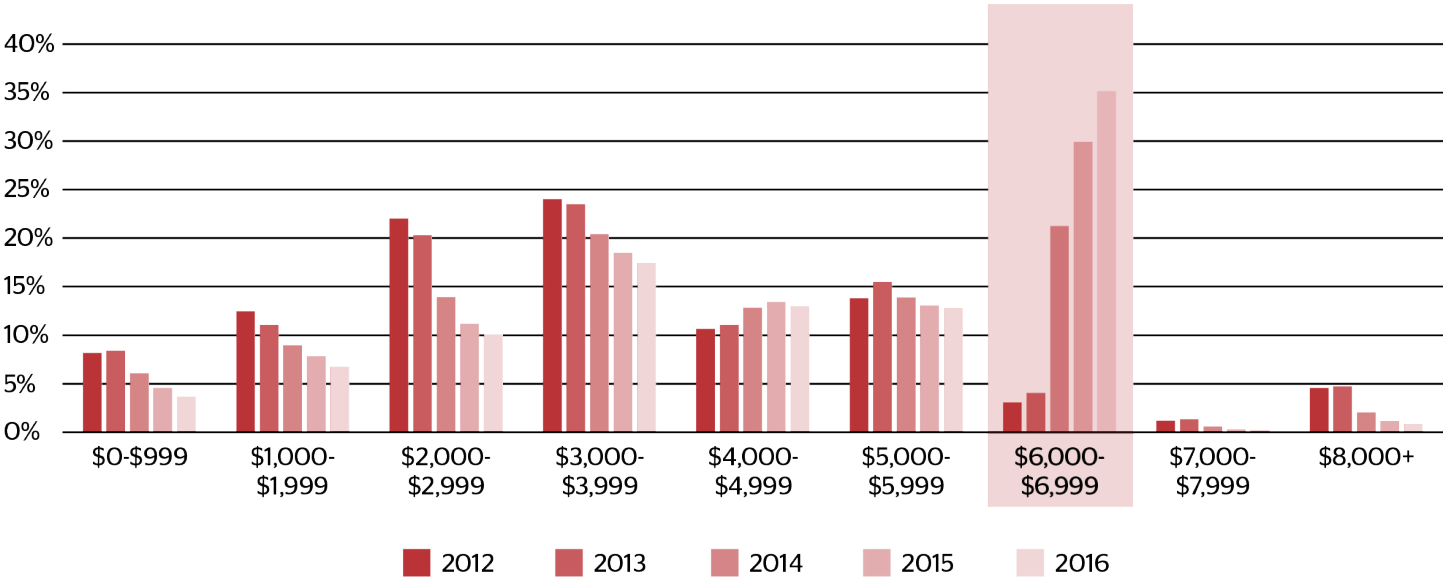
Individual Out-of-pocket Maximum

The most striking story that the individual OOPM data tells is about the popularization of plans with a deductible between $6,000 and $6,999 (highlighted below). The growth of these plans is staggering. In 2012, this segment represented only 3 percent of plans, but by 2016, more than 35 percent of plans were in this segment—an increase of more than 1,000 percent. And this trend only looks like it will increase. The $6,000 to $6,999 segment was the only segment to grow from 2015 to 2016, with every other segment decreasing in popularity.

The forces driving these changes seem to be employers' efforts to cope with the rising costs of health insurance and the effects of establishing an OOPM for non-grandfathered plans. The effects of increasing health care costs can be seen when looking at each segment with less than a $4,000 OOPM. In general, each segment has experienced year-on-year decreases since 2012, as employers have migrated to plans with higher OOPMs in order to deal with increasing health care costs.

The percent of plans that had an OOPM of $7,000 or greater went from relatively small to nearly nonexistent once the ACA regulation limiting the maximum OOPM took effect in 2014, but this reduction only accounts for 17 percent of the change in the $6,000 to $7,000 segment that occurred from 2013 to 2014. The rest of the massive increase in this segment is likely an indirect result of the ACA. It appears that with an upper threshold established, employers identified what OOPM amount was most affordable, but still compliant, and then rapidly adopted plans with an OOPM in that range.

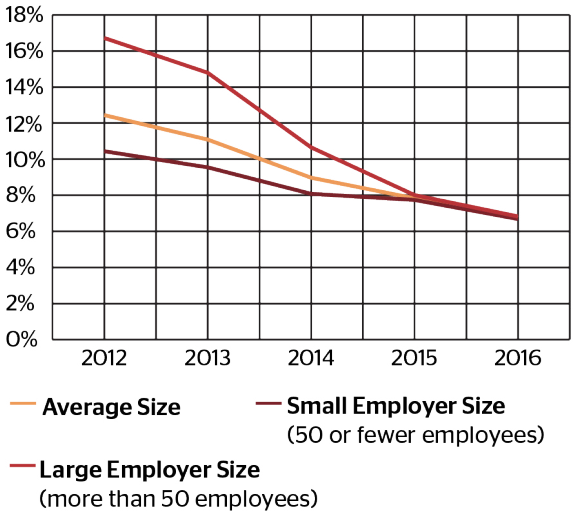
Percent of Plans with an Individual Out-of-pocket Maximum in Each Segment



