SURVEY Report

STRICTLY EMBARGOED UNTIL AUGUST 18, 2011 UNTIL 10:00 a.m. EDT

August 2011

Large Employers' 2012 Health Plan Design Changes

National Business Group on Health

Contents

Introduction

As employers continue to struggle in the uncertain U.S. economy and deal with the consequences of the Affordable Care Act, many are implementing innovative strategies to control costs and provide employees with crucial health and wellness benefits.

While employers' level of confidence about offering health care benefits in the future is beginning to wane, most employers (71%) remain very confident that they will continue to offer health benefits five years from now.[1] In addition, a growing number of employers are making their wellness programs accessible to spouses and children, and many employers continue to increase the level of incentives dependents can earn for participating in health improvement programs.

The results of this survey indicate that employers will continue to design and implement innovative changes to their health plans for controlling costs as well as maintaining compliance with the Affordable Care Act.

[1] National Business Group on Health/Towers Watson, 16th Annual Employer Survey on Purchasing Value in Health Care, *Survey Report,* March 2011.

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Key Findings

Changes as a Result of Health Care Legislation

As regulations from the Affordable Care Act continue to come into effect, employers are planning and making changes for the future. Employers with annual benefit limits in place are beginning to remove those limits in anticipation of the complete ban in 2014. In addition, 19% of employers are already planning to increase the amount of incentives an employee can earn beyond the current 20% of total plan costs threshold as soon as the threshold is extended to 30% in 2014.

As predicted, many employers with grandfathered health plans are not planning to keep their grandfathered status for 2012, but nearly a quarter of employers (23%) will still have at least one grandfathered health plan.

Medical Plan Costs

Employers estimated an average increase in health care costs to be 7.4% for 2011, with reported estimates ranging from no increase to a 15% increase. For 2012, employers are estimating a similar increase of approximately 7.2%.

In this year's survey, increasing employee cost-sharing was the most effective method for controlling costs, according to 25% of respondents. Although only 17% of employers indicated that wellness initiatives were the most effective tactic to control costs, 64% agreed that it was one of the top three most effective tactics in controlling costs.

In 2012, 63% of employers will increase the employee percentage contribution to premium costs, and 39% will increase in-network deductibles. Most employers will increase those amounts by less than 10%.

Consumer-Directed Health Care

More employers will be offering a consumer-directed health plan (CDHP) in 2012 than in previous years, with 73% planning to offer at least one CDHP next year. In addition, 17% of employers have or will move to a full replacement CDHP design in 2012. The most common type of CDHP employers will offer next year is a high-deductible health plan (HDHP) with a health savings account (HSA) (75%).

The most common method employers use to load health accounts is by contributing a pre-determined amount per participant, with 59% of employers with HSAs doing so, and 84% doing the same for health reimbursement accounts (HRA).

Healthy Lifestyles and Incentives

Among employers that offer incentives for healthy lifestyles, the average amount an employee could possibly earn is $383 a year, compared to $303 that a dependent could earn.

While there are still wellness programs for which only employees are eligible to participate, many employers are allowing spouses and children to access and utilize their online and

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telephonic wellness tools. Fifty-four percent of employers allow spouses to use online weight management tools, and 33% also allow children to use the tools.

Pharmacy Benefits

To manage pharmacy benefits, most employers use prior authorization (76%). The next most popular techniques are:

- quantity limits (72%)
- step therapy (65%)
- three-tier design (59%)

To manage specialty pharmacy benefits, the three most popular techniques are prior authorization (64%), utilization management (49%) and step therapy (49%).

Retiree Health

Sixty-five percent of employers offer benefits to their pre-65 retirees compared to 49% that offer benefits to retirees over age 65. Fewer employers offer retiree benefits to current active employees, with 26% covering all current actives and 38% covering a portion of their actives. Very few employers offer retiree health benefits for new hires, with 12% offering coverage to pre-65 retirees and 7% offering post-65 supplemental coverage to new hires.

The top strategies being used to control retiree health care costs are capping company contributions (45%), increasing employee contributions (31%) and eliminating coverage for future retirees (28%).

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About the Survey

The *Large Employers' 2012 Health Plan Design Changes* survey asks members to provide information on their 2012 plan offerings, including:

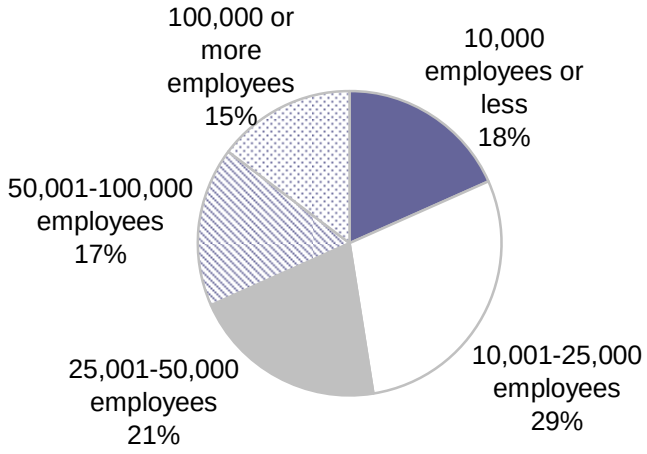
- Changes due to the Affordable Care Act
- Medical plan costs
- Consumer-directed health care
- Healthy lifestyles and incentives
- Pharmacy benefits
- Retiree medical coverage

The survey was fielded between June 1 and June 30, 2011, and reflects the plan design changes that employers are planning to make for 2012.

This year, 83 members participated in the survey.[2] The survey results reflect the plan design of various employers, ranging from those that have less than 10,000 U.S. employees to those that have more than 100,000 U.S. employees **(Figure 1)**.

Figure 1: Number of U.S. Employees

(Number of Responses=83)



Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

[2] Although 83 members completed the survey, they did not find all questions directly applicable. As a result, the number of responses varies by question.

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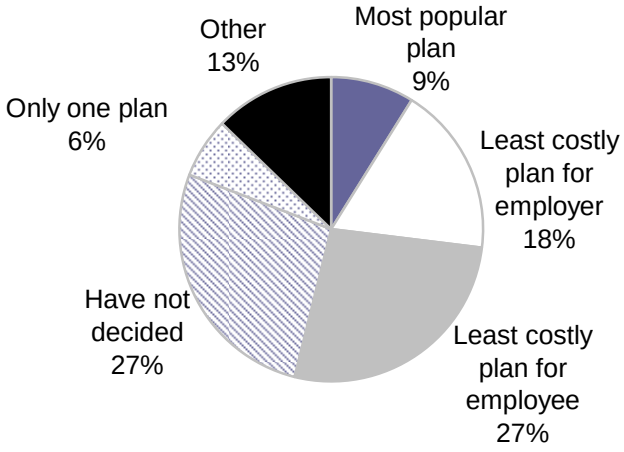
All Survey Findings

Changes as a Result of Health Care Legislation

As regulations from the Affordable Care Act have come into effect, employers have had to re-evaluate their health plan designs to conform to regulations and to control rising costs. We asked employers to indicate what changes they made and plan to make to comply with the health care legislation.

In anticipation of the new provision requiring employers to enroll new full-time hires in a health plan, employers were asked to select which plan they would use as the default health plan. Six percent of respondents indicated that they only offered one plan, while another 27% reported that they were still determining which plan they would select as the default plan **(Figure 2)**. Not surprisingly, the least costly plan for the employee was the most popular default selected by respondents of the survey.

Figure 2: Default Health Plan for New Hires
(Number of Responses=78)



Note: Other responses included: medium coverage plan; consumer-directed health plan; new plan designed to meet the ACA provisions; and union contract dictates default plan.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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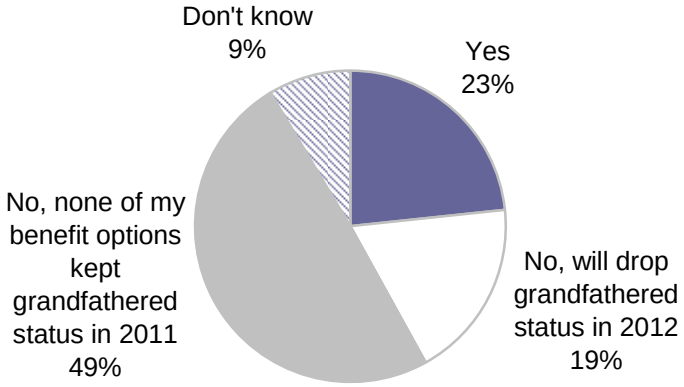
Twenty-three percent of employers will have at least one benefit option that keeps its grandfathered status in 2012, while 19% will drop the grandfathered status of any benefit options that had retained that status in 2011 **(Figure 3)**. Forty-nine percent of respondents did not have any benefit options in grandfathered status in 2011.

