2013 Employer-Sponsored Health Care: ACA's Impact

SURVEY RESULTS

International Foundation
OF EMPLOYEE BENEFIT PLANS
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Call (888) 334-3327, option 4, for price information or see www.ifebp.org/bookstore.

Published in 2013 by the International Foundation of Employee Benefit Plans, Inc.

ISBN 978-0-89154-731-0

Printed in the United States of America

RS130425

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Acknowledgments

We are very grateful to the industry experts who initially reviewed the survey questionnaire and the individuals who contributed their time to complete the survey.

About the International Foundation of Employee Benefit Plans

The International Foundation of Employee Benefit Plans is a nonprofit organization, dedicated to being a leading objective and independent global source of employee benefits and compensation education and information. Total membership includes 33,000 individuals representing multiemployer trust funds, corporations, public employer groups and professional advisory firms throughout the United States and Canada. Each year, the International Foundation offers over 100 educational programs, including conferences and e-learning courses. Membership provides access to personalized research services and daily news delivery. The International Foundation sponsors the Certified Employee Benefit Specialist® (CEBS®) program in conjunction with the Wharton School of the University of Pennsylvania and Dalhousie University in Canada.

About the International Society of Certified Employee Benefit Specialists

The International Society of Certified Employee Benefit Specialists (ISCEBS) is a membership organization for those who have earned or are pursuing the Certified Employee Benefit Specialist (CEBS), group benefits associate (GBA), retirement plans associate (RPA) and compensation management specialist (CMS) designations. Members have access to educational programs, information resources, networking at the local and national levels, publications and other services. Nearly 4,000 CEBS, GBA, RPA and CMS designees are members of ISCEBS; they work for corporations, consulting firms, multiemployer funds, insurance companies and in other industry professions.

About Research at the International Foundation

The International Foundation conducts, writes and disseminates research studies, surveys and special reports on a range of benefits, compensation and financial literacy issues. The purpose of International Foundation research efforts is to enhance the capacity of its members and constituents to understand, design and deliver employee benefits that improve the financial security of plan participants and employees. Research programs include benchmarking studies, attitudinal surveys, special reports, hot topic surveys and collaborative projects.

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I. Introduction

On March 19, 2013, the International Foundation of Employee Benefit Plans deployed its fourth survey in a series on how single employer plans are being affected by the Affordable Care Act (ACA).[1] The surveys are in-depth studies of how single employers with health care plans are responding to the challenges and opportunities presented by ACA. The first survey, conducted in May 2010, emphasized employers' immediate considerations and approaches for complying with the new law. The second and third surveys focused on the actions employers were taking in 2011 and 2012.

2013 Employer-Sponsored Health Care: ACA's Impact focuses on the most important health care reform issues facing employers this year. Topics addressed include employer concerns regarding plan design and funding, methods for communicating with employees, grandfathered plan status, reactions to health insurance exchanges, cost-management initiatives and the potential impact on health care benefit costs.

Those asked to participate in the 2013 survey were single employer plans (including corporations) in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCEBS).[2] Survey responses were received from 966 human resources and benefits professionals, and industry experts. The surveyed organizations represent a wide base of U.S. employers from nearly 20 different industries. Insurance and related fields (18.6%), manufacturing and distribution (16.6%), and health care and medicine (11.3%) are most represented. Surveyed employers range in size from fewer than 50 employees to more than 10,000. The demographic characteristics of the respondents in the 2010, 2011 and 2012 surveys were very similar to those in the 2013 survey. In several places throughout this report, comparison data is displayed by employer size and previous survey years. We urge readers to exercise caution when interpreting comparison data from previous surveys due to the nature of the sample designs and potential nonresponse error.

This report has seven sections beyond this introduction. Section II provides key findings. Detailed findings are presented in Sections III through VIII. Section III discusses employers' status in response to ACA and ways employers are communicating with their participants about reform. Cost implications of reforms, funding changes and cost-management initiatives are examined in Sections IV and V. Section VI focuses on employers' reactions to the opening of the health insurance exchanges. Retiree coverage options are examined in Section VII. Employer perspectives on grandfathered plans are examined in Section VIII. Section IX discusses the demographic profile of respondents.

This survey is the fourth in a series of reports on the impact of ACA on single employer benefit plans. Readers are encouraged to watch for additional reports that help plan sponsors benchmark their benefit programs and practices against other plans.

1. Electronic survey deployment began March 19, 2013 and was concluded March 26, 2013.
2. *Single employer plans* are maintained by one employer or by related parties such as a parent company and its subsidiaries.

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II. Key Findings

This section presents major survey findings concerning the impact of the Affordable Care Act (ACA) on single employer plans. Completed responses were received from 966 individuals representing single employer plans (including corporations). Attention is given to employers' status in response to ACA, their communications with plan participants regarding reform, cost implications, cost-management initiatives, reactions to health insurance exchanges and grandfathered plan status.

The survey includes questions posed in the context of, "What are you doing with your plan as a result of ACA?" The reader is cautioned that some of the changes employers are making may not be directly influenced by health care reform, although they may be a by-product (i.e., if ACA is causing other costs to increase, employers may make changes to benefits not otherwise affected by health care reform to offset those increases).

Overall status and adjustments

- Most organizations have moved beyond a "wait and see" approach (90%). More than half of organizations are beginning to develop tactics to deal with the implications of reform.
- Most organizations (69%) think their understanding of ACA is good but not excellent—They believe they need to do more analysis.
- About two in five employers are increasing their emphasis on wellness initiatives and incentives due to the impact of ACA.
- A considerable portion of employers are increasing or considering increasing emphasis on high-deductible health plans (HDHPs), particularly with health savings accounts (HSAs) attached.
- About 10% of plans have adjusted their funding approach—Typically, this involves the addition of stop-loss coverage.
- Most responding organizations report their plans meet the recently proposed minimum value (81%) and affordability (74%) requirements.
- Only about one-quarter of organizations remain grandfathered and, of those, less than half expect to keep their grandfathered status beyond the next two years.
- Most ACA communication to participants (73%) occurs during the annual enrollment period. About one in five organizations has noticed an increase in contacts made to their HR/benefits staff from participants regarding ACA.
- Organizations are communicating the implications of reform throughout the full year using e-mails (41%) and company websites (30%).
- Approximately 17% of organizations have already started to redesign their plans to avoid triggering the 2018 excise tax on high-cost health plans.
- Few organizations are changing their workforce hiring or reduction strategies as a result of ACA, but 16% have adjusted or plan to adjust hours so fewer employees qualify as full-time.

