Mercer

National Survey of Employer-Sponsored Health Plans 2020

survey report

welcome to brighter

About the survey

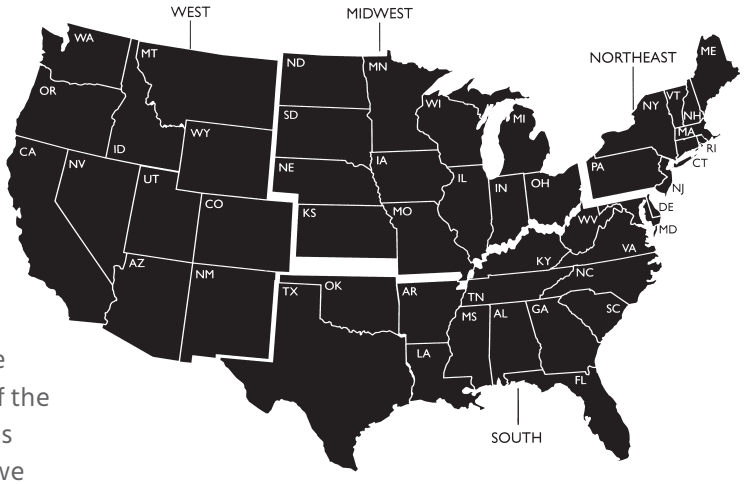
The survey results are representative of all US employers that have 50 or more employees and that offer health insurance. Since 1993, we have conducted the survey using a stratified national probability sample of US employers with 10 or more employees. Data was collected via a combination of telephone interviewing, an online survey, and a mailed questionnaire. In 2020, anticipating difficulties in reaching employers by phone or by mail at their worksites to recruit participation, we conducted the survey entirely online. Because participation in the smallest size strata (employers with 10–49 employees) was low, we have excluded them from the results. Where noted, we have restated the 2019 average cost per employee based on employers with 50 or more employees to show the year-over-year trend. Otherwise, any prior year results cited are based on employers with 10 or more employees.

Survey invitations were sent via email to all employers with instructions for accessing the web-based survey instrument. In total, 1,812 employers completed the survey. Of these, 821 are from the national probability sample; 991 are from the convenience sample.

The results from the random sample and the convenience sample were analyzed by survey scientists from the research firm SSRS who designed a weighting scheme that uses statistical calibration to allow for the combining of the convenience sample with the probability sample while minimizing potential bias from the non-probability based sample. Survey results have been weighted using employer size and geographic stratification to represent the approximately 246,000 employer health plan sponsors across the US with 50 or more employees. These organizations employ about 125 million full- and part-time employees.

Methodology

In 2020, the survey was fielded to a subset of employers selected in national probability samples used in the past three years, including private employers drawn from the D&B database and government agencies drawn from the Census of Governments. The survey is an enterprise survey, meaning that only one response per employer is accepted even if the employer has multiple work sites or establishments. In addition, we collected data from a convenience sample of clients and prospects.



The West region includes Alaska and Hawaii.

Industry groups used in the analysis	SIC code major group
Manufacturing	10–39
Transportation/Communication/Utility	40–49
Wholesale/Retail	50–59
Financial services	60–69
Services	70–89*
Healthcare	80
Government	91–97

*excluding 80

About the report

In the Overview, we present general findings for the entire surveyed population. Because health benefits vary greatly on the basis of employer size, we also examine results separately for large and small employers. We divide the two groups at 500 employees because our survey shows that plan characteristics change most dramatically at this point. The balance of the report looks at results for large employers only.

An appendix, containing tables of survey responses arranged by geographic region, industry and employer size, has been separately published.

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Report and tables $1,500
(tables not sold separately)

Key findings

1

Employers reported an overall increase of 3.4 percent in the average total health benefit cost per employee in 2020, but that varied sharply by employer size.

Disruption in care utilization in 2020 made cost projections difficult. Many large employers (those with 500 or more employees, typically self-funded) were able to adjust cost projections during the year and reported cost growth of just 1.9 percent on average, while small employers (those with 50–499 employees, more often fully insured), reported an increase of 6.9 percent, likely reflecting unadjusted premiums.

2

Employers largely avoided shifting health plan cost to employees in 2020

For a second year, there was little change in average deductible amounts or in other cost-sharing provisions among large employers. There was also continued movement away from full-replacement strategies in which a high-deductible consumer-directed health plan is the only plan offered. Only 10 percent of large employers now offer a CDHP as the only option at their largest worksite, down from 13 percent two years ago.

3

Enrollment in CDHPs continues to rise

With growth in offerings of CDHPs in 2020, enrollment in these plans rose to 38 percent of all covered employees, up from 36 percent in 2019. CDHPs are offered by 62 percent of small employers and 82 percent of large employers.

4 After years of little growth, telemedicine utilization jumped in first half of 2020

The average percentage of eligible members using the service at least once reached 14 percent among large employers in the first six months of 2020, up from just 9 percent in all of 2019. The great majority of employers (80 percent) say that virtual health care will play a larger role in their programs going forward.

5 For 2021, employers' priority is employee support — especially for mental health

Despite the troubled economy, few employers planned to cut health benefits in 2021 as way to reduce spending. Only 12 percent of employers said they would shift cost to employees in 2021, while 36 percent planned to add new benefits or resources to support employees — and this rises to 68 percent of those with 5,000 or more employees. In 2021, behavioral health is the top priority, by far, for large employers' well-being programs.

6 Employers focusing on benefits for remote workers

Employers with 5,000 or more employees were asked about benefits for employees working remotely. Apart from flexible work hours, digital behavioral health resources were the most common type of benefit offered to support remote workers — 60 percent currently offer them, with 48 percent planning to make them permanent — followed by organized online social events or activities.

Overview

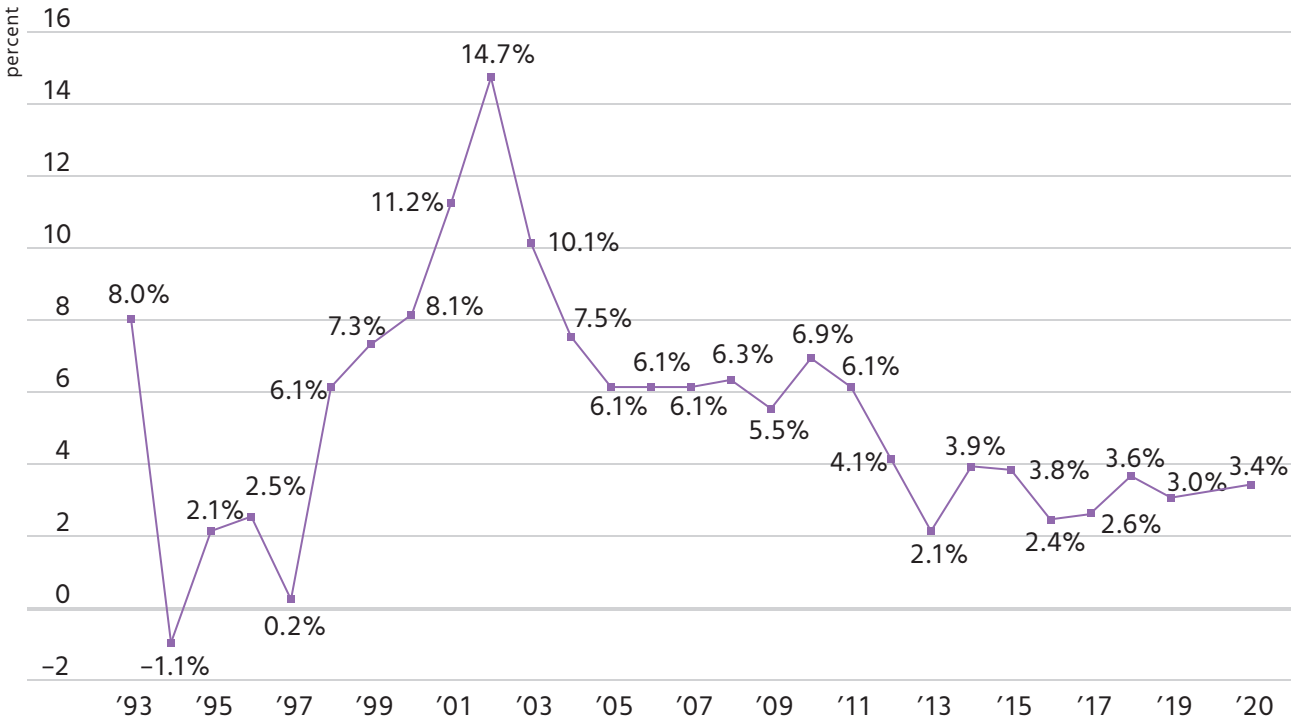
Employers with 50 or more employees

The COVID-19 pandemic had a significant impact on employer-sponsored health plan claims and cost in 2020. The survey was in the field from July through September, so employers provided cost for 2020 based on six months' of experience or their original budget. In a normal year, that's enough for a solid projection. But the major disruption in health care utilization that occurred as many facilities closed for non-emergency care, and many people chose to delay elective care, meant that cost trends were disrupted also. While some self-funded employers had already adjusted their cost projections for the year by the summer, others just provided their originally budgeted costs, as did most fully insured employers. Taken together, employers reported an average increase in total health benefit cost per employee of 3.4 percent, but that varied sharply by employer size, as we will discuss below (Fig. 1).

FIGURE 1

Annual change in average total health benefit cost per employee, 1993–2020

All employers

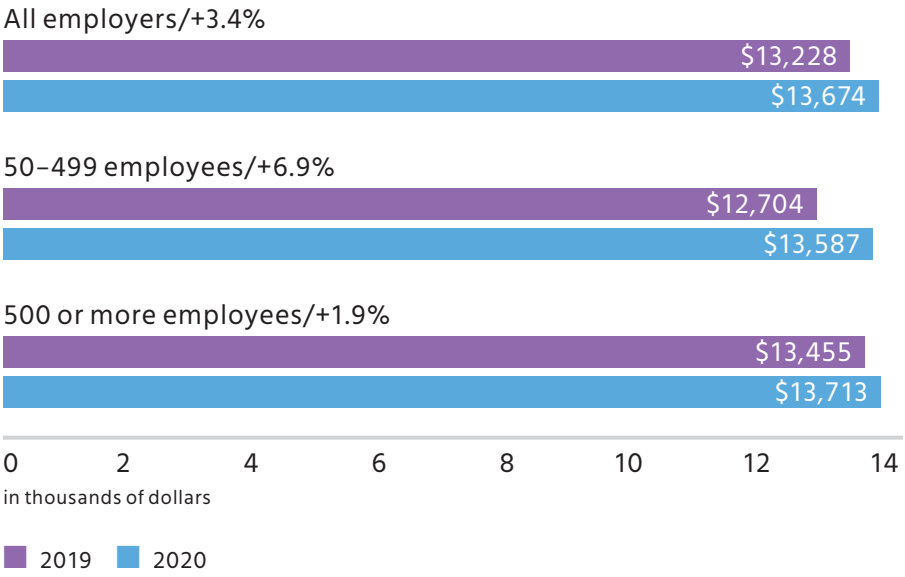


Note: From 1999 on, results are for active employees only; prior results include cost for retirees. Beginning in 2020, results are based on employers with 50 or more employees; prior results are based on employers with 10 or more employees.

FIGURE 2

Large employers report lowest cost increase in decades, reflecting disruption in utilization

Average total health benefit cost per employee



Based on projections made mid-year, total health benefit cost per employee averaged $13,674 in 2020 (Fig. 2). This includes both employer and employee contributions for medical, dental and other health coverage, for all covered employees and dependents. It does not include out-of-pocket costs.

Health benefit costs and cost increases vary widely

Most employers with 500 or more employees — mid-sized and large employers — are self-funded. By the summer, many of them had already adjusted their cost projections for 2020 downward to reflect the slowdown in health care utilization, resulting in the lowest average annual increase in two decades — 1.9 percent. Small employers — those with 50–499 employees — are most often fully insured, and fully insured plans would not see a decrease in cost in the current year. Small employers actually reported relatively stiff increases for 2020, averaging 6.9 percent. However, because many are likely to receive rebates from their carriers during the 2021 plan year, actual cost for 2020 is still something of a moving target at the time of this writing.

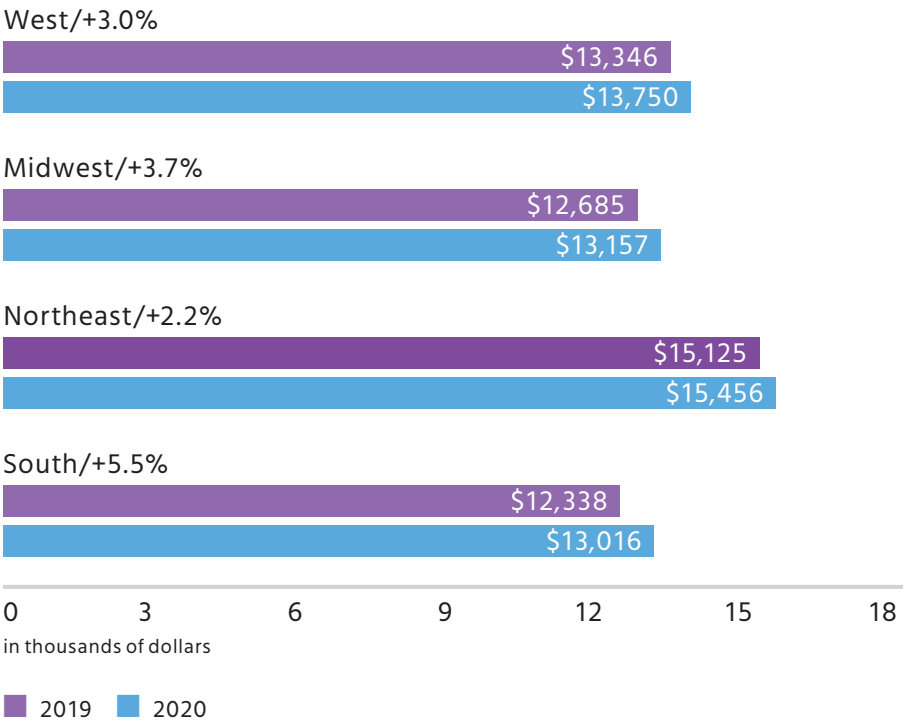
Employers with 500 or more employees typically report higher per-employee cost than small employers, reflecting generally richer benefit levels and higher levels of dependent coverage election. However, in 2020 the gap was unusually narrow — $13,713 compared with $13,587 — most likely because a substantial portion of larger, self-funded employers had already adjusted cost downward at the time the survey was conducted, while smaller, fully insured employers had not.

Average cost varies by geographic region as well, due to differences in the cost of living, employer benefit practices and health-care markets. In 2020, average per-employee cost was highest in the Northeast, at $15,456, and lowest in the South, at $13,016 (Fig. 3).

FIGURE 3

Total health benefit cost per employee, by region

All employers



Cost includes all medical, dental and freestanding health plans.

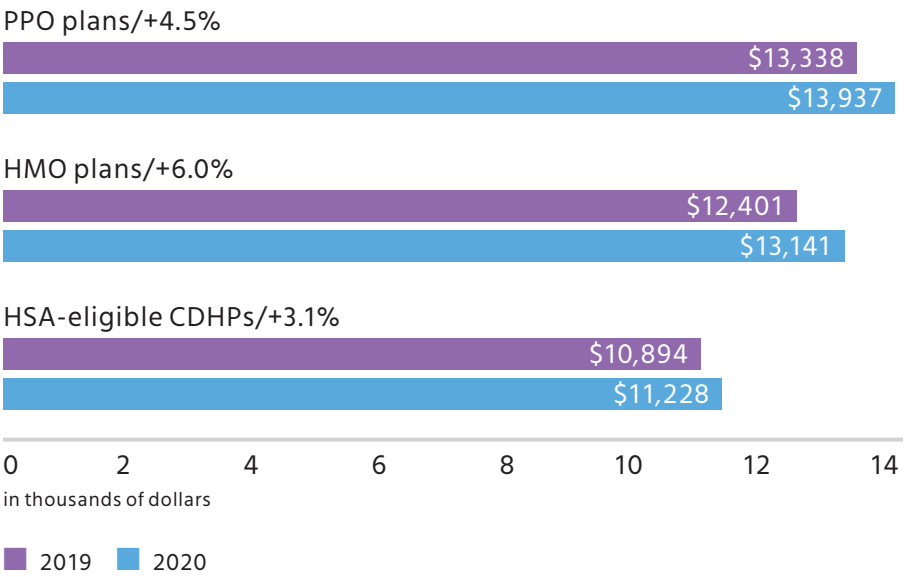
Medical plan cost and funding

PPO coverage is the most costly of the three medical plan types, averaging $13,937 per employee. While HMOs provide richer coverage than PPOs, average per-employee cost is significantly lower, at $13,141. Across employers' largest HMO plans, the average actuarial value (the percentage of total eligible expenses paid by the plan) is 94 percent compared with 87 percent for PPO plans; the trade-off, of course, is that members are required to seek care within a closed provider network. High-deductible consumer-directed health plans (CDHPs) that are eligible for a tax-advantaged health savings account (HSA) remain the least expensive type of medical plan; the average cost of coverage in these plans is $11,228 per employee, 19 percent lower than PPOs and 15 percent lower than HMOs (Fig. 4).