Figure 3: Employers Keeping Grandfathered Plan Status

(Number of Responses=81)

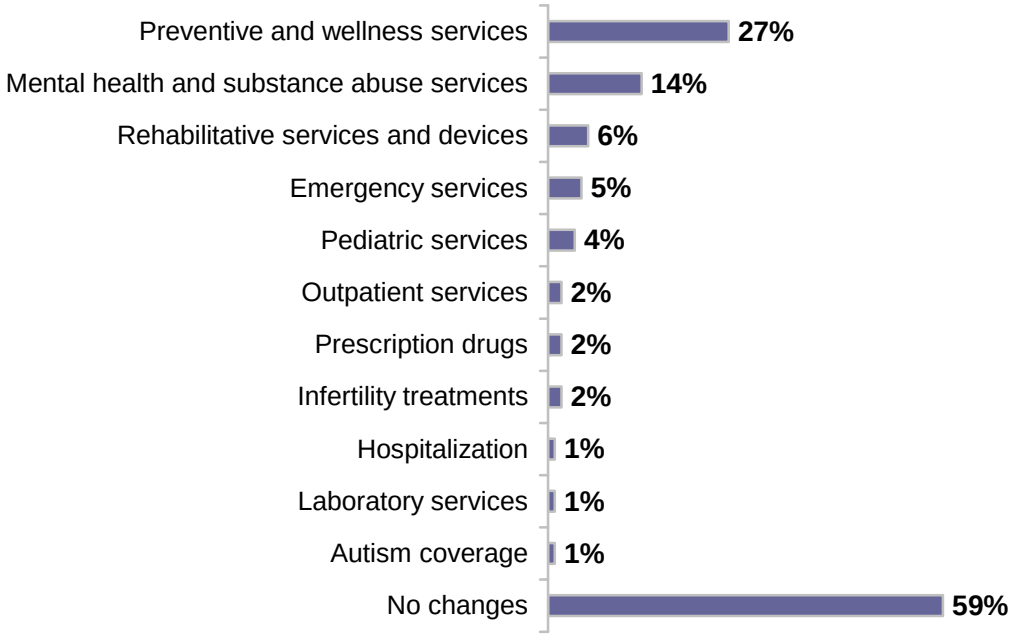


Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

Employers were asked if they made any changes to their annual benefit limits for 2012, as restrictions on annual benefit limits phase-in toward a complete ban in 2014. Majority of employers (59%) are not making any changes for 2012; however, more than a quarter (27%) of employers are making changes to annual benefit limits for preventive or wellness services **(Figure 4)**. Another 14% are making changes to annual limits on mental health and substance abuse services.

Figure 4: Changes to Annual Benefit Limits in 2012

(Number of Responses=81)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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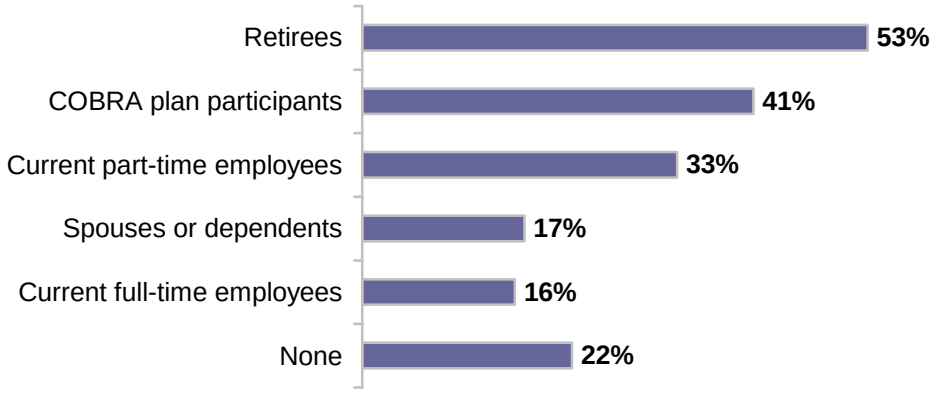
In regard to the health exchanges, employers were asked which groups of their employees would find the exchanges to be a viable option. Majority of employers (53%) indicated that some retirees might find the exchanges to be a useful option **(Figure 5)**. Additionally, many employers felt that COBRA plan participants (41%) and current part-time employees (33%) might find the exchanges to be a feasible option.

Figure 5: Employee Groups Expected To Find Health Exchanges a Viable Option

(Number of Responses=81)

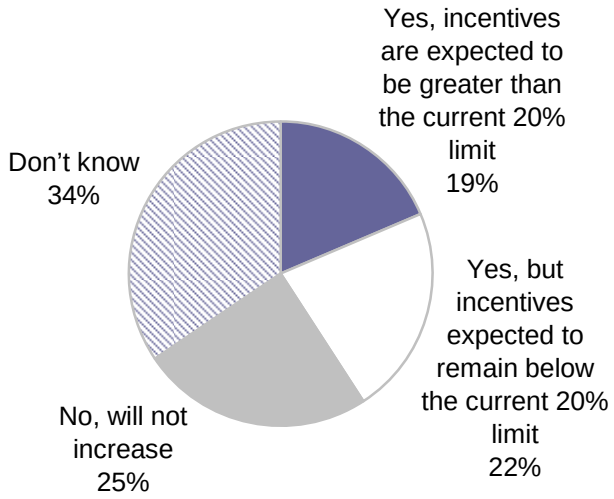


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

Employers were asked if they anticipated increasing wellness incentives as the HIPAA-allowed wellness incentive increases to 30% of total plan costs for an individual in 2014. A third of employers (34%) have not determined what they will do in 2014, but 19% of employers plan to increase incentives above 20% of total plan costs when the provision goes into effect **(Figure 6)**. Another 22% intend to increase incentives, but they will remain below the current 20% limit. Twenty-five percent of respondents do not have any plans to increase the level of incentives at this time.

Figure 6: Employers Expecting to Increase Incentives in 2014

(Number of Responses=81)



Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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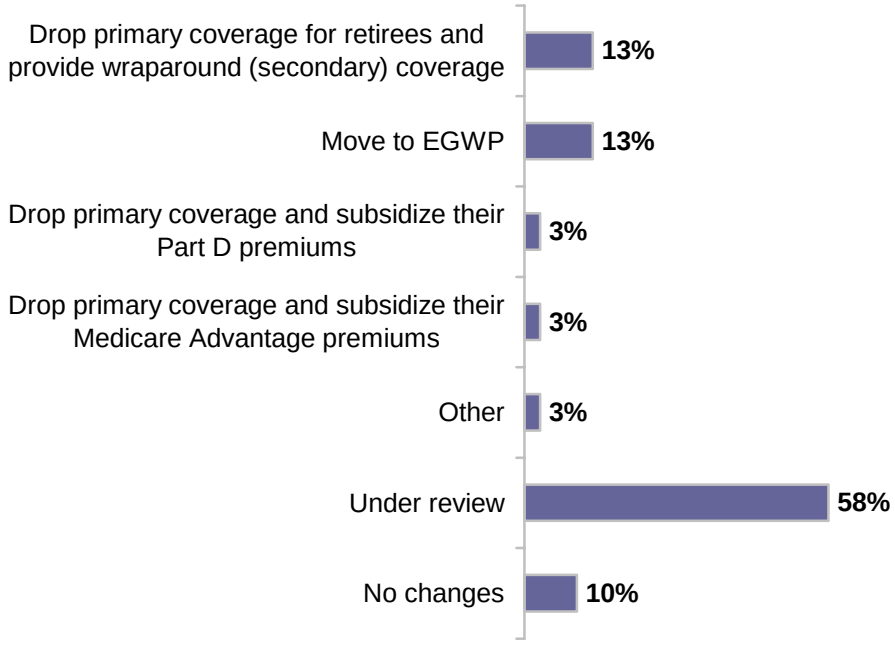
Of those employers who currently receive federal retiree drug subsidies (RDS), 13% are planning to drop primary coverage for retirees in lieu of wraparound (secondary) coverage in anticipation of the taxation of the RDS beginning in 2013. Another 13% of employers plan to move to an Employer Group Waiver Plan (EGWP). However, the majority of employers (58%) are still reviewing their options **(Figure 7)**.

Figure 7: Employer Reactions to Taxation of Federal Retiree Drug Subsidies

(Number of Responses=31)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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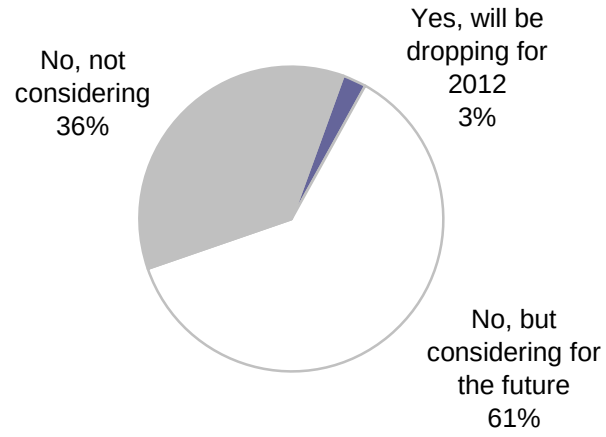
As a result of Medicare Part D becoming richer and the "donut hole" progressively closing (to be completely closed by 2020) employers who provide primary retiree health benefits to Medicare-eligible retirees are re-evaluating their plan offerings. For 2012, very few employers (3%) are planning to drop their primary retiree health benefits, but a majority of employers (61%) are considering doing so in the future **(Figure 8)**.

