Health Care Reform: 2012 Employer Actions Update

SURVEY RESULTS
MAY 2012

International Foundation
EDUCATION – BENEFITS • COMPENSATION

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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 35,000 individuals representing 8,400 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 in the United States and with 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 the CEBS, group benefits associate (GBA), retirement plans associate (RPA) and compensation management specialist (CMS) designations. Members have access to educational programs, informational 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 and 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 the International Foundation's 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.

I. Introduction

On April 9, 2012, the International Foundation of Employee Benefit Plans deployed its third survey in a series on how single employer plans are being affected by the Patient Protection and Affordable Care Act (PPACA).[1] The surveys are in-depth studies of the ways in which single employers with health care plans are responding to the challenges and opportunities presented by the 2010 legislation. The first survey, conducted in May 2010, emphasized employers' immediate considerations and approaches for complying with the new law. Deployed approximately one year later, the second survey focused on the actions employers were taking in 2011.

Health Care Reform: 2012 Employer Actions Update 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 and the potential impact on health care benefit costs. Readers are encouraged to reference the 2011 survey for data on topics not covered in this edition, including changes in dependent coverage, high-deductible health plan offerings, and prescription drug plan cost sharing and design.

Those asked to participate in the 2012 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 968 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 (21.9%), manufacturing and distribution (15.2%), and health care and medicine (9.9%) are the most highly represented. Surveyed employers range in size from fewer than 50 employees to more than 20,000. The demographic characteristics of the respondents in the 2010 and 2011 surveys were very similar to those in the 2012 survey.

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' progress in response to health care reform and ways employers are communicating with their participants about reform. Cost implications of reforms, funding changes and employers' cost management initiatives are examined in Sections IV and V. Section VI focuses on employers' reactions to the opening of the health insurance exchanges. Employer perspectives on grandfathered plans are reviewed in Section VII. Section VIII discusses the demographic profile of respondents.

This survey is the third in a series of reports on the impact of health care reform legislation on benefit plans. Readers are encouraged to watch for additional reports that can help plan sponsors benchmark their benefit programs and practices against other plans.

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1. Electronic survey deployment began April 9, 2012 and was concluded April 24, 2012.
2. *Single employer plans* are maintained by one employer or by related parties such as a parent company and its subsidiaries.

II. Key Findings

This section presents major survey findings concerning the impact of the Patient Protection and Affordable Care Act (PPACA) on single employer plans. Completed responses were received from 968 individuals representing single employer plans (including corporations). Attention is given to employers' progress in response to health care reform, employers' communications about implications of 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 health care reform?" 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 of it (i.e., if health care reform is causing other costs to increase, employers may make changes to benefits not otherwise affected by health care reform to offset those increases).

Progress in Response to Health Care Reform

- Nearly half of employers (47.2%) describe their current focus with regard to health care reform as implementing changes to make their plans compliant with legislation. Nearly two in five are focused on beginning to develop tactics to deal with the implications of reform (39.1%) or developing a multiyear approach (37.3%). Slightly fewer than one-third describe their focus as "wait and see."
- Among organizations in a "wait and see" phase, four in five (80.7%) are awaiting the Supreme Court decision, 62.4% are awaiting further regulatory guidance and 52.1% are awaiting the outcome of the 2012 presidential and congressional elections.
- When communicating with employees regarding health care reform, most employers (81.1%) use annual enrollment materials. E-mails sent to employees (34.8%), the company website (24.1%) and special written communication pieces (22.9%) are also popular channels of communication.

Cost Implications

- Nearly half of all employers (47.2%) have conducted an analysis to determine how health care reform legislation will impact their health care plan costs.
- A majority (69.6%) of organizations expect the legislation will raise their costs in 2012. One-quarter (25.6%) estimate the legislation will increase their costs by 1% to 2%, followed by one-fifth (19.8%) estimating cost increases of 3% to 4%. Employers that have not conducted an analysis of plan costs are slightly more likely to estimate cost increases.
- Of provisions currently in place, extending coverage to adult children until age 26 was listed as the top cost driver (38.7%). The nondeductible excise tax on high-cost health plans in 2018 (19.6%) was cited as the top forthcoming cost driver.
- Approximately 14% of responding employers are anticipating making a change in their funding approach with their primary medical plan due to changes imposed by health care reform. Most organizations anticipating funding changes are adding stop-loss insurance.

