

Large Employers' 2015 Health Plan Design Survey

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Introduction

As employers continue to comply with the various provisions of the Affordable Care Act (ACA), they also remain focused on the perennial challenge of controlling rising health care costs. Employers are projecting that health care costs would increase by 6.5% in 2015 if they made no plan changes. However, employers estimate that they will be able to keep cost increases to **5.0%** through plan design changes.

Given these continual costs, employers' top focus in 2015 will be on engaging consumers in better health care decision-making. More employers will offer consumer-directed health plans (CDHPs), including about a third who will offer only CDHPs. They will also expand the use of tools to help employees to be better consumers as well as incenting employees to lead healthier lifestyles. At the same time employers are evaluating the value proposition of private exchanges, although only a small percentage of employers have moved their active employees to a private exchange. All of these efforts will be implemented to control health care costs, as well as minimize the impact of the excise tax, which is expected to go into effect in 2018.

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Key Findings

Changes as a Result of Health Care Legislation

Employers Prepare for the Excise Tax

With the excise tax (i.e., “Cadillac tax”) expected to be enacted in 2018, employers are taking numerous steps to prepare their employees to be better consumers and live healthier lifestyles. Seventy-three percent of employers are adding/expanding consumerism tools, while 57% are also implementing/expanding consumer-directed health plans (CDHPs).

Employers’ Thoughts on Private Exchanges

As some employers begin to move their active employees to the private exchanges (2% in 2014 and 1% planned for 2015), employers express confidence in the ability of private exchanges to outperform employer-sponsored health plans in terms of plan choice and complying with regulations. However, many employers are less confident in the ability of private exchanges to control costs or engage employees in better health care decision-making.

Controlling Medical Plan Costs

Employers Expect Health Care Costs to Rise by 5% in 2015

Large employers expect that after they implement plan design changes that the median health care cost increases will be 5.0% in 2015, similar to 2014. Without any changes to their plan design, health care costs would rise by 6.5% in 2015.

Driven by High Cost Conditions and Medical Inflation, Employers Embrace CDHPs

The top cost drivers of medical trend are reported to be high cost claims, specific conditions/diseases and overall medical inflation. To combat those

drivers of health care costs, employers indicated that CDHPs, increased cost-sharing and centers of excellence are some of their most effective tactics.

Consumer-Directed Health Care

More Large Employers Move to Full Replacement

The percentage of employers offering only CDHPs (i.e., full replacement) continues to grow (32% planned for 2015, up from 22% in 2014). In addition, the percentage of employers offering a CDHP to their employees as an option has increased to 49%.

Pharmacy Benefits

Employers Adopt Specific Tactics for Controlling Specialty Pharmacy Costs

Prior authorization and step therapy continue to be used by most employers for traditional and specialty medications, but employers are now adopting tactics specific to controlling the rising costs of specialty medications. Tactics such as freestanding specialty pharmacy, only approving an initial 30-day supply and site-of-care management are becoming more common.

Health Improvement

Engaging Employees in Health Care Decisions and Weight Management are Top Focus Areas for 2015

Thirty-six percent of employers rate consumer engagement in health care decision-making as the top behavior they are focusing on in 2015, while 20% focus on helping employees to manage their weight.

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About the Survey

The *Large Employers' 2015 Health Plan Design Changes* survey asked members to provide information on their 2015 plan offerings, including:

- Changes due to the Affordable Care Act
- Medical plan costs
- Consumer-directed health care
- Pharmacy benefits
- Health improvement

The survey was fielded between June 5 and June 26, 2014. The survey results reflect the plan design changes of 136 employers.¹ Collectively, these respondents represent a wide variety of industry sectors, and employ approximately 7.5 million employees in the U.S. (Figures 1 and 2).

Figure 1: Industry Breakdown
(Number of Responses=136)

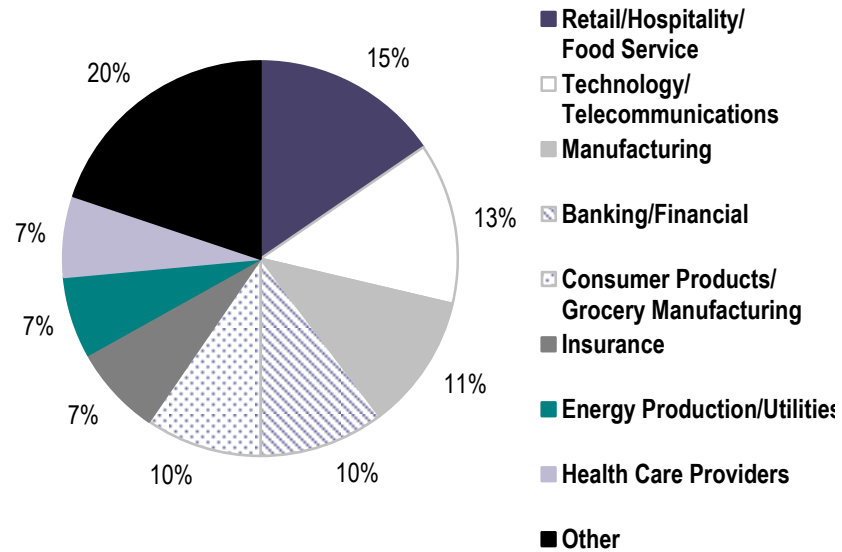
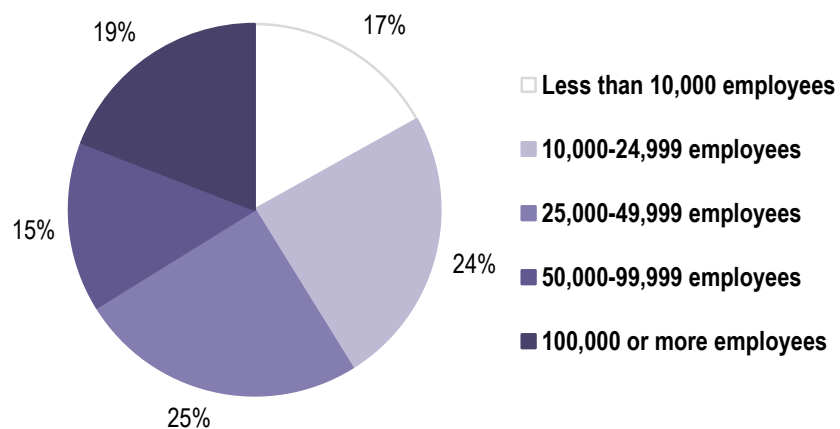


Figure 2: Number of U.S. Employees
(Number of Responses=136)

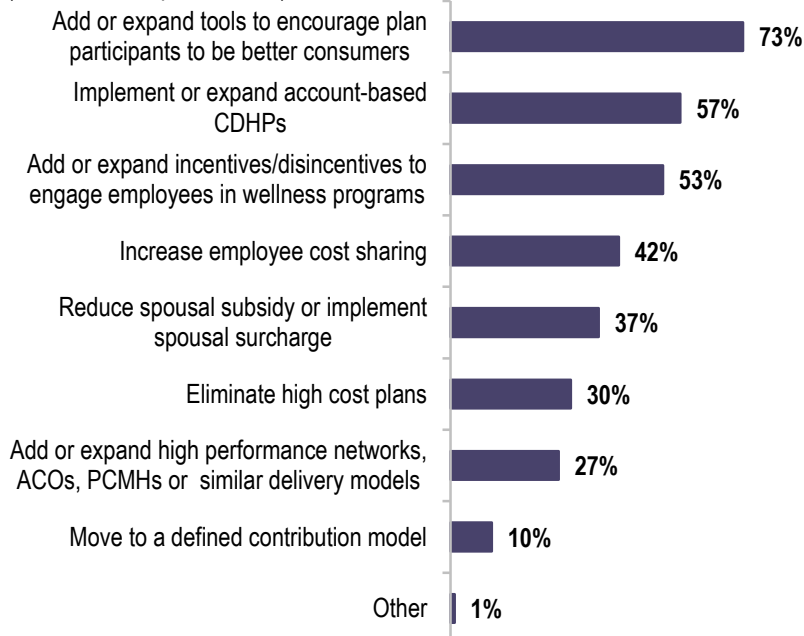


¹ Although 136 members completed the survey, not all members found all of the questions directly applicable to them. As a result, the number of responses varies by question.