FIGURE 4

Medical plan cost per employee, by plan type

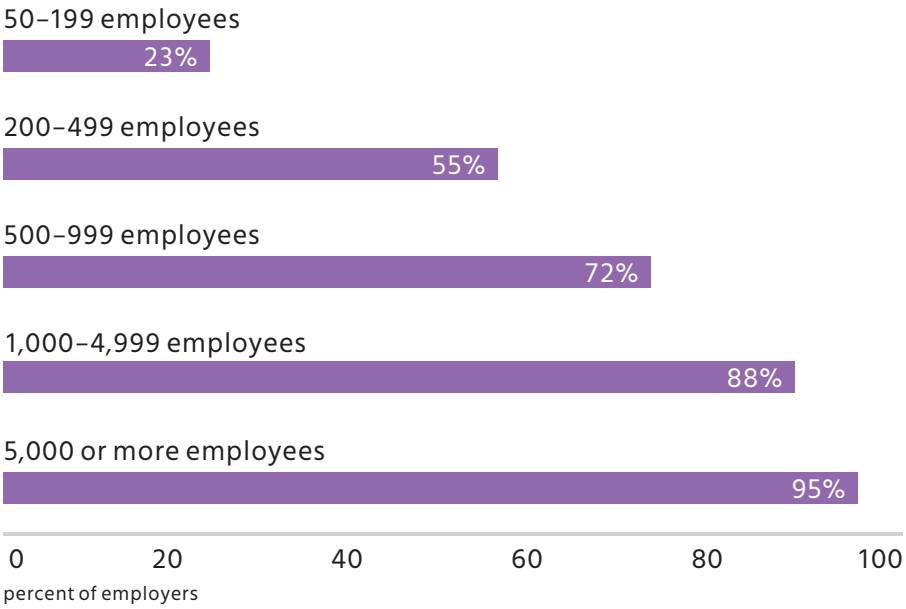
All employers



Does not include dental cost.

FIGURE 5

Self-funded primary medical plan, by employer size

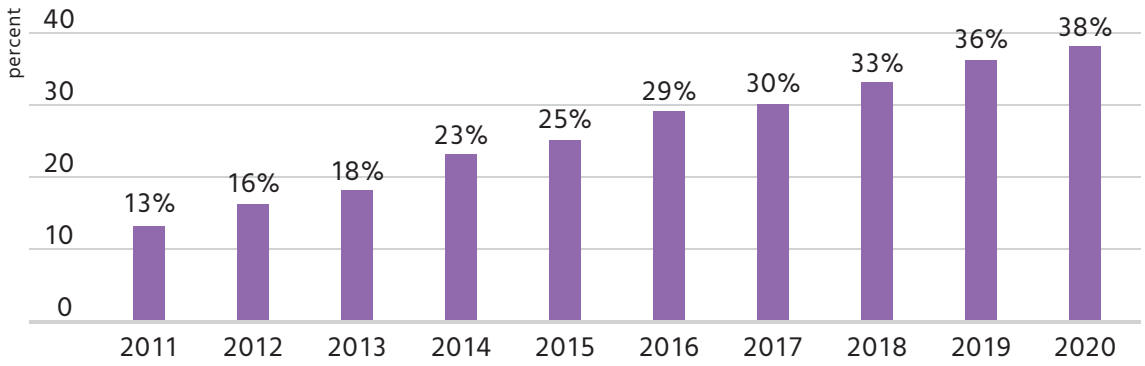


Self-funded vs insured plans Self-funding is relatively rare among small employers. Among those with 50–199 employees, only 23 percent self-fund. However, over the past two years we have seen growth in the use of self-funding among the next size group of employers — those with 200–499 employees — from 49 percent in 2018 to 55 percent in 2020. Among employers with 500–999 employees, nearly three-fourths (72 percent) self-fund, as do virtually all employers with 5,000 or more employees (Fig. 5). The use of stop-loss to mitigate the impact of big claims is also related to employer size. Almost universally used by self-funded employers with fewer than 5,000 employees, stop loss is becoming more common among larger employers to provide protection from very high cost claims for expensive new treatments and drug therapies. Among employers with 10,000 or more employees, 49 percent are self-funded with stop-loss. For these very large employers, the median per-person stop-loss deductible is a relatively high $750,000; for those with 500–4,999 employees, it is just $225,000.

FIGURE 6

CDHP enrollment growth continues at a steady pace

Percent of covered employees enrolled in CDHPs



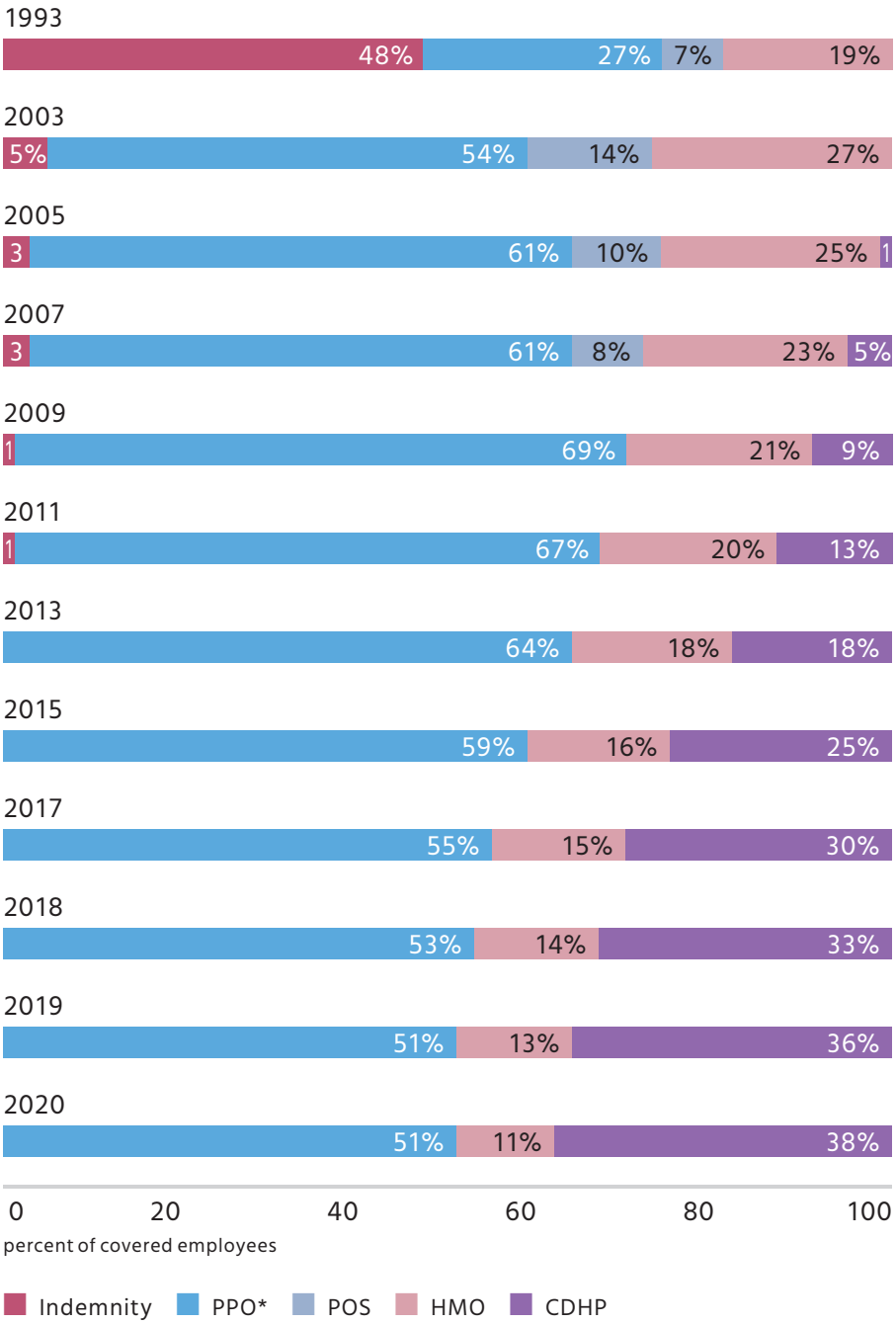
Enrollment in consumer-directed health plans continues to rise

Most consumer-directed health plans are high-deductible plans eligible for health savings accounts, although this category also includes health plans coupled with health reimbursement accounts. CDHPs have become a standard medical plan option, offered by 62 percent of employers with 50–499 employees and 82 percent of those with 500 or more employees. Compared to the growth in prevalence, growth in enrollment has been slow but steady, rising from 36 percent of all covered employees in 2019 to 38 percent in 2020, following a similar increase in 2018 (Figs. 6, 7). Medical plan enrollment varies significantly by region. CDHPs are most popular in the Midwest, where 42 percent of covered employees are enrolled, and less popular in the West, where just 31 percent are enrolled. In the West, 26 percent of all covered employees remain enrolled in HMOs, well above the national average of 11 percent (Fig. 8).

FIGURE 7

National employee enrollment, 1993–2020

All employers

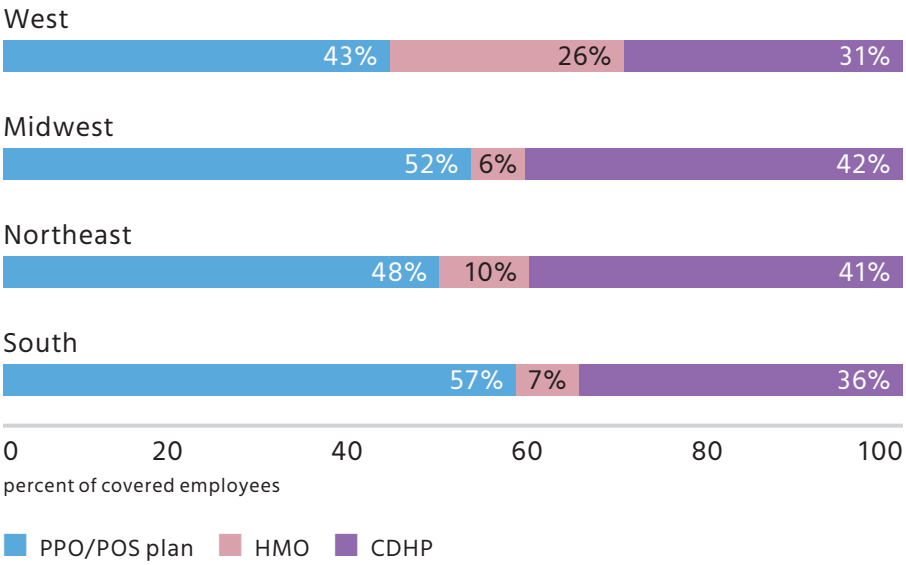


*Beginning in 2008, PPO enrollment includes POS plan enrollment.

FIGURE 8

Regional employee enrollment, 2020

All employers



Employers are using the events of 2020 to refocus priorities for 2021

In last year's report, as stringent pandemic restrictions were beginning to slow the economy, we wrote that the coming global recession might force employers to cut costs wherever they could, including in health benefit programs. Certainly, many employers pursued consumerism strategies during the last recession that involved giving employees more financial responsibility for out-of-pocket health-care spending.

So far, however, we have not seen this materialize. The survey found that relatively few employers planned to make changes to their programs for 2021 that would increase the financial burden on employees — in fact, as we will discuss, many added or expanded resources to support employees as they struggled to a greater or lesser extent with the disruptions of the pandemic. The unequal effects of the pandemic — which has killed Black,

Latin, Hispanic, and Native Americans at higher rates than whites — has shined a light on health disparities among different communities, and most employers rejected any action that might limit access to care for lower-income workers. In addition, the social justice movement sparked by the killing of George Floyd started conversations in organizations across the country, large and small, about what they could do differently to help end the systemic racism that breeds inequity.

But while most employers chose not to use cost-shifting tactics to manage health plan cost in 2021, they know that action will be needed to maintain a sustainable program in the challenging economy. More than ever, employers will need to commit to strategies that manage cost without shifting cost, such as steering employees to quality providers and maximizing the value of the health care received. Also on employers' agenda for the fast-arriving future: planning for a broader role for digital health care, which has been adopted by providers and patients during the pandemic at a pace that could not have been imagined just a year ago.

Health program strategy

Employers with 500 or more employees

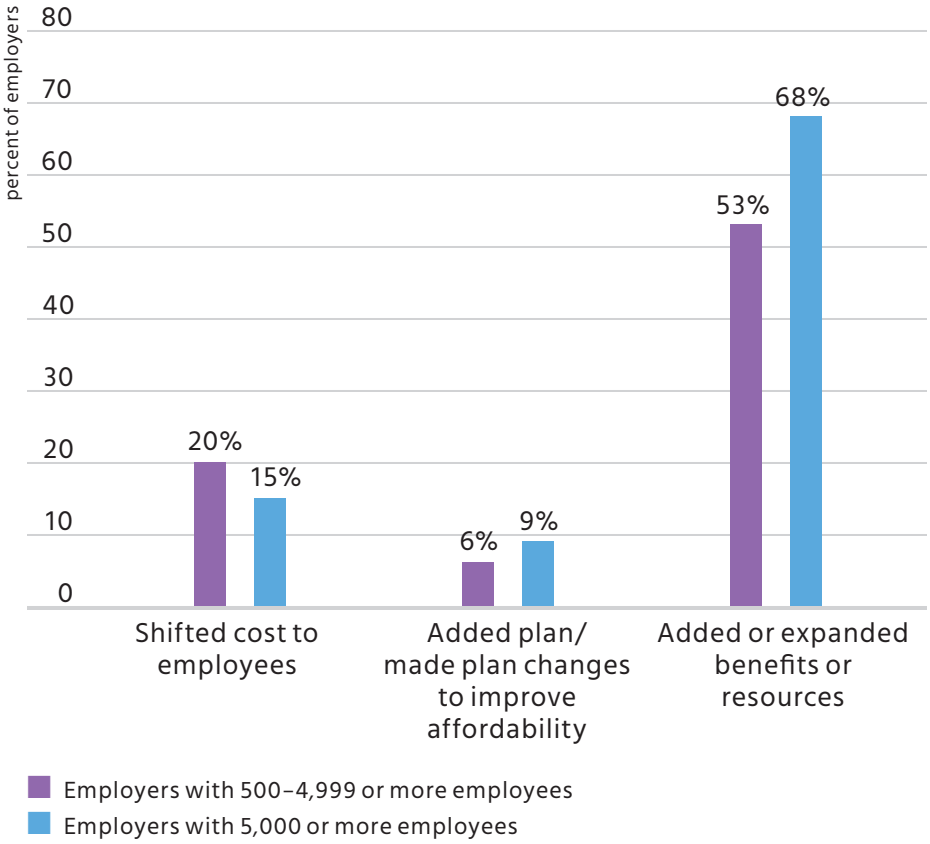
As employers deal with a confluence of crises — the economy, health of their people, racial and ethnic disparities and the sudden change in how people live and work — they have an opportunity to reinvent health and benefits offerings to derive more value from them. The need to manage cost without shifting cost to workers — and to counter the pandemic's negative impact on population health — is leading employers to network strategies that steer members to higher-quality providers and to explore new, more accessible forms of primary care. Behavioral health care is a critical necessity and employers have prioritized it in employee well-being initiatives. Emerging digital options are providing a "new front door" to health care, and employers are looking to capitalize on the pandemic-driven boost in telemedicine and other forms of virtual care. Employers also have a fresh opportunity to support a diverse, equitable and inclusive workforce by committing to health and benefits programs that are valued by minority groups and deliver equitable outcomes. And, with so many living and working differently today than a year ago, employers are planning for greater flexibility and rethinking what it means to deliver an exceptional health and well-being experience in a virtual work environment.