Cost Management Initiatives

- Increasing participants' share of premium costs, done by more than one in five respondents (23.1%), is the most common technique used to address cost increases caused by health care reform. Going forward in the next two years, 20.1% of employers plan to increase employees' proportion of dependent coverage cost to address cost increases.
- As a result of health care reform, nearly one-third of surveyed organizations (33.4%) have conducted dependent eligibility audits or plan to do so in the next two years, and another 29.5% have analyzed or plan to analyze claims.
- One-third of respondents (33.2%) are considering offering the increased wellness incentives allowed in 2014 provisions.
- Approximately 14% of responding organizations have already started to redesign their primary health plan to avoid triggering the 2018 excise tax.

Reactions to Health Insurance Exchanges

- Nearly half (46.2%) of responding organizations report they definitely will continue to provide health care coverage for all full-time employees in 2014 and an additional two in five (39.3%) are very likely to do so. At this point, only 1% of respondents believe they definitely will not provide coverage to all full-time employees in 2014.
- Among the respondents that are considering using the exchanges in 2014, more are likely to direct only some employees to the exchanges and continue to provide coverage for others as opposed to dropping coverage for all employees.
- Among employers that did not state that they definitely will continue to provide coverage to all full-time employees in 2014, the most likely cause for discontinuing coverage is that providing it is becoming too expensive (cited by 45.1% of respondents). Approximately one-third state the cause for dropping coverage would most likely be that other organizations in their industry or their geographic area are discontinuing coverage (27.5% and 4.8%, respectively).
- Among organizations that will definitely continue to provide coverage, respondents overwhelming chose three reasons for maintaining coverage: to retain current employees (55.4%), to attract future talent (55.4%), and to maintain or increase employee satisfaction/loyalty (53.5%).

Grandfathered Plans

- The primary health plan of more than one in three responding organizations (34.3%) is a grandfathered plan. However, almost half of employers with a grandfathered plan (46.9%) anticipate their plan will lose this status in 2014 or sooner.
- Respondents consider the top advantages of being grandfathered to be the exemption from the requirement to provide coverage for preventive care with no cost sharing or annual limits (29.6%), the exemption from implementing the appeals process (29.6%) and the exemption from essential benefits requirements applicable in 2014 (28.9%).

III. Progress in Response to Health Care Reform

Effective January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) 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 of work per week. The vast majority of surveyed employers (95.8% or 927 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 examines employers' communication strategies and general response to health care reform. Organizations are at varied stages of assessing the impact of and developing approaches to reform. As shown in Exhibit 1, nearly half (47.2%) describe their current focus as implementing changes for compliance. More than one-third describe their focus as beginning to develop tactics to deal with the implications of reform or developing a multiyear response (39.1% and 37.3%, respectively).

Slightly less than one-third (31.3%) are taking a "wait and see" approach. Smaller organizations, typically with fewer resources, are those most likely to be delaying response (Exhibit 2). Why are organizations waiting? Four in five (80.7%) are waiting for the Supreme Court decision, 62.4% want more regulatory guidance, and 52.1% are on hold for the outcome of the 2012 presidential and congressional elections (Exhibit 3).

When communicating with employees regarding health care reform, most employers (81.1%) use annual enrollment materials (Exhibit 4). E-mails sent to employees (34.8%), the company website (24.1%) and special written communication pieces (22.9%) are also popular channels of communication.

EXHIBIT 1

Current Focus Regarding Reform* (n = 927)

Focus	%
Taking a "wait and see" approach	31.3%
Just beginning to get a handle on the legislation	9.4%
Have not had time to perform an in-depth analysis of the implications	9.3%
Have modeled the financial impact of reform on our organization	24.9%
Beginning to develop tactics to deal with the implications of reform	39.1%
Implementing changes to make health plan(s) compliant	47.2%
Developing multiyear approaches for dealing with implications of reform	37.3%
Considering terminating our health care program for active employees as a result of reform	5.0%
Considering terminating our health care program for retired employees as a result of reform	4.2%

*Respondents were asked to select all that apply.

