This is an excerpt from the full report, which is available to participants. If you would like more information, please contact Erin.OConnor@aon.com.
Key Findings. Cammack Health is pleased to bring you the twelfth annual Benefits Survey of Hospitals, publishing from our new home, Aon.

This year’s survey brings a host of new information relating to plan governance, leave of absence management, paid time-off policies, physician practice benefits, and executive benefits. Many of these new features are provided to you as a result of the feedback we’ve received in prior surveys, so thanks to all of our participants for making this year’s survey better than ever! In this section, we review some of the important changes or trends that we observed as we prepared the data.

High-Deductible Health Plans On The Rise
In 2014, few participating hospitals offered High-Deductible Health Plans (HDHPs), defined here as plans coupled with HRAs or HSAs; but this year, 15% of respondents offer an HDHP, representing 7% of all plans offered. Few hospitals offer a HDHP as a full replacement, and most use HDHPs coupled with a funded HRA in order to preserve domestic steerage. HSA-qualified HDHPs are less common, because an HSA-qualified plan prohibits first dollar coverage of any kind—including first dollar coverage at a participants’ own hospital. Most non-specialty hospitals seek to offer incentives to stay within the home system, so HSA-qualified HDHPs undermine that effort. It is notable that while HDHPs remain more popular in certain areas, such as MD/DE, they have now penetrated every region covered in our survey.

Charging More to Cover Spouses
One noticeable change since our last survey is the number of plan sponsors targeting spouse enrollment. We saw the number of groups customizing spouse eligibility or cost-sharing go from 43% last year to 56% in 2017. Changes range from adding a surcharge, to only offering coverage to non-covered spouses, to not covering spouses at all. This does not include groups that simply charge proportionately higher cost share for spousal tiers. Clearly the consensus is that spouses should pay more to continue to participate in (comparatively rich) hospital plans.

The Pendulum Swings on Urgent Care
The growth of urgent care, and shifting attitudes toward the positive and negative aspects of urgent care, is reflected in the changes we have seen in urgent care copays over the past few years. Just 3-4 years ago, many plans did not maintain separate urgent care copays. Today, nearly all plans maintain a separate cost sharing requirement. While urgent care was initially designed as a less expensive alternative to emergency room care for non-emergent services, plan
sponsors concerned about urgent care’s encroachment into primary care are imposing higher cost share on urgent care, including deductibles and coinsurance. There are also plan sponsors concerned with urgent care drawing members away from their own domestic services, thus making it harder to manage chronically ill members within the home system. We observed a definitive trend toward higher urgent care cost sharing, possibly driven by these factors.

**Accepting Stop Loss Risk**
Stop loss coverage has also been experiencing some changes, as groups focus on reducing their fixed costs. While the median itself has not changed significantly, this year we saw a rise in the number of groups with stop loss in the range of $500,000-$715,000. More groups are willing to take on this risk in order to save premium costs.

**Pushing Back on Specialty Drugs**
The news for prescription drug plans is centered on reining in prices. 40% of the plans included in the survey now maintain separate specialty medication cost-sharing. We also noted that this year 12% of plan sponsors are setting coinsurance for non-formulary medications at 100%, effectively passing along the entire cost of the drug to the member. Specialty medications as a percentage of overall plan cost continues to climb, with one group reporting a specialty share of 54%. The top 3 drugs by plan cost were identical to last year’s report; Humira, Enbrel, and Harvoni. Metformin and its brand name counterpart, Januvia, both made the top 10 list at spots 6 and 10 respectively, after showing up in the number 8 spot last year as Glumetza. This medication, in both brand and generic forms, experienced large price increases over the past two years, and shows no sign of slowing down its inflation.

**Dental Coverage Evolves**
The usually quiet world of dental saw some changes this year, with our first ever $5,000 plan maximum, and our first hospital offering 4 different dental plans. We include a mix of both 100% employee-paid and partially employer paid plans in our analysis. Based on informal feedback, we view the expansion of dental options as part of a larger effort to ensure that the entire compensation package is comprehensive and meets many different participant needs.

**Banding by Region**
We continue to see a lot of similarity across plan offerings by region, but there are big differences in the way that plan sponsors charge for coverage depending on where they are. 72% of NJ hospitals salary-band contributions, making it the norm in the Garden State, while only 16% of MA hospitals vary contributions by salary.

**Cost Sharing for Domestic Claims**
Although domestic network cost share medians have not changed significantly, in our backup data we did note an increase in the number of groups imposing cost sharing on domestic claims. These groups continue to maintain differentials and incentives to use the domestic network, but are moving away from a “no/low-cost” approach to domestic claims.