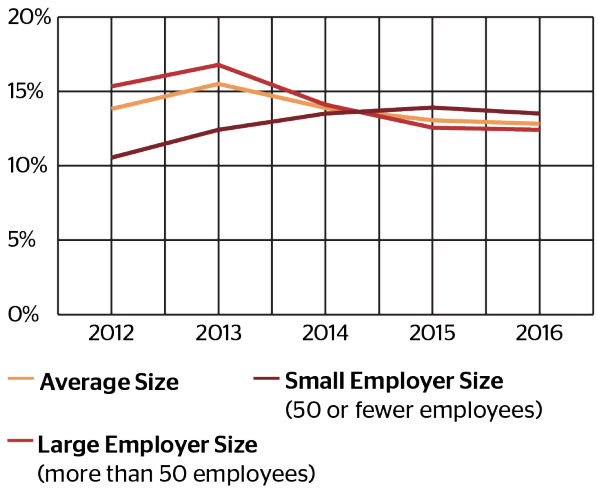
EMPLOYER SIZE ANALYSIS

Similar to the individual deductible trend, the differences between the individual OOPM that small employers and large employers select is small and appears to be shrinking. While there were few segments where the differences between small and large employers grew, the average gap between small and large employers for each segment narrowed from 2.53 percent in 2012 to 1.68 percent in 2016—a 34 percent decrease. The segments where the differences between small and large employers narrowed the most were the $1,000 to $1,999 and $5,000 to $5,999 segments. These changes indicate that small and large employer plans are becoming increasingly similar with the respect to OOPMs.

Percent of Plans with an OOPM Between $1,000 and $1,999, by Employer Size



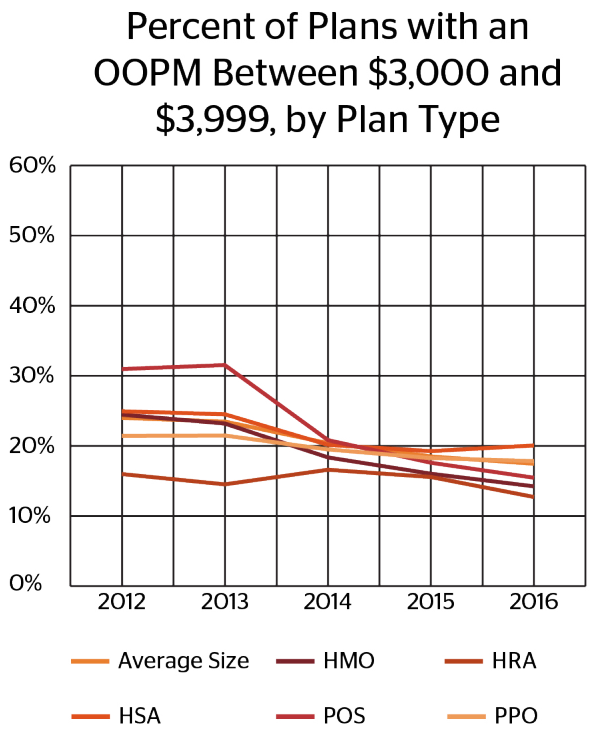
Percent of Plans with an OOPM Between $5,000 and $5,999, by Employer Size

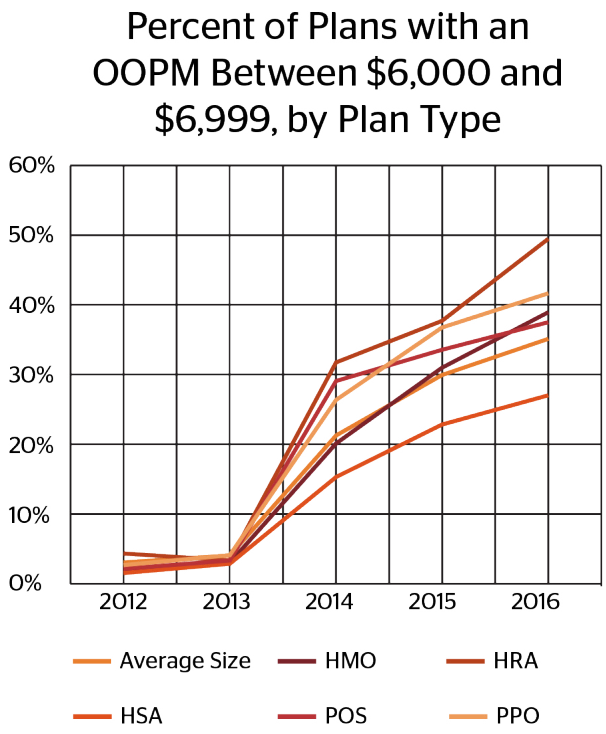


PLAN TYPE ANALYSIS

As was the case with the individual deductible, the standard deviation between the plans averaged across all segments of the OOPM component remained effectively unchanged from 2012 to 2016. However, unlike the individual deductible component, there were major variations within the OOPM segments. For example, within the $3,000 to $3,999 segment (shown below), the differences between the types of plans narrowed considerably over the past five years. For instance, the standard deviation has decreased by 2.3 percentage points since 2012. Standard deviation decreased in each segment, with the exception of the $6,000 to $6,999 segment (shown below). In this segment, the standard deviation increased by 6.2 percentage points.