EXHIBIT 2

Taking a "Wait and See" Approach (by Number of Benefits-Eligible Employees) (n = 927)

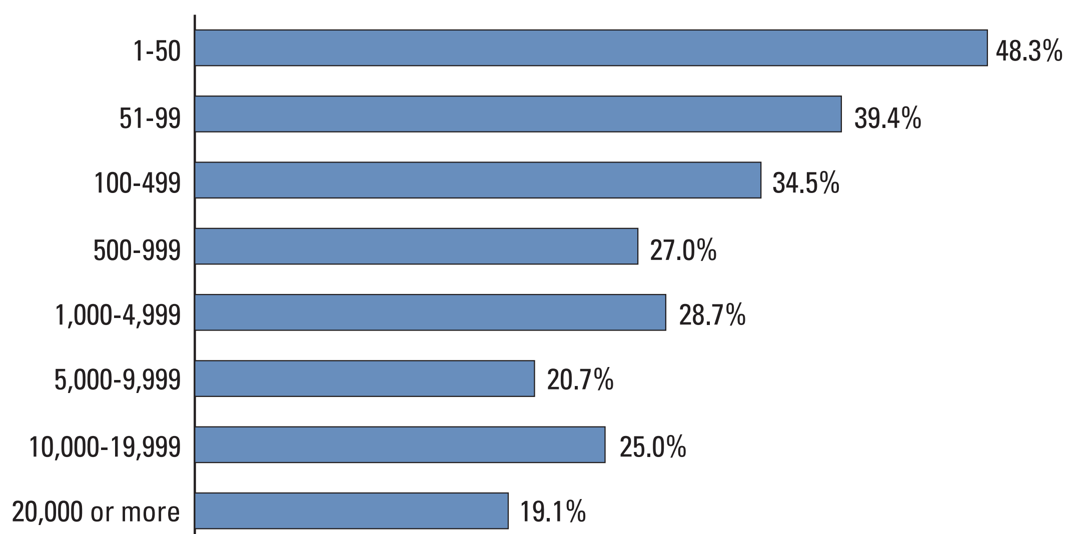


EXHIBIT 3

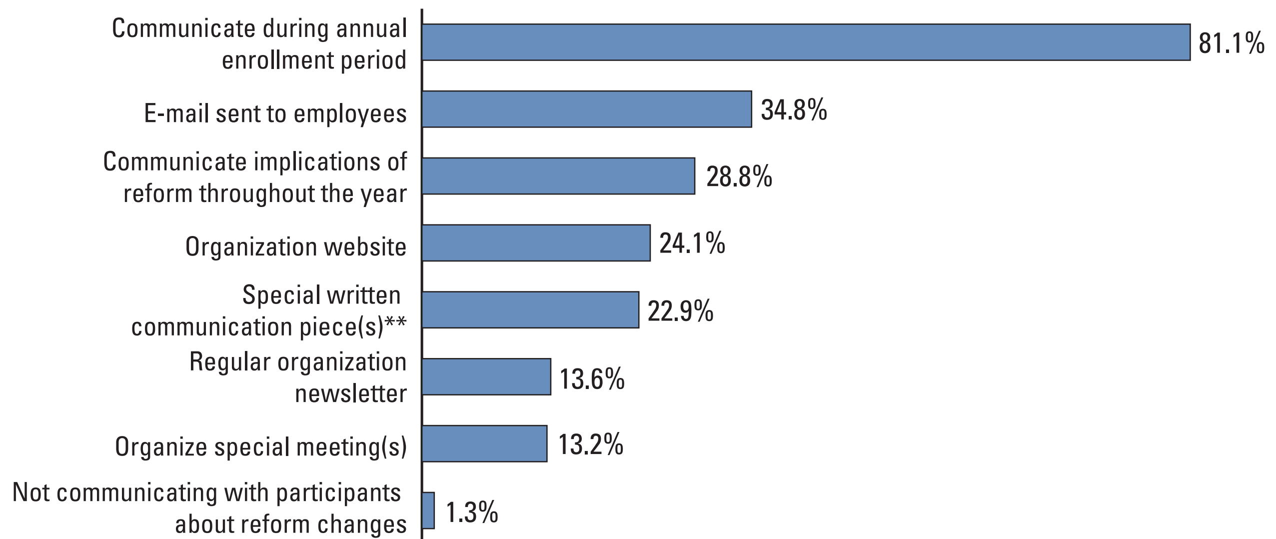
Reasons for Taking a "Wait and See" Approach* (n = 290)

Awaiting Supreme Court decision	80.7%
Awaiting further regulatory guidance	62.4%
Awaiting outcome of 2012 presidential and congressional elections	52.1%
Awaiting action from service providers	28.6%
Awaiting actions from other employers in our industry	17.2%
Awaiting actions from other employers in our geographic area	8.6%
Not sure	2.8%

*Respondents were asked to select all that apply.