Cost impact

- About two-thirds of organizations have analyzed the ACA's cost impact (64%). A majority estimate the result will be a 3-4% or greater cost increase in 2013 due to ACA.
- Employers have implemented and plan to implement diverse cost-management initiatives in the next 12 months due to ACA—most commonly increasing participants' share of premium costs (43%), increasing the employee portion of dependent coverage costs (34%), increasing in-network deductibles (33%) and increasing out-of-pocket limits (31%).
- Few organizations are intending to drop spousal coverage or structure premiums based on income to cut costs.
- The requirement to offer affordable coverage to all full-time employees is the forthcoming ACA implication organizations are most concerned will increase costs. Extending coverage of adult children to the age of 26 is the provision already in place that has most significantly increased costs.

Providing coverage vs. the exchanges

- The vast majority of organizations (94%) say they definitely or very likely will continue providing coverage when exchanges open in 2014, primarily to retain and attract talented employees. Fewer than 1% of all organizations say they definitely will discontinue coverage when exchanges open in 2014.
- Of those considering discontinuing coverage, two-thirds say they are at least somewhat likely to provide a financial subsidy. The cost of providing coverage becoming too expensive is the top reason employers will consider discontinuing coverage at some point.
- Discontinuing coverage is viewed as a slightly more likely option for retirees than for full-time employees.

Comparisons by size

- Employers with more than 50 employees are more likely to be investing in wellness and prevention.
- Employers with 50 or fewer employees are generally making more employment-based decisions with hiring, reductions and reallocating hours.
- Employers with 50 or fewer employees are slightly more likely to discontinue coverage. The smaller the organization the less concerned it is about the actions of competitors.
- Smaller employers are less likely to have measured the cost impact of ACA on their organization, and more likely to estimate a higher cost impact.

Comparisons to previous years

- The portion of organizations that are still in "wait and see" mode has decreased from 31% in 2012 to less than 10% in 2013.
- In 2013, the portion of organizations that have modeled the financial impact of reform on their organization and the portion developing tactics to deal with implications of ACA have increased.
- Compared to 2010, the rise in HR/benefits staff contacts regarding ACA has slowed—perhaps due to the increased communication by organizations and more employee familiarity with the law.
- Estimates of cost increases directly associated with ACA have increased from 2012 to 2013.
- The portion of organizations stating they definitely will continue to provide employer-sponsored health care when the exchanges open in 2014 increased from 46% in 2012 to 69% in 2013. (In both years, the second most common response was "very likely" to continue to provide coverage.)
- In the past three years, the portion of organizations with grandfathered status has steadily dropped—45% in 2011 to 34% in 2012 and 27% in 2013.
- In the past three years, the portion of organizations redesigning their plans to avoid the 2018 excise tax on high-cost plans has steadily increased from 11% in 2011 to 14% in 2012 and 17% in 2013.

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III. Progress in Response to the Affordable Care Act (ACA)

Effective January 1, 2014, the Affordable Care Act (ACA) requires most employers to offer affordable health care coverage to full-time employees or pay a penalty. *Full-time employment* is defined as 30 or more hours work per week. The vast majority of surveyed employers (91% or 879 total respondents) offer medical benefits to employees who work more than 30 hours on average per week. The survey results focus primarily on this group providing medical benefits.

This section of the survey report examines employers' general response to and strategies concerning ACA. Organizations are at various stages assessing the impact of and developing approaches to health care reform. As shown in Exhibit 1, more than half (51.9%) describe their current status as beginning to develop tactics to deal with the implications of reform. More than one-third describe their status as implementing changes to make health plan(s) compliant or developing a multiyear approach to dealing with the reforms (38.7% and 38.5%, respectively).

Exhibit 2 shows that many organizations have moved beyond the "wait and see" mode they were in a year ago and are now more likely to have modeled the financial impact of reform on their organizations and to be developing tactics for dealing with the implications of reform. Smaller organizations, typically with fewer resources, are less likely to be developing multiyear approaches in response to ACA (Exhibit 3).

Two-thirds of respondents described their organization's understanding of ACA as good (i.e., they understand most of the ACA requirements, but there are several elements that still need to be reviewed) (Exhibit 4). Most other organizations describe themselves as having an excellent understanding (16.3%) or just some understanding (12.4%). Very few (2.5%) stated they had limited or no understanding of ACA.

When communicating with employees regarding health care reform, most employers (72.5%) use annual enrollment materials (Exhibit 5). E-mail sent to employees (41.1%), a company website (29.6%) and special written communication pieces (22.1%) are also popular channels of communication. Exhibit 6 shows how ACA communication efforts have ramped up since 2012. About one in five (21.4%) organizations has noticed an increase in the number of contacts made by active employees to human resources and benefits staff, while 70.6% of organizations have not noticed a change. Exhibit 7 shows that compared to 2010, the rise in HR/benefits staff contacts regarding ACA has slowed—perhaps due to employers' increased communication and more employee familiarity with the law.

EXHIBIT 1

Current Status Regarding ACA* (n=879)

Taking a "wait and see" approach	9.6%
Just beginning to get a handle on the legislation	12.5%
Have not had time to perform an in-depth analysis of the implications	8.4%
Have modeled the financial impact of reform on our organization	37.5%
Beginning to develop tactics to deal with the implications of reform	51.9%
Implementing changes to make health plan(s) compliant	38.7%
Developing multiyear approaches to deal with implications of reform	38.5%
Have a firm handle on the law and its future implications for our organization	29.1%
Considering terminating our health care program for active employees as a result of reform	2.2%
Considering terminating our health care program for retired employees as a result of reform	3.5%

*Respondents were asked to select all that apply.