Consumerism strategies yielding to affordability concerns

Over the past two years, we have witnessed a flattening of annual increases in health plan cost-sharing provisions such as deductibles and out-of-pocket maximums, driven by growing concerns about health-care affordability among many large employers. The pandemic-driven slowdown in cost growth in 2020 helped make it possible for large employers to mostly avoid cost-management strategies that would increase health-care spending by their employees. Despite the economic troubles that often lead employers to cut benefits, surprisingly few said they would shift cost to employees in 2021 by raising deductibles or other cost-sharing provisions. Mid-sized employers — those with 500–4,999 employees — were the most likely to seek cost savings this way, at 20 percent (they also have the higher average cost per-employee compared to the other size groups). But only 15 percent of very large employers

FIGURE 9

Most employers avoided cost-shifting in 2021, while many added resources to support employees

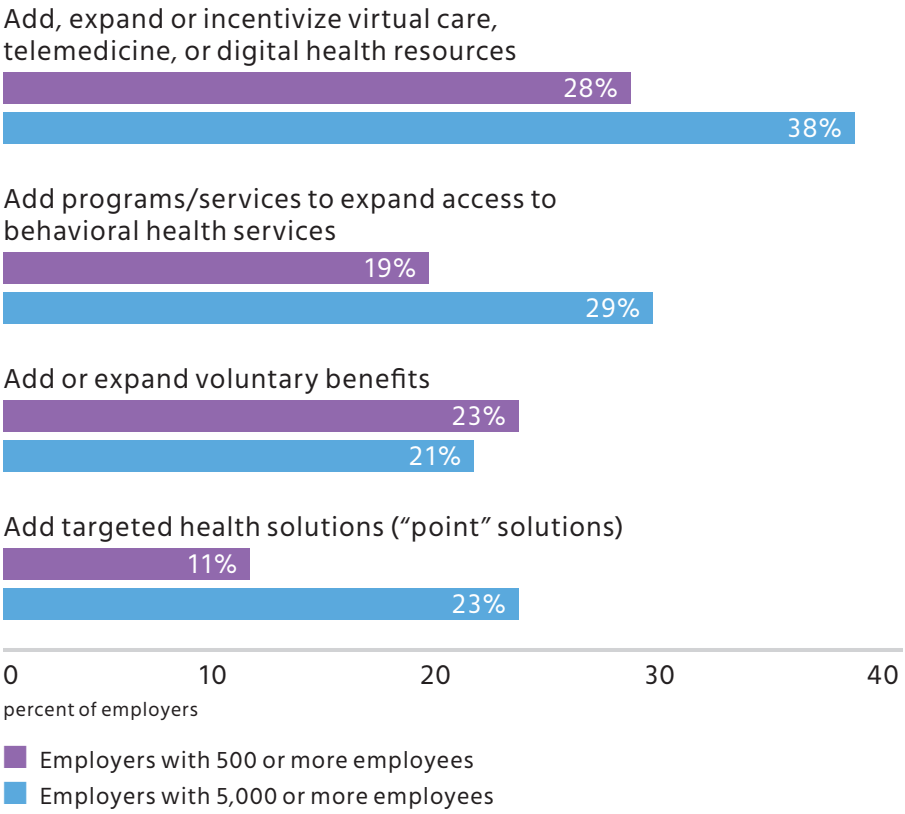


(those with 5,000 or more employees) planned to shift cost in 2021. In fact, some employers actually took steps to make health care more affordable for employees, by changing plan design or adding a plan with lower cost-sharing (Fig. 9).

Many planned to expand benefits or add new resources in 2021, especially the largest employers — more than two-thirds of employers with 20,000 or more employees found ways to provide additional support for employees in 2021. That support took different forms. To help employees access needed care while avoiding in-person visits to health facilities, employers added or expanded coverage for virtual care and telemedicine. They took steps to expand access to behavioral health care, such as by enriching EAP benefits or contracting with a behavioral health network.

FIGURE 10

Employers adding benefits and resources in 2021



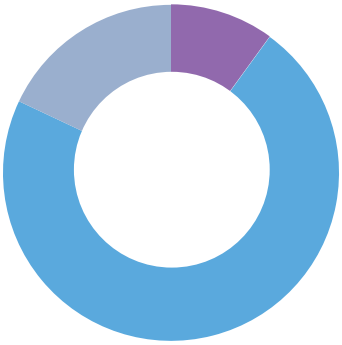
Some added new voluntary benefits to provide employees with options for minimizing various financial risks during uncertain economic times. A substantial number of very large employers (5,000 or more employees) added targeted health solutions (or "point solutions") that can empower employees to care for their own health, which is especially important when it's hard to see health-care professionals in person (Fig. 10).

Movement away from full-replacement strategies continues While the pandemic may have heightened employer concerns about health-care affordability, it is not a new issue. In our 2019 survey, we reported that some employers had reversed course on HSA full-replacement strategies as they learned that high-deductible plans were not a good fit for all employees, in particular those with little savings and/or significant

FIGURE 11

Few employers offer a CDHP as the only medical plan option

Employers with 500 or more employees



At the largest worksite, offer CDHP. . .

10% As full replacement

72% Alongside another plan

18% Do not offer CDHP

health expenses. That trend has continued in 2020. Just 10 percent of large employers offered a full-replacement CDHP at their largest worksite in 2020, down from 12 percent in 2019 and 13 percent in 2018. Among the largest employers (20,000 or more employees), the prevalence of full-replacement CDHPs has fallen sharply over the past two years, from 22 percent in 2018 to just 15 percent in 2020. These very large employers typically have a diverse workforce, and while an HSA plan might work well for a large segment of their population, most employers are now more comfortable providing a choice of plans (Fig. 11).

Of course, for many employees, a CDHP is a smart financial choice. HSA-eligible plans cost on average about 20 percent less than a traditional PPO. This can translate into significantly lower paycheck deductions along with the opportunity for tax-advantaged savings, both of which can help offset the higher deductible. In years when an employee's health expenses are low, their savings build up. In this way, HSA-eligible plans offer a tax-efficient means of saving for post-retirement health-care expenses.

The new "Transparency in Coverage" regulations will require most group health plans and insurers, as of January 1, 2023, to disclose out-of-pocket cost information and the underlying negotiated rates through an internet-based self-service tool for 500 shoppable health services. While this is a promising development, currently quality metrics are not required for the self-service tool, which would limit its effectiveness in supporting consumer decision-making.

Managing cost by seeking higher-value health care

As employers seek to control health plan cost without shifting cost, they are pursuing strategies for steering employees to higher-quality, higher-value providers, with the expectation that they will save money by reducing waste and getting better outcomes.

Specialty pharmacies One area where seeking value is especially important is the prescription drug benefit, where cost has been outpacing other medical plan costs for years, largely due to the explosion of expensive specialty drugs used to treat complex conditions like cancer, hepatitis and hemophilia. Cost for specialty drugs grew by a whopping 11 percent in 2020. In addition to preferred pricing, a specialty pharmacy provides enhanced care management for patients requiring these drugs, sometimes even arranging for infusions to take place in the patient's home rather than a hospital. In 2020, 71 percent of employers with 500 or more employees reported that they actively steer employees to a specialty pharmacy.

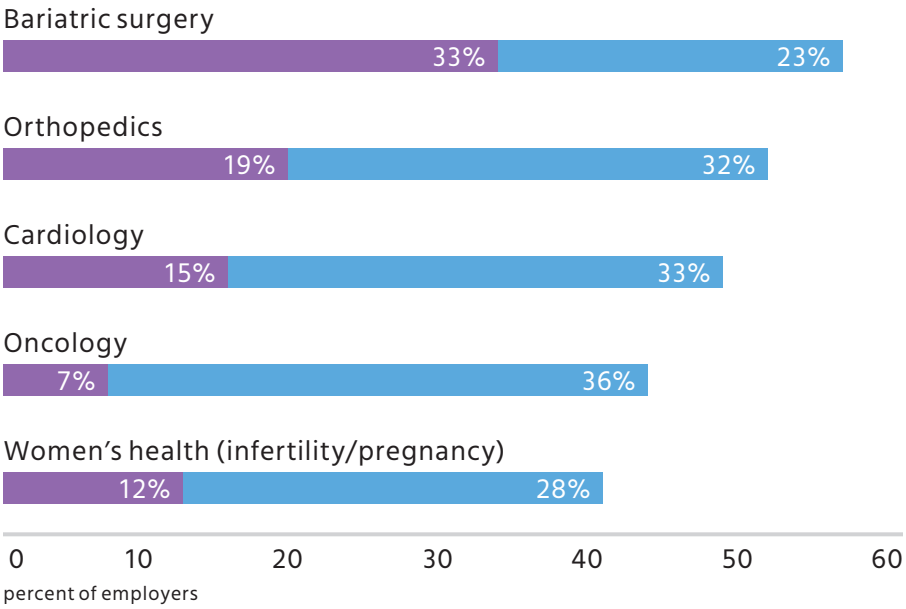
Centers of excellence Employers have embraced the Centers of Excellence (COE) model as a way to add value without adding cost. In 2020, employers with 5,000 or more employees added COEs to their provider networks for each of the complex medical services shown in

> While new transparency regulations will require health plans to provide cost information on shoppable services, quality metrics are not required, limiting the effectiveness of this consumerism initiative.

FIGURE 12

Giving employees access to centers of excellence—and encouraging their use

Employers with 5,000 or more employees



Source: *Mercer's 10-Minute Survey on Large Employer Health Strategies 2020*

the graph (Fig. 12). Making a COE available is an easy first step; adding provisions to steer employees to the COE is potentially disruptive but also potentially more impactful. Employers are most willing to actively steer employees to a COE for bariatric surgery and orthopedic surgery.

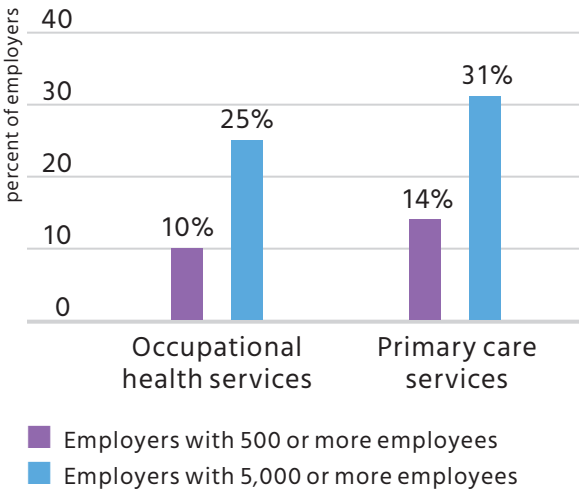
High-performance networks Employers have been working to both better manage health plan cost and potentially lower the cost of care for employees by steering employees to high-quality providers that are reimbursed based on the value of services provided, rather than on traditional fee-for-service methods. Most health plans now include Accountable Care Organizations (ACOs) or other high-performance networks, and some employers (in particular very large employers) have

strategies in place to encourage employees to use them. In our survey of very large employers, we found that 17 percent of employers with 20,000 or more employees say that employees can choose to enroll in a narrow, high-performance network during their annual open enrollment, and 14 percent say they can choose an ACO in which coverage is limited to one integrated health-care delivery system. The pandemic has undoubtedly slowed the momentum of ACOs. As we return to a more typical pattern of health care utilization, ACOs will n"eed to adjust, regroup and set new outcome targets and metrics. The extent to which they incorporate more virtual health care and steer members to the most appropriate care access points may factor in their future success.

While **worksite health clinics** range in scale, a growing number of employers have seen the benefits of providing comprehensive onsite primary care along with ancillary services such as physical therapy, chiropractic, mental health, pharmacy and more. By providing services that employees would otherwise seek in the community, employers gain more control over health-care quality and cost and ensure that employees — and even employees' families — have convenient access to care. In 2020, nearly a third of employers with 5,000 or more employees provide onsite primary care services (Fig. 13). Some employers that offer onsite clinic services are planning to use them to support the delivery of COVID-19 vaccines once they become more generally available — a unique opportunity to speed return to work for the organization and play a part in helping the country return to normalcy.

FIGURE 13

Provide onsite or near-site medical clinic



Designing a program that maximizes value for all

Health equity For many people — and many organizations — the social justice movement that ignited in the summer of 2020 following the killing of George Floyd has served as an important wake-up call about the extent and repercussions of systemic racism in the US. There are hopeful signs that greater awareness is leading to action. In a Mercer poll of 326 US employers conducted in November 2020,* we asked if the company's focus on diversity, equity and inclusion (DEI) had increased in 2020, and the great majority of respondents — 75 percent — agree that it had. Most encouragingly, 40 percent "strongly" agreed.

*Global pandemic survey #8: Work flexibility, inclusivity, and the continued impact of the pandemic (Nov. 2020)

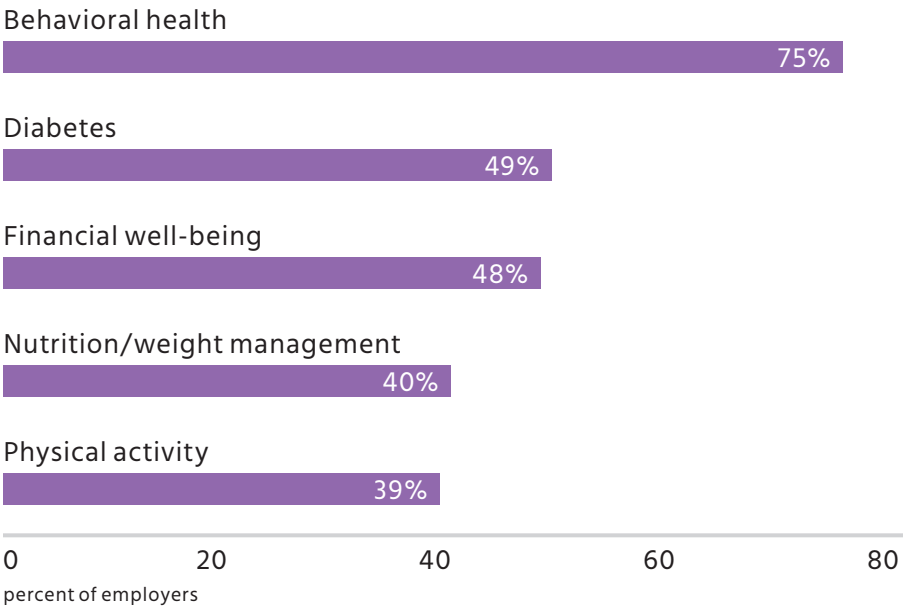
While we might think of DEI initiatives as mostly concerned with hiring, career advancement and culture, employers are now also thinking about how to mitigate racial and ethnic health disparities, building on early efforts to address the social determinants of health. As a start, 14 percent of respondents to the poll have reviewed data to identify health disparities, and 9 percent have set goals for achieving health equity. Of course, all players in the health ecosystem have a role in achieving health equity, and some respondents reported that they have already reached out to vendors to develop action plans.

Mental health and substance use disorders When asked about their most important priorities for well-being initiatives heading into 2021, behavioral health care headed the list, with 75 percent of employers calling it a priority (Fig. 14). The pandemic has added significant stress to peoples' lives: In August 2020, the CDC reported that, based on a June survey, 41 percent of US adults were experiencing an adverse mental or behavioral health condition, a far higher number than in the second quarter of 2019. This increased need has collided with an ongoing shortage of behavioral health-care providers. Even before the pandemic,

FIGURE 14

Behavioral health is employers' top priority for employee well-being in 2021

Employers with 500 or more employees



many employers — especially very large employers — had been taking steps to improve behavioral health access issue, and these efforts have accelerated over the past months. In our survey of very large employers, we found the most common actions have been to add coverage for tele-therapy and to enhance EAP services, but some employers have taken the larger step of adding a supplemental network of behavioral health-care providers to broaden access, and some have reduced cost-sharing for behavioral health care to remove cost barriers.

Reducing stigma is also key — sending the message that during abnormal times, it is normal to feel anxious, depressed and overwhelmed. Top-down communications can help, but it is also important that managers who have direct contact with employees are trained and empowered to support employees' emotional health and to direct them to available resources. Over half of large employers provided (or were planning to provide) this type of manager training.

> Reducing mental health stigma is key—sending the message that in abnormal times it is normal to feel anxious, depressed and overwhelmed.