It is worth noting that the massive increase in standard deviation in the $6,000 to $6,999 segment seems to be the result of the limit that the ACA placed on OOPMs for non-grandfathered plans. As noted above, after the limit went into effect in 2014, employers seemed to view this limit as a way to identify an OOPM that would allow them to cut costs and remain compliant. As a result, many employers opted to have an OOPM around this limit, which falls into the $6,000 to $6,999 segment. The increased standard deviation shows us that while all types of plans rapidly adopted OOPMs in this range, some plans did so at a faster rate than others. We anticipate that the standard deviation will eventually level off and remain consistent from year to year, even in the $6,000 to $6,999 segment. Additionally, this increased variance was entirely offset by decreases in standard deviation between plan types in other segments.





Office Visit Copay

For the office visit copay component, we continue to see a somewhat normal distribution between segments that was present in prior years. While the percent of plans with an office visit copay in the $20 to $34 range has been decreasing over the past five years, these mid-priced segments still represent more than 56 percent of the plans in the data set (down from 60 percent). Average copay amounts should continue to rise, but these mid-priced segments will likely continue to be the most popular segments over the next few years. The only segments in which we've seen overall growth since 2012 is in the $35 and up range. Out of these segments, the $50+ has seen the greatest absolute growth—increasing 3.6 percentage points over the span of five years.

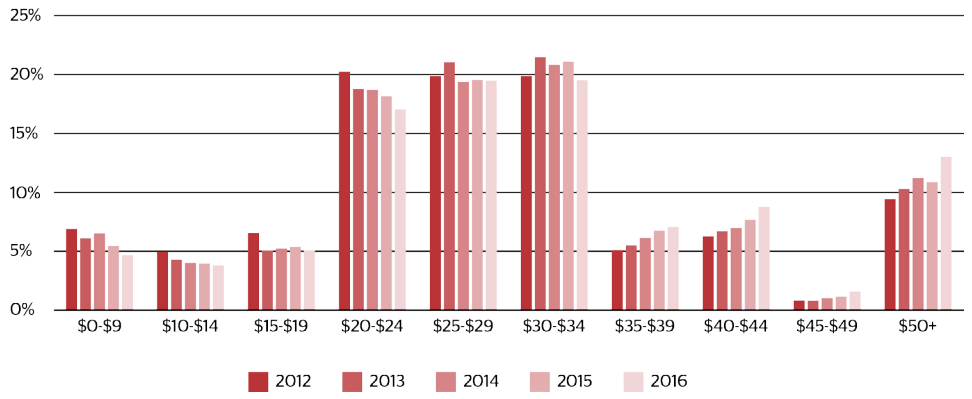
Since we don't see any dramatic movements within any of the segments, it's likely that these shifts have more to do with employers' responses to increasing costs than any type of regulation. Even though office visit co-pays generally count toward the OOPM limit, employers appear to have flexibility within their plan designs to gradually increase copay amounts.

It's also interesting to note that the response to increasing costs appears to be less pronounced in this plan component than in most other plan components analyzed. This could be a result of employers' hesitation to dramatically increase the cost of the plan components that employees will use the most. Most employees will have to pay an office visit copay during the course of a year, so employees may view their coverage as less desirable if copays are high.

While opting to increase less common plan components, like individual OOPM, has kept costs lower for most employees, in a zero-sum game, this drives up costs for unhealthy employees. That being said, this strategy has the added benefit of making basic health care more accessible, which could prevent more costly illnesses in the first place.

In reviewing the data for the specialty office visit copay component, we found a normal distribution centered on the price segments between $30 and $59—a full 61 percent of plans fell within this range of copays. Though there isn't historical data, we expect the average specialty office visit copay to follow the same general trend toward higher levels of cost sharing that we see in other plan components in the future.

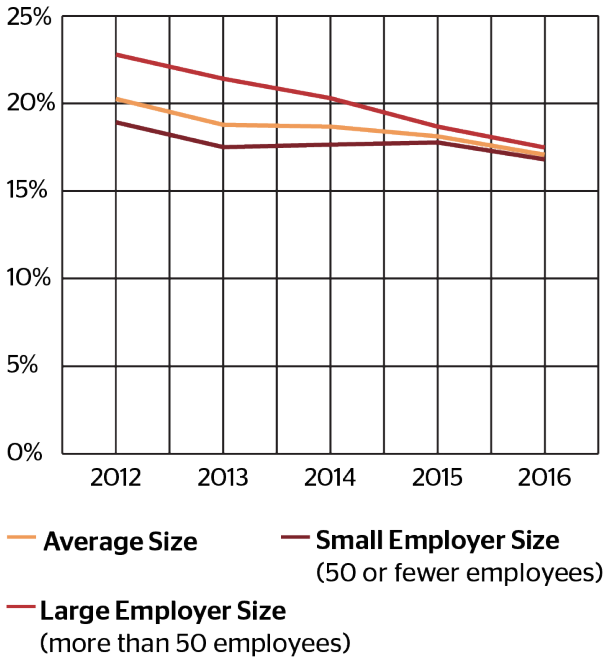
Percent of Plans with a Primary Office Visit Copay in Each Segment