EXHIBIT 4

Communication Initiatives About Reform* (n = 927)



*Respondents were asked to select all that apply.

**Either in payroll inserts, sent to employees'/retirees' homes, or distributed by some other means.

IV. Cost Implications

While the impact of PPACA varies from one employer to the next, it is generally agreed the law will increase plan costs in the short term. Nearly half of all employers (47.2%) have conducted an analysis to determine how health care reform legislation will affect their health care plan costs (Exhibit 5).

In general, survey respondents believe PPACA compliance will increase their health benefit costs in 2012. Most (69.6%) expect the legislation will increase their organizations' health care costs this year (Exhibit 6). Of those expecting an increase, one in four (25.6%) estimate a cost increase of 1% to 2%. A similar proportion (24.2%) predicts an increase of 5% or more. Fewer—one in five (19.8%)—estimate an increase that will fall somewhere in between of 3% to 4%. It is worth noting that those reporting their organizations had analyzed costs are slightly less likely to predict a cost increase (Exhibit 7).

Respondents were asked to identify the cost impact of health care reform provisions now in place as well as those that will be implemented later (Exhibits 8 and 9). Of those provisions in place, extending coverage to adult children until age 26 was listed as the top cost driver (38.7%). Nearly one in five respondents (19.4%) stated none of the previously implemented health care reform provisions have increased costs.

When asked which future reform provisions would increase costs the most, nearly one in five (19.6%) respondents identified the nondeductible excise tax on high-cost health plans in 2018. Other choices cited as high cost drivers include requiring employers to automatically enroll new hires (15.6%), providing affordable coverage to all employees working an average of 30 hours or more a week in a month (15.3%) and eliminating all preexisting condition exclusions for all enrollees (14.6%) (Exhibit 9).

Are employers anticipating changes in how they will finance their primary medical plans as a result of reform? Employers that self-fund benefit plans do so with the expectation that the arrangements will provide both management and financial advantages (e.g., offer greater flexibility in managing benefit plans, reduce administrative expenses, avoid state-mandated benefits and capture favorable claims experience).[3] In addition to these benefits, self-funded plans are exempt from a number of requirements under PPACA. Specifically, self-funded plans are not required to participate in a risk-adjustment system and are exempt from the annual fee placed on health insurers that starts in 2014.[4] As shown in Exhibit 10, a large proportion of responding employers (86.4%) do not anticipate making changes in how they fund their primary medical plan because of health care reform. Employers using self-funding may choose to limit potential medical claims exposure by purchasing stop-loss insurance that makes payments if claims exceed a predetermined amount for an individual participant or the entire group.[5] More than one in ten organizations (11.7%) are adding stop-loss insurance.

3. In a *self-funded* scenario, a benefit plan sponsor essentially acts as the plan insurer—determining what is covered and paying claims directly. Some self-funded plans contract with an insurance company or other third party to administer the plan. Most purchase stop-loss insurance as protection against catastrophic losses above a specific dollar amount.

4. The PPACA establishes a permanent risk-adjustment program for all nongrandfathered health plans and insurers in the small group and individual market inside and outside of the health insurance exchanges. As a premium stabilization mechanism included in the law, the program helps alleviate adverse selection by assessing charges on plans with lower-than-average health risk and transferring those payments to plans with higher-than-average health risk. The program does not apply to self-funded or large group plans.

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

EXHIBIT 5

Conducted Analysis of Reform Cost Implications (n = 927)