Support for parents Many working parents face additional sources of stress due to disrupted school schedules and lack of childcare. When the survey was fielded in the summer of 2020, 40 percent of all large employers were permitting flexible schedules to allow parents to care for children during daytime working hours, and another 23 percent were considering it (perhaps waiting to see what would happen with schools in the fall). However, relatively few are providing childcare subsidies or resources like onsite daycare or back-up childcare. Childcare support is somewhat more common among very large employers (5,000 or more employees) — 17 percent provide a financial subsidy for in-home childcare, and 14 percent provide a back-up childcare benefit.

Remote workers The rapid transition to "work from home" has been more successful than many expected it could be. It seems clear that, post-pandemic, many employers will continue to allow employees more flexibility in where they work, when they work, and even in the type of work they do. Fully 87 percent of respondents to a November 2020 poll* said they already have a flexible working strategy, are actively developing one, or plan to start soon.

What does this mean for engagement? Most employers say that creating a compelling employee experience is important; in fact, more than half say they are "extremely" or "very" focused on employee experience. Employee experience is defined as all aspects of employees' work life — the work

*Global pandemic survey #8: Work flexibility, inclusivity, and the continued impact of the pandemic (Nov. 2020)

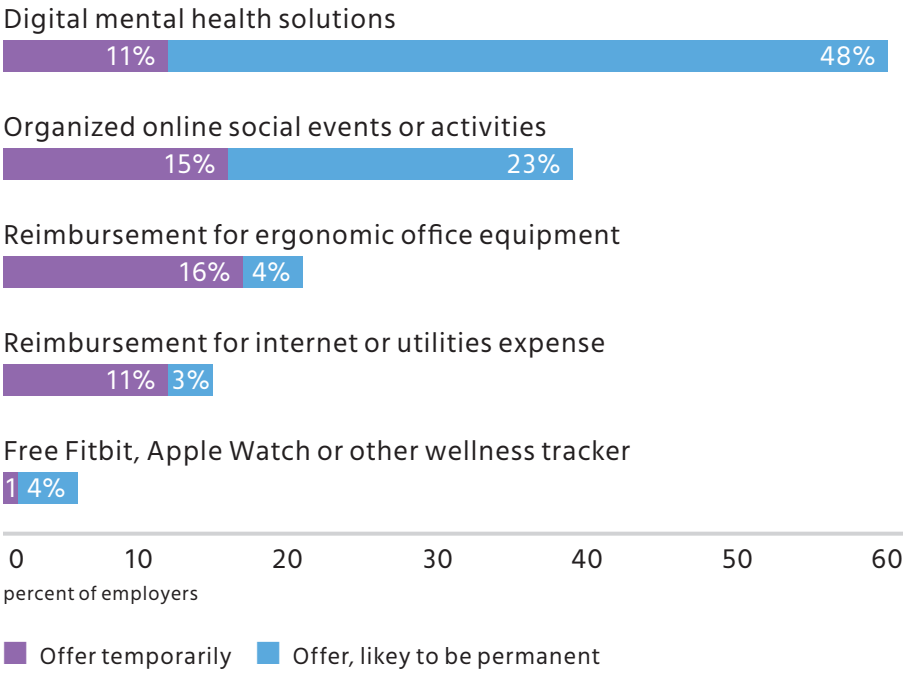
they do, their sense of purpose, their pay and benefits, their interactions with managers and coworkers, their work environment and company culture — all of it. When the pandemic forced many employees into remote working, creating a compelling employee experience got more complicated.

In our survey of very large employers, we asked about benefits for employees working remotely, and whether those benefits are likely to become permanent. Apart from flexible work hours, digital behavioral health resources were the most common type of benefit — and the most likely to be offered on a permanent basis — followed by organized online social events or activities. Fewer employers are providing financial support for home office furniture or other expenses. However, this may change with time. Flexible working is here to stay, even after employees can safely return to their worksites, and designing benefits of real value for remote workers may soon become necessary to maintain the employee value proposition (Fig. 15).

FIGURE 15

Benefits for remote workers

Employers with 5,000 or more employees

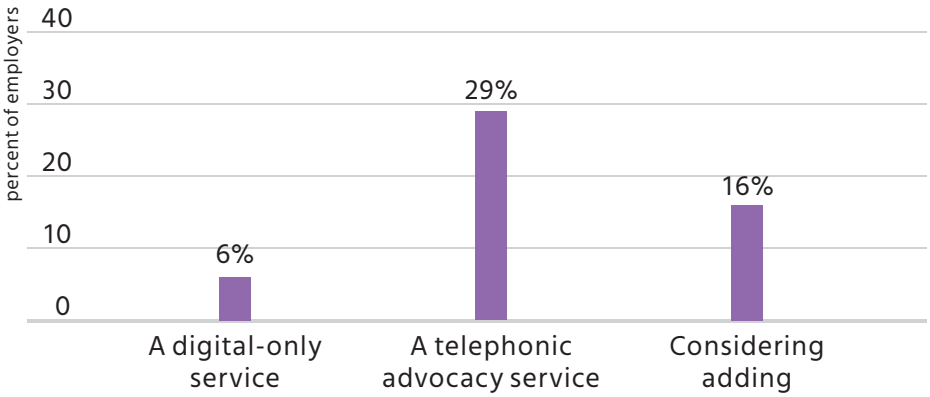


Source: *Mercer 10-Minute Survey on Large Employer Health Strategies 2020*

FIGURE 16

Offer health navigation or advocacy service beyond the standard health plan customer service

Employers with 500 or more employees



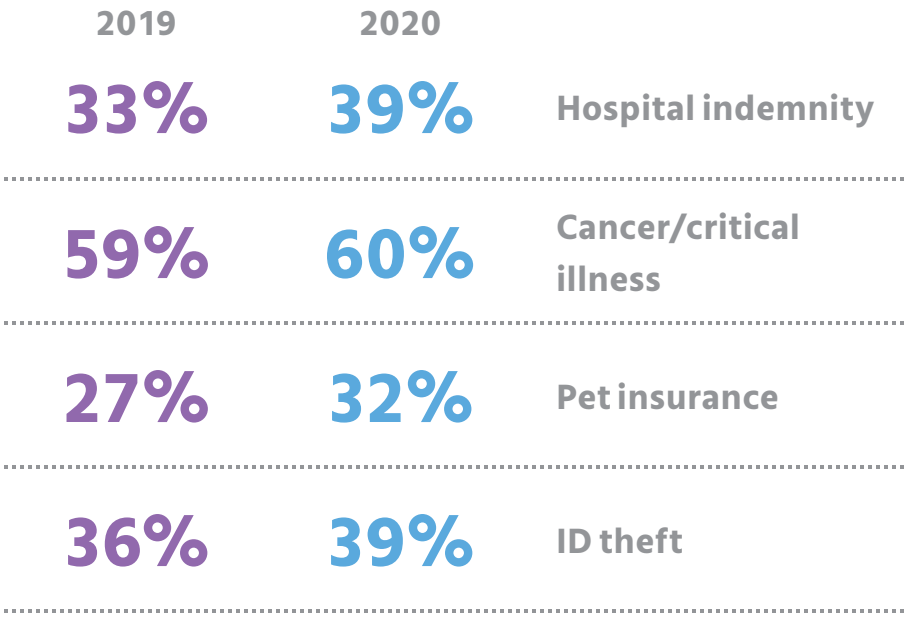
Online everything Employees increasingly expect to be able to easily find and access all of their health-care benefits and resources in one place, at any time, and for remote workers this can be especially important. Integrated technology-based platforms can improve member experience and increase utilization — adding value to all health offerings. Health navigation or advocacy is a way to make the entire health benefit more valuable by making it easier for employees and family members to find the right health-care provider and get answers to their questions about care and coverage. While health plans often provide basic help in locating providers, these programs go beyond the health plan's standard customer service. In 2020, 29 percent of large employers provided enhanced navigation/advocacy services that are available telephonically. A small number (6 percent) provided a digital, AI-powered navigation tool (Fig. 16).

Voluntary benefits for a personalized benefit package We saw growth in offerings of many types of voluntary benefits in 2020, both supplemental health insurances, such as hospital indemnity plans, and coverages to protect employees from other unexpected expenses, such as pet insurance. Nearly 9 in 10 large employers now offer voluntary benefits — on average, four different benefits — and as mentioned earlier, nearly a fourth said they would add more in 2021. By offering a wide range of

FIGURE 17

Growth in voluntary benefits to supplement health coverage and meet diverse needs

Employers with 500 or more employees



voluntary plans, employers give workers the ability to select benefits that meet their own particular needs right now. That helps strengthen the connection between employee and employer — whether the employee is at the worksite or working from home (Fig. 17).

The key to designing a benefit program that delivers optimum value for all starts with understanding the differences in employees' needs and values. Today's five-generation workforce was already plenty diverse. Flexible working adds a new dimension of diversity — and new challenges and opportunities for building employee engagement.

Planning for a larger role for virtual health care — in all its forms

One of the big health care stories of 2020 was acceleration in adoption of virtual care, which takes many forms. Traditional telemedicine services — such as Teladoc, Amwell, and MDLive — have been offered through most employer health programs for years now. More recently, employers have added digital health solutions such as "Text a doctor," for quick advice on reported symptoms, and AI programs to help identify care options. In addition, during the pandemic, many providers began offering virtual visits with their existing patients.

Utilization of traditional telemedicine services was low prior to the pandemic. In 2019, large employers reported that just 9 percent of eligible employees or family members used their telemedicine service at least once. In 2020, however, the utilization rate jumped to 14 percent within the first six months, and it is very likely that by the end of the year it had climbed still higher (Fig. 18). To encourage employees to use telemedicine services, many employers waived copays: where 82 percent charged a copay before the pandemic, just 48 percent did so in the summer of 2020. However, many said they were planning to reinstate cost-sharing for 2021; it will be interesting to see if that has a dampening impact on utilization (Fig. 19).

FIGURE 18

After years of slow growth, telemedicine utilization jumped in first half of 2020

Average percentage of eligible members using the service at least once, among employers with 500 or more employees

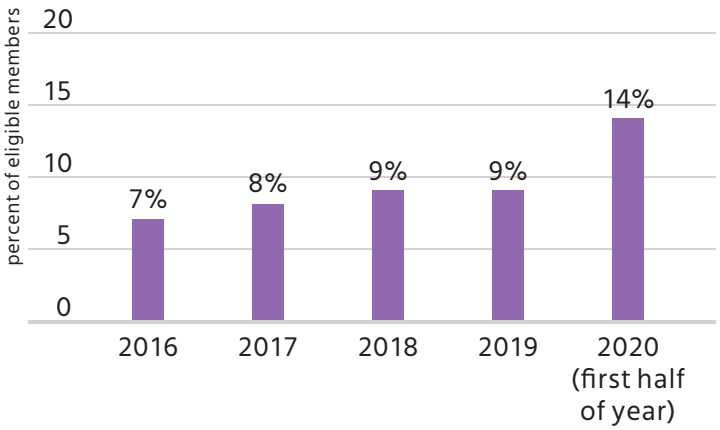


FIGURE 19

Most employers that waived cost-sharing for telemedicine in 2020 will reinstate it for 2021

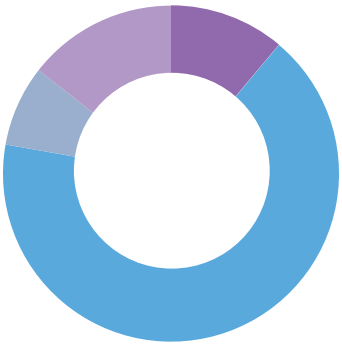
Employers with 500 or more employees

	Before the pandemic (on 1/1/20)	During the pandemic (on 7/20)	Planned for 2021
Require cost-sharing	82%	48%	72%
Median copayment amount	$25	$25	$25

FIGURE 20

Most employers anticipate a larger role for virtual care in their health programs in the future

Employers with 500 or more employees



20%	A much larger role
61%	A somewhat larger role
7%	Don't anticipate a larger role
13%	Not sure

Employers were largely pleased with the performance of their telemedicine provider in terms of customer service and wait time during the pandemic: 74 percent were very satisfied or satisfied and only 2 percent were dissatisfied (the rest didn't have enough feedback to say). It is not surprising, therefore, that the great majority of employers — 80 percent — see more virtual care in their future (Fig. 20).

During the pandemic, the value of virtual care was apparent, and providers and patients — including many who never used it before — have embraced it. But as employers begin to plan for a larger role for virtual care in their own programs, they'll need to think about how to incentivize employees to use the right modality for the service they need — AI, telemedicine, a virtual visit with their own provider, or an in-person visit. As we emerge from the pandemic, the most successful provider networks may be those that offer a full range of virtual and in-person services, and meet the challenge of making it easy — and cost-effective — for members to utilize the right level of care.

Moving on — but in a changed landscape

The roll-out of multiple effective vaccines and signs of economic recovery are reasons for US employers to feel optimistic about business results for 2021. Despite everything, throughout 2020 and the beginning of 2021 many US respondents to our global pandemic survey series reported high levels of employee productivity and a decrease in voluntary turnover.

But employers will need to keep in mind another important metric — employee engagement. In a Mercer poll of employers* conducted last fall, while 1 in 5 respondents reported increased employee engagement since the pandemic began, about the same number reported decreased engagement. As we start to look beyond the pandemic, employers will need to reinvent their health programs for the very changed landscape — and the new challenges — that it will leave behind.

*Global pandemic survey #8: Work flexibility, inclusivity, and the continued impact of the pandemic (Nov. 2020)

A note about the survey tables

Because of the survey's size and the methodology used, it's a valuable source of benchmark data. In the two tables that follow, the first 12 lines show results for employers with 500 or more employees broken out by region and industry. The national results for all employers (50 or more employees), and for small employers (50–499 employees) appear at the bottom. To read the tables, begin with the left column and read across. For example, in the table *National employee enrollment in each plan type* you would read the entry for employers in the Northeast region this way: "Among all employers in the Northeast region with 500 or more employees, 49 percent of covered employees are enrolled in a PPO/POS plan, 36 percent are enrolled in an HSA-eligible CDHP. . ." and so on. Where there is insufficient data in a category to report, "ID" will appear. A separate appendix of about 70 tables, covering most of the survey questions, is also available.

National employee enrollment in each plan type

	In 2020, percentage of all covered employees enrolled in:				
	PPO/POS	HSA-eligible CDHP	HRA-based CDHP	Either type of CDHP	HMO
500 or more employees	48%	34%	5%	39%	13%
BY REGION					
West	38%	29%	3%	33%	30%
Midwest	43	43	6	48	9
Northeast	49	36	4	40	11
South	57	29	6	35	8
BY INDUSTRY					
Manufacturing	52%	37%	4%	41%	7%
Wholesale/Retail	47	35	11	46	7
Services	44	40	3	43	12
Transport/Communic/Utility	43	36	8	43	14
Healthcare	50	27	5	32	18
Financial services	37	50	4	54	9
Government	59	6	4	10	31
BY NUMBER OF EMPLOYEES					
500–999	56%	34%	4%	37%	7%
1,000–4,999	49	36	4	40	11
5,000–9,999	46	37	5	42	12
10,000–19,999	44	34	9	43	13
20,000 or more	47	31	5	36	17
All employers (50+ employees)	51%	33%	5%	38%	11%
50–499 employees	57	30	5	35	8
	n = 1757				

1 2020 health benefit cost

2 2020 medical plan cost

3 2020 dental plan cost

	1 Average total health benefit cost* per employee	2 Average cost† per employee for:			3 Average dental plan cost per employee
		PPO/POS plan	HSA-eligible CDHP	HMO	
500 or more employees	$13,713	$14,048	$11,163	$13,738	$806
BY REGION					
West	$14,429	$14,619	$11,954	$13,139	$973
Midwest	13,045	13,600	10,950	13,736	748
Northeast	15,355	15,939	11,945	14,887	843
South	12,828	13,024	10,443	13,741	729
BY INDUSTRY					
Manufacturing	$14,140	$14,431	$11,523	$13,768	$840
Wholesale/Retail	10,604	11,369	8,405	11,853	600
Services	13,283	13,559	11,249	12,513	812
Transport/Communic/Utility	13,894	14,552	11,128	14,371	827
Healthcare	14,071	14,260	10,827	14,347	736
Financial services	14,008	14,635	11,998	13,366	887
Government	14,675	14,000	10,420	ID	812
BY NUMBER OF EMPLOYEES					
500–999	$14,653	$14,880	$12,517	$12,532	$874
1,000–4,999	13,952	14,347	11,133	13,954	799
5,000–9,999	13,549	13,591	11,223	13,536	812
10,000–19,999	14,014	14,652	11,737	13,404	818
20,000 or more	12,936	13,189	10,203	14,059	773
All employers (50+ employees)	$13,674	$13,937	$11,228	$13,141	$813
50–499 employees	13,587	13,717	11,382	11,372	828
	n = 1254	**n = 1053**	**n = 922**	**n = 407**	**n = 1172**

*Total gross annual cost (claims cost and administrative cost) for all medical, dental, prescription drug, mental health, vision and hearing benefits for active employees and their covered dependents, divided by the number of covered active employees. Total gross annual cost includes employee contributions (payroll deductions), if any, but not employee out-of-pocket expenses (deductibles, copays, etc.).

