The state of health care

Learn how today's health and benefits policies may affect your organization

Health benefits and policy changes depend on the priorities of the current administration. Staying up to date on policy trends may help your organization better manage this dynamic landscape.

Click the buttons below to explore some of the key topics associated with current health benefits and policy:

- Health policy timeline
- Trends to manage health care costs
- Obesity management
- Obesity treatments

Health benefits and policy regulations: a moving target over time

Loss of cost-sharing reduction (CSR) payments, which help contain lower-income members' out-of-pocket costs.[1*]

As a result of a new tax law, repeal of the **individual mandate is set to take effect in 2019.[2]**

Sign-ups through the federal marketplace during the open enrollment period exceeded expectations with a total of **8.8 million individuals.[2]**

2016 → **2017** → **2018**

States open public exchanges to employers with **100 or fewer employees.[3]**

The **employer mandate** extends to employers with 50 or more full-time equivalent employees.[4]

The Department of Labor proposes a rule to **allow individuals and small businesses to band together** to purchase health insurance that would be exempt from some of the 10 essential health benefits of the Affordable Care Act (ACA).[6]

For now, change is the only constant for the health care market

*Many state regulators allowed health plans to adjust premium rates after removing CSR payments prior to open enrollment to avoid a potential financial loss.[1]

Common strategies to help employers manage health care costs

CO-PAY ACCUMULATORS[7]

- With a co-pay accumulator, **manufacturer payments do not count toward a deductible** or out-of-pocket maximum obligations. The manufacturer funds prescriptions until the maximum value of its co-payment program is reached, after which, patient out-of-pocket payments begin counting toward annual deductibles and out-of-pocket maximums

CONSUMER-DIRECTED HEALTH PLANS[8]

- **75% of employers** offer one or more consumer-directed health plan options, a number expected to reach **82% by 2019**
- If you choose to offer consumer-directed health plans, consider developing **employee education materials** to help your workforce make smart decisions

HIGH-DEDUCTIBLE HEALTH PLANS (HDHPs)

- In 2017, **30% of large employers** offered HDHPs[9,a]
- HDHPs may allow you to **strategically avoid the Cadillac tax** by shifting some costs and health care management to employees[9]
- The Centers for Disease Control and Prevention's National Health Interview Survey reports that among all employees under age 65, **40% were in a HDHP in 2016 compared to 25.3% in 2010[8]**

[a]Large employers consist of 200 or more workers.

PRIVATE EXCHANGES[10]

- Under the ACA, employees can buy insurance on their own through **federal or state-sponsored private exchanges**
- The private exchange market is expected to cover about **40 million lives in 2018**
- Benefits to employers include:
  - Cost stability by shifting to a **defined contribution**
  - Administrative support and efficiency
  - The option to focus more on **wellness as a supplement** to the exchange carrier's offering
  - Improved **data collection** and aggregation

DIRECT CONTRACTING TO PROVIDERS[8]

- **23% of employers** are already **contracting directly with health systems or provider groups,** foregoing a relationship with health plans
- This type of contract may maximize and streamline employee health care utilizations
- Employer direct contracting with health systems and risk-based purchasing is gaining traction in **84% and 81% of markets, respectively**

POPULATION HEALTH

- Many employers are shifting toward a health management model that **inspires the workforce to actively change their behaviors** to elicit positive results[11]
- **85% of employers** currently have a **wellness improvement strategy** in place in an effort to help shape employee behaviors[11]
- Among employers utilizing a health system or provider group for population health management services, **23% also have a risk-based contract in place**, a number expected to more than double to 50% by 2019[8]

ONSITE AND NEAR-SITE CLINICS[8]

- **38%** of employers offer an **onsite clinic** for employees. An additional 4% of employers plan to offer an onsite clinic within the next 2 years
- The top 5 services offered at onsite clinics are immunizations, screenings, health education, workplace injuries, and preventative care
- Near-site clinics offer the same services as onsite clinics but involve a partnership between 2 or more employers to pool resources together into a shared clinic
- **One-fifth of employers** currently offer a near-site health clinic and 6% plan to add one by 2019
- **17% of employers** offer onsite-based pharmacies, a number expected to rise to 19% in the near future