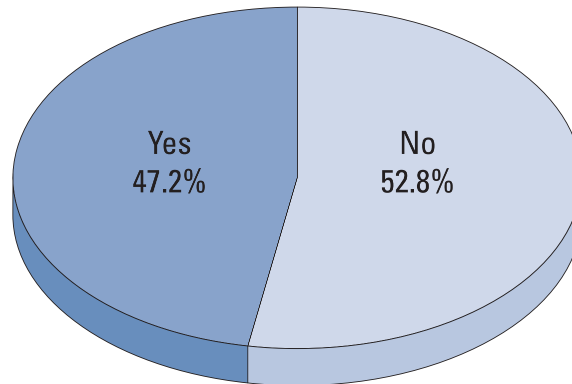
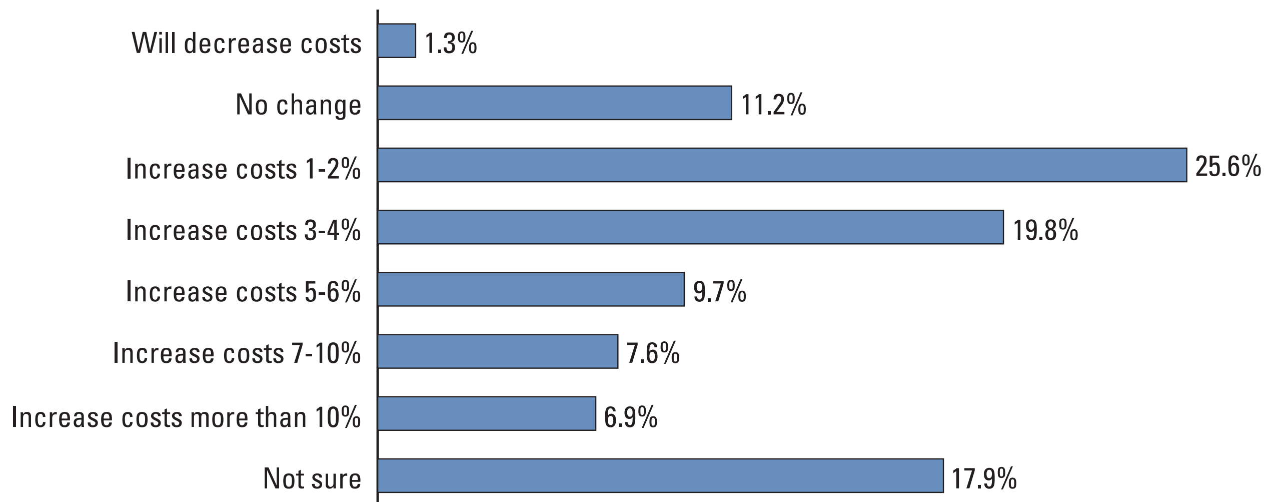


EXHIBIT 6

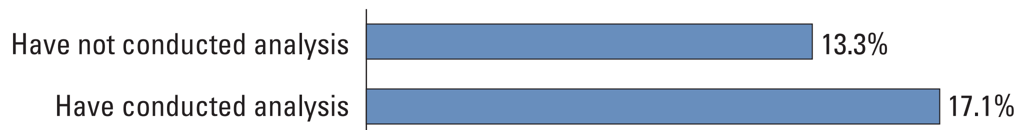
Change in 2012 Health Care Costs Due to Reform Compliance* (n = 927)



*Organizations that have not analyzed the cost implications were asked to estimate.

EXHIBIT 7

Portion Estimating Health Care Reform Will Not Increase Health Care Costs in 2012* (n = 761)



*Totals exclude "not sure" responses.

EXHIBIT 8

Provision Most Significantly Increasing Costs (n = 927)

Provision	%
Extending coverage of adult children to age 26	38.7%
No cost sharing for preventive care (nongrandfathered plans)	8.6%
Administrative costs (other than reporting and disclosure)	7.6%
Eliminating lifetime dollar limits on "essential benefits"	5.5%
Eliminating annual limits on "essential benefits"	5.3%
Reporting, disclosure and notification requirements (e.g., grandfather notice, adult children enrollment)	5.3%
Cost shifting due to reduced payments to providers from Medicare and Medicaid	3.8%
Ending of tax-advantaged treatment of over-the-counter drugs in high-deductible health plans or flexible spending accounts	3.2%
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)	0.5%
Requirement to provide new internal and external appeals procedures (nongrandfathered plans)	0.5%
None	19.4%

EXHIBIT 9

Forthcoming Provision Most Significantly Increasing Costs (n = 927)

Provision	%
Nondeductible excise tax on high-cost health plans in 2018	19.6%
Requirement that employers automatically enroll new hires into a health plan	15.6%
Offering affordable coverage to all employees working an average of 30 hours or more a week in a month	15.3%
Eliminating all preexisting condition exclusions for all enrollees	14.6%
Administrative costs (other than W-2 and SBC reporting and disclosure requirements)	9.5%
Additional W-2 reporting requirements	6.0%
Summary of benefits and coverage (SBC) disclosure	5.8%
Prohibiting waiting periods over 90 days in 2014	3.0%
Eliminating tax deduction for Medicare Part D drug subsidy	2.9%
None	7.6%

EXHIBIT 10

Anticipated Changes in Plan Funding Approach* (n = 927)

No changes to plan funding approach	86.4%
Becoming fully insured	1.3%
Becoming completely self-funded with stop-loss coverage	5.8%
Becoming completely self-funded without stop-loss coverage	0.3%
Already self-funded, but will now purchase stop-loss coverage	1.6%
Already self-funded, but will now purchase additional stop-loss coverage	4.3%
Already self-funded, but will drop stop-loss coverage	0.2%

*Due to health care reform legislation.