†Total gross annual cost for medical plan divided by the number of covered active employees. Dental benefits are not included.

Medical plans

Employers with 500 or more employees

In our 2019 survey, conducted in the midst of an economic boom, we reported that employers had "hit pause" on health plan cost-management strategies that gave employees more risk for out-of-pocket expense. The upward trend in the average PPO deductible had flattened, and some employers even reversed course on full-replacement strategies that moved employees into high-deductible plans by eliminating other medical plan choices. Our current survey results show that both these trends continued into 2020, suggesting an ongoing commitment to improving health-care affordability and providing more choice, at least during a time of prosperity and record levels of employment. Then the pandemic hit. Business in many sectors slowed, in some cases to a standstill, and job losses in the hardest-hit industries were inevitable. Elsewhere employers sought to avoid layoffs by slashing expenses wherever possible. But predictions that this might result in health benefit cuts did not bear out, and it seems that 2021 will be the third year in which we see virtually no growth in employee cost-sharing amounts. It may be that employers were simply unwilling to add any financial barriers to care during a public health crisis — or it may be that health-care consumerism has been sidelined in favor of strategies to reduce cost for both employer and employee with higher-quality, higher-value health care.

Preferred provider organizations

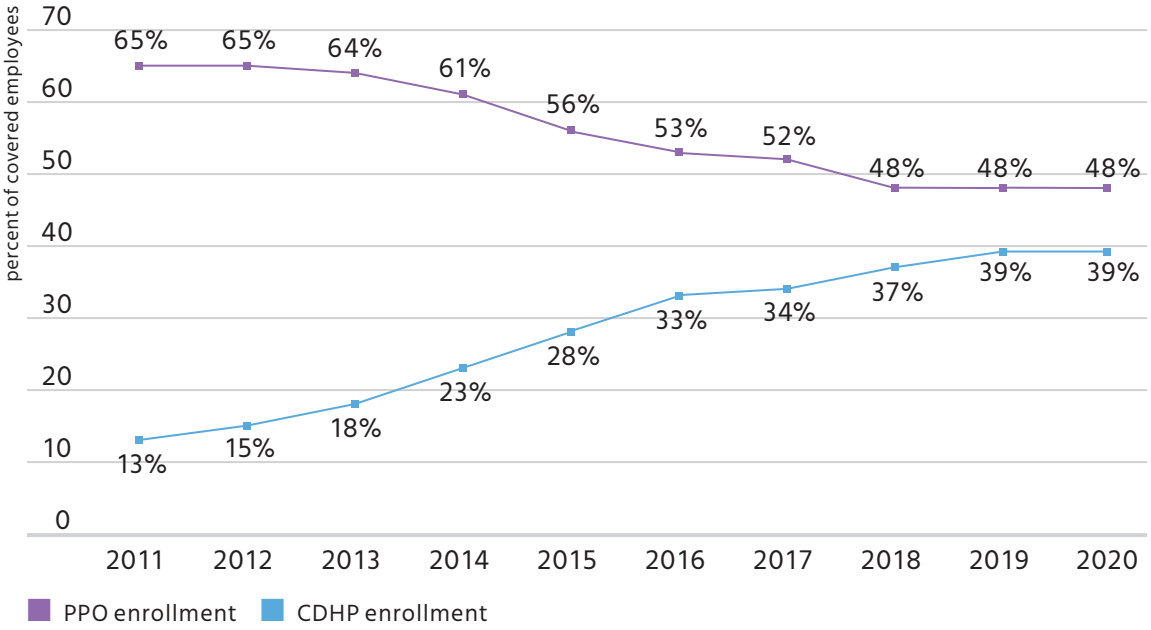
PPOs are the most common plan type, offered by 87 percent of employers. About two-thirds of employers (68 percent) offer a CDHP alongside a PPO at their largest worksite. Only 13 percent of employers offer a PPO alone.

PPO enrollment has held steady for 3 years in a row, with 48 percent of covered employees enrolled (Fig. 21). Regionally, PPO enrollment ranges from 57 percent of covered employees in the South to 38 percent in the West.

FIGURE 21

PPO enrollment steady for a third year as CDHP growth flattens

Employers with 500 or more employees



Plan cost

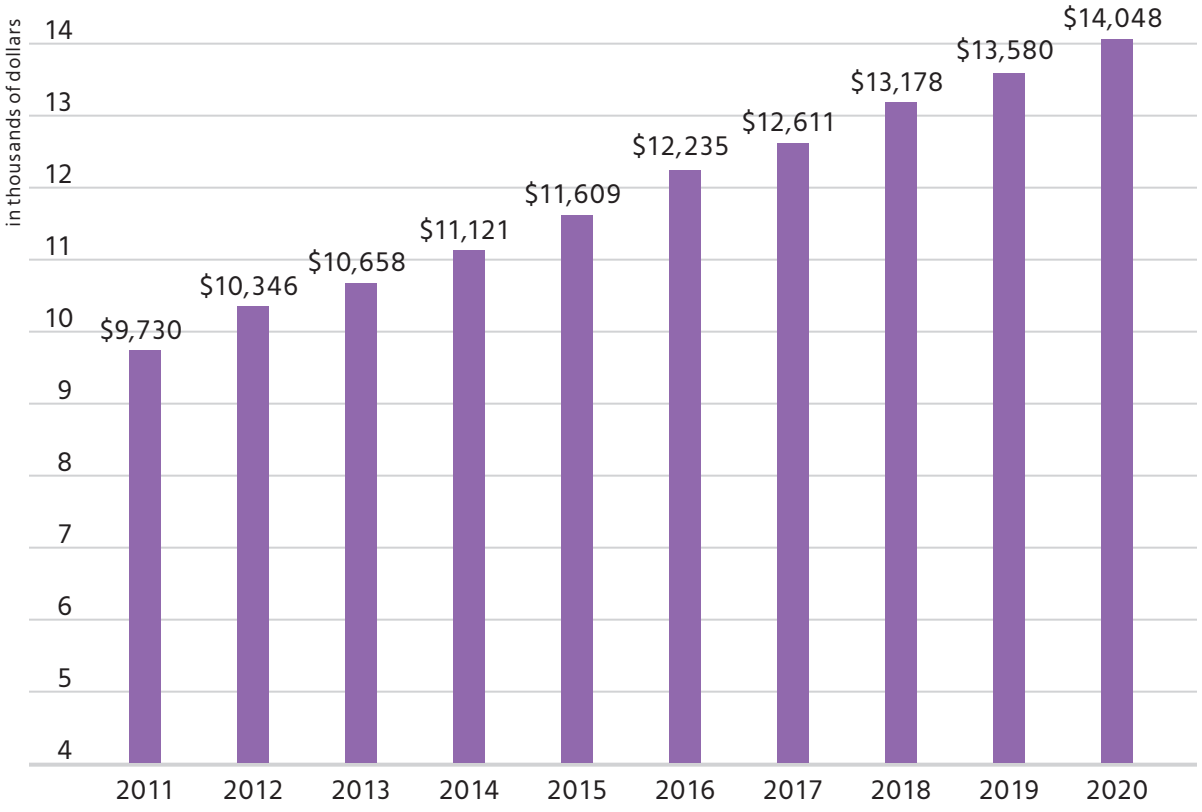
Cost for PPO coverage rose 3.4 percent among employers in 2020, to an average of $14,048 per employee (Fig. 22). Cost was highest in the Northeast ($15,939) and lowest in the South ($13,024), where PPO sponsors impose higher employee cost-sharing than in other regions (Fig. 23).

Employee contributions Nearly all PPO sponsors require an employee payroll contribution for PPO coverage (Fig. 24). The average employee contribution for employee-only coverage is 25 percent of premium, and the average contribution for family coverage is 30 percent of premium. Monthly contribution amounts in dollars averaged $160 for employee-only coverage and $590 for family coverage.

FIGURE 22

PPO* cost per employee, 2011–2020

PPO sponsors with 500 or more employees



*Results include PPO and POS plans.

Note: All prescription drug costs are included in the medical plan cost, even if the prescription drug benefit was carved out.

FIGURE 23

PPO cost per employee, by region

PPO sponsors with 500 or more employees

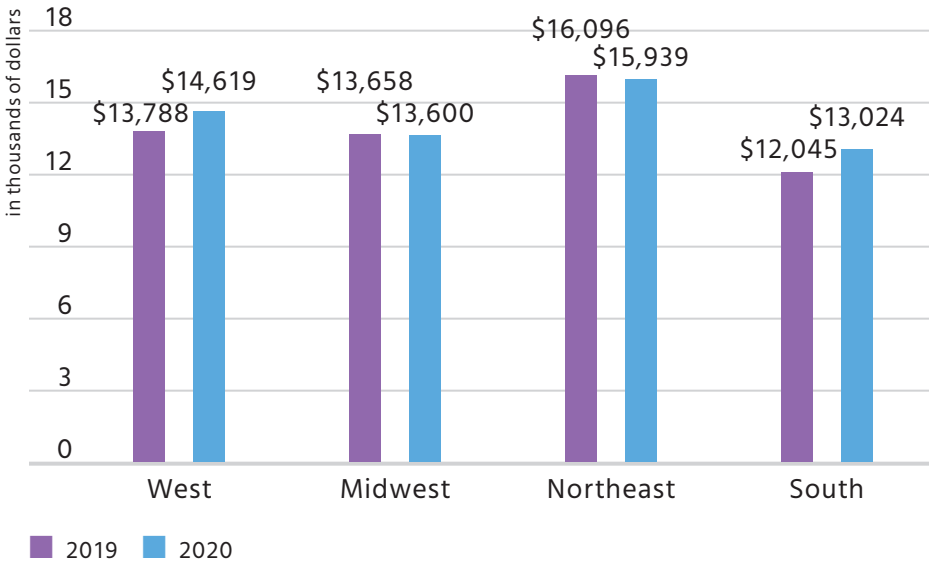


FIGURE 24

Employee contributions for PPO

PPO sponsors with 500 or more employees

	Employee-only	Family
Employers requiring contribution	95%	98%
Average contribution as a % of premium	25%	30%
Average monthly contribution	$160	$590

Plan design

Deductibles One in ten employers in the Northeast still provide first-dollar coverage. This is down from 15 percent five years ago, and elsewhere the use of a deductible is nearly universal. The median deductibles for in-network care remained at $750 for individual coverage and $1,500 for family coverage (Fig. 25). Out-of-network deductibles also held steady in 2020, at $1,500 for an individual and $3,000 for a family.

Physician office visits An employee copayment for in-network primary care physician office visits is required by 88 percent of plan sponsors. The average copay is $25, unchanged since 2017. The use of coinsurance in-network has been steadily declining over the past five years, with just 14 percent of all large employers requiring it. While the largest employers are somewhat more likely to use coinsurance, they are moving away from it as well; 27 percent of sponsors with 20,000 or more employees require it, down from 36 percent in 2019. Requiring a consistent, relatively low copayment rather than an unpredictable coinsurance amount may help to increase utilization of primary care, increasingly recognized as a high-value service.

Higher cost-sharing for specialist visits is common, required by 72 percent of sponsors. The average specialist copayment (when higher) is $45.

Hospitalizations Virtually all PPO sponsors require cost-sharing for in-network hospital services, typically coinsurance (required by 87 percent of sponsors, up from 82 percent). The median coinsurance remained at 20 percent of eligible charges. Just 16 percent require a deductible or daily copay. For out-of-network services, the median coinsurance amount is 40 percent.

Nearly four-fifths of PPO sponsors require a copayment or separate deductible for a visit to the emergency room, as a way to curb unnecessary utilization. The median copay is $150. Just under half of PPO sponsors (48 percent) require coinsurance. The median coinsurance is 20 percent of eligible charges.

Employee out-of-pocket limitations Under the ACA, an employee's out-of-pocket (OOP) costs for qualified in-network medical expenses may not exceed an overall maximum

FIGURE 25

Employee cost-sharing requirements for PPO

PPO sponsors with 500 or more employees

	In-network	Out-of-network
Deductible (median)		
Individual	$750	$1,500
Family	$1,500	$3,000
Out-of-pocket maximum (median)		
Individual	$3,000	$6,000
Family	$7,000	$12,000
PCP office visit		
Employers requiring copay	88%	6%
Copay amount (average)	$25	—
Employers requiring coinsurance	14%	96%
Coinsurance amount (median)	20%	40%
Specialist visit copay when higher than PCP copay (average)	$45	—
Inpatient hospital stay coinsurance (median)	20%	40%
Emergency room visit		
Employers requiring copay	78%	—
Copay amount (median)	$150	—
Employers requiring coinsurance	48%	—
Coinsurance amount (median)	20%	—

established under the law. Most employer plans have OOP maximums well below the ACA requirements. The median out-of-pocket maximum for in-network services is $3,000 for individual coverage and $7,000 for family coverage. For out-of-network coverage, the median out-of-pocket maximum is $6,000 for individual coverage and $12,000 for family coverage, unchanged from 2019.

Consumer-directed health plans

CDHP enrollment held steady in 2020, remaining at 39 percent of all covered employees. We define a CDHP as a health plan with an account feature: either a health savings account (HSA) or a health reimbursement arrangement (HRA), although HSA-eligible plans are far more common. HRA-based plans generally offer richer benefits (there is no IRS-mandated deductible), and the notional accounts are funded only by the employer. The HSA offers portability, tax advantages and even investment-income potential for employees. Employees own the account, which follows them if they change jobs, and unused money accumulates and may be spent in any year, even after retirement. Account contributions and earnings are not subject to federal tax at the time withdrawal, as long as they are used for qualified expenses.

Health savings accounts

Most HSA sponsors offer an HSA-eligible plan alongside another medical plan option at their largest worksite rather than as a full replacement. As discussed earlier (see page 19), the percentage of employers offering a high-deductible CDHP as the only medical plan available to employees at the largest worksite has fallen over the past two years.

HSA-eligible plan cost and premium contributions The average per-employee cost of coverage in an HSA-eligible CDHP rose 2.7 percent in 2020, to an average of $11,163. This is about 20 percent lower than the average cost of PPO coverage ($14,048 per employee) and about 19 percent lower than average HMO coverage ($13,738 per employee). The higher deductible in the HSA plans explains some, but not all, of the differences in cost between the plan types. While the average HSA plan deductible is $2,164 in 2020, the gap between it and the average employer

FIGURE 26

Employee contributions for HSA-eligible CDHP

HSA sponsors with 500 or more employees

	Employee-only	Family
Employers requiring contribution	95%	98%
Average contribution as a % of premium	17%	22%
Average monthly contribution	$93	$356

account contribution — the effective deductible — was $1,628. Among PPO sponsors with deductibles of $1,000 or more, the average per-employee cost is $12,120, which is still about $1,000 higher than the average HSA plan cost.

Employee contributions Employers typically set employee premium contributions for HSA plans at a lower level than for other medical plan types to balance the higher deductible in this medical plan option. The average contribution for employee-only coverage is 17 percent of premium, while for PPO and HMO coverage it is 25 percent and 22 percent, respectively (Fig. 26). The contribution for family coverage is 22 percent of premium on average, also lower than the average PPO and HMO contributions (30 percent and 29 percent, respectively). Given the HSA plan's lower premium cost, the difference in the dollar amounts of the monthly contributions is significant, especially for family coverage: $356 for HSA coverage compared with $590 for PPO coverage.

Deductibles and account contributions The minimum annual deductible required by law in 2020 for HSA-eligible CDHPs was $1,400 for employee-only coverage and $2,800 for family coverage, but HSA sponsors typically set deductibles well above the minimum amounts. The median in-network deductibles in 2020 were $2,000 for employee-only coverage, and $4,000 for family coverage, in line with 2019 levels (Fig. 27).

The great majority of HSA sponsors make account contributions — 85 percent, up from 78 percent in 2019. The median employer contribution is $500 for employee-only coverage, and $1,000 for family coverage. Over a third of HSA sponsors that make contributions (34 percent) fully prefund the account so that employees can access funds on the first day of the plan year. Because prefunding puts the employer at risk if the employee leaves the company early in the year, some employers, especially those that experience high turnover, contribute with every paycheck (36 percent), on a monthly basis (10 percent), or on some other schedule (20 percent).