Figure 8: Dropping Primary Retiree Health Benefits for Medicare-Eligible Retirees as the "Donut Hole" Closes

(Number of Responses=39)

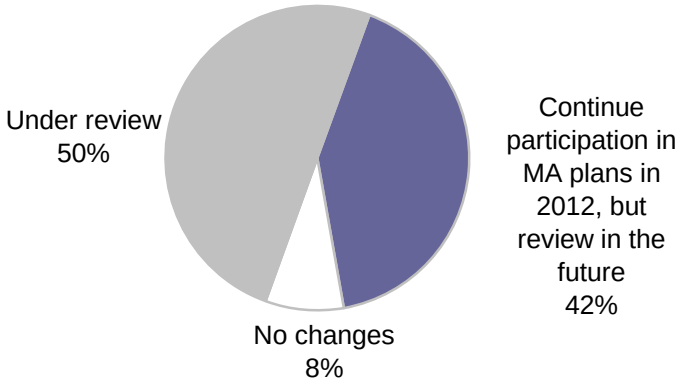


Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

For those employers who currently participate in a Medicare Advantage (MA) plan, no employers reported that they would drop their MA plans for 2012; however, 50% are currently reviewing their MA plans and 42% reported that they will review whether to continue participating in the future **(Figure 9)**.

Figure 9: Continued Employer Participation in Medicare Advantage

(Number of Responses=12)



Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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Medical Plan Costs

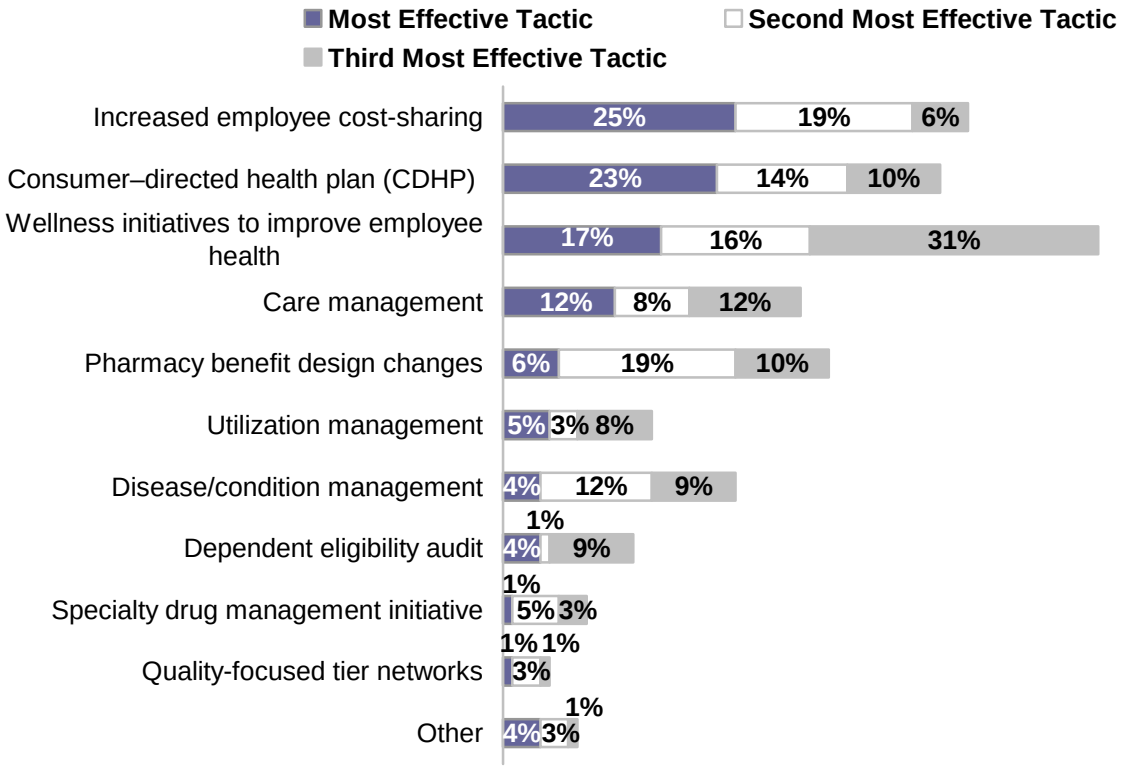
In this section, respondents were asked about current and future health care costs as well as their efforts to control these costs.

Employers were asked what percentage increase they were planning for 2011 budgeting purposes. The average increase for 2011 was 7.4%, which varied from no increase to a 15% increase. For those employers who indicated an estimate for 2012, the average increase was 7.2%.

When employers were asked what they consider to be the top three most effective steps they have taken or will take to control health care cost increases, the most effective tactic selected was increasing employee cost-sharing (25%), followed by offering a consumer-directed health plan (23%) and wellness initiatives (17%). Similarly, these tactics were most commonly reported as one of the top three most effective tactics **(Figure 10)**.

Figure 10: Most Effective Steps to Control Health Care Costs

(Number of Responses=77)



Note: Respondents were allowed to select more than one option.
Note: Other responses included: vendor management; switching PBMs; switching from copays to coinsurance; and network optimization.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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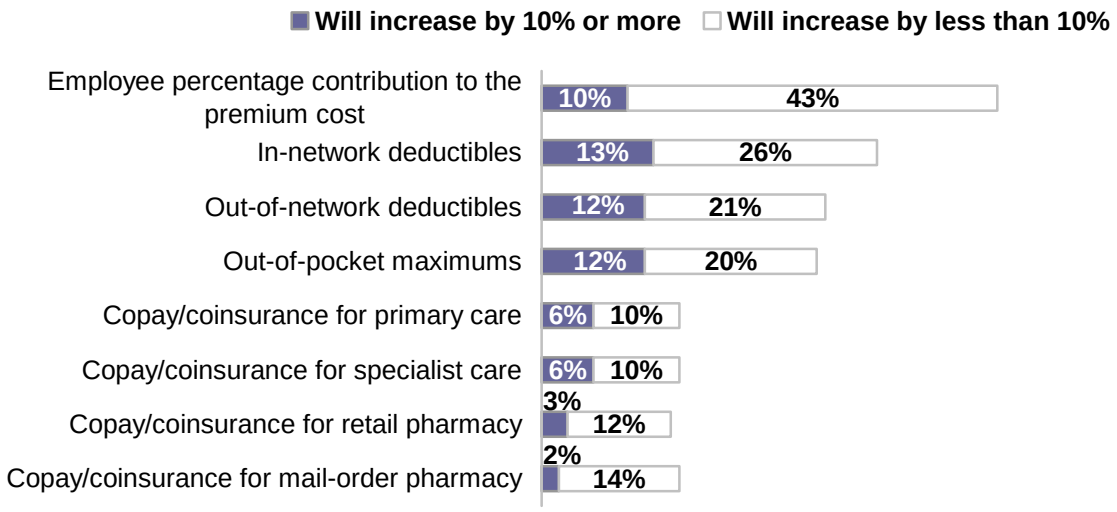
To combat rising costs, employers are using a variety of tactics. The most common tactic is increasing the employee percentage contribution to the premium with 53% of employers in 2012 using this strategy; however, most indicated that they would be increasing costs by less than 10% (Figure 11). Additionally, 39% of employers will increase in-network deductibles.

Figure 11: Employee Cost-Sharing Tactics

(Number of Responses=72)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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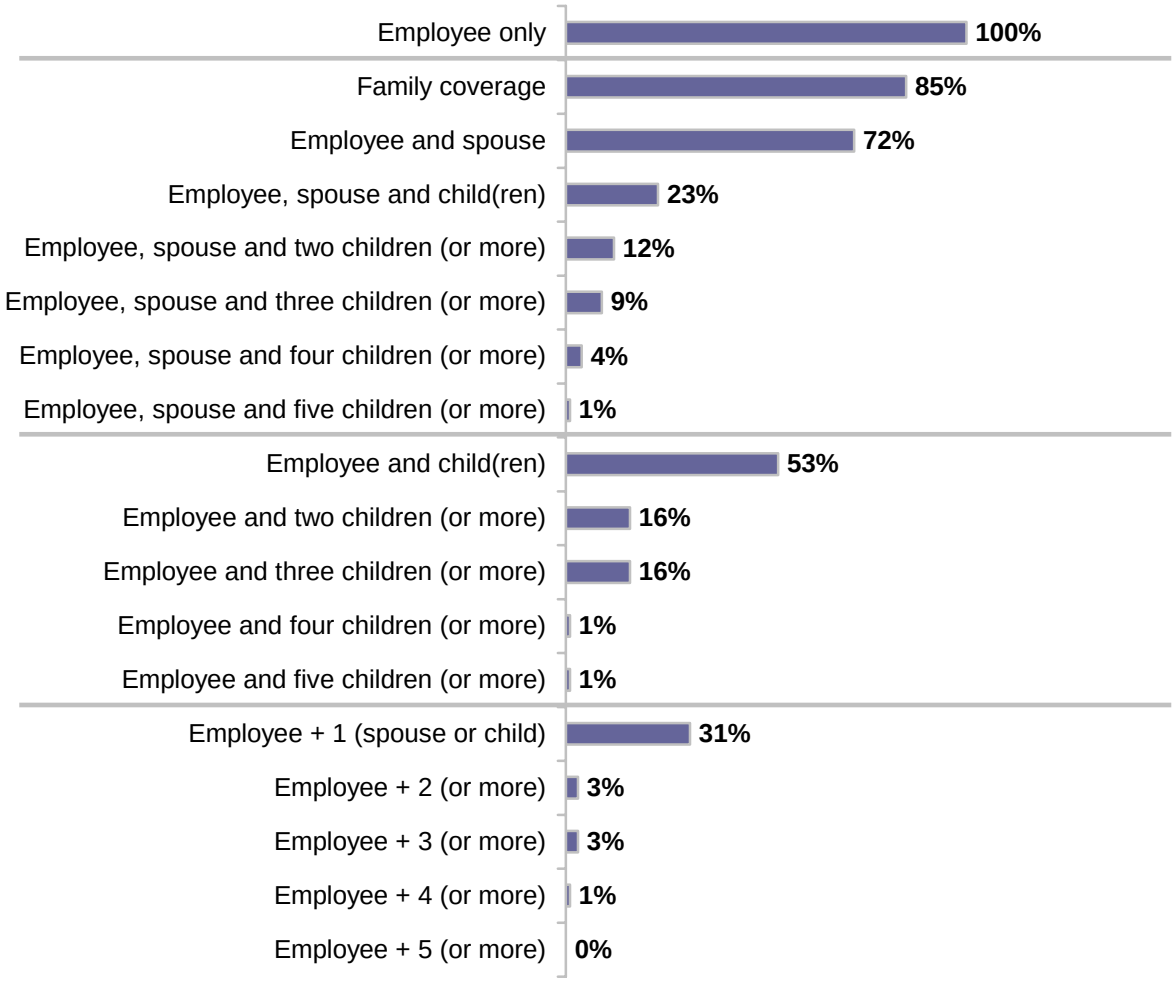
Employers were asked how they designed coverage tiers in their health plans. When asked to identify the tiers available in their most prevalent plans, the average number of tiers in a health plan was four, with tiers ranging from two to twelve tiers. In employers' most prevalent plans, the most prevalent tiers available were employee only (100%), family coverage (85%), employee and spouse (72%) and employee and child(ren) (53%) **(Figure 12)**. Consequently, the most common tier design was a 4-tier design with employee only, employee and spouse, employee and child(ren) and family coverage with a full third of respondents indicating this design.