V. Cost Management Initiatives

This section examines employer changes in plan design to curb anticipated rising costs and avoid triggering the excise tax on high-cost plans. Respondents were asked whether their organizations had increased or planned to increase participant cost sharing as a means to contain costs. Nearly one-quarter (23.1%) have already increased participants' share of plan premiums (Exhibit 11). Slightly lower proportions reported they had increased in-network deductibles (19.1%), out-of-pocket limits (17%), copayments or coinsurance for primary care (16.7%), and the amount of dependent coverage cost paid by employees (15.9%).

In the next two years, an additional 20.1% plan to increase the employee portion of dependent coverage cost and 19.2% plan to increase participants' share of premium costs. Among the other changes in cost sharing planned are increases in out-of-pocket limits (16.9%) and in-network deductibles (16.2%) (Exhibit 11).

As a result of health care reform, nearly one-third of surveyed organizations (33.4%) have conducted dependent eligibility audits or plan to do so in the next two years. Another 29.5% have analyzed or plan to analyze claims utilization while 22.7% have conducted or plan to conduct health care claims audits (Exhibit 12).

In 2014, employers will be able 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.[6] In some situations, an incentive of as much as 50% will be permitted. One-third (33.2%) of respondents are considering offering increased incentives (Exhibit 13). Only 14.2% state that they are not considering these increased incentives. The remainder—the majority (52.6%)—had made no decision.

Starting in 2018, PPACA imposes a nondeductible excise tax on employers with high-cost health plans.[7] 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.[8] While the 2018 deadline is several years away, Exhibit 14 shows that 13.9% of responding organizations have already started to redesign their primary health plan to avoid triggering the 2018 excise tax. Nearly three times this many (39.9%) are considering action. Another 18.6% do not have plans that meet the definition of a high-cost plan.

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

7. 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).

8. Both figures will be indexed for inflation.

EXHIBIT 11

Cost Containment Measures* (n = 927)

	Used*	Plan on Using**
Increase participants' share of premium costs	23.1%	19.2%
Increase in-network deductibles	19.1%	16.2%
Increase out-of-pocket limits	17.0%	16.9%
Increase copayments or coinsurance for primary care	16.7%	12.7%
Increase employee proportion of dependent coverage cost	15.9%	20.1%
Modify/add tiers to cost-sharing structure	9.2%	13.3%
Increase voluntary (employee-pay-all) benefit offerings	8.1%	11.7%
Structure premiums based on income	3.5%	6.0%

*Due to the enactment of health care reform legislation.

**In the next two years, due to health care reform legislation.

EXHIBIT 12

Audits/Analysis Conducted* (n = 927)

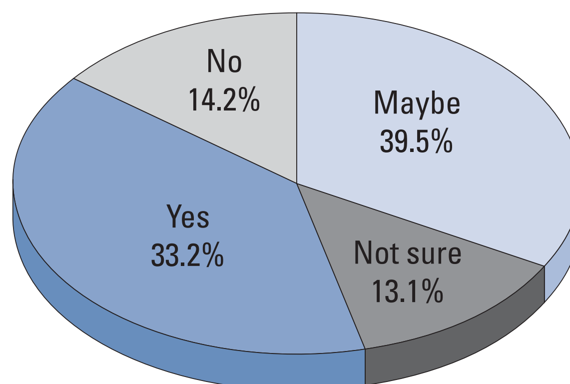
	Conducted*	Plan on Conducting**
Dependent-eligibility audits	18.7%	14.7%
Health care claims utilization analysis	15.0%	14.5%
Health care claims audits	9.2%	13.5%

*Due to the enactment of health care reform legislation.