To encourage employees to put money in the HSA, some sponsors (10 percent) match some or all of the employee's contribution. Others make incentive-based contributions (13 percent) to encourage employees to take actions such as

FIGURE 27

Employee cost-sharing requirements for HSA-eligible CDHP

HSA sponsors with 500 or more employees

	In-network	Out-of-network
Employer account contributions		
Employers making contribution	85%	
Contribution amount (median)*		
Employee-only	$500	
Family	$1,000	
Deductible (median)		
Employee-only	$2,000	$3,500
Family	$4,000	$7,000
Out-of-pocket maximum (median)		
Employee-only	$4,000	$8,000
Family	$7,400	$15,000
Physician office visits		
Coinsurance amount (median)	20%	40%
Employer does not require cost sharing for office visit	11%	3%

*Among employers making contributions.

completing a health assessment or participating in a lifestyle-coaching program. The largest employers are the most likely to make incentive-based contributions (26 percent of those with 20,000 or more employees).

Among employers that offer the HSA plan as a choice, those making account contributions report higher enrollment levels (on average, 41 percent of covered employees) than those not making contributions (31 percent of covered employees).

Employee out-of-pocket maximums The legal limit in 2020 on employee out-of-pocket spending in an HSA-eligible plan was $6,900 for an individual and $13,800 for a family. However, the median maximum amounts for in-network services set by employers are significantly lower, at $4,000 for employee-only coverage (unchanged from 2019) and $7,400 for family coverage (down from $7,900 in 2019). Median out-of-network maximums were $8,000 for employee-only coverage and $15,000 for family coverage, up from $7,500 and $14,400, respectively.

Physician office visits The majority of HSA plan sponsors require cost-sharing for in-network physician office visits after the deductible is met, almost always coinsurance (86 percent) rather than a copay (3 percent). The median coinsurance amounts are 20 percent in-network and 40 percent out-of-network.

Health reimbursement accounts

While HRAs are also nontaxable for health-related expenses, they are funded solely by the employer and are rarely portable if the employee leaves the company. With no deductible requirements, an HRA can be added to any medical plan, which makes an HRA a good vehicle for financial incentives for company-wide health and well-being initiatives. This plan is far less common than the HSA-eligible plan, now offered by only 10 percent of employers, down from 11 percent in 2019.

HRA employee premium contributions Nearly all employers offering an HRA require employee contributions for employee-only coverage (97 percent) and family coverage (99 percent). The average contributions are 20 percent of premium for employee-only coverage and 24 percent for family coverage, which are higher than the average contributions for HSA plans but lower than those for PPOs (Fig. 28).

FIGURE 28

Employee contributions for HRA-based CDHP

HRA sponsors with 500 or more employees

	Employee-only	Family
Employers requiring contribution	97%	99%
Average contribution as a % of premium	20%	24%
Average monthly contribution	$126	$479

HRA deductibles and account contributions The median in-network deductible for employee-only coverage is $1,750, while the median employer account contribution is $500 (Fig. 29). That leaves $1,250 for the employee to pay out of pocket before the deductible is met. The median in-network deductible for family coverage is $4,000 and the median account contribution is $1,000, leaving about $3,000 for the employee to pay.

Employee out-of-pocket maximums The median out-of-pocket maximums for in-network services are $4,000 for employee-only coverage and $8,000 for family coverage. For out-of-network services, the median out-of-pocket maximums are $7,550 and $15,200 for employee-only and family coverage, respectively.

Physician office visits Most HRA sponsors require cost-sharing for in-network physician office visits; coinsurance is required by 67 percent and copayments by 29 percent. Nearly all sponsors require coinsurance for out-of-network services (97 percent).

FIGURE 29

Employee cost-sharing requirements for HRA-based CDHP

HRA sponsors with 500 or more employees

Employer account contribution (median)		
Employee-only	$500	
Family	$1,000	
	In-network	**Out-of-network**
Deductible (median)		
Employee-only	$1,750	$3,000
Family	$4,000	$6,000
Out-of-pocket maximum (median)		
Employee-only	$4,000	$7,550
Family	$8,000	$15,200
Physician office visits		
Employer requires a copayment	29%	4%
Employer requires coinsurance	67%	97%
Coinsurance amount (median)	20%	40%

Health maintenance organizations

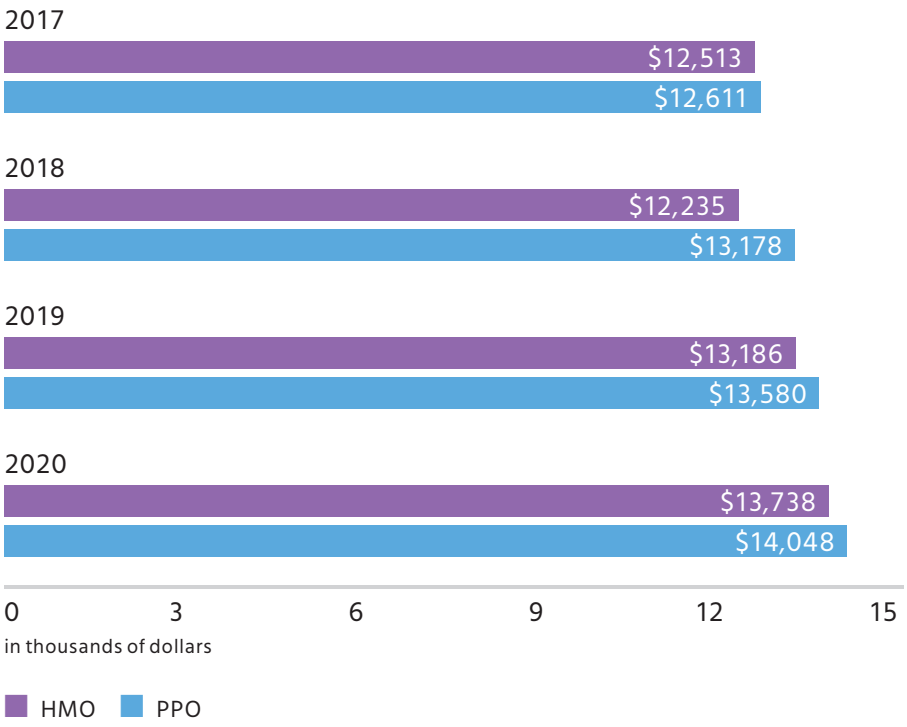
Nearly fifty years have passed since the HMO Act of 1973 caused this plan model to proliferate across the US health-care market. After peaking in 2001, national HMO enrollment has slowly declined. HMOs have essentially become a regional offering among employers in the West, where 58 percent offer them. However, for a fourth year in a row, HMO coverage has cost less, on average, than PPO coverage, while providing a richer benefit (Fig. 30).

With employers seeking solutions that reduce total health-care costs over solutions that maintain costs while shifting financial responsibility to employees, we may see them increasingly pursue HMO, EPO (Exclusive Provider Organization) and other narrow network plans in which medical costs can be tightly controlled, administrative expenses are low and member cost sharing can be limited.

FIGURE 30

For a fourth year, HMO coverage cost less than PPO coverage

Average cost per employee, among HMO sponsors with 500 or more employees



Prevalence and enrollment

HMO offerings held steady in 2020. Among employers with 500 or more employees, 30 percent offer an HMO plan, essentially unchanged from 29 percent in 2019. HMO offerings are most common among the largest employers, which typically operate in many states: among those with 20,000 or more employees, 59 percent offer an HMO in at least one location.

In the West, average HMO cost per employee was about $1,500 lower than average PPO cost.

The level of HMO enrollment remained at 13 percent of all covered employees in 2020. Notably, that same stability in enrollment held for CDHPs and PPOs as well — there was no change in enrollment level for any plan type. Regionally, HMO enrollment was highest in the West by far, at 30 percent.

Plan cost and employee contributions

The average per-employee cost of HMO coverage rose to $13,738 per employee in 2020, an increase of 4.2 percent. Nationally, average HMO cost is 2.2 percent lower than PPO cost. In the West, where enrollment is strongest, average HMO cost is only $13,139, and has been lower than PPO cost for the past five years.

With an average actuarial value (AV) of 94 percent, HMOs offer generally richer benefits than PPO plans, which have an average AV of 88 percent. (Actuarial values were calculated using plan design information provided by survey respondents and Mercer's proprietary plan value model, MedPrice.) While many factors affect plan cost, HMO enrollment has become increasingly concentrated in the West, where staff model HMOs using capitation dominate. In the West, the difference in average cost per employee between HMOs and PPOs is nearly $1,500. Outside of the West, HMOs more typically use fee-for-service reimbursement. In the Midwest, for example, the difference in average cost between the two plan types is less than $150.

The average employee contribution as a percentage of premium is 22 percent for employee-only coverage and 29 percent for family coverage. The average monthly contribution amounts are $128 and $523 for employee-only and family coverage, respectively (Fig. 31).

FIGURE 31

Employee contributions for HMO

HMO sponsors with 500 or more employees

	Employee-only	Family
Employers requiring contribution	93%	97%
Average contribution as a % of premium	22%	29%
Average monthly contribution	$128	$523

Plan design

While the typical HMO plan still offers richer coverage than the typical PPO plan, some HMO sponsors have implemented cost-sharing provisions comparable to PPO plans — and some even offer plans with deductible levels eligible for HSAs. In fact, a slight majority of HMOs — 55 percent — requires a general deductible (this compares to 95 percent of PPO plans). The median deductible amount for an individual is $500, far below the median deductible of $750 for a PPO (Fig. 32). And while 45 percent of HMO sponsors require coinsurance for an inpatient hospital stay, that compares to 87 percent of PPO sponsors.

FIGURE 32

Employee cost-sharing requirements for HMO

HMO sponsors with 500 or more employees

Deductible	
Employers requiring general deductible	55%
Individual deductible (median)	$500
Family deductible (median)	$1,250
Physician office visit copay (average)	
PCP	$23
Specialist (when higher)	$40
Hospital stays	
Employers requiring set amount per stay	45%
Median deductible	$250
Employers requiring coinsurance	45%
Emergency room	
Employers requiring copayment	80%
Median copayment	$150
Employers requiring coinsurance	24%

Specialty medical benefits

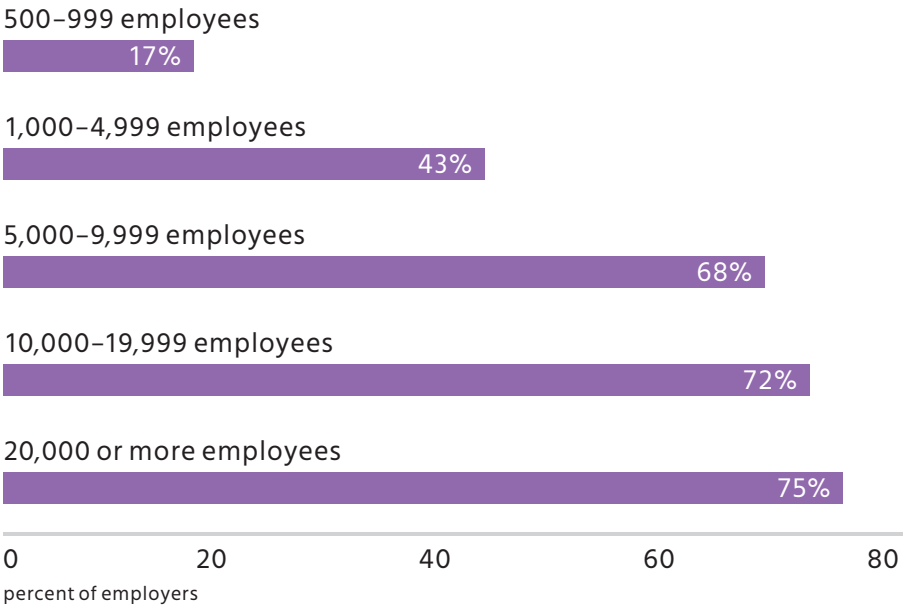
Prescription drug benefits

Prescription drugs remained a cost driver for large employers in 2020. They reported an average increase in prescription drug cost per employee of 7 percent, much higher than the overall increase in medical plan cost. Notably, this is the sharpest prescription drug cost increase since 2017, and employers predict a similar — even slightly higher — increase of 7.6 percent in 2021.

Pharmacy benefit managers Very large employers typically contract directly with a pharmacy benefit manager (PBM), carving out their pharmacy benefits from the medical plan — 71 percent of those with 5,000 or more employees have done so, compared to 43 percent of those with 1,000–4,999 employees and just 17 percent of those with 500–999 employees (Fig. 33). Employers contract with a PBM with the expectation that these specialized vendors will secure better pricing and provide a higher level of service relative to the health plan. It's possible that we will see this trend reverse, as carriers are increasingly trying to win back carve-out business by charging higher fees to carve out, or, more helpfully, by improving their own pharmacy capabilities. In addition, many major health plans have also combined with PBMs. While in many cases these combinations can result in better pricing, true integration between the combined entities is still developing.

FIGURE 33

Use a pharmacy benefit manager (PBM) outside the medical plan



Purchasing coalitions Participation in a prescription drug purchasing coalition provides leverage in negotiating contracts with pharmacy providers and access to enhanced clinical oversight. Again, larger employers are the most likely to join a coalition: just 21 percent of those with 500–4,999 employees have done so, compared to 39 percent of those with 5,000 or more employees. (That drops to just 24 percent among employers with 20,000 or more employees, perhaps because they already have considerable leverage in the market.) Smaller employers might benefit most from the market leverage afforded by a purchasing coalition, but they are more likely to be fully insured, which makes carving out the pharmacy benefit more challenging.

Benefit design Employee cost-sharing requirements for prescription drugs remained relatively stable in 2020 (Fig. 34). Copayments remain the most common type of cost-sharing provision, but just over half (51 percent) of employers with 500 or more employees use coinsurance in at least one drug category in retail plans, as do 70 percent of those with 5,000 or more employees. For mail-order plans, coinsurance is used by 45 percent, unchanged from 2019. The median coinsurance is highest for nonformulary brand drugs, at 30 percent.

To provide a financial incentive to use mail-order plans over retail plans, copays are set so that, in the typical mail-order plan, participants receive three times the amount of medication for only about double the cost of purchasing it under the retail plan.

Specialty medications Spending on specialty drugs continues to drive up total spending on pharmacy benefits. These are high-cost medications (typically biologics) that treat an ever-expanding list of complex diseases such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and certain forms of cancer. In 2020, employers reported an increase of 11.4 percent in spending on specialty drugs.

Specialty pharmacies are one avenue for employers seeking to control rising costs. These vendors specialize in procuring, storing, and dispensing specialty drugs; they also provide patient education and clinical support beyond the capabilities of a traditional retail pharmacy, with the goal of improving clinical outcomes. (In fact, when asked about plans to provide additional resources to employees in 2021, 9 percent of employers cited enhancing support for complex cases, such as with a specialty pharmacy or intensive case management.) Nearly three-quarters of large employers (71 percent) actively encourage their employees to fill specialty medications through a specialty pharmacy, most commonly by excluding some specialty medications from the retail drug plan or medical benefit (42 percent) or by offering lower cost-sharing (10 percent) if the plan member uses the specialty pharmacy (Fig. 35).