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Figure 3: Employer Actions to Minimize the Impact of the Excise Tax

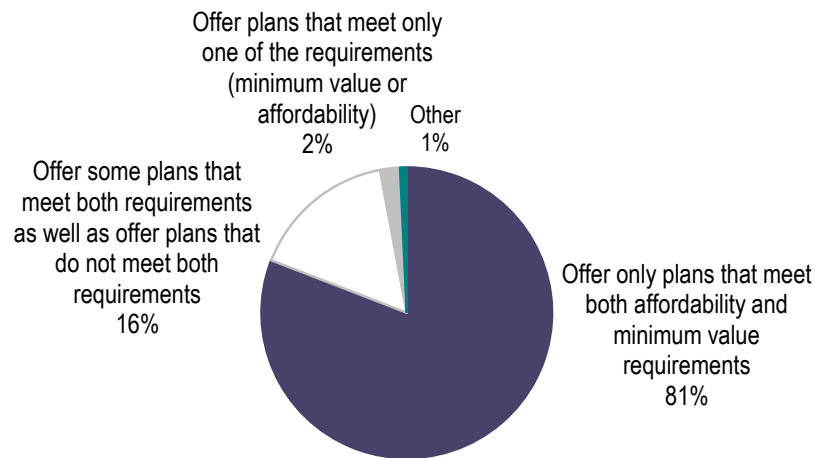
(Number of Responses=136)



Note: Respondents were allowed to select more than one option. Other responses included: benefit changes to drive low cost consumer choices.

Figure 4: Employer-Shared Responsibility Payments

(Number of Responses=136)



Note: Other responses included: offers plans meeting both the affordability and minimum value tests, but not to variable hour employees not consistently working 30+ hours per week.

Changes as a Result of Health Care Legislation

Employers were asked about the changes they would be making to their health plans to comply with ACA regulations effective in the upcoming year. With the excise tax set to be implemented in 2018, employers are implementing different tactics to minimize the impact. Employers are focusing on helping employees to be better consumers, by adding/expanding consumerism tools and implementing/expanding account-based CDHPs (**Figure 3**). The majority of employers will either add or expand current wellness incentives. However, 42% indicated that, even with those and other changes, they will have to increase employee cost sharing to minimize the impact of the excise tax.

With the employer mandate currently slated to begin in 2015, employers were asked about offering coverage meeting the affordability² and minimal value tests.³ Under ACA regulations, employers who do not offer coverage that meets ACA affordability and minimum value standards to all full-time employees may face a penalty.

The survey found that 81% of employers would offer only plans that meet both the affordability and minimum value tests (**Figure 4**). Another 16% reported that they would offer at least one plan meeting both requirements, but would offer additional plans that did not meet both the affordability and minimum value tests. Only 2% of employers indicated that they would not offer any plans in 2015 that would meet both requirements.

² Affordable coverage is defined by the ACA as employee-only coverage costing less than 9.5% of household income.

³ The ACA requires plans to cover at least 60% of allowed costs, including essential benefits.

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Private Exchanges

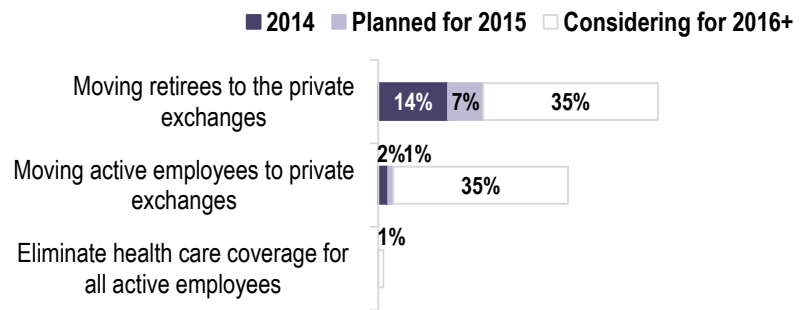
While no employers have or plan to eliminate health care coverage for their active employees in 2015, there is some movement and interest in private exchanges. By 2015, 3% of responding employers plan to move their active employees to a private exchange (Figure 5). Fourteen percent of employers are partnering with a private exchange for their retirees in 2014 (up from 10% last year) and another 7% are planning to do so in 2015.

Given employers' interest in private exchanges, employers were asked how confident they were that private exchanges would be able to outperform employers in certain areas. The three features that most employers were confident a private exchange would do better were providing more choice of plans, complying with regulations and supporting a defined contribution approach (Figure 6). They were less confident in the ability of private exchanges to outperform employer efforts to control health care costs, assist employees with questions/problems and engage employees in better health care decision-making.

The Business Group's "[Private Health Insurance Exchanges](#)" toolkit is a guide for employers thinking about whether or not private exchanges fit into their health care strategy. A recently added section, "[Questions to Consider When Requesting Information from Private Exchanges](#)," lists questions that employers should include in a request for information of companies offering private exchanges.

Figure 5: Employer Plans for Private Exchanges

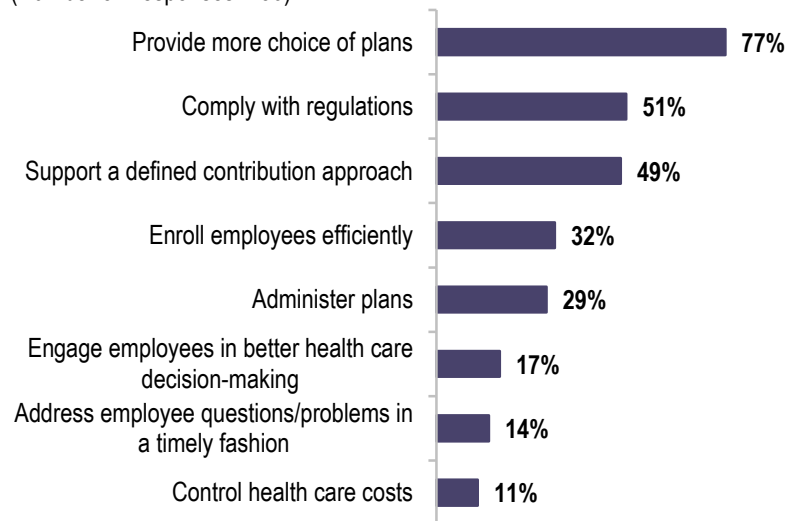
(Number of Responses=136)



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

Figure 6: Employers Confident That Private Exchanges Will do the Following Better Than Employers do Today

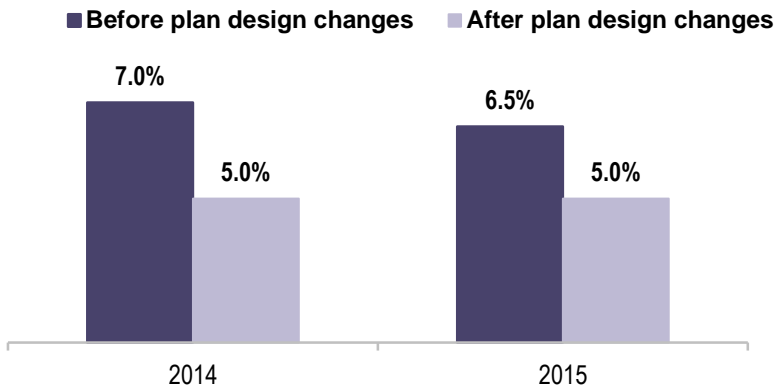
(Number of Responses=136)



Note: The data above reflects the percentage of employers who selected 4 or 5 on a 5-point scale, where 5= very confident.