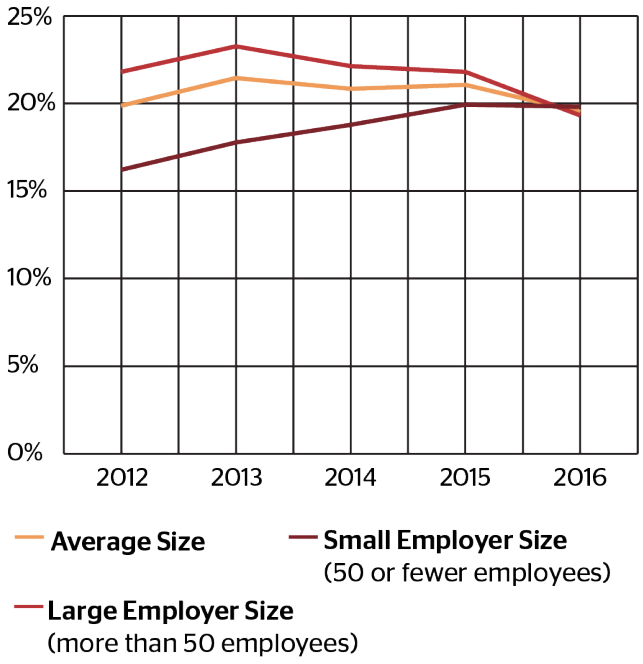
EMPLOYER SIZE ANALYSIS

Similar to other plan components, the difference between what employees of a small organization pay and what employees of a large organization pay for an office visit copay is small and seems to be getting smaller. Averaged between all segments, the differences between the percent of small employer plans that offered an office visit copay in a given segment and the percent of large employer plans that offered an office visit copay in that segment went from 2.26 percent in 2012 to 1.11 percent in 2016. The segments where the differences between small and large employers narrowed the most were the $20 to $24 and $30 to $34 segments, both of which are shown below.

Percent of Plans with an Office Visit Copay Between $20 and $24, by Employer Size



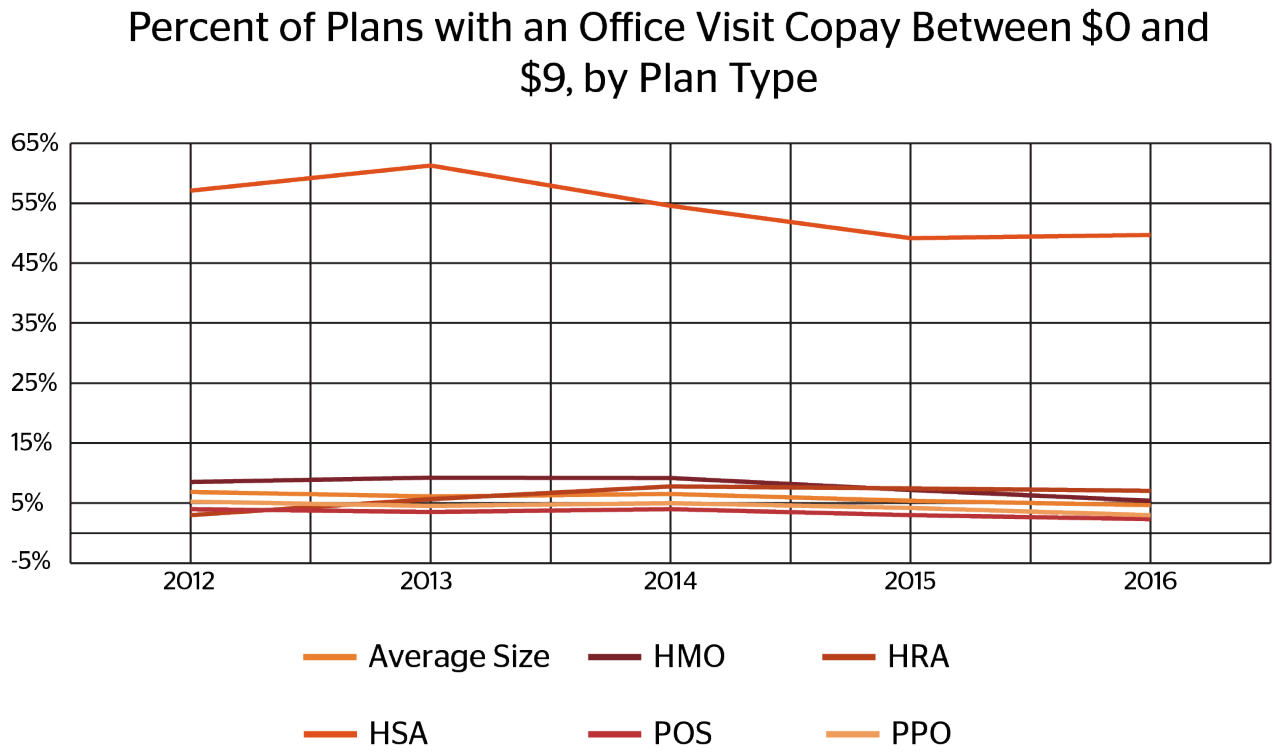
Percent of Plans with an Office Visit Copay Between $30 and $34, by Employer Size