While the numbers are still small, some employers are experimenting with a greater number of tiers. Twenty percent of respondents indicated having five or more tiers in place.

Figure 12: Prevalence of Different Types of Tiers in Employer Health Plans

(Number of Responses=72)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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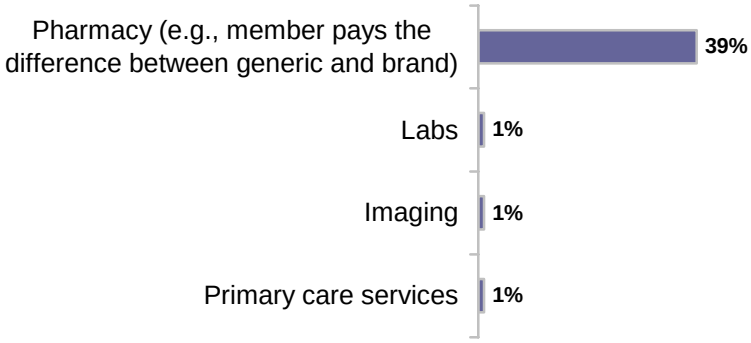
Few employers have begun using reference pricing for services beyond pharmacy. Thirty-nine percent of employers indicated that they require an enrollee to pay the cost difference between generic and brand name drugs **(Figure 13)**.

Figure 13: Use of Reference Pricing for Selected Medical Services

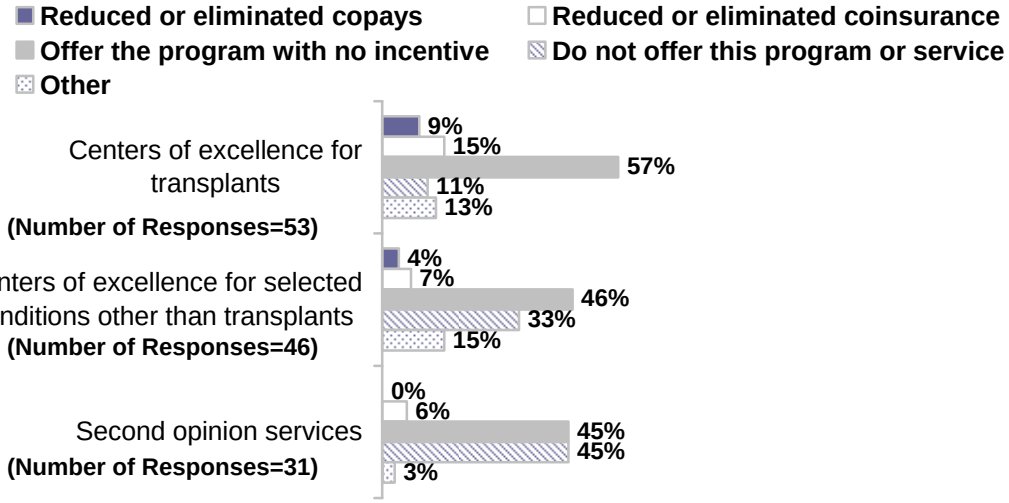
(Number of Responses=75)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

Few employers incentivize their employees to use centers of excellence (COEs). Majority of employers (57%) have COEs for transplants, but do not encourage their use with any type of incentive. Other employers reduced or eliminated copays (9%) or coinsurance (11%) **(Figure 14)**. An additional 13% had some other type of method of encouraging participation in the COE for transplants, mostly by mandating that all transplants be done at a COE.

Figure 14: Encouraging Use of Centers of Excellence and Second Opinion Services



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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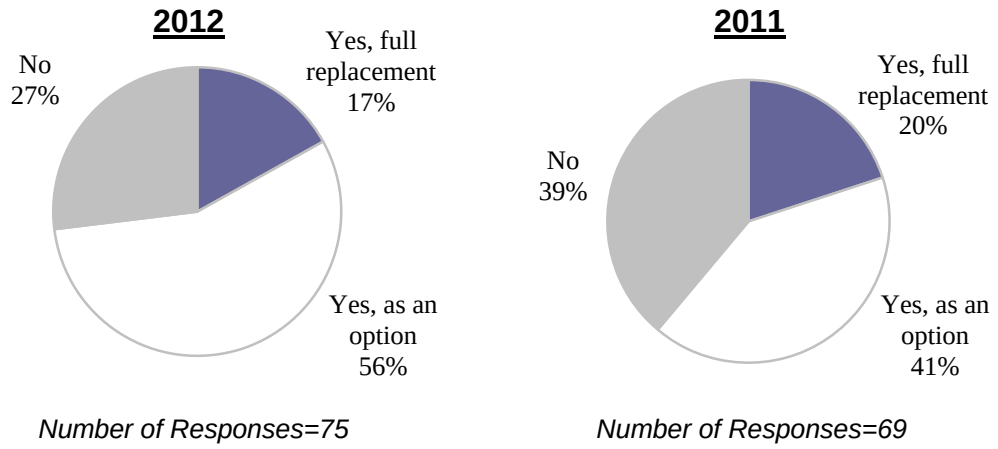
Consumer-Directed Health Care

More employers are offering consumer-directed health care (CDHP) than in previous years. In 2012, 73% of employers will be offering at least one consumer-directed health plan as compared to 61% in 2011 **(Figure 15)**.

Figure 15: CDHP Offerings in 2012 and 2011



Number of Responses=75 *Number of Responses=69*

Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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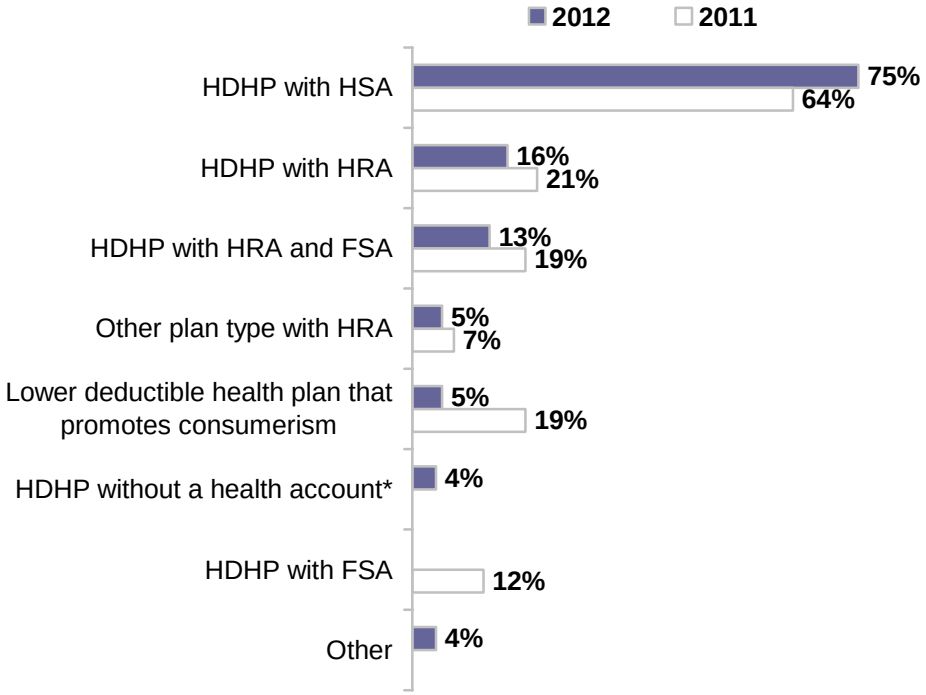
Among employers with at least one CDHP, the most prevalent type of CDHP was a high-deductible health plan (HDHP) with a health savings account (HSA) (75%) **(Figure 16)**. The remaining options had a much lower prevalence rate, with 16% offering an HDHP with a health reimbursement account (HRA) and 13% offering an HDHP with an HRA and a flexible spending account (FSA).