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Figure 7: Median Health Care Cost Increase Projections



Note: Projections are based on employers who had estimates for 2014 and 2015. Not all respondents were able to provide estimates for 2014 and 2015 cost projections. For 2014, 111 respondents were able to provide cost projection before and after plan design changes. For 2015, 101 employers were able to provide projections before plan design changes, and 83 provided projections for after plan design changes.

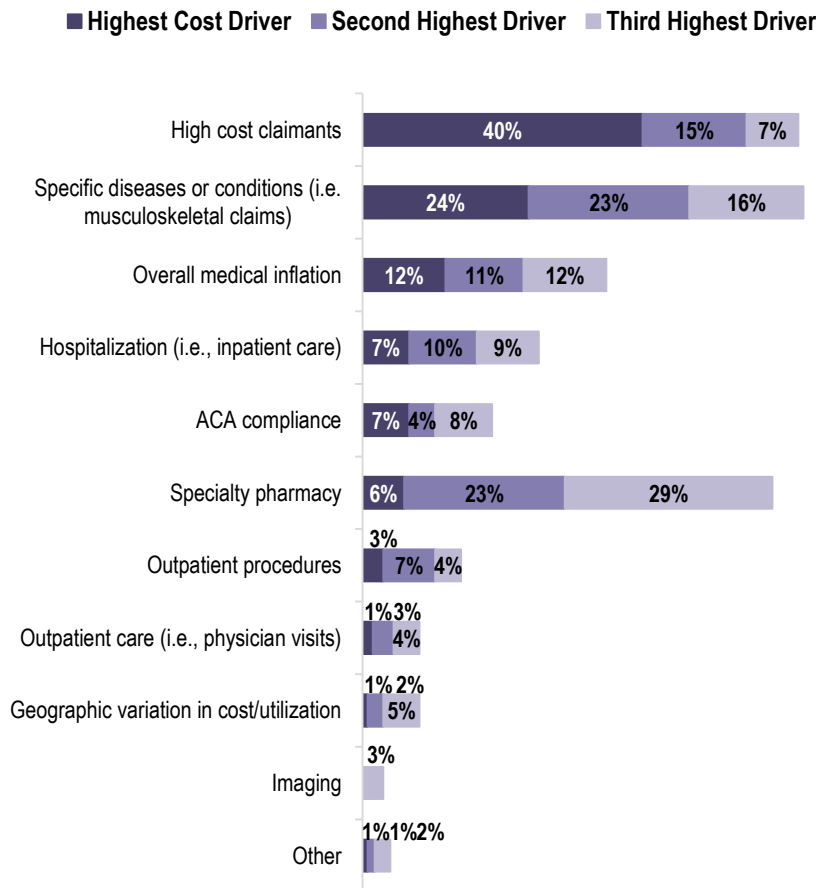
Controlling Medical Plan Costs

After plan design changes, employers expect to be able to keep health care cost increases to 5.0% for both 2014 and 2015 (Figure 7). If employers had not made any changes in 2014, they estimated that health care costs would have increased by 7.0%, and they are projecting costs to increase by another 6.5% in 2015.

Driving those costs are a variety of factors. Employers indicate that high cost claimants and specific diseases/conditions are two of the biggest drivers of rising health care costs (Figure 8). Although not designated as the highest cost driver, specialty pharmacy is cited as a significant driver of costs as well.

Figure 8: Top Cost Drivers of Rising Health Care Costs

(Number of Responses=136)



Note: Other responses included: provider consolidation; readmissions; pregnancy costs; inappropriate use of the emergency room; and an aging workforce.

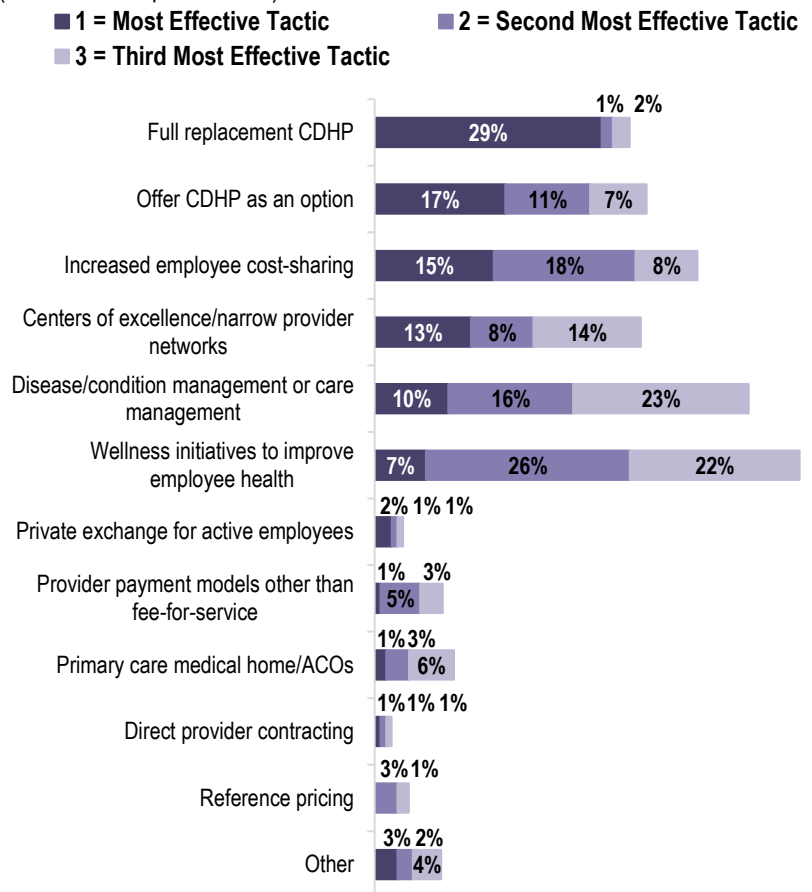
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Employers were asked to indicate the top three tactics they are using to control rising costs. Two-thirds of employers reported that implementing CDHPs as an option or going full replacement were some of their most effective tactics (Figure 9). Fifty-five percent of employers indicated that providing wellness initiatives was one of their top three most effective tactics to control health care costs, and 49% indicated disease/condition management or care management programs. These findings are consistent with findings from prior years when employers also indicated that wellness initiatives and CDHPs were effective tactics for controlling costs. The Business Group's "[Controlling Health Care Costs in the New Reality of ACA](#)," provides additional tactics employers should consider implementing to control health care costs.

Employers were asked to provide details on employee cost-sharing provisions in their plan with the most participation, including the employee percentage contribution to the premium as well as the in-network deductibles for employee-only and family coverage.

Employers were split between a PPO (46%) and a CDHP (44%) on what was their most common plan type. Across all plan types, the median percentage contribution to the premium for employee-only coverage is 20%, and 23% for family coverage. On average, employees will be responsible for 24% of the cost of the premium for spousal coverage. With the greater prevalence of CDHPs, the median deductible for 2015 will be \$1,000 for employee-only coverage and \$2,325 for family coverage (Figure 10).

Figure 9: Most Effective Tactics to Control Health Care Costs
(Number of Responses=136)



Note: Other responses included: transparency tools; medical decision-support tools; on-site health center with primary care; employee education initiatives; step therapy for select prescription drugs; and defined contribution.