PLAN TYPE ANALYSIS

Similar to other plan components, the standard deviation of the average office visit copay segment remained effectively unchanged from 2012 to 2016. All plan types seemed to react in a similar manner to the increasing cost of health care, gradually trending toward higher copay amounts.

The largest outlier in terms of dispersion is the $0 to $9 segment (shown below), which has the highest standard deviation of all segments—18 percent in 2016. The relatively large standard deviation between plan types is almost entirely due to the HSA plan type acting as an outlier—nearly 50 percent of HSA plans have an office visit copay that falls within the $0 to $9 segment. Though the HSA plan type acts as an outlier in this segment, it is entirely consistent with the consumer driven strategies associated with HDHPs.

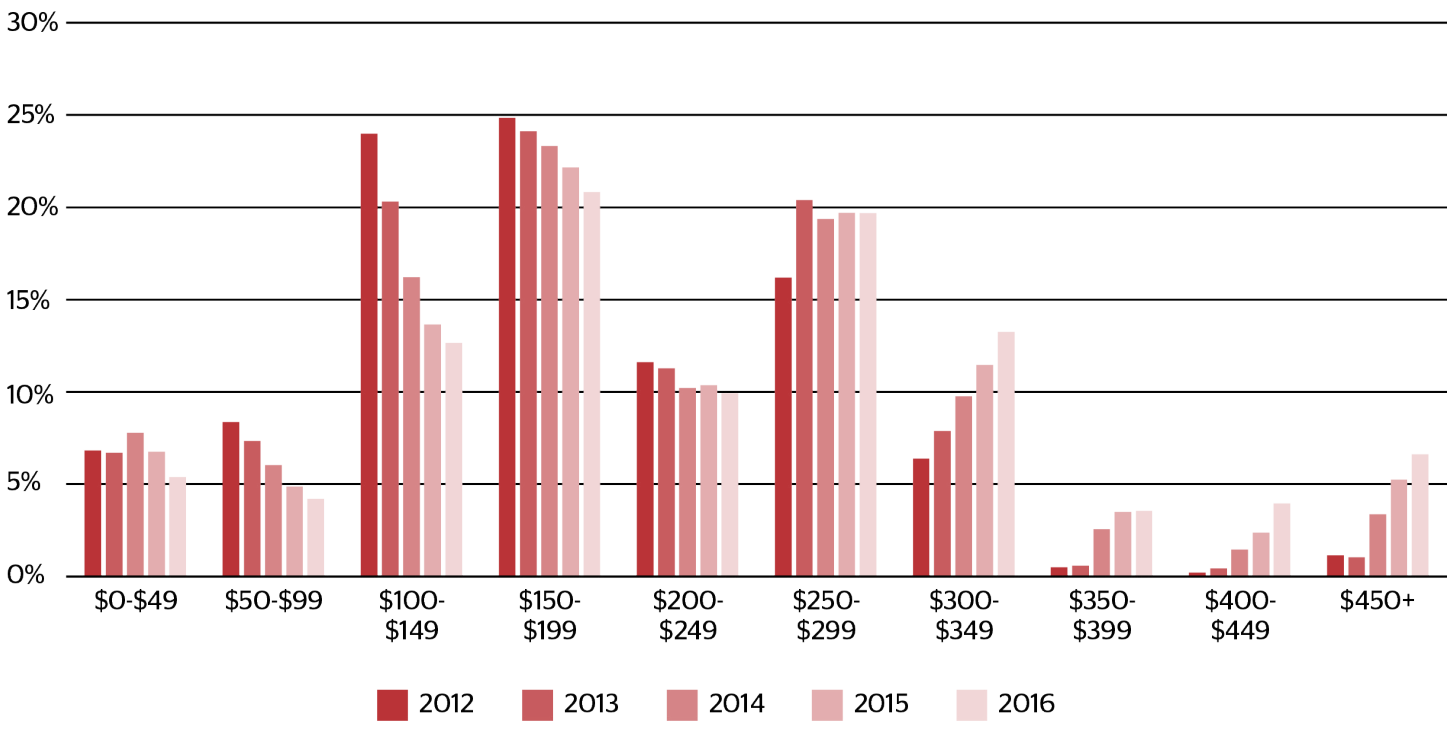


Emergency Room Copay

As was the case with the other plan components, there is a movement from lower ER copays to higher cost segments. While the $100 to $149 segment had the most significant drop of any segment—going from 24 percent in 2012 to only 13 percent of total plans in 2016—every segment below $250 declined significantly over the past five years. Conversely, there has been continuous annual growth in nearly every segment above $300, highlighting the shift to higher ER copays.