EXHIBIT 2

Organizational Status by Year

	2012 (n=927)	2013 (n=879)
Taking a "wait and see" approach	31.3%	9.6%
Have modeled the financial impact of reform on our organization	24.9%	37.5%
Beginning to develop tactics to deal with the implications of reform	39.1%	51.9%

EXHIBIT 3

Developing Multiyear Approaches by Employer Size* (n=879)

0-50	21.6%
51-499	26.8%
500-4,999	41.0%
5,000-9,999	46.7%
10,000+	59.8%

*Developing multiyear approaches to deal with implications of ACA.

EXHIBIT 4

Organizational Understanding of ACA (n=879)

Excellent. My organization fully understands the new requirements of ACA.	16.3%
Good. My organization understands most of the ACA requirements, but there are several elements we still need to review.	68.8%
Some. My organization is currently getting up to speed on the new requirements.	12.4%
Limited. My organization just started reviewing the new requirements for ACA.	2.3%
None. My organization does not have an understanding of the ACA requirements.	0.2%

EXHIBIT 5

ACA Communication Initiatives* (n=879)

Communicate during annual enrollment period	72.5%
E-mail sent to employees	41.1%
Communicate implications of reform throughout the year	32.1%
Organization website	29.6%
Special written communication piece(s) either in payroll inserts, sent to employees'/retirees' homes or distributed by some other means	22.1%
Organize special meeting(s)	18.5%
Regular organization newsletter	14.1%
No communication	7.7%

*Respondents were asked to select all that apply.

EXHIBIT 6

Increase in Number of Contacts Due to ACA* (n=879)

Yes, increase in the number of contacts made by active employee participants	21.4%
Yes, increase in the number of contacts made by retirees	5.5%
No	70.6%
Not sure	7.3%

*Contacts made by participants to the human resources/benefits staff.

EXHIBIT 7

Increase in Contacts From Active Employees Regarding ACA by Year*

2010	49.7%
2013	21.4%

*Contacts made by active employees to the human resources/benefits staff.

IV. Cost Implications

While the impact of ACA varies from one employer to the next, it is generally agreed the law will increase plan costs in the short term. Nearly two-thirds of all employers (63.7%) have analyzed how ACA will affect their health care plan costs (Exhibit 8). Many more have conducted a cost analysis in 2013 compared to 2012 (63.7% to 47.2%, respectively) (Exhibit 9). Larger employers are more likely to have conducted an analysis (Exhibit 10).

Most organizations estimating costs associated with ACA (88.3%) expect the law will increase their organizations' health care costs this year (Exhibit 11). One in four (24.6%) estimates a cost increase of 1% to 2%. A similar proportion (22.8%) predicts an increase of 3% to 4%. One in six organizations (16.8%) estimates a cost increase greater than 10%. Costs associated with ACA appear to be hitting smaller employers harder than larger ones (Exhibit 12). Estimates of cost increases associated with ACA have risen from 2012 to 2013 (Exhibit 13). In 2012, three in ten employers expected cost increases of 5% or more due to ACA; this year the figure has jumped to four in ten.

Respondents were asked to identify the cost impact of the ACA provisions now in place as well as those that will be implemented later. Of the provisions in place, extending coverage to adult children until the age of 26 was listed as the top cost driver (30.6%) (Exhibit 14).

When asked which future provisions would increase costs the most, the top three responses were providing affordable coverage to all employees working an average of 30 hours or more a week in a month (21.2%), the nondeductible excise tax on high-cost health plans in 2018 (21.0%) and administrative costs (19.2%) (Exhibit 15).

EXHIBIT 8

Conducted Analysis of ACA Costs (n=879)

Yes	63.7%
No	36.3%

EXHIBIT 9

Conducted Analysis of ACA Costs by Year (Yes Responses)

2012 (n=927)	47.2%
2013 (n=879)	63.7%

EXHIBIT 10

Conducted Analysis of ACA Costs by Employer Size (Yes Responses) (n=879)

0-50	51.5%
51-499	45.5%
500-4,999	68.2%
5,000-9,999	73.9%
10,000+	84.3%

EXHIBIT 11

Cost Impact Due to ACA* (n=715)

Will decrease costs	0.7%
No change	11.0%
Increase costs 1-2%	24.6%
Increase costs 3-4%	22.8%
Increase costs 5-6%	14.0%
Increase costs 7-10%	10.1%
Increase costs more than 10%	16.8%

*Respondents were asked about 2013 costs directly associated with ACA. "Not sure" responses were excluded to provide clearer interpretation. Organizations that have not analyzed the cost implications were asked to estimate.

EXHIBIT 12

Cost Impact Due to ACA by Employer Size* (n=715)

	0-50	51-499	500-4,999	5,000-9,999	10,000+
Will decrease costs	1.2%	1.3%	0.3%	0.0%	1.1%
No change	3.7%	15.7%	12.9%	8.5%	5.7%
Increase costs 1-2%	6.1%	17.6%	27.0%	34.1%	36.8%
Increase costs 3-4%	17.1%	20.3%	25.7%	20.7%	24.1%
Increase costs 5-6%	12.2%	12.4%	14.1%	18.3%	13.8%
Increase costs 7-10%	8.5%	12.4%	11.6%	7.3%	4.6%
Increase costs more than 10%	51.2%	20.3%	8.4%	11.0%	13.8%

*Respondents were asked about 2013 costs directly associated with ACA. "Not sure" responses were excluded to provide clearer interpretation. Organizations that have not analyzed the cost implications were asked to estimate.

EXHIBIT 13

Cost Impact Due to ACA by Year*

	2012 (n=761)	2013 (n=715)
Will decrease costs	1.6%	0.7%
No change	13.7%	11.0%
Increase costs 1-2%	31.1%	24.6%
Increase costs 3-4%	24.2%	22.8%
Increase costs 5-6%	11.8%	14.0%
Increase costs 7-10%	9.2%	10.1%
Increase costs more than 10%	8.4%	16.8%

*Respondents were asked about costs directly associated with ACA. "Not sure" responses were excluded to provide clearer interpretation. Organizations that have not analyzed the cost implications were asked to estimate.