FIGURE 34

Prescription drug plan cost-sharing requirements

Employers with 500 or more employees

	Retail	Mail-order
Average copayment		
Generic	$11	$23
Formulary brand-name	$34	$73
Nonformulary brand-name	$57	$124
Specialty/biotech	$102	$165
Median coinsurance		
Generic	20%	20%
Formulary brand-name	20%	20%
Nonformulary brand-name	30%	30%
Specialty/biotech	20%	20%

FIGURE 35

Steer members to specialty drug pharmacy

	Employers with 500 or more employees
Exclude some or all specialty medications from retail/ medical benefit	42%
Offer lower cost-sharing at specialty pharmacy	10
Other	27
Do not steer members to specialty pharmacy	29

Behavioral health benefits

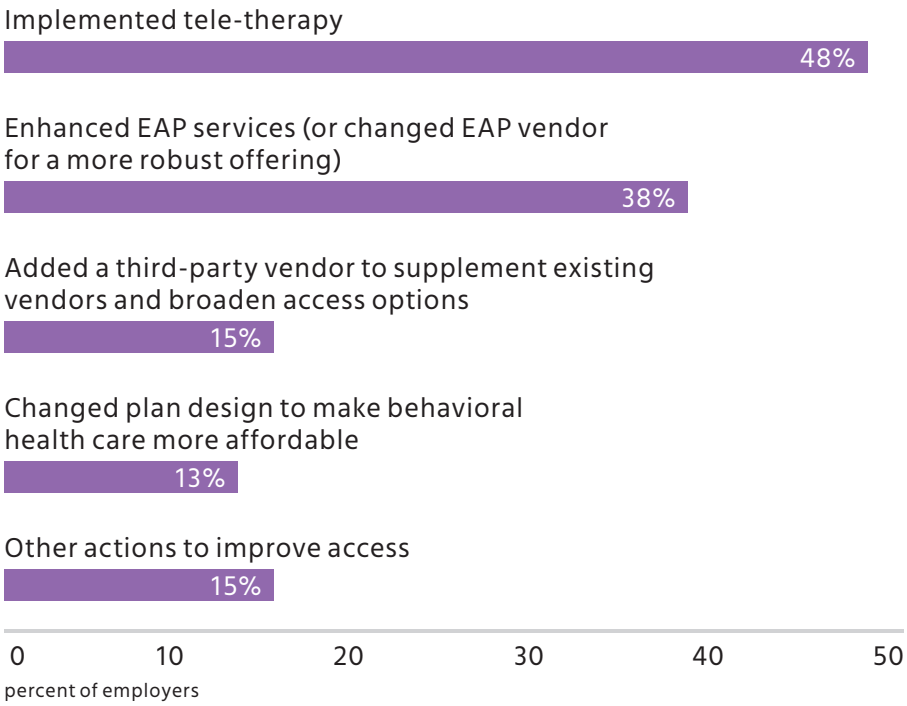
Behavioral health has been a growing priority for employers in recent years, and the COVID-19 pandemic has only added urgency to their efforts. In our survey of very large employers, nearly half of employers with 5,000 or more employees have implemented tele-therapy in the past two years as a way to improve behavioral health access (Fig. 36). Other steps taken by these employers include enhanced EAP services (38 percent), adding a third-party vendor to supplement existing vendors and broaden access options (15 percent) and changing plan design to make behavioral health care more affordable (13 percent).

Employers have also recognized a need for training managers to support employees' emotional and behavioral health needs during the pandemic. In the summer of 2020, 44 percent of employers with 5,000 or more employees had either completed or begun manager training, and another 21 percent had plans to provide it.

FIGURE 36

Actions taken in the past two years to improve behavioral health access

Employers with 5,000 or more employees



Source: *Mercer 10-Minute Survey on Large Employer Health Strategies 2020*

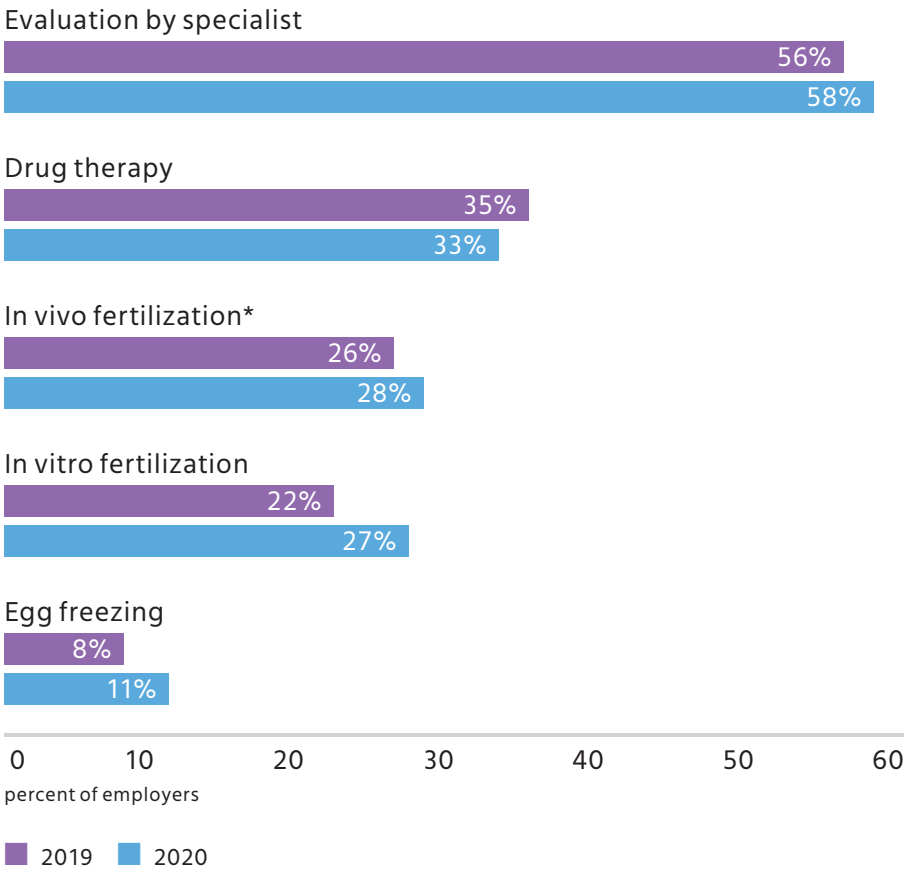
Other special coverages

While 61 percent of employers cover some type of **infertility care**, some limit it to evaluation by an infertility specialist. One-third cover drug therapy (33 percent) and just over a fourth cover in vitro fertilization (27 percent) (Fig. 37). Coverage for egg freezing rose from 8 percent to 11 percent of all large employers in 2020, and is provided by 20 percent of employers with 5,000 or more employees. Regionally, employers in the Northeast are the most likely to cover infertility treatment; for example,

FIGURE 37

Coverage for infertility treatment

Employers with 500 or more employees



*Intrauterine insemination

nearly half (49 percent) cover in vitro fertilization and 17 percent cover egg freezing. Among employers providing infertility treatment beyond an evaluation, 39 percent have a lifetime maximum benefit in place and 20 percent have other limitations, such as a limit on the number of IVF cycles they will cover. The median lifetime maximum benefit for infertility treatment remains unchanged at $15,000.

Employers adding infertility coverage to make benefits more inclusive

The Survey on Fertility Benefits was sent to participants in the National Survey of Employer-Sponsored Health Plans in February 2021 to collect additional information on fertility benefits and explore the reasons employers choose or don't choose to provide it. Of the 459 employers responding, 254 provide some type of coverage. The study was commissioned by RESOLVE: The National Infertility Association.

Over the past five years we've begun to see stronger growth in the prevalence of infertility coverage particularly among the largest employers (those with 20,000 or more employees) — driven by improvements in treatment protocols, shifts in workforce demographics, a sharper focus on inclusivity and a broader definition of what constitutes health and well-being. Since the largest employers are often trendsetters, it seems likely they are the leading edge of a broader movement — especially since fully 97 percent of survey respondents say that providing infertility coverage did not result in a significant increase in medical plan cost.

The three reasons for covering infertility treatment cited by the most respondents (about 50 percent for each) were to "ensure employees have access to quality, cost-effective care," "stay competitive to recruit and retain top talent," and "be recognized as a 'family friendly' employer." Notably, two-fifths of respondents (40 percent) offer coverage to "support diversity, inclusion and equity (DEI) efforts" — and among those that have added coverage within the last two years, 61 percent cited this as a primary objective.

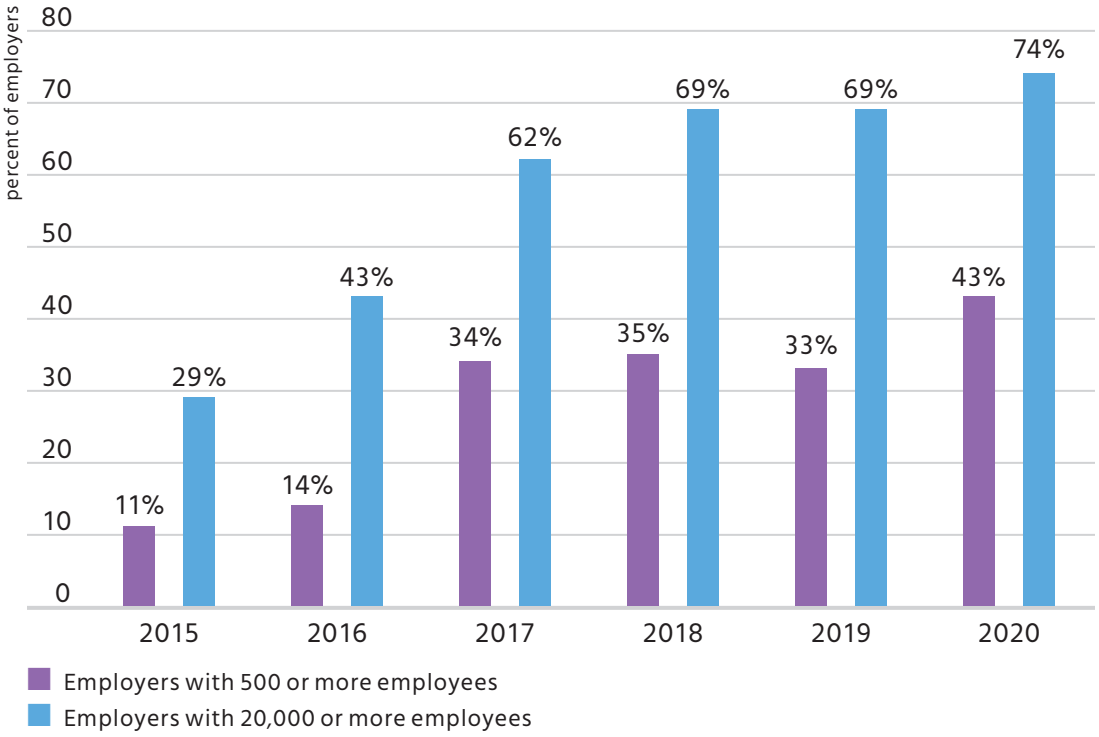
Employers that offer any type of infertility coverage — in some cases, just an evaluation by a specialist — were asked if these benefits have helped the organization achieve certain positive outcomes. While the majority of respondents reported positive outcomes, we saw a sharp contrast between employers that cover in vitro fertilization (IVF) and those that don't — respondents are much more likely to achieve positive outcomes if they cover IVF. For example, 81 percent of those covering these treatments report success in satisfying employee requests, compared to just 44 percent of those not covering them. In terms of supporting DEI efforts, the difference is even greater: 79 percent of those covering IVF believe their infertility coverage has helped advance DEI goals, compared to just 27 percent of those covering other fertility services, but not IVF.

You can access the full report here.

Gender affirmation surgery is covered by 43 percent of employers, up sharply from 35 percent two years ago in 2018 (Fig. 38). Coverage is still far more common among the largest employers (74 percent of those with 20,000 or more employees offer it). Among employers covering the surgery, 84 percent also cover some associated services, primarily behavioral health services/counseling (78 percent) and non-surgical gender affirmation treatment/hormone therapy (68 percent). Just over half cover other associated services such as reconstructive procedures or puberty suppression (51 percent).

FIGURE 38

Coverage for gender affirmation surgery



Employee well-being

Employers with 500 or more employees

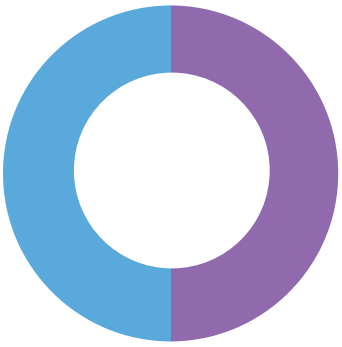
2020 created unique challenges for employers' well-being initiatives. Where previously access to onsite services such as gyms, fitness classes, and healthy eating options in the office cafeteria were highly valued elements of well-being programs, with so many employees now working remotely, employers have had to adjust their policies. Still, well-being programs on the whole remain a key focus for employers, especially given the additional stress so many employees have experienced due to the pandemic. As employers and employees begin to adjust to a more flexible working environment, well-being programs will likely change shape but the importance of these initiatives and the value employees place on them will continue.

Half of employers now provide access to all or most of their health and well-being programs through an integrated technology-based platform (Fig. 39). Employees increasingly expect to be able to easily find and access all of their health-care benefits and resources in one place, at any time, and for remote workers this can be especially important. Integrated technology-based platforms can improve member experience and increase utilization — adding value to all health offerings.

FIGURE 39

Employees can access most health and well-being benefits and resources via an integrated tech-based platform

Employers with 500 or more employees



50% Use integrated platform now

50% Don't use

Demonstrating a commitment to health

Two-fifths of employers have already made a firm commitment to support a healthy workplace culture by including it in their company vision or mission statement. Among employers with 20,000 or more employees, over three-fifths (62 percent) have taken this step.

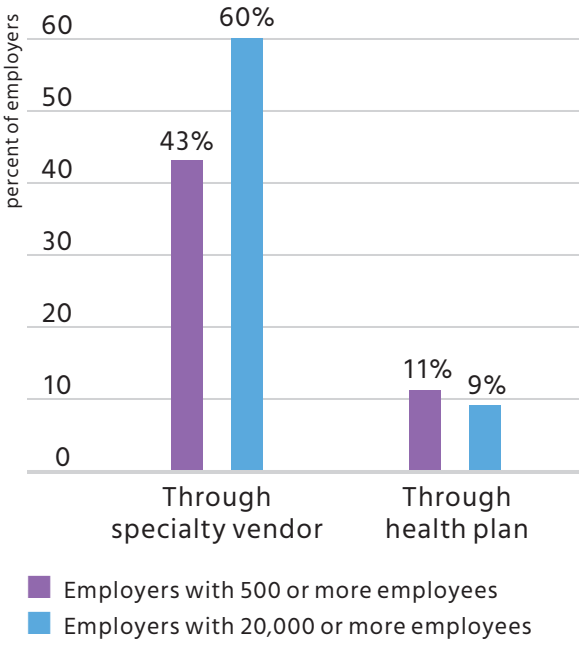
For 2021, behavioral health was cited as a top well-being priority by three-fourths of employers (see Fig. 14, page 24). Nearly half (49 percent) said that diabetes would be a focus in 2021 and 40 percent said that nutrition/weight management was high on the priorities list. Not surprisingly, physical activity was right behind that with 39 percent.

Nearly half of employers (48 percent) also prioritized financial well-being for their employees in 2021. Just over half of employers (51 percent) offer tools, advice or guidance to help employees improve their financial health (beyond just retirement planning). In most cases, these services are offered through a specialty vendor (43 percent), although the health plan provides these services for 11 percent of employers (Fig. 40).

Tobacco-free incentives A quarter of employers (25 percent) offer lower premiums for non-tobacco users (Fig. 41). Larger employers are the most likely to use a premium differential to encourage employees not to use tobacco: Among employers with 5,000 or more employees, 39 percent do so. The median annual reduction in premium per employee for non-tobacco use remains unchanged at $600.

FIGURE 40

Offer financial tools, advice, or guidance*

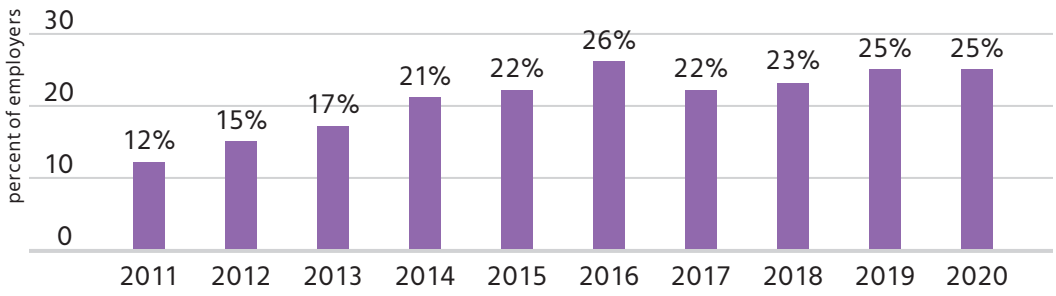


*Other than for retirement planning

FIGURE 41

Offer lower premium contributions to non-tobacco users

Employers with 500 or more employees



The HERO Health and Well-Being Best Practices Scorecard in Collaboration with Mercer: New update released in 2021

Building a strong culture of health within an organization requires a holistic view of well-being, leadership support, data-driven solutions and innovative use of technology. Employers that do the most to help employees thrive have been shown to have better business results. The HERO Health and Well-Being Best Practices Scorecard in Collaboration with Mercer© is a free online assessment tool that has been used by over 2,500 employers. Employers use their program score (which is automatically calculated upon submission of the completed Scorecard) to assess their program relative to their peers and to identify opportunities for improvement. At the same time, the information employers provide is aggregated to build a database that is used by industry experts to learn more about what makes employee health and well-being programs work.