The primary force behind this shift appears to be employers' attempts to cope with rising health care costs. Unnecessary ER visits are a notoriously expensive, yet avoidable cost for employers. One way to encourage employees to make smarter decisions about when to go to the ER is to expose them to some of these costs. The shift to higher ER copays represents employers' attempts to encourage employees to seek care for non-emergency conditions in a more cost-effective setting (e.g., an urgent care facility or the doctor's office).

Percent of Plans with an Emergency Room Copay in Each Segment



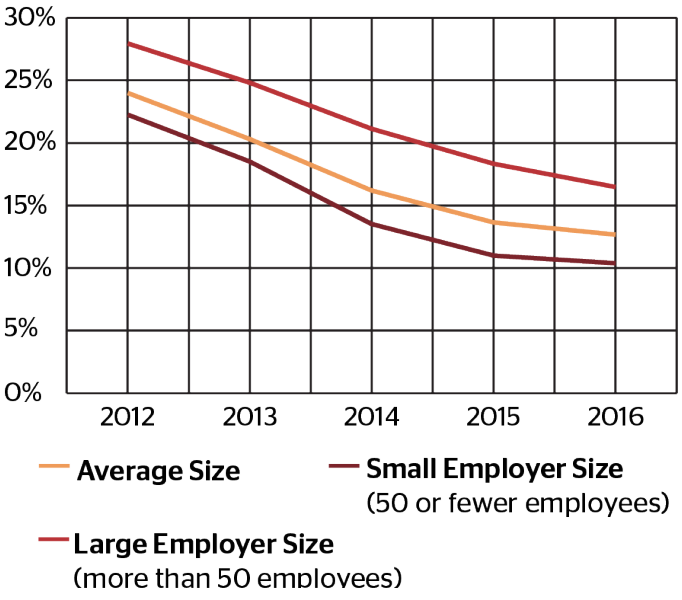
EMPLOYER SIZE ANALYSIS

Unlike other plan components that were analyzed, group size seems to play more of a role when employers select an ER copay amount. On average, the difference between the percent of small employer plans that offered an ER copay in a given segment and the percent of large employer plans that offered an ER copay in that segment increased from 1.91 percent in 2012 to 3.74 percent in 2016. This difference runs counter to the trends found in other plan components.

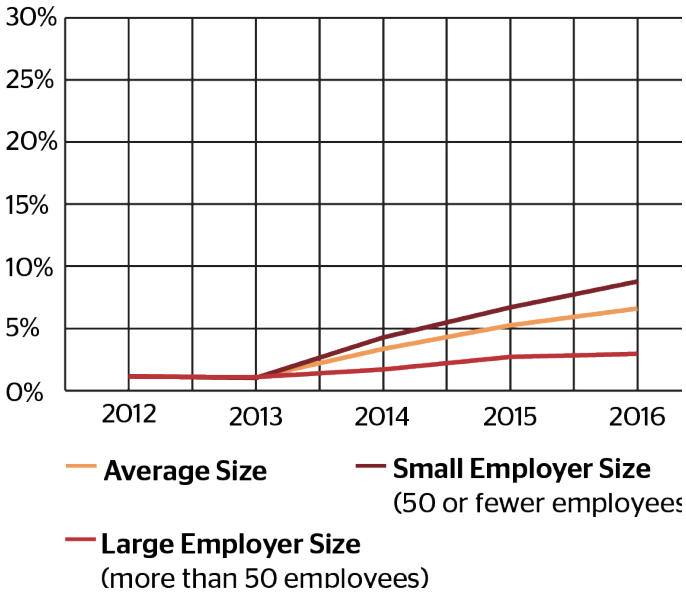
While there is an overall shift toward higher ER copays, when we compare the preferences of small and large employer plans, we see that small employers are more quickly adopting this strategy than large employers. This can be seen when we examine the $450+ segment. The percent of small employer plans that offer an ER copay in this segment has grown at a much quicker rate than the percent of large employer plans in this segment. This is likely because small employers are typically more price sensitive; therefore, they tend to expose employees to additional costs.

However, it is important to note that while large employers are slower to adopt higher ER copays than small employers, the average large employer ER copay has still been increasing each year. For instance, over the past few years, fewer large employers have been offering copays in the $100 to $149 range.