EXHIBIT 14

Provision With Most Significant Cost Increases (n=879)

Extending coverage of adult children to the age of 26	30.6%
Reporting, disclosure and notification requirements (e.g., grandfathered notice, adult children enrollment, summary of benefits and coverage)	10.4%
Administrative costs (other than reporting and disclosure)	10.1%
No cost sharing for preventive care (nongrandfathered plans)	9.9%
Eliminating lifetime dollar limits on "essential benefits"	4.6%
Additional W-2 reporting requirements	3.8%
Eliminating annual limits on "essential benefits"	3.3%
Eliminating tax deduction for Medicare Part D drug subsidy	2.7%
Cost shifting due to reduced payments to providers from Medicare and Medicaid	2.4%
Ending of tax-advantaged treatment of over-the-counter drugs in HDHPs or FSAs	2.3%
Eliminating preexisting condition exclusions for enrollees under the age of 19	1.5%
Required coverage of emergency services without prior authorization and at in-network cost-sharing levels (nongrandfathered plans)	1.0%
Requirement to provide new internal and external appeals procedures (nongrandfathered plans)	0.5%
None	17.1%

EXHIBIT 15

Forthcoming Provision With Most Significant Cost Increases* (n=879)

Offering affordable coverage to all employees working an average of 30 hours or more a week in a month	21.2%
Nondeductible excise tax on high-cost health plans in 2018	21.0%
Administrative costs	19.2%
Eliminating all preexisting condition exclusions for all enrollees	11.8%
Requirement that employers autoenroll new hires into a health plan	9.6%
Nondiscrimination rules applying to fully insured plans	2.8%
Prohibiting waiting periods over 90 days in 2014	2.2%
None	8.0%
Other	4.2%

*Respondents were not specifically asked about Patient-Centered Outcomes Research Institute (PCORI) or transitional reinsurance fees. These fees will be addressed in subsequent surveys.

V. Strategies, Actions and Initiatives

This section examines changes in organizational strategy, plan design and initiatives to curb anticipated rising costs. Respondents were asked about workforce adjustments they planned to make due to ACA. In general, the vast majority of larger employers appear uninterested in such adjustments due to ACA; however, employers with 50 or fewer employees are taking some actions (Exhibit 16). One in five (19.5%) employers with 50 or fewer employees is reducing hiring in order to stay under the 50-employee ACA threshold for small employers. The same proportion (19.5%) is adjusting hours so fewer employees qualify for the full-time employee medical insurance requirement.

Respondents were asked whether their organizations had increased or plan to increase participant cost sharing as a means to contain costs. Nearly one in five (18%) has increased participants' share of plan premiums (Exhibit 17). Slightly lower proportions report they have increased in-network deductibles (14.9%), out-of-pocket limits (13.8%), or copayments or coinsurance for primary care (12.7%).

In the next two years, an additional 25.3% plan to increase participants' share of premium costs, and 23.5% plan to increase the employee portion of dependent coverage cost. Among the other changes in cost sharing planned are increasing in-network deductibles (18%) and increasing out-of-pocket limits (17.6%) (Exhibit 17).

One in five organizations (19.3%) has adopted or expanded their wellness initiatives in the last 12 months due to ACA and another 24.5% plan on doing so in the next 12 months (Exhibit 18). Lower proportions report they have adopted or expanded the use of financial incentives to encourage healthy behaviors (14.2%) or a disease management program (7.7%). Larger organizations are more likely to be adopting or expanding wellness initiatives and incentives (Exhibit 19).

As a result of ACA, one-quarter of surveyed organizations (25.4%) have conducted dependent eligibility audits or plan to do so in the next two years. Another 27% have analyzed or plan to analyze claims utilization while 17.1% have conducted or plan to conduct health care claims audits (Exhibit 20).

One in four organizations (24.5%) is increasing their emphasis on a high-deductible health plan (HDHP) with a health savings account (HSA), while14.3% are assessing the feasibility of adding one (Exhibit 21). Lower proportions reported they are increasing their emphasis on or assessing the feasibility of adding an HDHP with a health reimbursement arrangement (HRA) (18.4%) or an HDHP with no account (8.9%).

The Patient-Centered Outcomes Research Institute (PCORI) has been authorized by Congress to conduct research to provide information about the best available evidence to help patients and health care providers make more informed decisions. Organizations are required to pay a fee to support PCORI. Respondents were asked who is most likely to handle the administration of the new fee for their organizations. Approximately one-third are having their benefits/human resources departments administer the fee (Exhibit 22). One in five (19.2%) says their insurance company will handle the fee. Another 15.2% will give the task to their third-party administrator.

The Treasury Department and Internal Revenue Service (IRS) have published a proposed rule implementing the ACA's employer shared responsibility penalty. The rule consists of both affordability and value requirements. Generally, a plan with a 60% actuarial value meets the minimum value requirement. Coverage meets the affordability requirement if the employee portion of self-only premiums for an employer's lowest cost coverage (meeting the minimum value standard) does not exceed 9.5% of the employee's household income. Respondents were asked whether their plans currently meet these requirements (Exhibit 23). The majority report their health plans currently meet the minimum value test (81.3%) and the affordability test (74.1%).

As shown in Exhibit 24, ACA has not prompted plan funding changes for a large majority of responding employers (90.6%). Some employers using self-funding may choose to limit potential medical claims exposure by purchasing stop-loss insurance in case claims exceed a predetermined amount for an individual participant or the entire group.[3] A small portion of organizations (7.4%) has added stop-loss insurance.