Figure 10: Median Employee Cost-Sharing Amounts for 2015

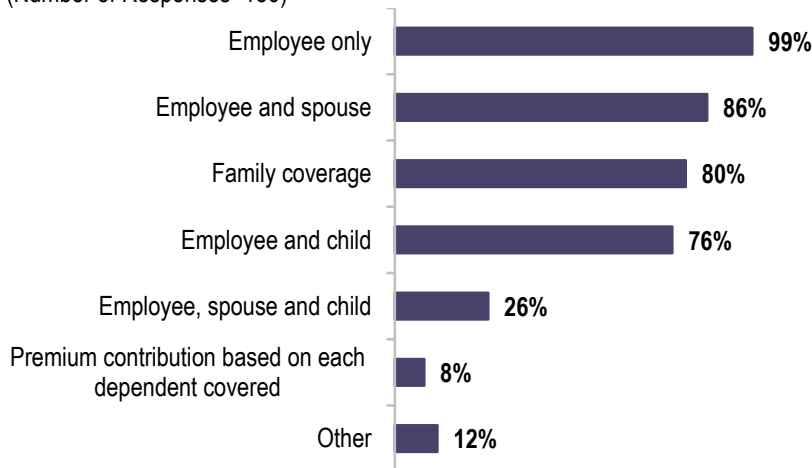
	All Plan Types	PPOs	CDHPs
Employee % of the premium			
Employee-only	20%	21%	20%
Spouses	24%	24%	23%
Family Coverage	23%	24%	23%
In-network deductibles			
Employee-only	\$1,000	\$450	\$1,500
Family Coverage	\$2,325	\$1,168	\$3,000

Note: Employers were asked to provide cost sharing information for their plan with the greatest participation. Of the 136 respondents, 46% reported that a PPO was their most common plan type, and 44% indicated a CDHP.

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Figure 11: Tier Design in Employer Health Plans

(Number of Responses=136)



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

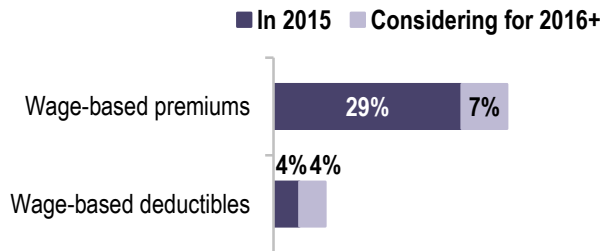
Note: Other responses included: one tier regardless of the number of people participating; employee plus one, employee plus children; employee with less than/greater than 3 children; family coverage with less than/greater than 3 children.

The most common tier-design is the 4-tier design (i.e., employee-only, employee and spouse, employee and child, and family coverage) with 53% of employers reporting having this design. Still, there is a small group of employers who are basing premium contributions on the number of dependents enrolled in the plan (8%) (Figure 11).

In addition to tier-design, 29% of employers adjust premiums based on an employee’s salary (Figure 12). A smaller percentage (4%) of respondents do the same for deductibles, making employer-sponsored health coverage more affordable for lower-income employees. These rates are very similar to prior years. In addition, some employers with consumer-directed health plans also use wage-based health account contributions (see Figure 21).

Figure 12: Wage-Based Premiums and Deductibles

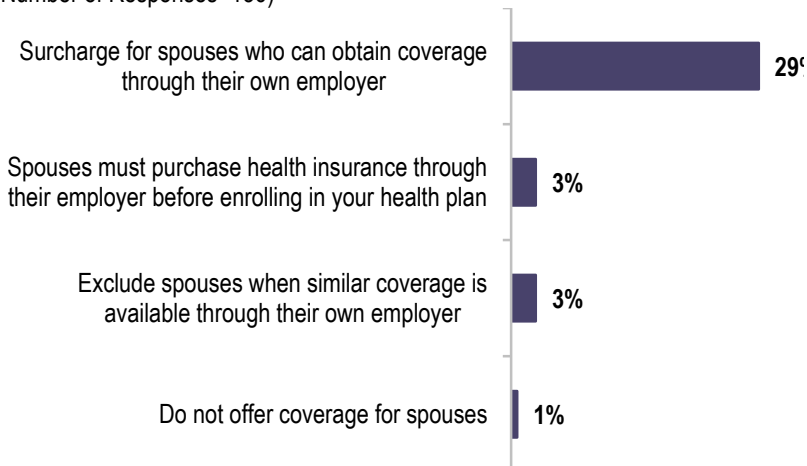
(Number of Responses=136)



Respondents were also asked specifically about spousal coverage. Twenty-nine percent of respondents apply a premium surcharge for spouses who are offered health coverage through their own employer (Figure 13). Only 1% of respondents do not offer coverage to spouses.

Figure 13: Spousal Coverage

(Number of Responses=136)



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

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While there has been a lot of attention on narrow networks recently, only 26% of employers reported that their plans include a narrow network. Some employers (13%) offer plans that allow employees to receive a reduced copay/coinsurance or other price differential to use a narrow network within their plan, while others (10%) offer plans with a narrow network alongside plans with a broader network. Only 3% of respondents reported that all of the plans they offer include a narrow network (Figure 14).

To ensure the employee receives high-quality care, the majority of large employers now work with centers of excellence (COEs) for transplants (63%) and other select conditions (57%). Many employers also offer medical decision support and/or second opinion services to help employees choose the best treatment option (Figure 15). Telehealth is another option that is now commonly offered to employees of large employers, with 48% of employers in 2015 making telehealth options available to employees in states where it is legal.

Relatively few employers are planning to contract directly with providers in 2015, but many are considering it for the future. Direct contracting with high-quality providers can help control costs, improve quality/safety and ensure the most appropriate care for specific services. Currently 4% of employers partner with a specific provider for transplants, and 7% do so for conditions/procedures other than transplants (Figure 16). Other employers are contracting with ACOs (5%) and PCMHs (2%). For more information on this topic, see the Business Group's ["Selecting and Contracting with Accountable Care Organizations."](#)

Figure 14: Large Employers Use of Narrow Networks
(Number of Responses=136)

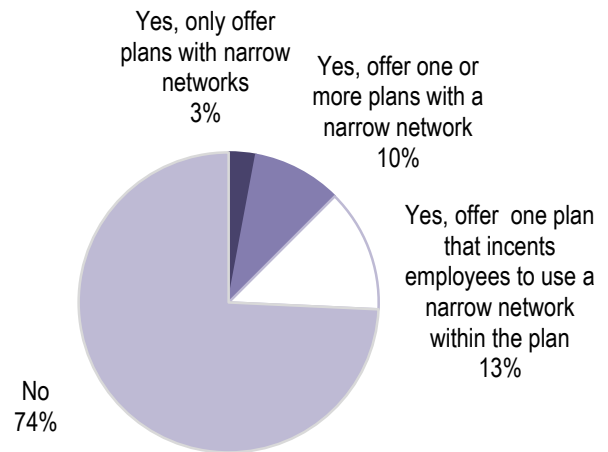


Figure 15: Use of Centers of Excellence and Other Delivery Solutions
(Number of Responses=136)

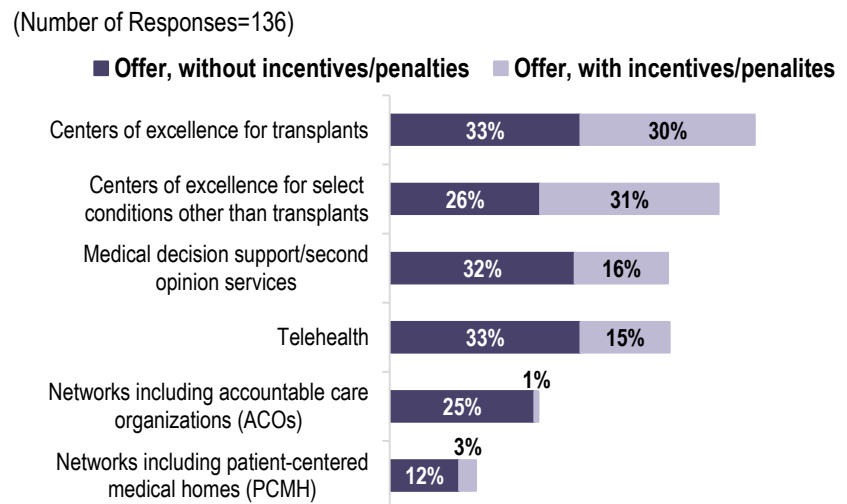
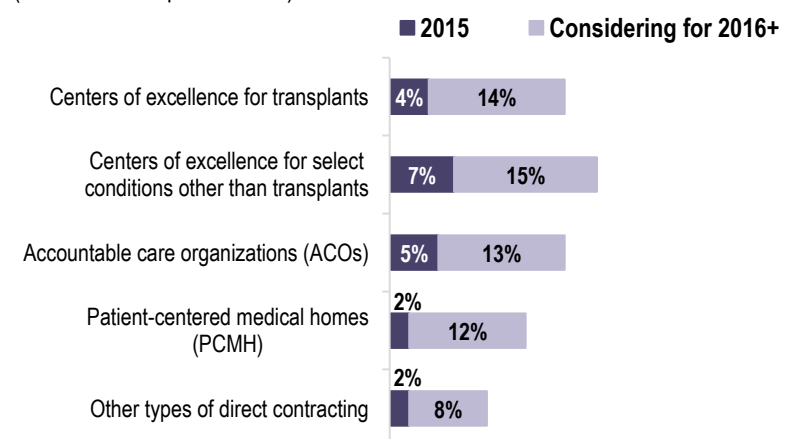