Percent of Plans with an ER Copay Between $100 and $149, by Employer Size



Percent of Plans with an ER Copay of $450 or more, by Employer Size



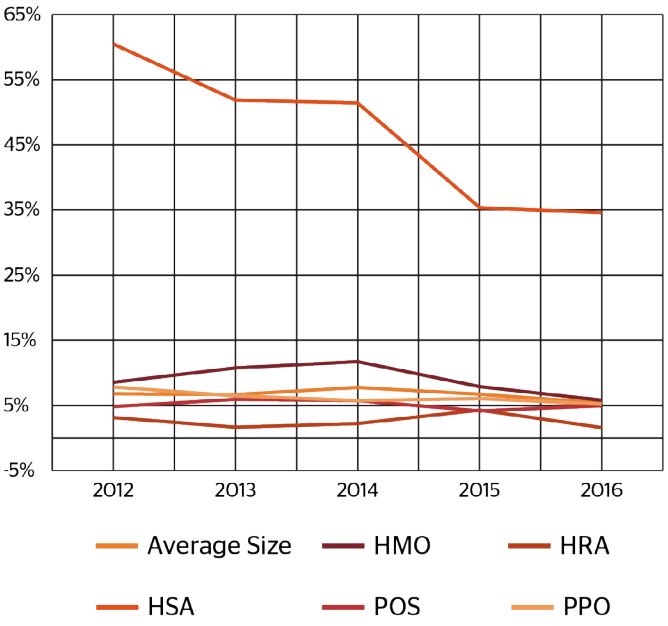
PLAN TYPE ANALYSIS

Similar to other components, the average standard deviation between plan types in each segment in the office visit copay component remained effectively unchanged from 2012 to 2016. But, similar to the OOPM component, this average masks shifts within individual segments. The main outlier among plan types is again the HSA plan type—a much higher percent of these plans have an ER copay in the $0 to $49 segment than any other plan type (shown below).

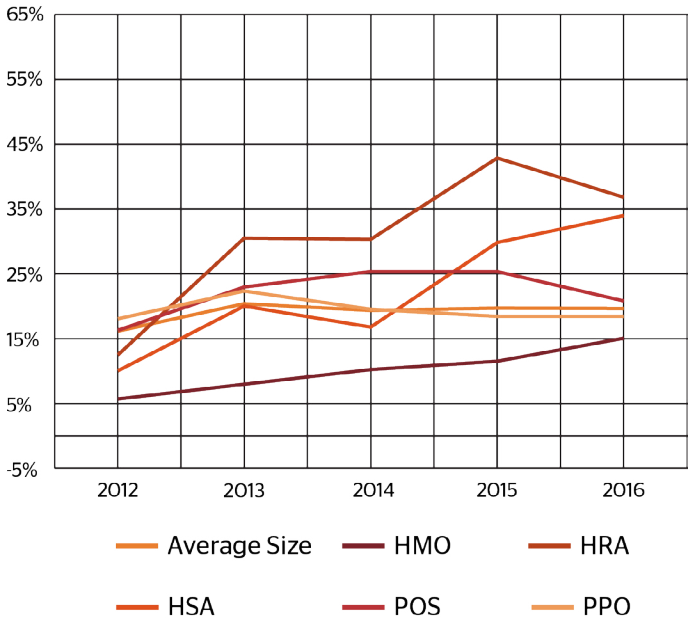
While the $0 to $49 segment is still the most common segment for the HSA plan type, the fact that fewer plans have had an ER copay in this range in recent years means that the standard deviation between plans in this segment has decreased.

Conversely, in segments like the $250 to $299 segment (shown below), we see standard deviation gradually increasing over the years. The segments that are experiencing growth are the higher cost segments, and they are generally the ones that have seen an increasing standard deviation. This indicates that the strategies associated with each type of plan continue to play a significant role in the adoption rate of higher ER copays. However, all plans are trending in that direction.