In 2014, employers will be permitted to offer employees incentives of up to 30% of the cost of health plan coverage for participating in a wellness program and meeting certain health-related standards.[4] To prevent or reduce tobacco use, an incentive of as much as 50% will be permitted. One-quarter (24.1%) of respondents are considering increased incentives (Exhibit 25). Another one-quarter (23.2%) state they are not considering them. The remainder—the majority (52.6%)—have made no firm decision.

Starting in 2018, ACA imposes a nondeductible excise tax on employers with high-cost health plans.[5] *High-cost plans* are defined as any health-related coverage in which combined employer/employee premiums exceed $10,200 for single coverage or $27,500 for family coverage.[6] While the 2018 deadline is several years away, Exhibit 26 shows that 16.8% of responding organizations have already started to redesign their primary health plan to avoid triggering the 2018 tax. More than twice as many (40%) are considering action. Exhibits 27 and 28 show there has been a steady increase in organizations redesigning their health plans to avoid triggering the excise tax since 2011, and larger organizations are more likely to be taking this action.

3. Insurance coverage that caps the total claims experience of the group is known as *aggregate stop-loss.* An organization might also limit its liability using specific stop-loss, which sets a limit on the amount that a plan sponsor will pay for an individual case.

4. Prior to 2014, the allowed incentive level is 20%.

5. The nondeductible excise tax will equal 40% of the premium cost in excess of the annual limit ($10,200 for single coverage and $27,500 for family coverage).

6. Both figures will be indexed for inflation.

EXHIBIT 16

Workforce Adjustments Due to ACA by Employer Size* (n=879)

	0-50	More than 50	Overall
Reduction in hiring to get/stay under the 50-employee ACA threshold for small employers			
Have done	11.3%	0.5%	1.7%
Plan on doing in the next 12 months	8.2%	0.5%	1.4%
Adjusting hours so fewer employees qualify for full-time employee medical insurance requirement			
Have done	11.3%	3.8%	4.7%
Plan on doing in the next 12 months	8.2%	11.5%	11.1%
Adding workers to help keep compliant with ACA			
Have done	6.2%	1.5%	2.0%
Plan on doing in the next 12 months	4.1%	4.1%	4.1%
Reduction in workers due to costs directly associated with ACA			
Have done	7.2%	1.2%	1.8%
Plan on doing in the next 12 months	9.3%	1.9%	2.7%

*Respondents were asked about the actions they have taken specifically due to ACA. Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 17

Cost-Containment Measures Due to ACA* (n=879)

Increase participants' share of premium costs	
Have used	18.0%
Plan on using in the next 12 months	25.3%
Increase in-network deductibles	
Have used	14.9%
Plan on using in the next 12 months	18.0%
Increase employee proportion of dependent coverage cost	
Have used	10.4%
Plan on using in the next 12 months	23.5%
Increase out-of-pocket limits	
Have used	13.8%
Plan on using in the next 12 months	17.6%
Increase participants' share of prescription drug costs	
Have used	11.7%
Plan on using in the next 12 months	16.0%
Increase copayments or coinsurance for primary care	
Have used	12.7%
Plan on using in the next 12 months	13.0%
Modify/add tiers to cost-sharing structure	
Have used	6.9%
Plan on using in the next 12 months	14.8%
Increase voluntary (employee-pay-all) benefit offerings	
Have used	4.3%
Plan on using in the next 12 months	10.7%
Structure premiums based on income	
Have used	2.6%
Plan on using in the next 12 months	6.9%

*Respondents were asked about the actions they have taken specifically due to ACA. Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 18

Changes in Plan Design/Utilization Due to ACA* (n=879)

Adopt/expand wellness initiatives	
Have done	19.3%
Plan on doing in next 12 months	24.5%
Adopt/expand the use of financial incentives to encourage healthy behaviors	
Have done	14.2%
Plan on doing in next 12 months	25.4%
Adopt/expand disease management	
Have done	7.7%
Plan on doing in next 12 months	14.7%
Drop spousal coverage	
Have done	1.3%
Plan on doing in next 12 months	4.2%

*Respondents were asked about the actions they have taken specifically due to ACA. Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 19

Changes in Plan Design/Utilization Due to ACA by Employer Size* (n=879)

	0-50	More than 50
Adopt/expand wellness initiatives		
Have done	17.5%	19.6%
Plan on doing in next 12 months	15.5%	25.6%
Adopt/expand the use of financial incentives to encourage healthy behaviors		
Have done	10.3%	14.7%
Plan on doing in next 12 months	19.6%	26.1%

*Respondents were asked about the actions they have taken specifically due to ACA. Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 20

Audits/Analysis Conducted Due to ACA* (n=879)

Health care claims utilization analysis	
Conducted	11.4%
Plan on conducting in the next 12 months	15.6%
Dependent eligibility audits	
Conducted	10.7%
Plan on conducting in the next 12 months	14.7%
Health care claims audits	
Conducted	5.7%
Plan on conducting in the next 12 months	11.4%

*Respondents were asked about the actions they have taken specifically due to ACA. Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 21

ACA's Impact on HDHPs* (n=879)

HDHP with health savings account (HSA)	
Increasing emphasis	24.5%
Assessing feasibility of adding	14.3%
Assessing feasibility of dropping	0.6%
Decreasing emphasis	0.6%
HDHP with health reimbursement arrangement (HRA)	
Increasing emphasis	9.4%
Assessing feasibility of adding	9.0%
Assessing feasibility of dropping	1.0%
Decreasing emphasis	2.3%
HDHP with no account	
Increasing emphasis	3.3%
Assessing feasibility of adding	5.6%
Assessing feasibility of dropping	0.7%
Decreasing emphasis	1.0%

*Respondents were asked about the actions they have taken specifically due to ACA. Remaining respondents answered "No change" or "Not applicable."

EXHIBIT 22

Most Likely to Administer PCORI Fee* (n=879)

Benefits department/Human resources	32.9%
Insurance company	19.2%
Third-party administrator (TPA)	15.2%
Accounting/tax department	10.1%
Broker/consultant	7.7%
Not sure	14.8%

*Fees for the Patient-Centered Outcomes Research Institute (PCORI) are described on page 15.