**In the next two years, due to health care reform legislation.

EXHIBIT 13

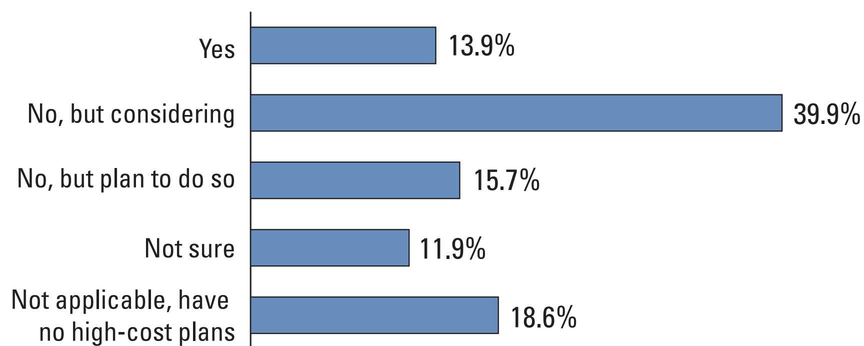
Considering Offering Increased Wellness Incentives* (n = 927)



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

EXHIBIT 14

Taking Action to Avoid 2018 Excise Tax (n = 927)



VI. Reactions to Health Insurance Exchanges

Employer reactions to the health insurance exchanges and the "play or pay" provisions of PPACA 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.[9] This employer requirement is controversial. Supporters maintain that 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.

The survey results show that most employers will not stop providing employees with health insurance in 2014 when the provisions become effective (Exhibit 15). Nearly half (46.2%) of responding organizations report they definitely will continue to provide health care coverage for all full-time employees in 2014 and an additional two in five (39.3%) are very likely to do so. At this point, only 1% of respondents believe they definitely will not provide coverage to all full-time employees in 2014.

Among the respondents that are considering using the exchanges in 2014, more are likely to direct only some employees to the exchanges and continue to provide coverage for others as opposed to dropping coverage for all employees (Exhibit 16). Only 1.1% of employers at this point believe they definitely will drop coverage for some employees and keep coverage for others in 2014, but nearly one-quarter (23%) are very likely or somewhat likely to do so. Just 0.2% of employers at this point believe they definitely will drop coverage for all employees in 2014 while 7.8% are very likely or somewhat likely to do so.

It is interesting to note that among the small group of 41 employers without employer-sponsored health insurance in 2012, nearly one-third (31.7%) said they definitely will offer coverage in 2014 and another quarter said they were very likely or somewhat likely to provide coverage in 2014 due to the "play or pay" provisions (14.6% and 9.8%, respectively).

The 499 respondents that did not state that they definitely will continue to provide coverage to all full-time employees in 2014 were asked their likelihood of offering a financial subsidy if they were to drop coverage and their most likely cause for discontinuing coverage. Exhibit 17 reveals a great deal of uncertainty on this point. A very small proportion (3.8%) have decided they will definitely provide a subsidy and a similar very small proportion (4.2%) have decided they will not. Two-thirds were able to say only that they are very likely or somewhat likely to offer a subsidy (28.5% and 38.5%, respectively).

The most common reason given by the group for possibly discontinuing coverage is that the cost is becoming too high—cited by 45.1% of respondents (Exhibit 18). Approximately one-third state the reason they would most likely end coverage is if other organizations in their industry or geographic area discontinued coverage (27.5% and 4.8%, respectively).

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9. On April 15, 2011, the final appropriations bill for the 2011 fiscal year was signed into law by President Barack Obama. This bill included the repeal of the PPACA free-choice voucher program. Health plan sponsors will no longer be required to offer vouchers in 2015 to employees who purchase coverage through exchanges. This repeal does not apply to the employer responsibility penalty, which penalizes employers when employees buy coverage through the exchanges.

The 428 respondents that stated they definitely will continue to provide coverage to all full-time employees were asked their top reasons for maintaining coverage (Exhibit 19). The decision to provide coverage was more of a value than a cost issue. Respondents overwhelmingly chose one of three reasons for maintaining coverage: to retain current employees (55.4%), to attract future talent (55.4%), and to maintain or increase employee satisfaction/loyalty (53.5%).