Figure 16: Use of Direct Contracting
(Number of Responses=127)

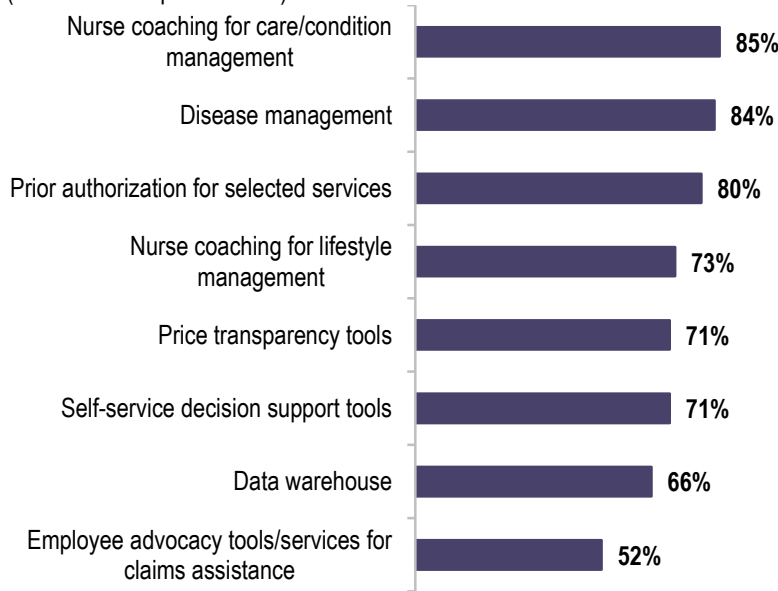


Note: Other types of direct contracting included: contracting for lab services; and contracting with specific pharmacies.

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Figure 17: Employer Tools and Programs

(Number of Responses=136)



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

Employers offer a variety of other programs and tools to help employees navigate the health care system and manage their health. Eighty-five percent reported offering nurse coaching for care/condition management, and 73% offered coaching for lifestyle management (**Figure 17**). In 2015, 80% of employers will require prior authorization for select services, compared to only 65% in 2014. Other common tools/services included:

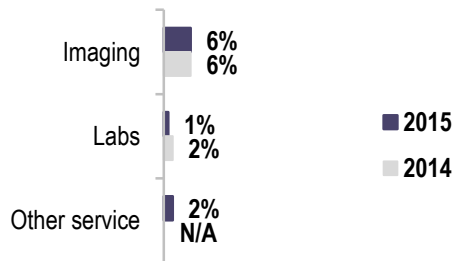
- Disease management (84%)
- Price transparency tools (71%)
- Decision-support tools (71%)
- Employee advocacy tools/services for claims assistance (52%)

Employers offering CDHPs were more likely to make price transparency tools available to employees compared to employers without a CDHP (77% vs. 48%). Eighty-one percent of employers who have gone full replacement CDHP offer a price transparency tool.

The use of reference pricing for services remains uncommon. Six percent of respondents will use reference pricing for imaging services (6%) in 2015, and a few employers will extend those reference prices to other services such as labs, select surgical procedures and preventive screenings (**Figure 18**).

Figure 18: Reference-Based Pricing

(Number of Responses=136)



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

Note: Other services reported by employers included: select surgical procedures and screenings such as mammograms and colonoscopies.

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Consumer-Directed Health Care

The adoption of consumer-directed health plans (CDHP) continues to increase among large employers. In 2015, 81% of employers will offer at least one CDHP, up from 72% in 2014 (**Figure 19**). In addition, the percentage of employers who will only offer CDHPs to their employees will increase from 22% to 32% in 2015. For employers considering moving to CDHPs or those with CDHPs that want to increase enrollment, see the Business Group's ["Your CDHP Toolbox: Taking Enrollment to the Next Level."](#)

A high-deductible health plan (HDHP) with a health savings account (HSA) remains the most common type of CDHP offered by large employers. Eighty-five percent of employers offering a CDHP offer at least one plan with an HSA (**Figure 20**).

Other employers offer health reimbursement arrangements (HRA), which can be offered alongside an HDHP, paired with a flexible spending account (FSA) or offered with a plan type other than an HDHP. In 2014, 45% of employers with CDHPs offered at least one plan with an HRA, but that number dropped to 37% in 2015.

Figure 19: Availability of CDHPs Among Employers

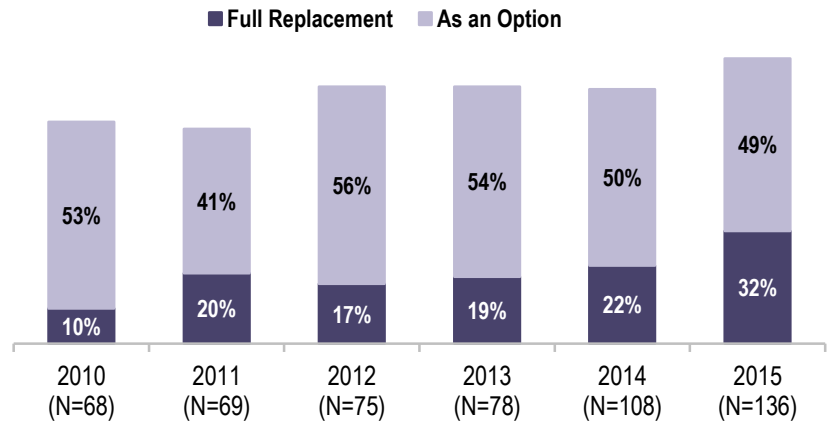
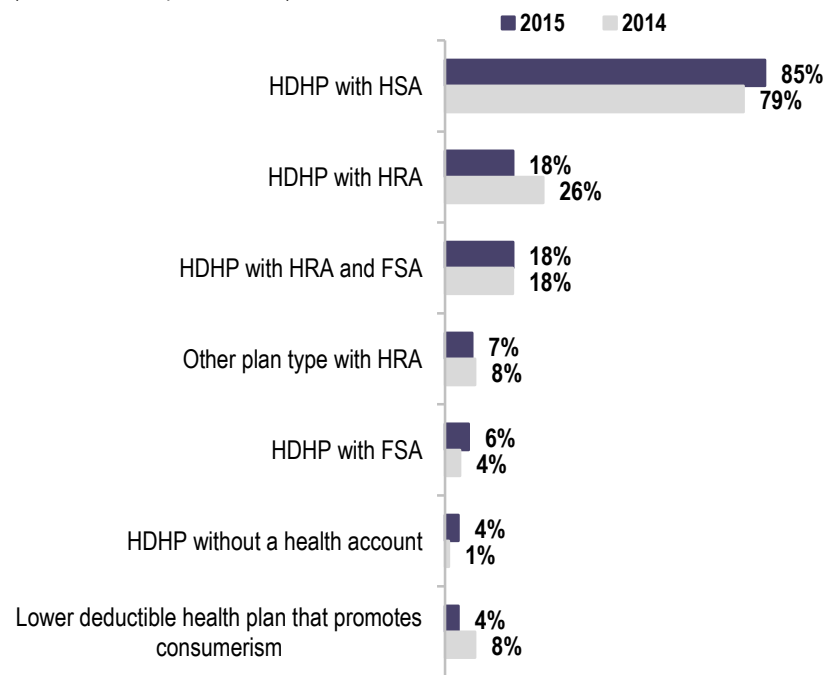