Figure 16: Prevalence of Consumer-Directed Health Plan Types in 2012

(Number of Responses=55)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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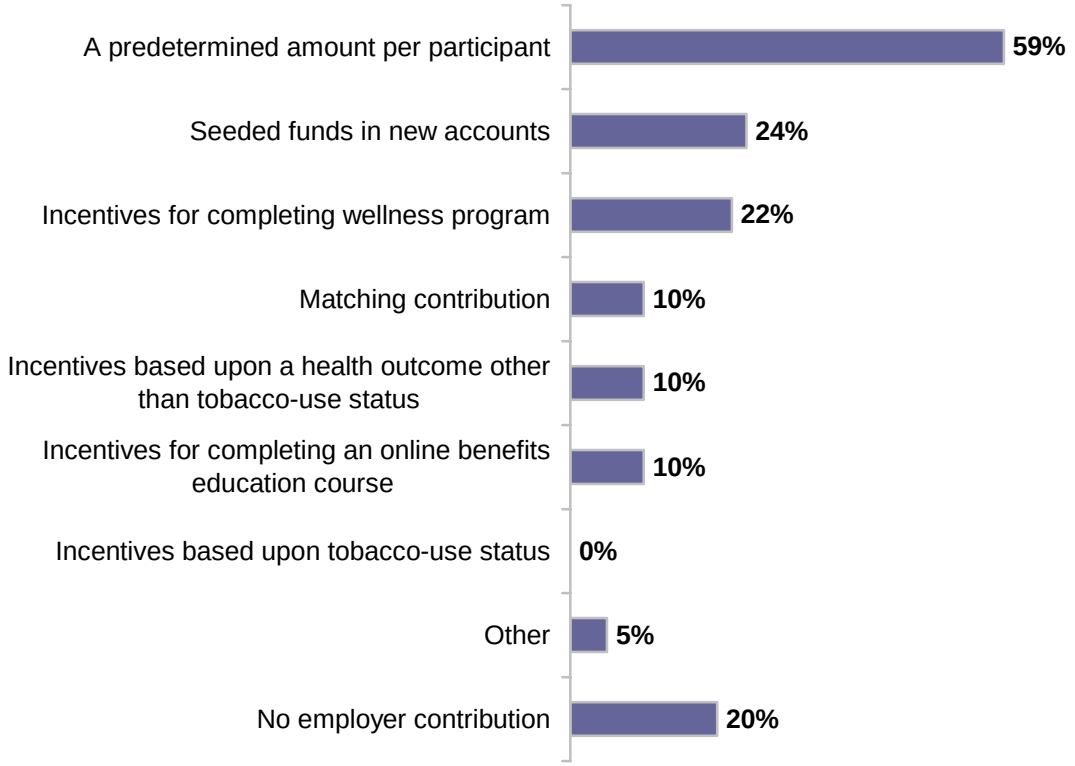
Employers that offer a health plan with a health savings account (HSA) were asked how they contributed to the account. Most employers (59%) contribute a predetermined amount per participant. Other contribution strategies included seeding funds in new accounts (24%) and providing incentives for completing a wellness program (22%). Twenty percent of respondents did not contribute to the accounts **(Figure 17)**.

Figure 17: Employer Contribution to Health Savings Accounts

(Number of Responses=41)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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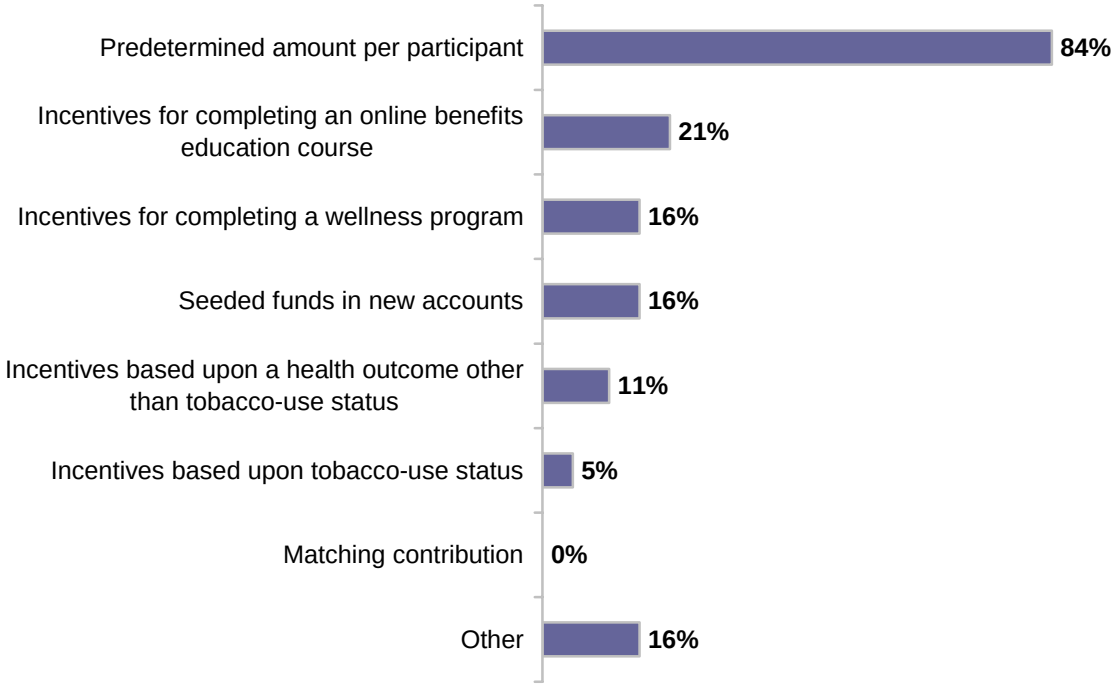
For employers that offer a health plan with a health reimbursement account (HRA), most of them (84%) contribute a predetermined amount to an employee's account. Other contribution strategies included offering incentives for completing an online benefits education course (21%), offering incentives for completing a wellness program (16%) and seeding funds into new accounts (16%) **(Figure 18)**.

Figure 18: Employer Contribution to Health Reimbursement Accounts

(Number of Responses=19)

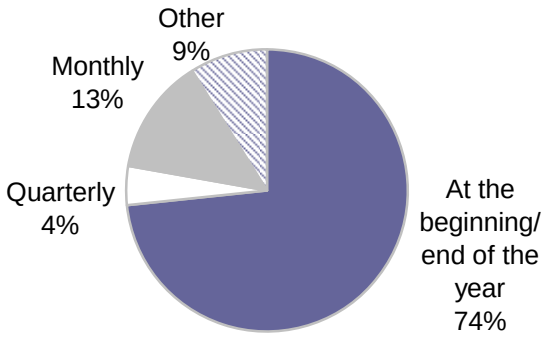


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

Most employers (74%) load an employee's health account at the beginning of the year, while others load the accounts quarterly (4%) or monthly (13%). Some employers load a portion of the amount every pay period **(Figure 19)**.

Figure 19: Loading of Funded Medical Accounts

(Number of Responses=45)



Note: Other responses included: per pay period contributions; splitting half of the amount at the beginning of the year and the other half loaded monthly; and it varies based on whether it is the HSA or HRA.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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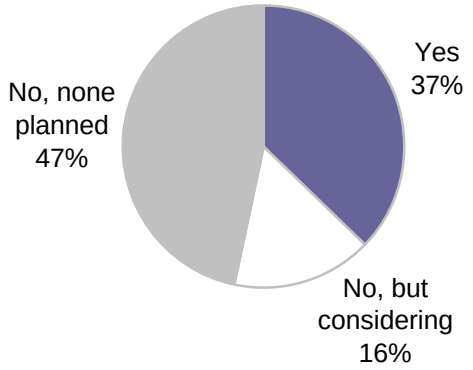
Healthy Lifestyles and Incentives

Employers were asked about a variety of initiatives they use to manage the health of their employees. Employers were first asked about the prevalence of on-site health clinics. Thirty-seven percent of respondents said that in at least one of their locations they had an on-site health clinic, and another 16% were considering implementing a clinic in the future **(Figure 20)**.