**Doctors are Different**
By popular demand, for the first time this year we offer a feature section on physician practice benefit coverage. Predictably, we noted a higher portion of physicians employed at larger hospitals. We include data in our survey about the number of systems covering off-site staff and off-site physicians, and the types of plans offered. We plan to expand this section in future years, and welcome your feedback on improving the information collected.
Plan Costs

What plans do health systems offer?

Around half of all respondents offer two health plans. Three-tier plans are by far the most popular offering, with 92% of respondents offering one. 15% of respondents offer an HSA or HRA, which are not called out in the charts below.

- 53% offer two plans
- 21% offer one plan
- 3% offer more than three plans
- 23% offer three plans

How are spouses covered?

Health systems are encouraging spouses of employees to accept coverage from their own employers—and some are dropping spousal coverage entirely.

- 44% of respondents have no restrictions on covering spouses
- 34% of respondents levy a surcharge (median cost of $1,105 per year) to cover spouses who are offered coverage by their employers
- 11% of respondents do not cover spouses who are offered coverage by their employers
- 11% do not cover spouses
Stop Loss

76% of respondents are self-insured with stop loss; over half of those control costs by excluding domestic claims from reimbursement. No respondent with more than 2,000 employees is fully-insured. Overall, systems are increasing their individual stop loss.

Stop Loss Coverage

50% of respondents with stop loss have an aggregate stop loss benefit in addition to individual stop loss.

25% of respondents with stop loss use a captive for stop loss coverage. Of those, 13% use it for something other than health plan stop loss.

Overall Stop Loss

<table>
<thead>
<tr>
<th>2017 Individual Stop Loss Level (ISL)</th>
<th>Stop Loss (Pooling) PEPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum $150,000</td>
<td>$20</td>
</tr>
<tr>
<td>Median $300,000</td>
<td>$222</td>
</tr>
<tr>
<td>Maximum $1,000,000</td>
<td>$1,528</td>
</tr>
<tr>
<td>Average $395,658</td>
<td>$368</td>
</tr>
<tr>
<td>2016 Median $300,000</td>
<td>$222</td>
</tr>
</tbody>
</table>

See Appendix A for methodology details.
Costs Over Time

Costs continue to rise from year to year, although efforts by systems to control costs across the board seem to be seeing results.

Year-Over-Year Cost Per Employee per Year (PEPY)

This chart represents 27 respondents who have participated in the Survey for the last four consecutive years.
Governance and Strategy

Management of an employee health plan is not restricted to human resources—especially as the move towards value-based care accelerates.

Who Governs Health Plans?

27% of health plans are overseen by the CHRO.

23% are overseen by the CHRO and CFO together.

50% of respondent health plans are governed by a mixed team who advise executives.

Governance strategies continue to evolve. Health systems are working with an array of partners—vendors, physician organizations, and other employers—taking different routes toward similar goals.

Governance teams include:

- Human Resources: 100%
- Finance: 73%
- Pharmacy: 27%
- Wellness: 27%
- Physicians: 18%
- Other: 45%

“Other” includes Managed Care, Employee Health, Administration, University or Medical Center Leadership, General Counsel, etc.

Building Partnerships

67% of respondents already participate in a Value-Based Contract with a payer.

53% have at least discussed the concept of partnering to manage health plan members at non-hospital employers.

Physician-based Partnerships include:

- ACO (Accountable Care Organization): 41%
- CIN (Clinically Integrated Network): 32%
- PHO (Physician Hospital Organization): 27%

Value-Based Care Strategies

Half of respondents have already made plan changes to move towards a value-based model.

- 50% have modified their employee health plan as part of a Value-Based Care strategy
- 59% have identified a Value-Based Care strategy in the first place
- 36% do not have a strategy
- 5% are unsure
## Analysis of 2-Tier Plans

### Domestic

<table>
<thead>
<tr>
<th></th>
<th>Deductible (single/family)</th>
<th>Co-insurance</th>
<th>OOP Max1 (single/family)</th>
<th>Medical OOP Max2 (single/family)</th>
<th>copays</th>
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</thead>
<tbody>
<tr>
<td>Min</td>
<td>$0/ $0</td>
<td>0%</td>
<td>$0/ $0</td>
<td>$1,250/ $2,625</td>
<td>$0/ $0</td>
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<tr>
<td>Med</td>
<td>$0/ $0</td>
<td>0%</td>
<td>$3,575/ $7,125</td>
<td>$4,000/ $8,000</td>
<td>$15/ $22.5</td>
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<td>Max</td>
<td>$2,100/ $4,200</td>
<td>20%</td>
<td>$7,150/ $14,300</td>
<td>$5,650/ $11,300</td>
<td>$40/ $50</td>
</tr>
</tbody>
</table>