Figure 20: Prevalence of Consumer-Directed Health Plan Types in 2014 and 2015

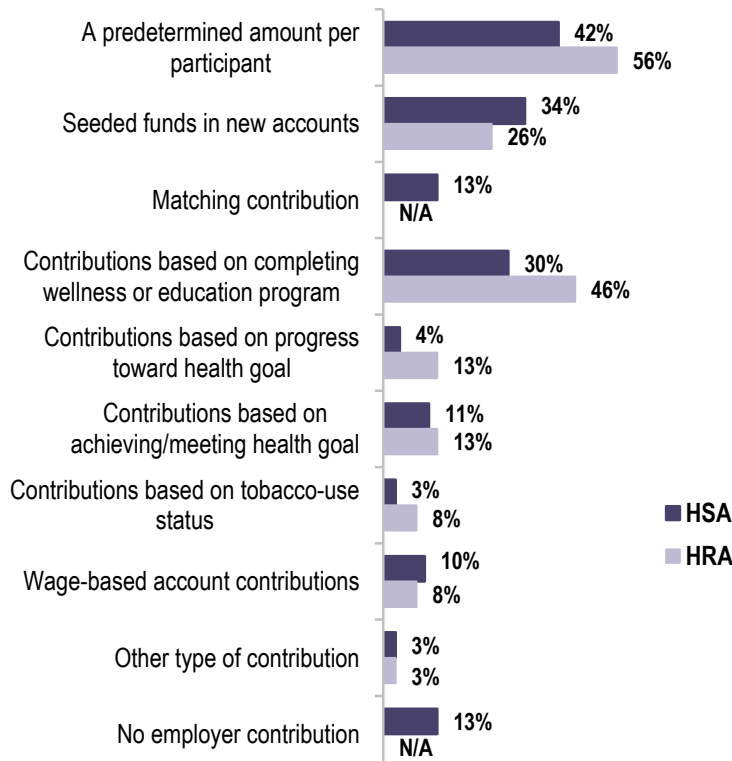
(Number of Responses=111)



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

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Figure 21: Employer Contribution to Health Accounts



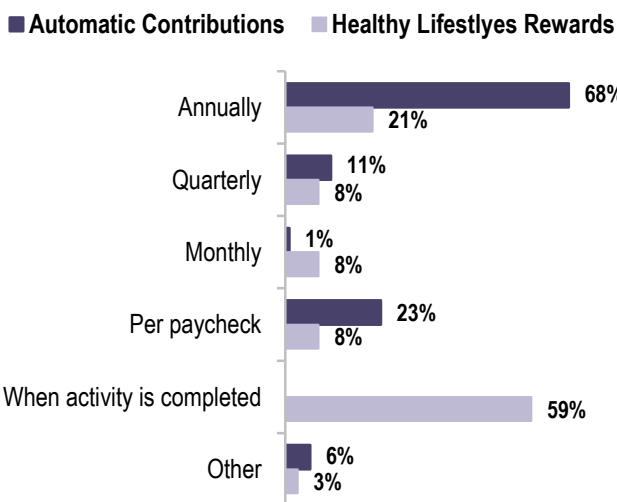
Note: Number of responses: 90 for HSA; and 39 for HRA.
Note: Respondents were allowed to select more than one option.

Employer Contributions to Health Accounts

Employers offering a health plan with an HSA or HRA were asked how they would contribute to the accounts. Many employers reported that they will contribute a predetermined amount per participant to the HSA (42%) and HRA (56%). Many other employers will make contributions to the accounts if employees participate in select wellness programs (30% for the HSA/46% for the HRA). Other employers will seed funds in new accounts and/or provide a matching contribution. Thirteen percent of employers offering an HDHP with an HSA do not contribute any funds to the account (Figure 21).

Among the 77 employers who provided data, the maximum amount an employee could receive from their employer (including both automatic and earned amounts) was a median of \$600.

Figure 22: Loading of Funded Health Accounts



Note: Number of responses: 84 for automatic contributions; and 39 for healthy lifestyle contributions.
Note: Other responses include semi-annually (twice a year) or half of the funds front loaded while the remaining distributed per paycheck.

Employers who fund a predetermined amount for all participants typically do so once a year (68%) (Figure 22). A few employers contribute the amount quarterly (11%), monthly (1%), or per paycheck (23%).

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Pharmacy Benefits

Overall spending on prescription drugs continues to grow. While the per-member-per-year (PMPY) cost of traditional drugs is projected to decrease by 1.9% in 2015, the PMPY cost of specialty drugs is projected to increase by 18.0%.⁴ To manage these rising costs, employers will continue to utilize a variety of pharmacy benefit management tactics.

When asked about the techniques employers will use to manage their traditional pharmacy benefits in 2014, the three most common techniques were prior authorization on select high cost medications (80%), step therapy (77%) and quantity limits (68%). Other techniques include: member pays the difference between generic and brand (62%); integration of medical and pharmacy data (46%); and mandatory mail order for maintenance medications (40%). When an employer implements mandatory mail-order, the employee may still receive his or her medications through retail. However, the employer only pays the equivalent to the mail-order cost level and the employee is responsible for the remaining portion (Figure 23).

Figure 23: Traditional (Non-Specialty) Pharmacy Benefit Management Techniques for 2015

(Number of Responses=136)



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

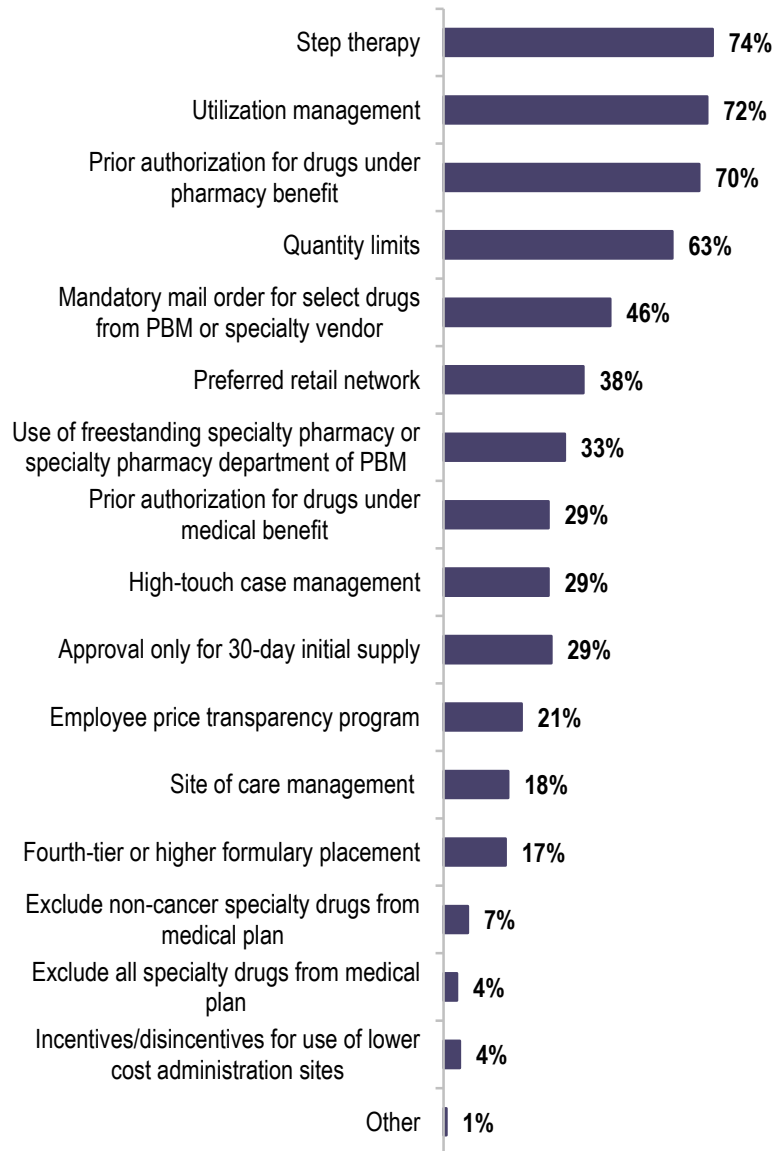
Note: Other responses included: prior authorization on compounded drugs; considering excluding compounded drugs; narrowing retail pharmacy network; and utilization review.