Figure 20: Prevalence of On-Site Health Clinics in at Least One Business Site

(Number of Responses=75)

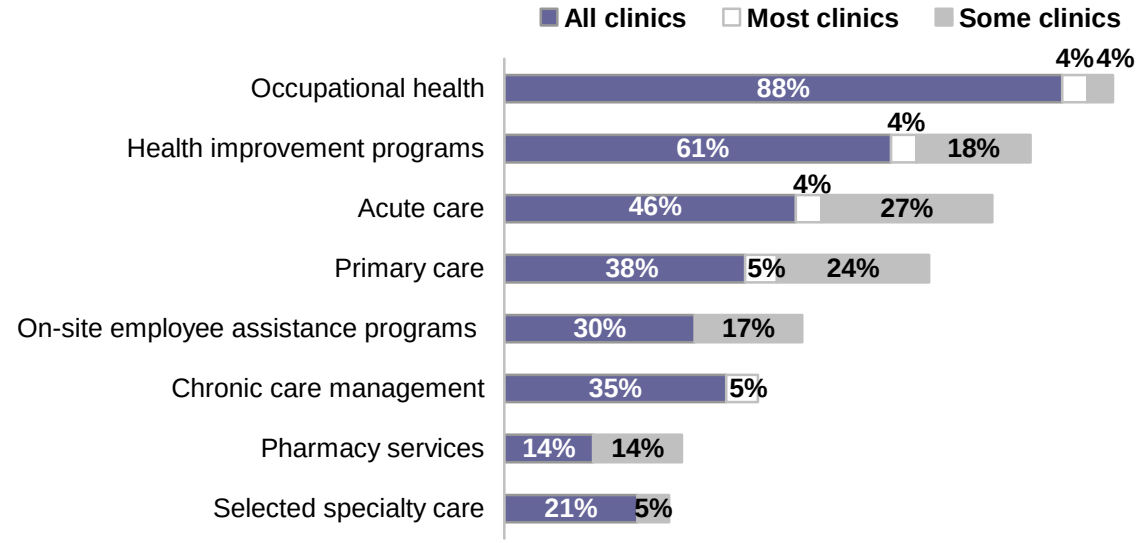


Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

The most common type of service provided at on-site health clinics is occupational health. Eighty-eight percent offer occupational health services at all of their clinics **(Figure 21)**. Other services include: health improvement programs (61% at all clinics); acute care services (46% at all clinics) and primary care services (38% at all clinics).

Figure 21: Services Provided at On-Site Health Clinics

(Number of Responses=77)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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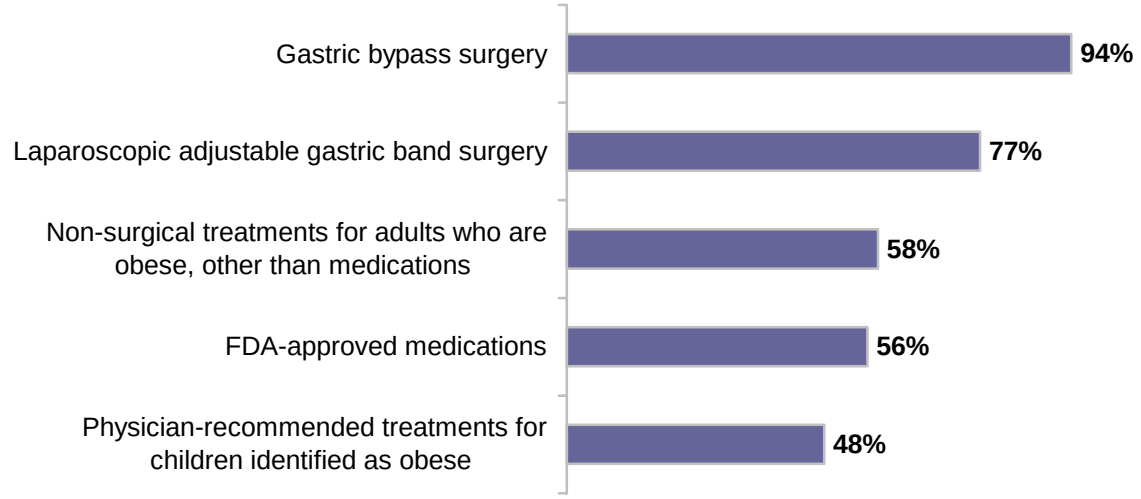
Employers were asked questions specific to obesity and morbid obesity treatments, and whether employers currently or will cover a variety of treatments. Nearly all employers (94%) covered gastric bypass surgery for qualifying adults, and most (77%) covered laparoscopic adjustable gastric band surgery **(Figure 22)**. Additional treatments covered by many employers included non-surgical treatments for obese adults such as office visits, behavioral counseling for diagnosis of obesity and meal replacement programs (58%), FDA-approved medications (56%) and physician-recommended treatments for children identified as obese (e.g., specialist visits and medically supervised programs) (48%).

Figure 22: Coverage of Treatments for Obesity and Severe Obesity

(Number of Responses=66)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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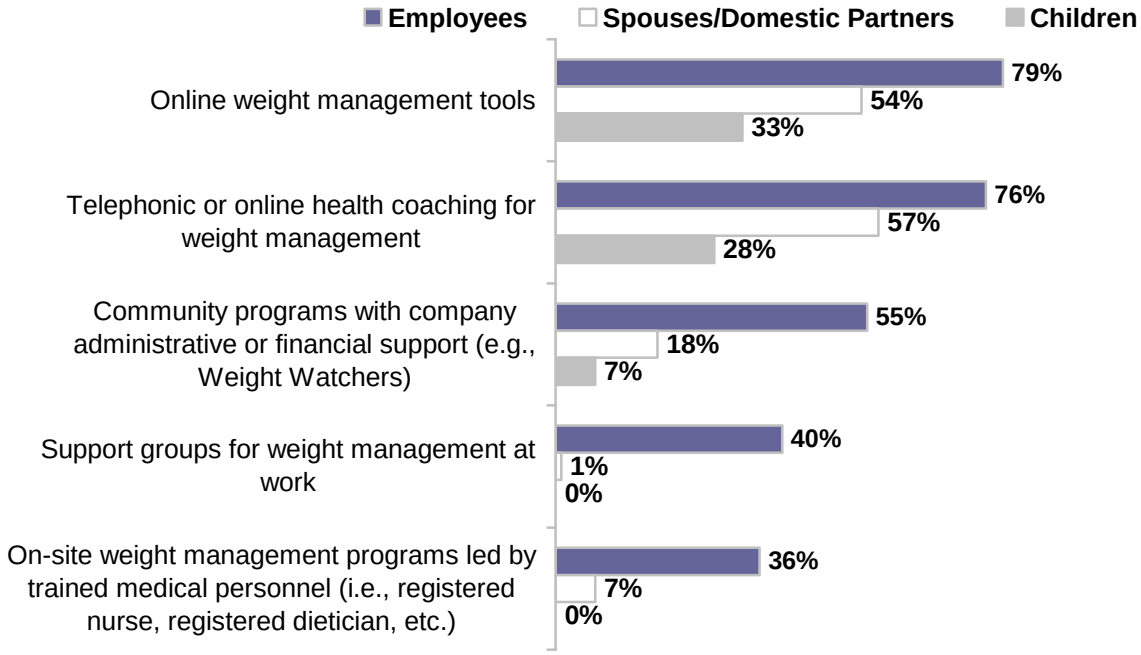
Employers were also asked about what programs were in place for overweight or obese employees, spouses and children. Online weight management tools were the most common option available to employees (79%), spouses/domestic partners (54%) and children (33%) **(Figure 23)**. Another program offered by many employers was telephonic or online health coaching for weight management. Seventy-six percent of employers offer health coaching for weight management to employees, and many employers also make it available to spouses/domestic partners (57%) and children (28%).

Figure 23: Programs for Overweight and Obese Employees, Spouses/ Domestic Partners and Children

(Number of Responses=67)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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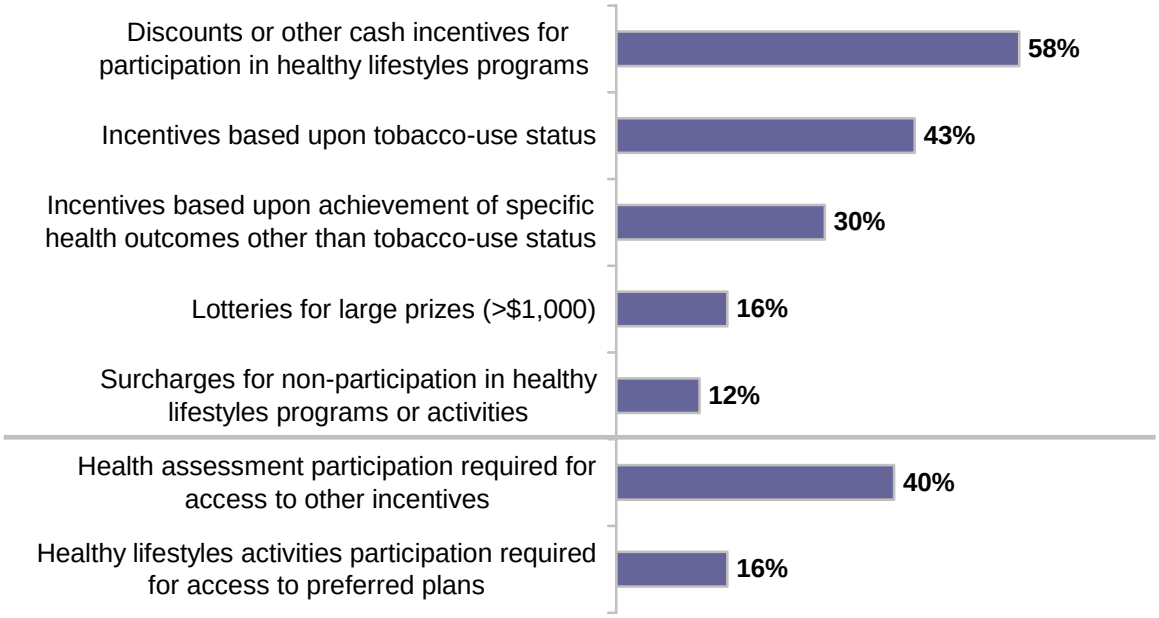
When asked how employers have incorporated incentives/surcharges into their healthy lifestyles programs, the most common types of incentives used were premium discounts or other cash incentives for participation in healthy lifestyle programs (58%) **(Figure 24)**. Other types of incentives included: incentives based on tobacco-use status (43%); incentives based on outcomes other than tobacco-use status (30%); lotteries for large prizes (16%); and surcharges for not participating in healthy lifestyles programs (12%). Additionally some employers require health assessment participation for employees to be eligible for any incentives (40%) or require participation in healthy lifestyles programs for access to preferred health plans (16%).