CENTERS OF EXCELLENCE (CoEs)[8]

- Some employers are **establishing CoEs** on their own or with their medical plan carrier or third-party administrator for **various specialty areas**
- CoEs help ensure that employees with particular needs **receive quality care.** Consider this tactic if many of your employees have **complex needs,** such as those **associated with obesity**

NARROW NETWORKS

- Despite anticipation, employers contracting with **narrow networks,** which restrict physician networks and encourage contracts with retail pharmacies to control costs, has remained stable (8%)[9]
- When narrow networks are developed based only on minimizing costs, they may not provide the best quality of care. Consider **both cost and quality** if you're implementing this initiative
- The Employee Benefit Research Institute suspects employers have not moved more heavily into narrow networks due to[12]:
  - A lack of evidence for sustained long-term savings
  - Worry of whether particular hospitals and physicians will remain a part of these new and narrower networks year after year
  - **Political uncertainty regarding the ACA** in Washington, DC
- The use of narrow networks based on quality as well as price is projected to **increase by 42% of employers by 2019[8]**

Cross-sector collaboration may help your organization withstand the uncertainty of health care policy

Managing obesity may help cut costs for employers

Obesity is associated with both direct and indirect costs

ABSENTEEISM

Employees with a **body mass index (BMI) of 40 kg/m²** miss **~77% more days** of work versus employees of healthy weight (BMI=25 kg/m²).[13,a]

PRESENTEEISM

Men with **BMI ≥40 kg/m²** reported **21.9 days** of presenteeism, and women with the same BMI reported **22.7 days.**[14,b]

DISABILITY

There was a **70% difference in short-term disability days** between employees with and without obesity.[15,c]

WORKERS' COMPENSATION

Workers with **BMI ≥40 kg/m²** had **2x the average** number of compensation claims compared to workers of healthy weight (11.65 claims versus 5.80).[16,d]

Today, cost savings goes beyond traditional medical and pharmacy costs and employers are considered active participants in maintaining employee health[17]

[a]Missed work days are due to sick days, short-term disability days, and workers' compensation days.[13]
[b]Presenteeism is the average amount of time between arriving at work and starting work on days an employee is not feeling well and the average frequency with which an employee engages in 5 specific behaviors: losing concentration, repeating a job, working more slowly than usual, feeling fatigued at work, and doing nothing at work.[14]
[c]Difference in study was between BMI >30 cohort and BMI <27 cohort.
[d]Per 100 full-time employees.[16]

Treating obesity may require more than lifestyle interventions

There is a range of treatment options to help keep your employees healthy:

WELLNESS PROGRAMS[18]

- In early 2018, the Supreme Court ruled that Equal Employment Opportunity Commission (EEOC) must reconsider employer wellness regulations
- The EEOC may either:
  - Reduce the percentage of its allowable inducement (or penalty) below 30% of the employee cost for participation in any employer-sponsored wellness program to be considered voluntary, or
  - Return to its former position that any reward or penalty renders participation involuntary
- Evaluate your programs to consider whether incentives, rewards, or other systems are done in a compliant way and lead to effective outcomes
- Take a look at our **Measuring Wellness** guide on **NovoNordiskWorks.com** for tips on how to **measure the success** of your programs

ANTI-OBESITY MEDICATIONS[19]

- Clinical guidelines **recommend medication** use in addition to behavioral modification for people who have **struggled to lose weight** in the past
- **Weight-loss drugs may help adherence to behavioral changes** and aid in the physical activity needed to lose weight

BARIATRIC SURGERY[19,20]

- This treatment is recommended for **individuals with a BMI ≥40 kg/m², or BMI ≥35 kg/m² with 1 obesity-related comorbidity**
- There are several types of bariatric surgery, including Roux-en-Y gastric bypass, adjustable gastric band, biliopancreatic diversion with a duodenal switch, and vertical sleeve gastrectomy

Interested in learning more? Visit **NovoNordiskWorks.com**

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