EXHIBIT 23

Currently Meeting Proposed Requirements (n=879)

Minimum value requirement	
Yes	81.3%
No	2.0%
Not sure	16.6%
9.5% affordability test requirement	
Yes	74.1%
No	5.7%
Not sure	20.3%

EXHIBIT 24

Change in Funding Approach* (n=879)

No changes to plan funding approach	90.6%
Have become fully insured	1.5%
Have become completely self-funded with stop-loss coverage	3.6%
Have become completely self-funded without stop-loss coverage	0.2%
Already self-funded, but now purchased stop-loss coverage	1.0%
Already self-funded, but now purchased additional stop-loss coverage	2.8%
Already self-funded, but dropped stop-loss coverage	0.2%

*Respondents were asked what actions they have taken specifically due to ACA.

EXHIBIT 25

Considering Offering Increased Wellness Incentives* (n=879)

Yes	24.1%
No	23.2%
Maybe	40.0%
Not sure	12.6%

*Based on increased incentives allowed through a provision effective in 2014.

EXHIBIT 26

Taking Action to Avoid 2018 Excise Tax (n=879)

Yes	16.8%
No, but considering	40.0%
No, no plan to do so	13.5%
Not sure	9.6%
Not applicable, have no high-cost plans	20.0%

EXHIBIT 27

Taking Action to Avoid 2018 Excise Tax by Employer Size (Yes Responses) (n=879)

0-50	4.1%
51-499	13.1%
500-4,999	18.2%
5,000-9,999	18.5%
10,000+	29.4%

EXHIBIT 28

Taking Action to Avoid 2018 Excise Tax by Year (Yes Responses)

2011 (n=1,134)	10.5%
2012 (n=927)	13.9%
2013 (n=879)	16.8%

VI. Reactions to Health Insurance Exchanges

Employer reactions to the health insurance exchanges and the "play or pay" provisions of ACA are explored in this section. Beginning in 2014, organizations with 50 or more employees will face penalties for not providing health care coverage or for providing plans that are not sufficient or affordable. This employer requirement is controversial. Supporters maintain the "play or pay" requirement will strengthen the employment-based system by giving more workers access to improved health coverage. Critics maintain the requirement will increase business costs.

Survey results show most employers will continue to provide employees with health insurance in 2014 when the provisions become effective (Exhibit 29). More than two-thirds (68.5%) of respondents report they definitely will continue to provide health care coverage for all full-time employees in 2014—representing a considerable increase in confidence since a year ago when this figure was 46.2%. An additional 25% state they are very likely to continue to provide health care coverage for all full-time employees in 2014. At this point, less than 1% of respondents say they definitely will not provide coverage to all full-time employees in 2014. Exhibit 30 shows that employers with 50 or fewer employees are slightly more likely to be considering discontinuing coverage.

Among the respondents considering use of the exchanges in 2014, more are likely to continue to provide coverage and encourage only some employees to take coverage through the exchanges as opposed to dropping coverage for all employees (Exhibit 31). Only 0.8% of employers report they definitely will continue to provide coverage but encourage some employees to seek coverage through the exchanges in 2014—An additional 14.5% say they are very likely or somewhat likely to do so. Just 0.2% of employers definitely will drop coverage for all employees in 2014 while another 2.1% are very likely or somewhat likely to do so.

It is interesting to note that among the small group of 87 employers without employer-sponsored health insurance in 2013, three in five (60.9%) say they very likely will offer coverage in 2014. Another 16.1% say they are somewhat likely to do so.

The 277 respondents that did not state that they definitely will continue to provide coverage to all full-time employees in 2014 were asked how likely it is that their organization will offer a financial subsidy if coverage is dropped and their most likely cause for discontinuing coverage. Exhibit 32 reveals uncertainty about the subsidy. A very small proportion (2.9%) have decided they will definitely provide a subsidy while about one in ten (10.5%) has decided they will not. Nearly two-thirds were able to say only that they are very likely or somewhat likely to offer a subsidy (28.2% and 36.1%, respectively).

The most common reason given by the group for possibly discontinuing coverage is the cost becoming too high—cited by 50.2% of respondents (Exhibit 33). About one-third state the reason they would most likely end coverage is if other organizations in their industry or geographic area discontinued coverage (27.1% and 4.7%, respectively). Larger organizations are more likely to be concerned with the actions of others in their industry while smaller organizations are more likely to be solely focused on costs (Exhibit 34).

The 602 respondents that stated they definitely will continue to provide coverage to all full-time employees were asked their top reasons for maintaining coverage (Exhibit 35). Respondents overwhelmingly chose two reasons for maintaining coverage: to retain current employees (70.3%) and to attract future talent (65.0%).

EXHIBIT 29

Likelihood of Continuing Coverage for All Full-Time Employees by Year

	2012 (n=927)	2013 (n=879)
Definitely will	46.2%	68.5%
Very likely	39.3%	25.0%
Somewhat likely	9.8%	4.0%
Somewhat unlikely	2.4%	1.6%
Very unlikely	1.4%	0.5%
Definitely won't	1.0%	0.5%

EXHIBIT 30

Likelihood of Continuing Coverage for All Full-Time Employees by Employer Size (n=879)

	0-50	More than 50
Definitely will	60.8%	69.4%
Very likely	23.7%	25.2%
Somewhat likely	7.2%	3.6%
Somewhat unlikely	5.2%	1.2%
Very unlikely	3.1%	0.1%
Definitely won't	0.0%	0.5%

EXHIBIT 31

Likelihood of Taking Action When Exchanges Open (n=879)

Our organization will continue to provide coverage, but we will encourage some employees to seek coverage through the exchanges.	
Definitely will	0.8%
Very likely	5.9%
Somewhat likely	8.6%
Somewhat unlikely	6.1%
Very unlikely	7.6%
Definitely won't	70.9%
Our organization will drop coverage for all employees and direct them to the exchanges.	
Definitely will	0.2%
Very likely	0.5%
Somewhat likely	1.6%
Somewhat unlikely	4.8%
Very unlikely	15.9%
Definitely won't	77.0%

EXHIBIT 32

Likelihood of Offering Subsidy if Coverage Is Discontinued* (n=277)

Definitely will	2.9%
Very likely	28.2%
Somewhat likely	36.1%
Somewhat unlikely	11.2%
Very unlikely	11.2%
Definitely won't	10.5%

*Respondents that said they definitely will continue coverage were not asked this question.