Building on the HERO Scorecard's success and stature in the industry, in February 2021 we released version 5, which incorporates new learnings from industry research. It adds new practices related to employer involvement in their communities; mental and emotional well-being; social determinants of health; and diversity, equity, and inclusion — providing a broader value proposition for investment in employee health and well-being.

Other benefits

Dental benefits

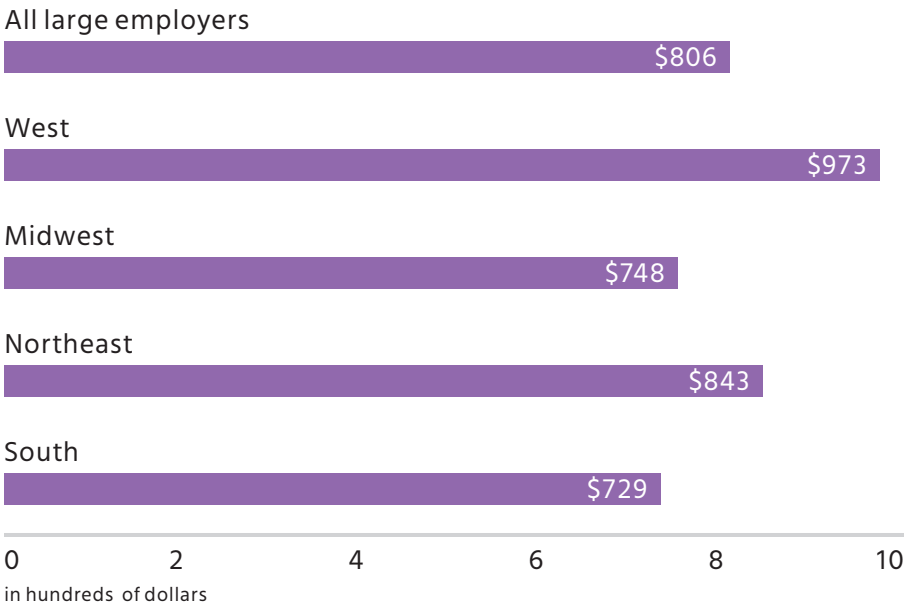
Dental coverage is offered by 99 of large employers. In most cases, employers contribute to the cost of coverage, but 13 percent make dental coverage available as an employee-paid (voluntary) benefit.

Cost and contributions The cost of dental coverage averaged $806 per employee in 2020 (Fig. 42). This is about a 3 percent decrease from last year's average cost and undoubtedly reflects the disruption in the normal utilization of dental services caused by the pandemic. Cost remained highest in the West and lowest in the South, where it rose slightly (0.1 percent). Most sponsors require an employee contribution for dental

FIGURE 42

Dental cost per employee, by region

Dental plan sponsors with 500 or more employees



coverage; the average contribution amount is 48 percent of premium for employee-only coverage, and 51 percent for family coverage.

Dental benefit design The great majority of sponsors (90 percent) require a deductible for restorative care. To contain premium costs, employers cap benefits on preventive and restorative care; the median annual maximum benefit for an individual is $1,500, the same as a decade ago (Fig. 43).

Children's orthodontic services are covered by most sponsors, and the percentage that also provides this coverage for adults reached 51 percent in 2020, up from 46 percent in 2019. In the West, 65 percent of sponsors cover adult orthodontics (Fig. 44).

Voluntary benefits

Employers have embraced voluntary benefits as an important part of the employee benefits package; nearly nine in 10 employers offer at least one, and on average four out of the 12 included in the survey question. The COVID-19 pandemic has further elevated the value of voluntary benefits, changing how they are viewed by employees and employers alike. Faced with new concerns about health and financial stability, employees are looking for ways to protect themselves and their families and may be more inclined than formerly to prepare for unforeseen setbacks. Voluntary benefits are a way that employers can quickly respond to these new priorities, especially since, for many types of products, they can allow employees to enroll at any time. The survey found that employers added a number of specific voluntary benefits in 2020 (see Fig. 17, page 28).

Voluntary benefits programs are most effective when customized to address specific employer objectives and combined with a robust education and communication campaign. The campaign works best when designed to reflect the different preferences employees have regarding how they receive the information and support. Among employers with 5,000 or more employees, providing greater benefit choice is the most important objective for offering voluntary benefits.

FIGURE 43

Employee contributions and cost-sharing requirements for dental plans

Dental plan sponsors with 500 or more employees

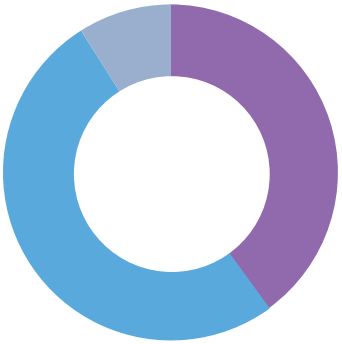
	Individual	Family
Employee contributions		
Employers requiring contribution	88%	93%
Average contribution as a % of premium	48%	51%
Average monthly contribution	$18	$58
Deductible* (median)	$50	$150
Annual maximum benefit (median)	$1,500	—
Lifetime maximum orthodontic benefit (median)	$1,500	—

*For restorative services.

FIGURE 44

Orthodontic coverage

Dental plan sponsors with 500 or more employees



40% Cover orthodontia for children only

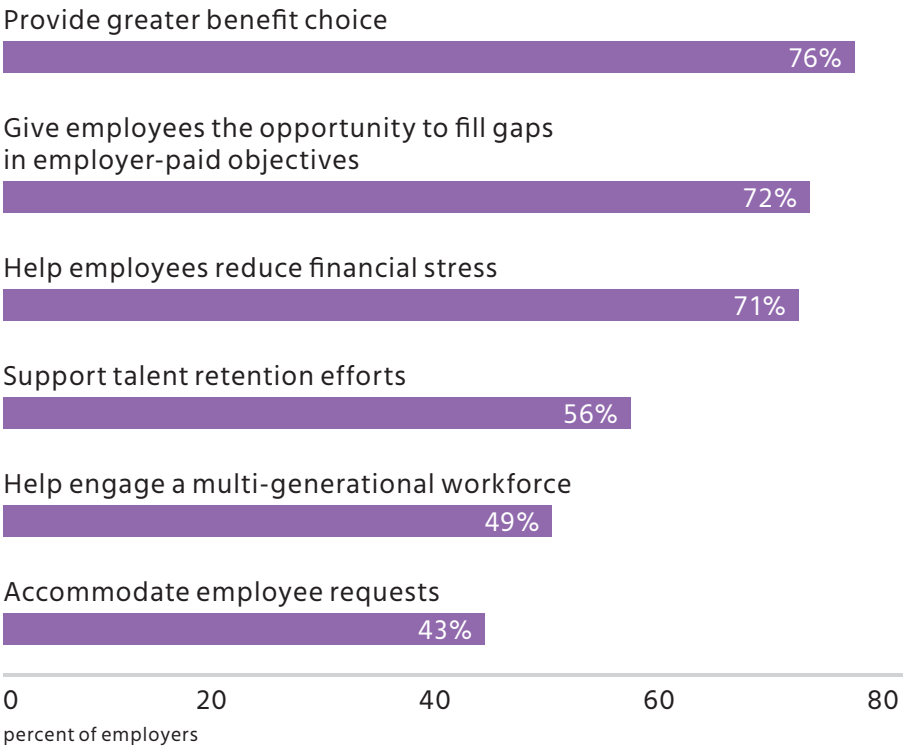
51% Cover orthodontia for children and adults

9% Don't cover orthodontia

FIGURE 45

Most important objectives for voluntary benefits program

Employers with 5,000 or more employees



Source: *Mercer 10-Minute Survey on Large Employer Health Strategies 2020*

However, the objectives of helping employees reduce financial stress and helping to engage a multi-generational workforce both grew considerably (Fig. 45). On average, 34 percent of eligible employees enrolled in one or more voluntary benefits in 2020 and it is likely that percentage will rise in 2021.

Flexible spending accounts Employees can set aside tax-free funds in flexible spending accounts (FSAs) for either health-care or dependent-care expenses. Nearly one-fifth of employees (18 percent) with access to a health FSA participated in 2020, and the average annual account contribution was $1,369. Far fewer — just 5 percent — participated in a dependent care FSA, but the average amount of the tax-sheltered

FIGURE 46

Flexible spending accounts

Employers with 500 or more employees

	Health-care spending account	Dependent-care spending account
Average employee participation rate	18%	5%
Average annual employee contribution	$1,369	$3,208
Average % of contribution dollars forfeited in 2019	5%	5%

contribution was higher ($3,208). In a normal year, most employees typically spend all the money in their accounts; employers reported that in 2019, on average, about 5 percent of account funds were forfeited (Fig. 46).

In 2020, however, the COVID-19 pandemic disrupted employees' ability to seek health care and to use dependent care. In late December 2020 a number of rules governing FSAs were relaxed so that employers could help minimize forfeitures. Employers were permitted to make the following changes:

- Unrestricted carryover
- Extended 12-month grace periods
- Allowances for terminated employees
- Eligibility age for dependent care increased to 13 years
- Election changes permitted without a qualifying event

Retiree health care

Employers with 500 or more employees

While retiree medical plan prevalence declined slightly in 2020, the drop was seen only among organizations with 500–999 employees, which have always been less likely to offer retiree medical benefits than larger employers. Overall, 21 percent of employers with 500 or more employees offer an ongoing plan to early retirees and 16 percent offer a plan to Medicare-eligible retirees. Among the largest employers — those with 20,000 or more employees — 30 percent offer an ongoing plan for pre-Medicare-eligible retirees and 26 percent for Medicare-eligible retirees, unchanged from 2019. Many more continue to provide coverage for a closed group of current and future retirees. Short of providing subsidized coverage, some employers are helping retirees access individual coverage through a private exchange.

About a fifth of employers with 500 or more employees (21 percent) offer health coverage on an ongoing basis — in other words, a plan for which new hires are eligible — to pre-Medicare-eligible retirees, through either a traditional plan or a private exchange, and 16 percent offer coverage to Medicare-eligible retirees. This represents a slight decrease from 23 percent and 17 percent offering coverage in 2019 (Fig. 47). Including those offering coverage only to a closed group, a total of 37 percent of employers sponsor a retiree plan. The largest employers (those with 20,000 or more employees) are most likely to offer retiree coverage: 30 percent offer coverage for pre-Medicare-eligible retirees and 26 percent for Medicare-eligible retirees (Fig. 48).

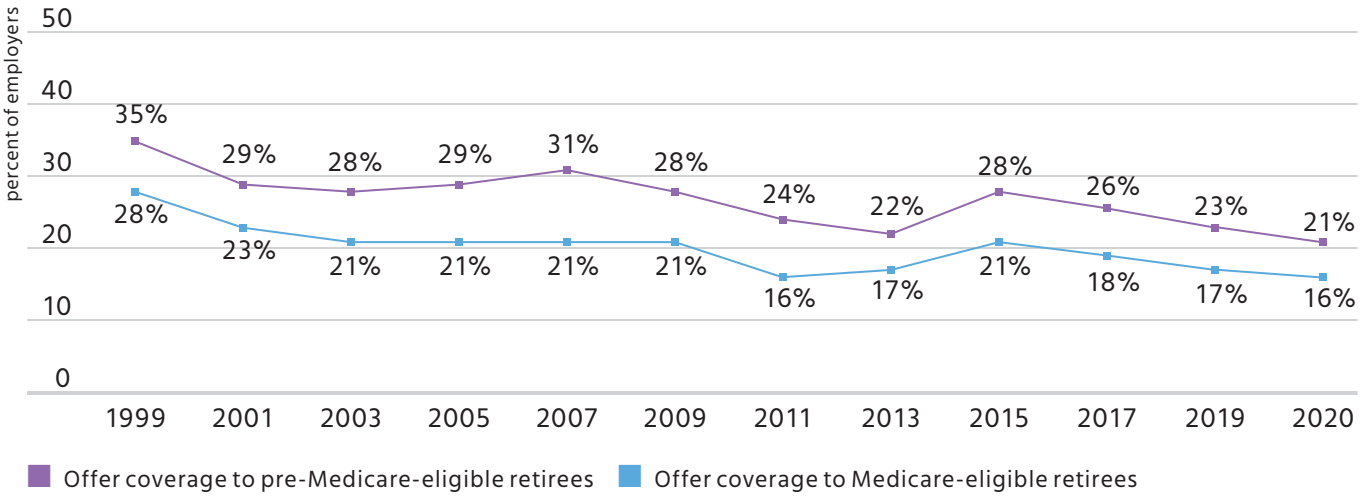
Private health exchanges

As an alternative to sponsoring a medical plan, employers can help retirees access individual coverage through a private health benefits exchange. These solutions are a way for employers to provide support to retirees by offering a range of health coverage choices and decision-support tools. Employers can take a defined contribution approach to subsidizing retiree coverage using an HRA as the payment vehicle.

FIGURE 47

Offer retiree health coverage to new hires

Employers with 500 or more employees



Plan must be offered on ongoing basis (i.e., new hires are eligible). Includes plans offered without an employer subsidy. Beginning in 2014, includes retiree medical exchanges.

Over a third (35 percent) of current retiree plan sponsors — those offering benefits either to new hires or only to a closed group — use an exchange to deliver benefits to at least some of their Medicare-eligible retirees. Exchanges for pre-Medicare-eligible retirees are less common: about a fifth of retiree plan sponsors (21 percent) offer an exchange to early retirees. Most often, this is an individual policy exchange, with public or private policy options. However, some sponsors offer a combined exchange for pre-Medicare-eligible retirees and active employees, and some offer a separate retiree exchange with group coverage.

Retiree contributions

About a third of retiree sponsors (34 percent) require pre-Medicare-eligible retirees to pay the full cost of individual coverage (Fig. 49). When cost is shared by the employer and the retiree, the retiree is responsible for an average of 41 percent of the cost of individual coverage and 43 percent of coverage for a retiree and spouse.

FIGURE 48

Offer retiree coverage to new hires, by employer size

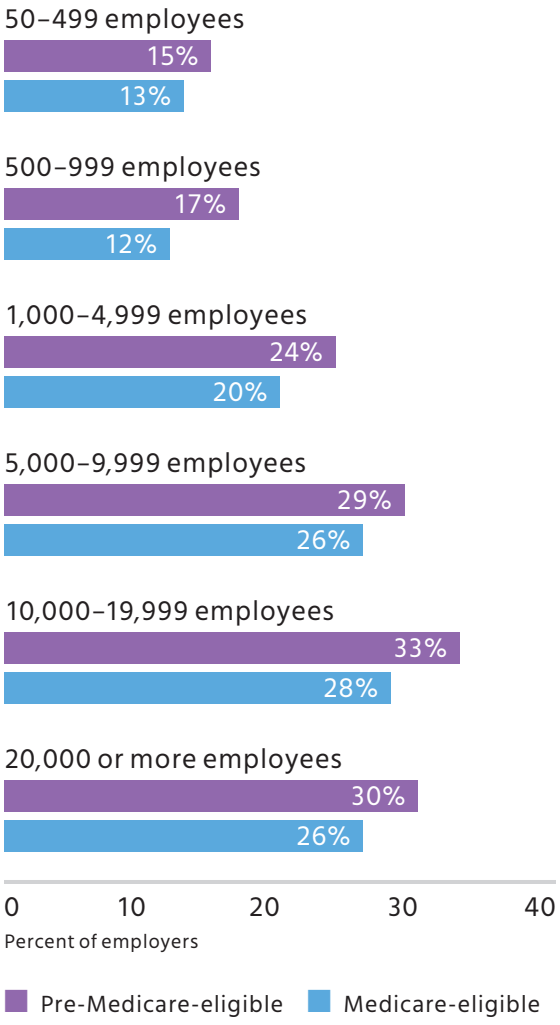


FIGURE 49

Contribution strategies for retirees*

Retiree plan sponsors with 500 or more employees

	Pre-Medicare-eligible retirees	Medicare-eligible retirees
Retiree pays all	34%	37%
Employer pays all	7	10
Cost is shared	59	53

*For retiree-only coverage.

Medicare-eligible retirees are required to pay the full cost of retiree-only coverage by 37 percent of sponsors. When cost is shared, retirees pay an average of 43 percent of the cost of individual coverage, and 46 percent of the cost for retiree and spouse coverage.

For more information, visit **mercer.us/nationalsurvey**