### In-Network

<table>
<thead>
<tr>
<th></th>
<th>Deductible (single/family)</th>
<th>Co-insurance</th>
<th>OOP Max1 (single/family)</th>
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</thead>
<tbody>
<tr>
<td>Min</td>
<td>$0/ $0</td>
<td>0%</td>
<td>$2,000/ $5,000</td>
<td>$1,000/ $2,000</td>
<td>$0/ $0</td>
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<tr>
<td>Med</td>
<td>$250/ $500</td>
<td>10%</td>
<td>$5,080/ $12,700</td>
<td>$3,000/ $7,000</td>
<td>$20/ $40</td>
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<tr>
<td>Max</td>
<td>$3,000/ $6,000</td>
<td>50%</td>
<td>$7,150/ $14,300</td>
<td>$5,650/ $11,700</td>
<td>$85/ $95</td>
</tr>
</tbody>
</table>

*See Appendix A for methodology details.*

In recent years, urgent care copays have been low to steer employees away from emergency room care. This may be changing: copays for urgent care are beginning to trend upward, outpacing physician and specialist copays.

1. OOP Max includes medical and Rx deductibles, coinsurance, and copays.
2. Medical OOP Max includes medical-only deductibles, coinsurance, and copays.
Spotlight: Cost Sharing by Region

3-Tier Plan Deductible, by Region (In-Network, Single)

3-Tier Plan PCP Copay, by Region (In-Network)

See Appendix A for methodology details.
Mary H. Clark
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Mary's work includes qualitative and quantitative research and evaluation, performance measurement development, and strategic planning. She serves as a senior liaison to clients, has extensive knowledge of federal and state healthcare regulations, and is an expert in the current health care legislation.

Mary has over fifteen years of in-depth experience specifically with non-profits and hospital systems.

Frank Lonardo
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Frank specializes in data analytics, business intelligence and the design and implementation of organizational transformations. He has spearheaded innovative approaches to healthcare cost and quality improvement, including direct provider contracting, employer purchasing coalitions and population health management processes that link hospitals, physicians and patients.

Frank has over twenty years of experience in consulting with complex health systems, national non-profits and corporations.

Erin M. O’Connor
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Erin works with industry leaders and clients to develop strategic partnerships and deliver best practices for accountable care solutions. Erin's key areas of expertise include organizational development, engagement, and change management.

Erin has twenty-five years of experience in human resources and health care operations. She excels at creating and embedding processes to overcome barriers to change.
We Welcome 2018 Survey Participants

This survey becomes more valuable as it grows; your referrals to other healthcare organizations help us expand its scope and increase its value to participants. We hope you will invite hospitals and medical centers in the Northeast (NY, NJ, DE, MD, CT, PA, MA, and RI) to participate in our 2018 Benefits Survey of Hospitals.

There is no cost to participate in this project. All participants receive complimentary copies of the report, both digitally and from our limited print run, providing invaluable and competitive benchmarking information from their peer group. The final survey is only provided to participants and is not for sale.

All information is confidential: data is de-identified, and the results are presented in aggregate form. This is an excellent opportunity to compare hospital benefit strategies among other hospitals in your region, and we are always happy to prepare custom benchmarking reports for participants.

Please call me at (212) 766-9089 or e-mail me at Frank.Lonardo@aon.com with any questions about the survey or referrals, and we can send you a referral email to forward to potential participants. Thank you for your participation and referrals!

Frank Lonardo
About Aon

Aon plc (NYSE:AON) is the leading global provider of risk management, insurance and reinsurance brokerage, and human resources solutions and outsourcing services. Through its more than 72,000 colleagues worldwide, Aon unites to empower results for clients in over 120 countries via innovative and effective risk and people solutions and through industry-leading global resources and technical expertise. Aon has been named repeatedly as the world’s best broker, best insurance intermediary, best reinsurance intermediary, best captives manager, and best employee benefits consulting firm by multiple industry sources.

In 2016, Aon acquired Cammack Health LLC, bringing this health system expertise and 35 healthcare-focused employees into the Aon family. Cammack Health’s Partners, Frank Lonardo, Erin O’Connor and Mary Clark, are Senior Vice Presidents at Aon, leading strategic initiatives with Cammack Health / Aon clients throughout the Eastern region.

Visit www.aon.com for more information about Aon, and visit aon.com/manchesterunited to learn about Aon’s global partnership with Manchester United.

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