EXHIBIT 33

Likely Cause for Discontinuing Coverage* (n=277)

The cost of providing coverage becoming too expensive	50.2%
Other organizations in our industry discontinuing coverage	27.1%
Exchanges are proving to provide adequate health coverage for individuals.	9.4%
Employees voluntarily moving to the exchanges	8.7%
Other organizations in our geographic area discontinuing coverage	4.7%

*Respondents that said they definitely will continue coverage were not asked this question.

EXHIBIT 34

Likely Cause for Discontinuing Coverage by Employer Size* (n=277)

	0-50	51-499	500-4,999	5,000-9,999	10,000+
The cost of providing coverage becoming too expensive	65.8%	57.1%	46.0%	42.9%	33.3%
Other organizations in our industry discontinuing coverage	5.3%	17.1%	33.1%	38.1%	50.0%

*Respondents that said they definitely will continue coverage were not asked this question.

EXHIBIT 35

Main Reasons to Continue Coverage* (n=602)

To retain current employees	70.3%
To attract future talent	65.0%
To maintain/increase employee satisfaction and loyalty	37.9%
To avoid paying penalties	6.8%
To maintain tax advantages (e.g., tax deductions, no increase in payroll taxes, etc.)	5.6%
To maintain/increase productivity	1.8%
Other	1.0%

*Respondents were asked to select the top two reasons. Only those that said they will definitely continue coverage were asked this question.

VII. Retiree Coverage

Employer strategies regarding their retiree populations are examined in this section. Approximately three in five responding organizations provide some form of retiree coverage, while 61.4% offer no coverage to retirees (Exhibit 36). Most employers currently offering retiree coverage have not made a firm decision whether they will continue this coverage when the health insurance exchanges open in 2014. Approximately half (51%) say they definitely will or are very likely to continue providing retiree coverage in 2014 and 25.4% are somewhat likely. Less than one-quarter (23.6%) are somewhat unlikely, very unlikely or definitely won't continue to provide retiree coverage (Exhibit 37). Regarding private exchanges, 16.8% are pursuing this option for future retirees, 16.3% for early retirees (55-64 years old) and 13.8% for retirees aged 65 and older (Exhibit 38). Exhibit 39 shows that larger employers are more likely to pursue private exchanges for their retiree groups compared to small employers.

EXHIBIT 36

Offer Coverage to Retirees* (n=879)

Yes, for Medicare-eligible retirees (aged 65 and older)	29.5%
Yes, for pre-Medicare-eligible early retirees (55-64 years old)	34.0%
No	61.4%

*Respondents were asked to select all that apply.

EXHIBIT 37

Likelihood to Continue Retiree Coverage* (n=339)

Definitely will	22.1%
Very likely	28.9%
Somewhat likely	25.4%
Somewhat unlikely	10.0%
Very unlikely	7.7%
Definitely won't	5.9%

*Only respondents that currently have some form of retiree coverage were asked this question.

EXHIBIT 38

Considering Private Exchanges for Retiree Groups (n=879)

Coverage for retirees aged 65 and older	
Actively pursuing	3.9%
Considering pursuing	9.9%
Not considering	48.2%
Not sure/not applicable	38.0%
Coverage for early retirees (55-64 years old)	
Actively pursuing	1.5%
Considering pursuing	14.8%
Not considering	46.3%
Not sure/not applicable	37.4%
Coverage for future retirees	
Actively pursuing	1.6%
Considering pursuing	15.2%
Not considering	43.2%
Not sure/not applicable	39.9%

EXHIBIT 39

Considering Private Exchanges for Retiree Groups by Employer Size (n=879)

	0-50	51-499	500-4,999	5,000-9,999	10,000+
Coverage for retirees aged 65 and older					
Actively pursuing	0.0%	2.0%	3.3%	7.6%	9.8%
Considering pursuing	4.1%	5.6%	10.5%	14.1%	17.6%
Coverage for early retirees (55-64 years old)					
Actively pursuing	0.0%	1.0%	1.5%	1.1%	3.9%
Considering pursuing	6.2%	8.1%	14.4%	27.2%	26.5%
Coverage for future retirees					
Actively pursuing	0.0%	1.0%	1.8%	1.1%	3.9%
Considering pursuing	7.2%	10.6%	14.1%	23.9%	28.4%

VIII. Grandfathered Plans

If an organization had at least one individual enrolled in a group health plan or health insurance coverage when ACA was first enacted (March 23, 2010), the plan or coverage is considered grandfathered. These plans are generally exempt from reform requirements such as first-dollar preventive benefits, new grievance and appeals processes, and nondiscrimination provisions. Grandfathered plans also have delayed effective dates for certain changes.

The portion of organizations with a primary plan that is grandfathered has steadily declined over the last three years—moving from 44.6% in 2011 to 27.3% in 2013 (Exhibit 40). Exhibit 41 shows that larger employers are more likely to maintain grandfathered status.

Because they will be able to make only limited health plan changes, maintaining grandfathered status can be a challenge for employers.[7] One-third of employers with a grandfathered plan (33.8%) anticipate their plan will lose this status in 2014 or sooner (Exhibit 42).

Respondents were asked to identify up to two advantages of maintaining grandfathered status (Exhibit 43). The top advantages chosen are the exemption from the requirement to provide preventive care coverage with no cost sharing or annual limits (27.5%), the exemption from essential benefits requirements applicable in 2014 (23.3%) and the exemption from implementing the appeals process (15.8%).