⁴ Express Scripts Inc., 2013 Drug Trend Report, April 2014.

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Figure 24: Specialty Pharmacy Benefit Management Techniques for 2015

(Number of Responses=136)



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

Note: Other responses included: split pill program.

As specialty medications continue to drive overall pharmacy costs, employers are using a variety of management techniques to reduce inappropriate use of these costly medications. The most common management techniques are the same as for traditional medications, including: step therapy (74%); utilization management (72%); prior authorization under the pharmacy benefit (70%); and quantity limits (63%) (Figure 24).

Beyond those tactics, some employers continue to adopt techniques specific to specialty medications, such as use of a freestanding specialty pharmacy (33%), approval only for 30-day initial supply (29%) and employee price transparency programs (21%). The percentage of employers using site-of-care management for specialty medications will nearly double from 10% in 2014 to 18% in 2015. For more information on ways to manage specialty pharmaceuticals, see the Business Group's ["Employer Solutions to Escalating Specialty Pharmacy Costs."](#)

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Health Improvement

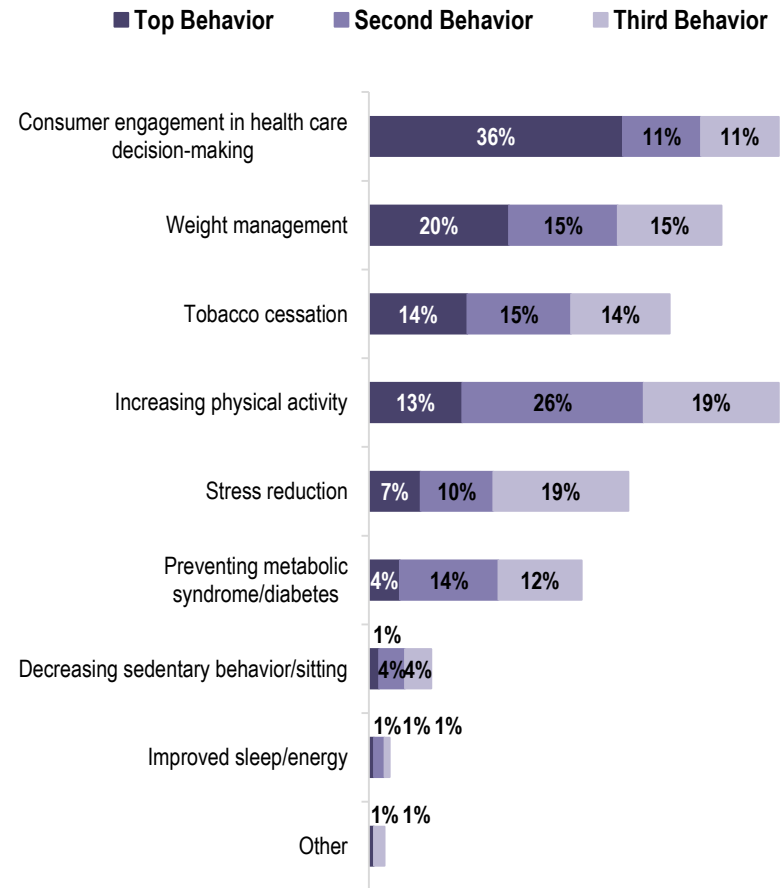
Employers were asked about a variety of initiatives they use to manage the health of their employees. This year's survey looked at employers' top focus areas relating to behavior change, on-site health clinics and treatments for obesity.

Top Focus Areas for 2015

When asked which three behaviors were employers top focus areas for 2015, 58% of respondents reported that they were focusing on helping employees to become more engaged in health care decision-making, and 36% reported that it was their top focus area (Figure 25). Employers are also focused on:

- Increasing physical activity (58%)
- Weight management (50%)
- Tobacco cessation (43%)
- Stress reduction (36%)

Figure 25: Top Behaviors Employers are Focusing on in 2015
(Number of Responses=136)



Note: Other responses included: nutrition; and biometric results.

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Figure 26: Prevalence of On-Site Health Clinics in at Least One Business Site

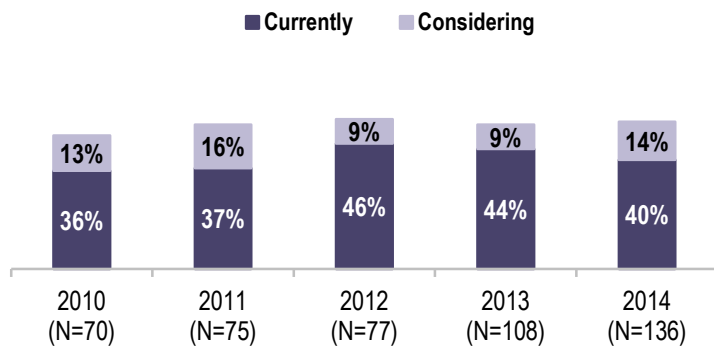


Figure 27: Importance of On-site Health Clinics to Health Care Management Strategy

(Number of Responses=55)

1= Not important 2 3 4 5=Very important Don't know

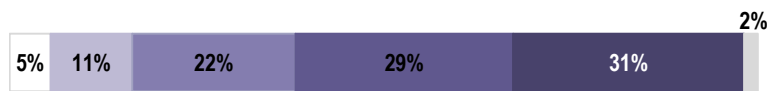
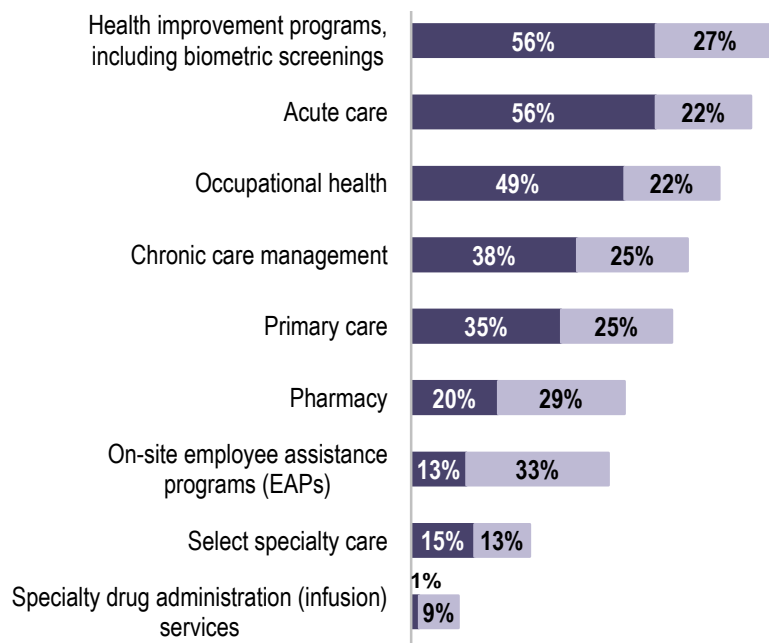


Figure 28: Services Provided at On-Site Health Clinics

(Number of Responses=55)

All centers At least one center



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

On-Site Health Clinics

Employers were first asked if they had on-site health clinics (OHCs) at any of their locations in 2014. Forty percent of respondents had an on-site health clinic in at least one of their locations, and another 14% were considering building a clinic in the future (Figure 26).

Employers operating an OHC in at least one of their locations were asked how important their OHCs were to their health care management strategy. On a scale of 1 to 5, where 5=very important, the average rating was 3.7, with 31% of respondents reporting that their OHCs were very important to their health care management strategy (Figure 27).