Figure 24: Role of Incentives in Encouraging Participation in Healthy Lifestyles Programs

(Number of Responses=67)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

Among employers that offer incentives, the annual amount that could be earned by an employee ranged from $50 to $1,000. The average amount was $383. Last year, the average maximum incentive an employee could earn was approximately the same at $386. For dependents, the amount that could be earned ranged from $50 to $750 with an average amount of $303 **(Figure 25)**.

Figure 25: Annual Incentive Amounts for Healthy Lifestyles

	Employee	Dependent
Mean	$383	$303
Median	$300	$250
Minimum	$50	$50
Maximum	$1,000	$750
Number of Responses	*43*	*25*

Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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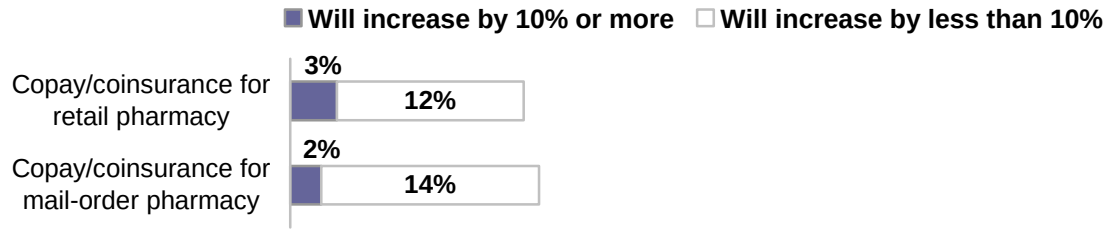
Pharmacy Benefits

Few employers are planning to raise the copay/coinsurance for retail pharmacy and mail-order pharmacy to help manage the rising costs of pharmaceuticals in 2012, but most employers will increase copays and coinsurance by less than 10% **(Figure 26)**.

Figure 26: Employee Cost-Sharing Strategies for Pharmacy

(Number of Responses =72)

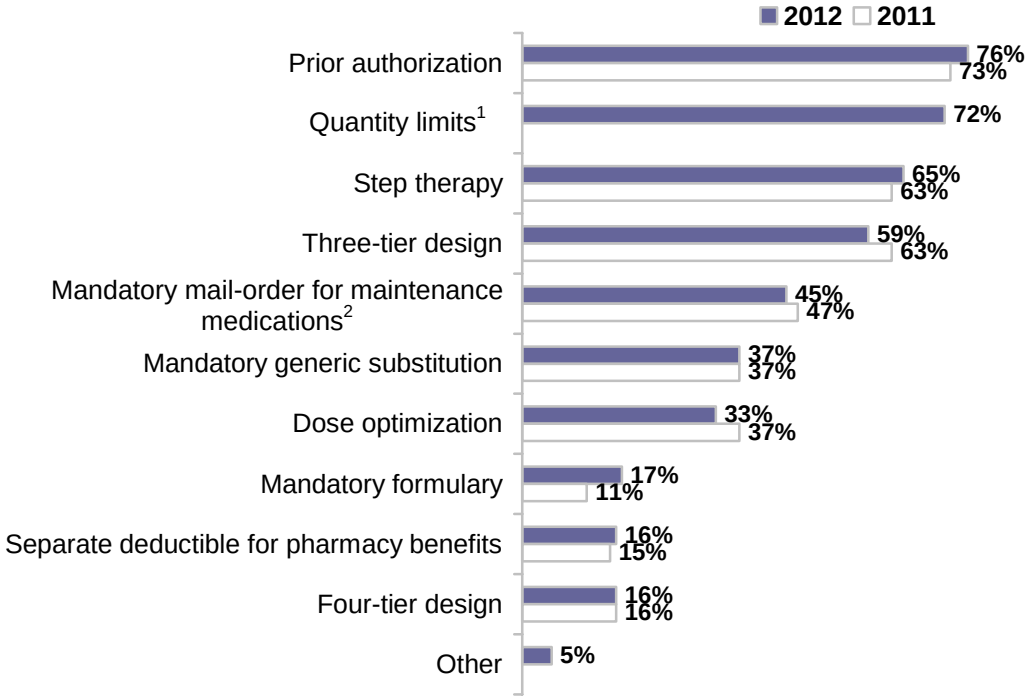


Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

When asked about what techniques employers are using to manage their pharmacy benefits, the three most popular techniques were prior authorization (76%), quantity limits (72%) and step therapy (65%). Other techniques include: three-tier design (59%); mandatory mail-order for maintenance medications (45%); and mandatory generic substitution (37%) **(Figure 27)**.

Figure 27: Pharmacy Benefit Management Techniques in 2012

(Number of Responses =75)



[1] Quantity limits were not asked about in 2011.
[2] When an employer implements mandatory mail-order, the employee may still receive his or her medications through retail. However, the employer only pays the equivalent to the mail-order cost level and the employee is responsible for the remaining portion.
Note: Respondents were allowed to select more than one option.
Note: Other responses included: pharmacogenomics; five-tier design; and education programs.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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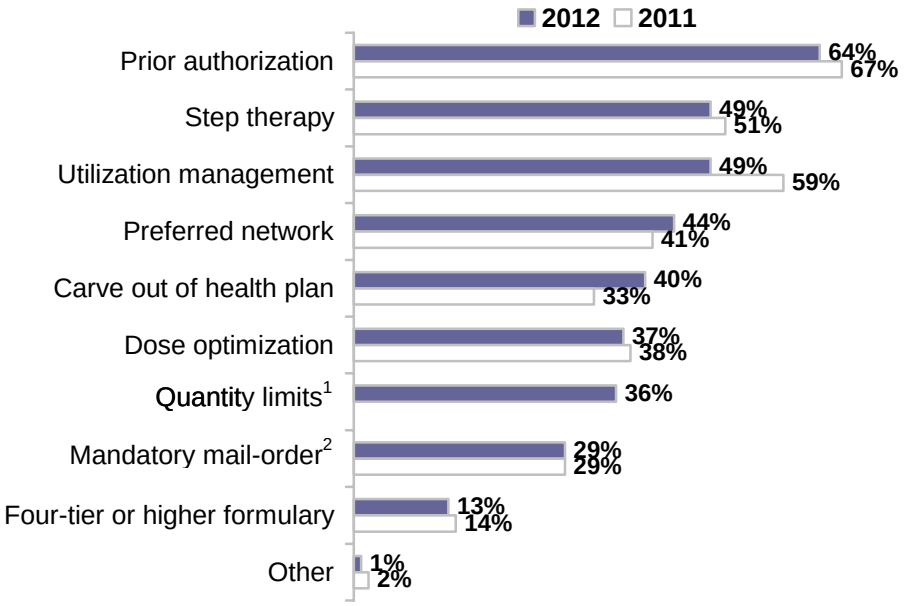
Similar to general pharmacy benefits, the most common technique employers use to manage the rising costs of specialty pharmaceuticals is prior authorization. Other methods include: utilization management (49%); step therapy (49%); preferred networks (44%); carve-out from the health plan (40%); dose optimization (37%); quality limits (36%); and mandatory mail-order (29%) **(Figure 28)**.

Figure 28: Specialty Pharmacy Management Techniques in 2012

(Number of Responses =75)



[1] Quantity limits were not asked about in 2011.

[2] When an employer implements mandatory mail-order, the employee may still receive his or her medications through retail. However, the employer only pays the equivalent to the mail-order cost level and the employee is responsible for the remaining portion.

Note: Respondents were allowed to select more than one option.

Note: Other responses included: pharmacogenomics; five-tier design; and education programs.

Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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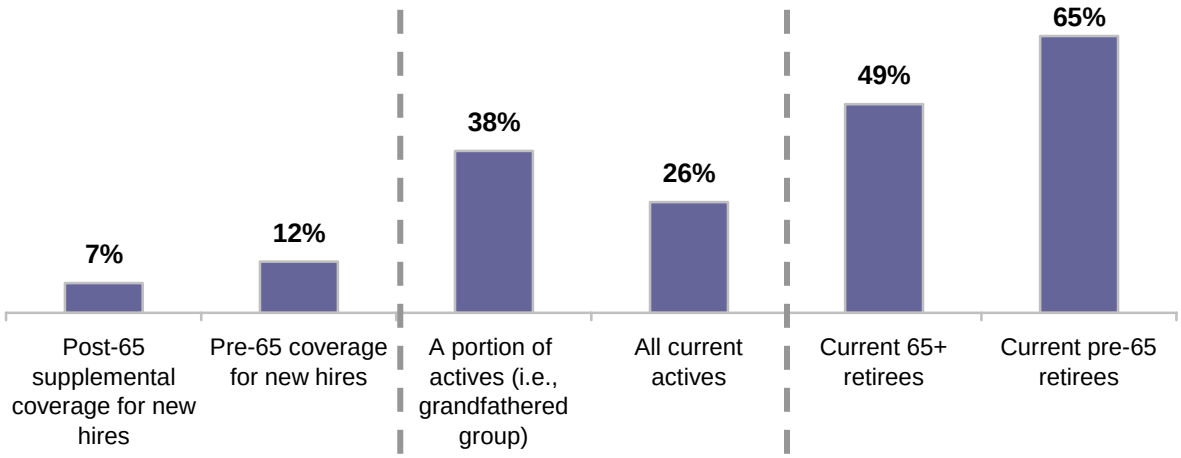
Retiree Health

As in previous years, employers were asked which groups they provide or will be providing medical coverage upon retirement. Among employees who have already retired, 65% of employers provide medical coverage for pre-65 retirees and 49% provide coverage for 65+ retirees. Among current active employees, 26% cover all current active employees and 38% cover only a portion of actives (i.e., grandfathered group). Very few employers offer retiree health benefits for new hires, with 12% offering coverage to pre-65 retirees and 7% offering post-65 supplemental coverage to new hires **(Figure 29)**.

Figure 29: Retiree Medical Coverage by Employment Type

(Number of Responses =73)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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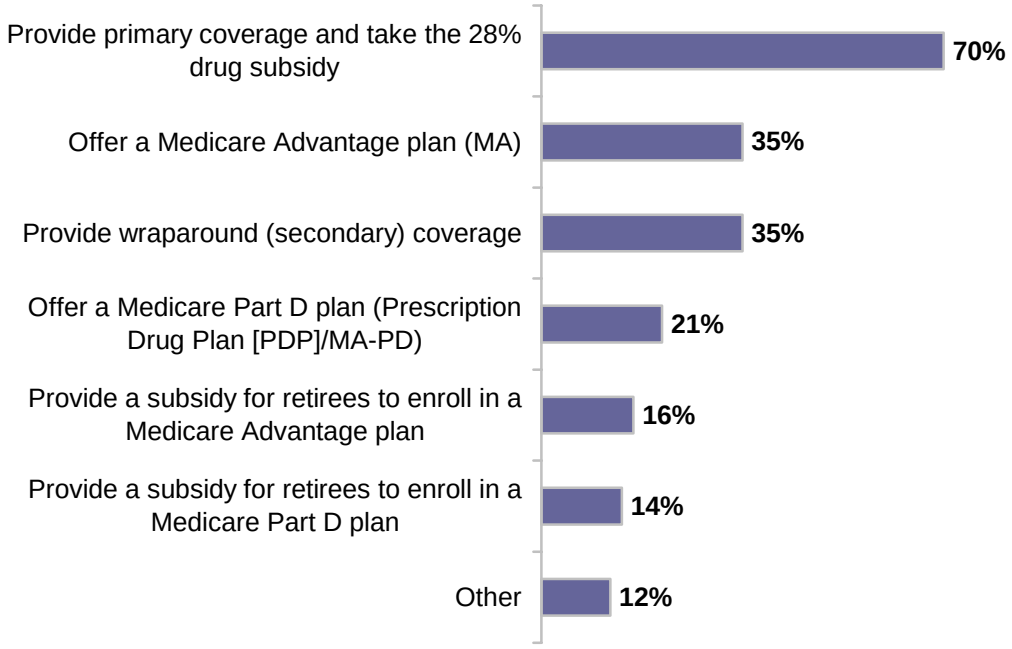
Of those employers that offer retiree coverage to post-65 retirees, the most common type of offering in 2012 was the 28% drug subsidy (70%). Over a third of employers (35%) offer a Medicare Advantage plan, another 35% provide wraparound or secondary coverage and 21% offer a Medicare Part D plan **(Figure 30)**.

Figure 30: Retiree Offerings in 2012

(Number of Responses =43)



Note: Respondents were allowed to select more than one option.
Note: Other responses included: offering an Employer Group Waiver Plan (EGWP); offering a retiree health reimbursement account; and offering an access only plan.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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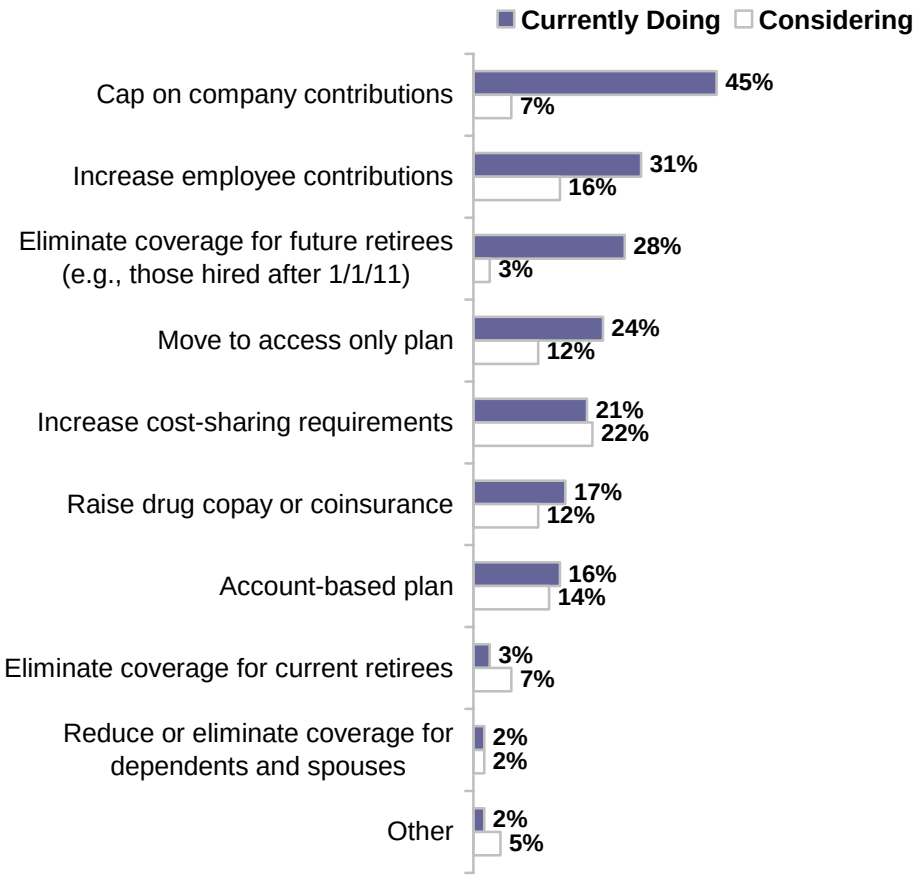
The most popular strategy for controlling retiree health care costs was placing caps on company contributions (45%) and increasing employee contributions (31%). Employers continue to show signs that they are moving away from offering retiree health benefits in the future by eliminating coverage for future retirees (28%) and moving to access only plans (24%) **(Figure 31)**.

Figure 31: Strategies for Controlling Retiree Health Care Costs

(Number of Responses =58)



Note: Respondents were allowed to select more than one option.
Source: National Business Group on Health, *Large Employers' 2012 Health Plan Design Changes*, August 2011.

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Conclusion

Employers continue to face a multitude of challenges posed by rising health care costs, the weak economy and the financial and administrative impact of complying with the Affordable Care Act. As a result, employers are being more aggressive in controlling costs and making certain that employees have more reasons to be more cost-sensitive consumers. In addition, employers are now more committed to encouraging employees and their families to maintain healthy lifestyles than ever before. Employers are also increasing the number and quality of health improvement programs that are available to spouses and children, and further encouraging participation with financial incentives.

Other Resources

For other sources of information relating to changes in plan design, please see the following resources.

- National Business Group on Health, Large Employers' 2011 Plan Design Costs, *Survey Report,* August 2010. http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=2820
- National Business Group on Health/Towers Watson, 16th Annual Employer Survey on Purchasing Value in Health Care, *Survey Report,* March 2011. http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=3059
- National Business Group on Health, Controlling Health Care Costs: What Employers Should Do, *Top Solutions*, January 2011. http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=3025

SURVEY Report

August 2011

Large Employers' 2012 Health Plan Design Changes

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Survey Report

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About The National Business Group on Health

The National Business Group on Health (the Business Group) is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care and health benefits challenges.

Business Group members are primarily Fortune 500 companies and large public-sector employers— representing the nation's most innovative health care purchasers—that provide health coverage for more than 50 million U.S. workers, retirees and their families. The Business Group fosters the development of a safe, high quality health care delivery system and treatments based on scientific evidence of effectiveness. Business Group members share strategies for controlling health care costs, improving patient safety and quality of care, increasing productivity and supporting healthy lifestyles.