EXHIBIT 40

Portion of Plans With Grandfathered Status by Year

2011 (n=1,134)	44.6%
2012 (n=927)	34.3%
2013 (n=879)	27.3%

EXHIBIT 41

Currently Grandfathered by Employer Size (n=879)

0-50 employees	17.5%
More than 50 employees	28.5%

7. Plans can lose grandfathered status for cutting or reducing benefits, raising coinsurance charges, raising copayment charges, raising deductibles, lowering employer contributions, and adding or tightening an annual limit on what the insurer pays.

EXHIBIT 42

Outlook for Maintaining Grandfathered Status (n=240)

Will lose in 2013	2.5%
Will lose in 2014	31.3%
Do not expect to lose grandfathered status in the next two years	44.6%
Not sure	21.7%

EXHIBIT 43

Top Benefits of Maintaining Grandfathered Status* (n=240)

Eliminate requirement to provide coverage for specified preventive care with no cost sharing or annual limits	27.5%
Avoid essential benefits requirements applicable in 2014	23.3%
Exempt from implementing the appeals process required under ACA, which includes external appeals	15.8%
Avoid application of Internal Revenue Code Section 105(h) nondiscrimination rules to fully insured plans	12.9%
Avoid limiting participant annual out-of-pocket maximum in 2014	12.1%
Avoid 60% actuarial value minimum benefit requirements applicable in 2014	10.8%
Exempt from requirements to cover emergency services at non-network facilities without prior authorization and at the same cost-sharing levels as in-network facilities	8.8%
Avoid premium-rating structure limitations for plans with fewer than 100 employees, applicable in 2014	5.0%
Don't see value/benefits of being classified as a grandfathered plan	15.0%
Not sure	22.5%

*Respondents were asked to select up to two responses.

IX. Demographics

Individuals invited to participate in the 2013 survey were single employer (including corporate) representatives in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCEBS). Responses were received from 966 individuals including benefits and human resources professionals, general and financial managers, and other professionals. Exhibits 44 through 47 present demographic characteristics of the respondents' organizations. Surveyed organizations were asked in which type of medical plan the majority of their participants are enrolled. Half (52.2%) state most of their employees are enrolled in a preferred provider organization (PPO). Approximately one in four (24.6%) uses some sort of high-deductible health plan (HDHP) as their primary medical plan—Fewer than 2% use an HDHP with no account, while 23% use an HDHP with a health savings account (HSA) or health reimbursement arrangement (HRA) (Exhibit 44).[8]

Exhibit 45 shows that organizations from all regions of the country were represented in the survey. Employers located in the Midwest (26.5%) and Northeast/Mid-Atlantic (23.8%) regions are more prevalent than those located in other regions as well as those having a national or international presence. Surveyed organizations are dispersed across all employer size categories (Exhibit 46). Most common were those with between 500 and 4,999 benefits-eligible employees (43.3%) followed by those with 51-499 employees (22.5%). As shown in Exhibit 47, a wide range of industries is represented by the responding organizations. Most frequent are those from insurance and related fields (18.6%), manufacturing and distribution (16.6%), and health care and medicine (11.3%).

8. A *high-deductible health plan (HDHP)* is a lower cost insurance arrangement that features a higher annual deductible than that of a traditional health insurance arrangement. HDHPs were created to provide affordable coverage for health events that might result in financial havoc on a household. With an HDHP, the insured pays for nearly all medical expenses until the annual deductible amount is reached. The deductible is usually at least $1,000; then traditional health insurance coverage begins. An HDHP may be offered with a *health savings account (HSA)* or a *health reimbursement arrangement (HRA)*. An *HSA* is a tax-exempt trust or custodial account established for individuals who are covered under an HDHP meeting specific federal requirements. Contributions to the account may be made by the employer and/or the employee. The employee, not the employer, owns the account which makes the account portable. An *HRA* is a tax-exempt arrangement established by and funded by employers for employees and retirees to pay qualified medical expenses. Money remaining in an HRA at year-end can roll over and be used to cover future medical costs, but the portability of the account is left to the discretion of the employer.

EXHIBIT 44

Plan With Majority Enrolled (n=966)

Do not offer coverage	2.4%
Traditional indemnity/fee-for-service plan	1.2%
Preferred provider organization (PPO)	52.2%
Health maintenance organization (HMO)	9.6%
High-deductible health plan (HDHP) with health savings account (HSA)	15.3%
High-deductible health plan with health reimbursement arrangement (HRA)	7.7%
High-deductible health plan without account	1.6%
Point-of-service plan (POS)	6.4%
Exclusive provider organization (EPO)	3.6%

EXHIBIT 45

Region* (n=966)

Midwest	26.5%
Northeast/Mid-Atlantic	23.8%
South	16.6%
West	13.8%
Nationwide	17.5%
International	1.9%

*Regions are comprised as follows: Midwest (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI), Northeast/Mid-Atlantic (CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VA, VT, WV), South (AL, AR, FL, GA, KY, LA, MS, NC, NM, OK, SC, TN, TX), West (AZ, AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY).

EXHIBIT 46

Number of Eligible Employees (n=966)

0-50	12.6%
51-499	22.5%
500-4,999	43.3%
5,000-9,999	9.9%
10,000 or more	11.7%

EXHIBIT 47

Primary Industry (n=966)

Accommodation/food service	2.3%
Agriculture	0.3%
Arts/entertainment/recreation	0.8%
Banking/finance	6.5%
Communication/telecommunications	1.1%
Construction	2.5%
Education	5.0%
Energy/utilities/mining	4.8%
Health care/medicine	11.3%
High technology	4.2%
Insurance-related	18.6%
Manufacturing/distribution	16.6%
Nonprofit	8.6%
Professional services	7.3%
Real estate-related	1.3%
Retail/wholesale trade	4.5%
Transportation	1.2%
Other services	1.6%
Multiple industries	1.4%

2013 Employer-Sponsored Health Care: ACA's Impact is the fourth in a series of reports on the impact of health care reform legislation on single employer benefit plans by the International Foundation of Employee Benefit Plans. Readers are encouraged to watch for upcoming studies and to monitor the Foundation's website, www.ifebp.org, for the latest ACA news, analysis and additional resources.