Seventy-eight percent of employers report that at least some of their clinics provide acute care, and 60% provide primary care services (Figure 28). Many employers often integrate their health improvement programs such as biometric screenings into their OHCs. Other common services included:

- Occupational health
- Chronic care management
- Pharmacy services
- On-site employee assistance programs

For more information about on-site health clinics, see the Business Group’s [“On-Site Health Centers: Policies to Preserve and Promote an Effective Employer Solution”](#) and [“Toolkit: The Value of On-Site Health Centers.”](#)

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Weight Management

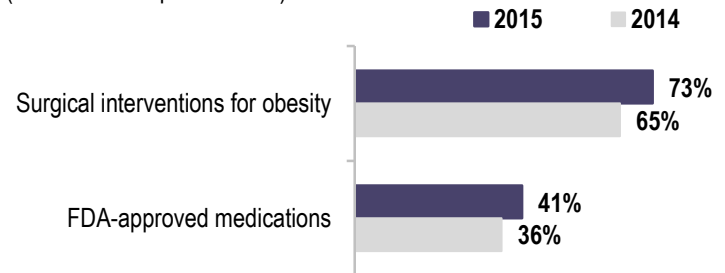
Employers cover a variety of services/medications for the treatment of obesity and severe obesity. Nearly three-quarters of respondents (73%) will cover surgical interventions for the treatment of severe obesity in 2015 (**Figure 29**). In addition, 41% of employers will cover FDA-approved medications for the treatment of obesity in 2015, an increase from 36% last year.

For those employers whose plans cover FDA-approved weight loss medications for the treatment of obesity, the most common management technique to ensure appropriate use is prior authorization (84%). Other management techniques include placing restrictions on eligibility (51%) and quantity limits (45%) (**Figure 30**).

As part of a recently released toolkit, the Business Group produced a report on "[Obesity Drug Coverage Considerations.](#)"

Figure 29: Coverage of Treatments for Obesity and Severe Obesity in 2015

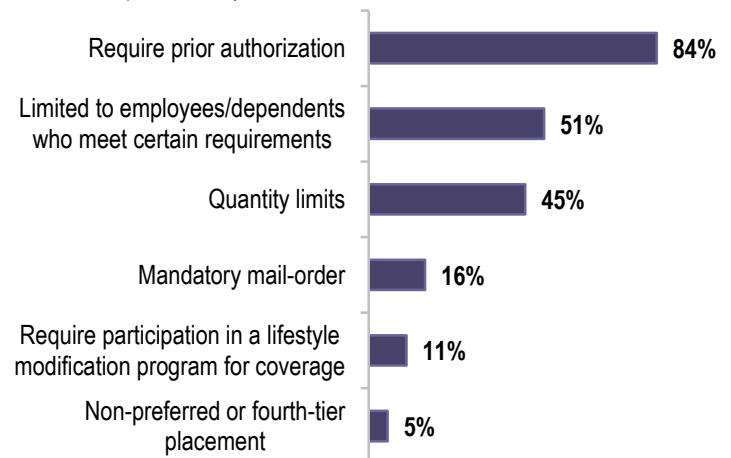
(Number of Responses=136)



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

Figure 30: Management Techniques for FDA-Approved Obesity Medications

(Number of Responses=55)



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

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Conclusion

Large employers are moving into 2015 with a focus on helping employees become better consumers of health care. Along with the increased adoption of CDHPs, employers are making price transparency tools available to employees – both for medical care and pharmacy – to increase awareness around the true cost of health care. While some employers have moved or are considering offering employees health insurance through a private exchange, large employers are confident that they will continue to offer their employees health coverage into the future.

Other Resources for Business Group Members

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

- National Business Group on Health, Large Employers' 2014 Health Plan Design Changes, *Survey Report*, August 2013.
<https://www.businessgrouphealth.org/pub/57c7e143-782b-cb6e-2763-058e211f304f>
- National Business Group on Health/Towers Watson, 19th Annual Employer Survey on Purchasing Value in Health Care, *Survey Report*, March 2014.
<https://www.businessgrouphealth.org/pub/d35ccf12-782b-cb6e-2763-b10f0c1c646f>
- National Business Group on Health/Towers Watson, 2013/2014 Staying@WorkTM Survey, *Survey Report*, January 2014.
<https://www.businessgrouphealth.org/pub/49e8d32b-782b-cb6e-2763-9b5b03518757>
- National Business Group on Health, Plan Design Network, *Online Forum*.
<https://www.businessgrouphealth.org/benchmarking/plandesignforum>

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Participants

A total of 136 Business Group members participated in this survey, and the following 115 companies agreed to be listed as participants of the survey.

- 3M Company
- AbbVie
- Advanced Micro Devices, Inc.
- Aetna, Inc.
- Air Products
- Alcatel-Lucent
- Allstate Insurance Company
- American University
- AmeriGas Partners, L.P.
- Andersen Corporation
- Apple Inc.
- ARAMARK
- Ascension Health
- Assurant, Inc.
- Baker Hughes Incorporated
- Baptist Health South Florida
- Best Buy
- BNY Mellon
- BorgWarner Inc.
- Cameron International Corporation
- Cargill, Incorporated
- Carlson, Inc.
- CBS Corporation
- CH2M Hill
- Chevron
- Chrysler
- The Clorox Company
- The Coca-Cola Company
- Comcast Corporation
- ConAgra Foods, Inc.
- Costco Wholesale Corporation
- Cracker Barrel Old Country Store, Inc.
- CVS Caremark
- Delhaize America
- Dell Inc.
- Delta Air Lines, Inc.
- Direct Energy
- Dollar General Corporation
- Dover Corporation
- Edward Jones
- Ernst & Young LLP
- The Estee Lauder Companies, Inc.
- FedEx
- Fidelity Investments
- First American Financial Corp.
- FM Global
- Freescale
- G4S Secure Solutions
- Gen Re
- General Electric Company
- General Mills, Inc.
- The Hartford
- HCA Inc.
- Health Care Service Corporation
- Health Net
- Ingersoll Rand Company
- Intel Corporation
- JetBlue Airways
- John Hancock Financial Services, Inc.
- Jones Lang LaSalle
- KeyBank
- Kraft Foods Group
- The Kroger Co.
- Lowe's Companies Inc.
- Macy's Inc.
- Marathon Petroleum Corporation (MPC)
- Marriott International
- Medtronic, Inc.
- Mohawk Industries, Inc.
- Mondelez International, Inc.
- Mutual of Omaha
- NextEra Energy, Inc.
- NIKE, Inc.
- Nissan North America, Inc.
- OhioHealth
- Oracle Corporation
- PepsiCo, Inc.
- Pitney Bowes, Inc.
- The PNC Financial Services Group
- PPG Industries, Inc.
- Praxair, Inc.
- Principal Financial Group
- The Procter & Gamble Company
- Publix Super Markets, Inc.
- PVH Corp.
- QVC, Inc.
- RR Donnelley
- SABIC Innovative Plastics
- Sanofi
- The Schwan Food Company
- Silgan Containers Corporation
- Sodexo
- Sprint Corporation
- Stanley Black & Decker, Inc.
- State Farm®
- TE Connectivity
- Tennessee State and University Employees Health Plan
- Teradata Corporation
- Tesla Motors
- Texas Health Resources
- Texas Instruments Incorporated
- Tyson Foods, Inc.
- UnitedHealth Group
- Universal Health Services, Inc.
- US Bank
- US Foods
- VeriSign, Inc.
- VHA, Inc.
- Visant Corporation
- Volvo Group North America
- Walgreen Co.
- Wegmans Food Markets
- Wells Fargo
- The Wendy's Company
- Xerox Corporation

SURVEY Report

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Large Employers' 2015 Health Plan Design Survey



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Additional copies of this *Survey Report* are available to members at www.businessgrouphealth.org, or by contacting benchmarking@businessgrouphealth.org for more information.

Survey Report

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About the National Business Group on HealthSM

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

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