Percent of Plans with an ER Copay Between $0 and $49, by Plan Type

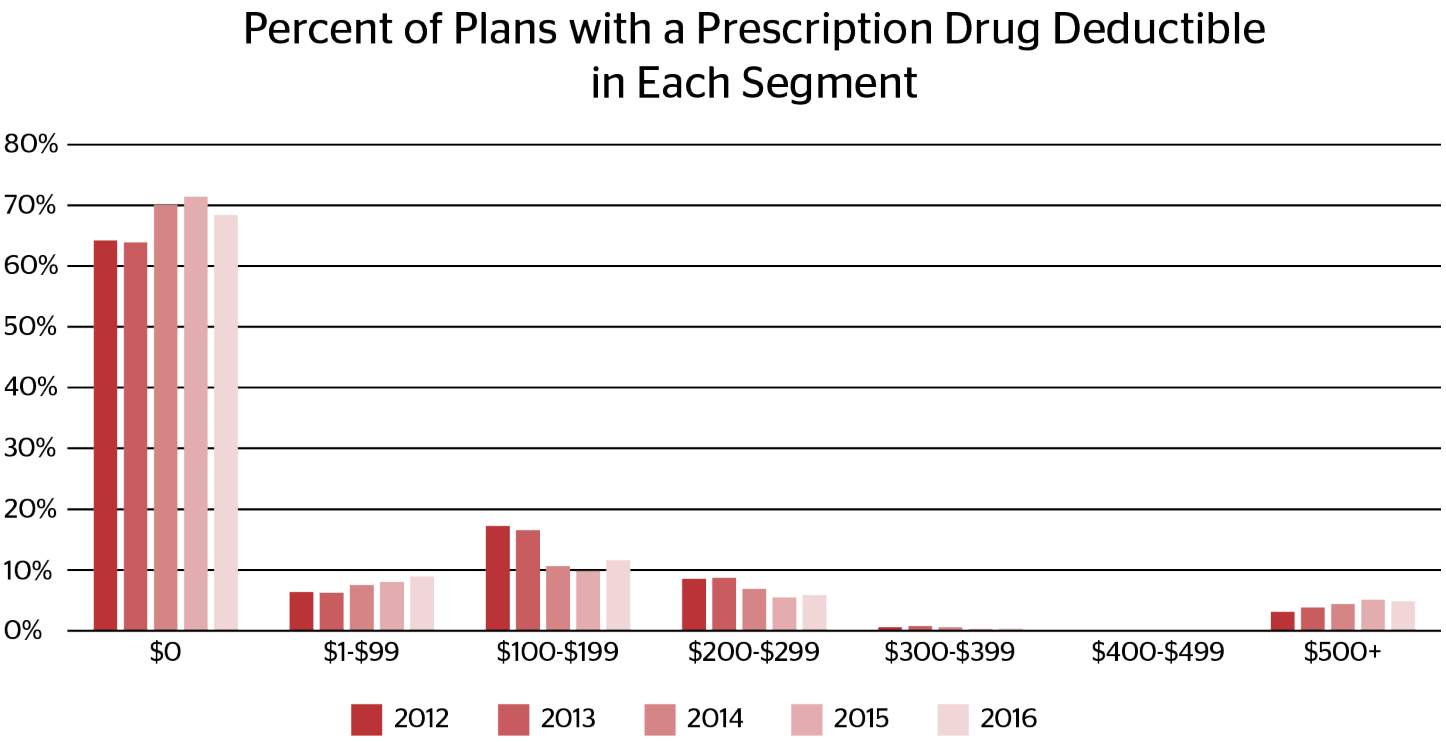


Percent of Plans with an ER Copay Between $250 and $299, by Plan Type



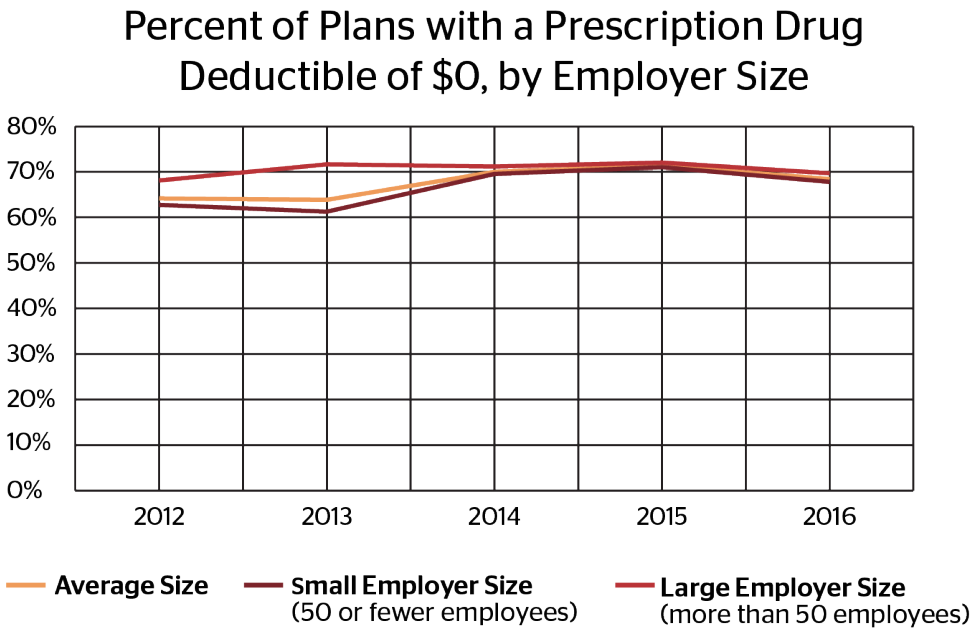
Prescription Drug Deductible

The overwhelming majority of plans have a prescription drug deductible of $0, with most other segments generally decreasing over the past five years. The $0 segment has increased slightly as the other segments have decreased, but has remained relatively stable since 2012.



EMPLOYER SIZE ANALYSIS

Consistent with the majority of plan components analyzed, the differences between what small and large employers select in terms of prescription drug deductibles has been decreasing over the past five years. Most notably, in the $0 segment, the gap between small and large employers shrank, as shown below.



PLAN TYPE ANALYSIS

There was little variance between plans from year to year within the prescription drug deductible component. Similar to other components, all plan types generally appear to respond in a similar manner to regulatory and economic forces. A good example of this is the $0 segment (shown below), in which the standard deviation between plans changed by less than 1 percentage point from 2012 to 2016.