EXHIBIT 15

Likelihood of Offering Coverage to All Full-Time Employees in 2014 (n = 927)

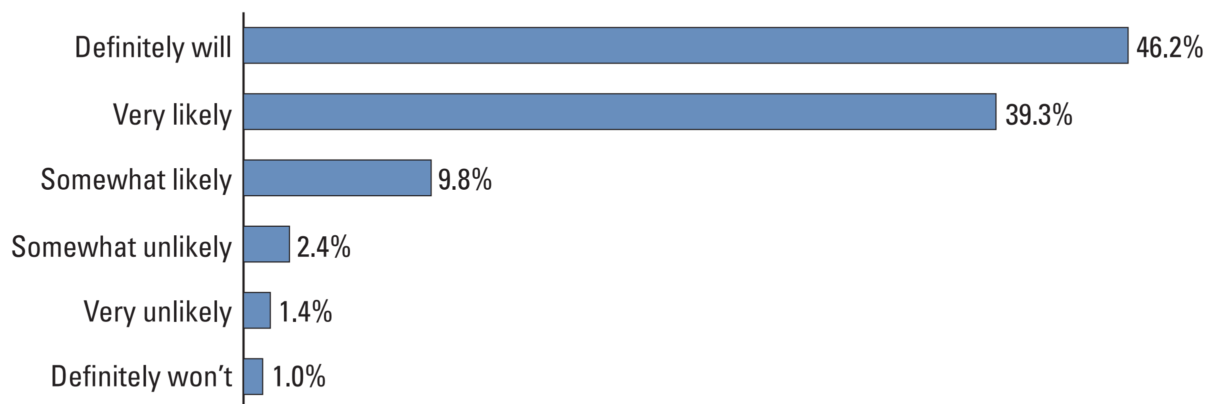


EXHIBIT 16

Likelihood of Action When Exchanges Open (n = 927)

Our organization will continue to provide coverage to some employees, but direct others to the exchanges.

Definitely will	1.1%
Very likely	8.0%
Somewhat likely	15.0%
Somewhat unlikely	11.1%
Very unlikely	15.3%
Definitely won't	49.5%

Our organization will drop coverage for all employees and direct them to the exchanges.

Definitely will	0.2%
Very likely	1.5%
Somewhat likely	6.3%
Somewhat unlikely	8.1%
Very unlikely	27.1%
Definitely won't	56.9%

EXHIBIT 17

Likelihood of Offering Financial Subsidy if Coverage Discontinued (n = 499)

Definitely will	3.8%
Very likely	28.5%
Somewhat likely	38.5%
Somewhat unlikely	12.2%
Very unlikely	12.8%
Definitely won't	4.2%

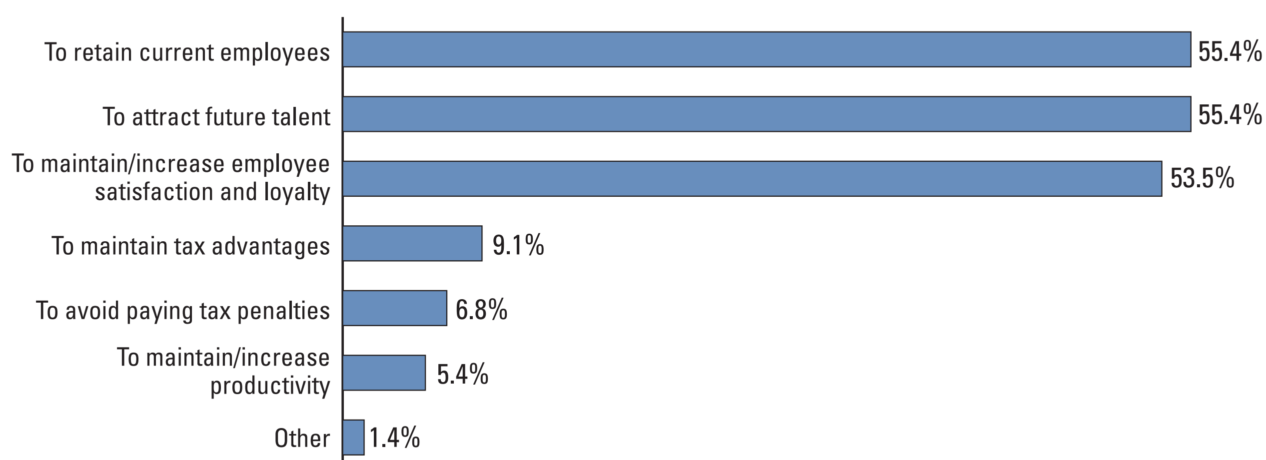
EXHIBIT 18

Most Likely Cause for Discontinuing Coverage (n = 499)

The cost of providing coverage becoming too expensive	45.1%
Other organizations in our industry discontinuing coverage	27.5%
Exchanges are proving to provide adequate health coverage for individuals	12.0%
Employees voluntarily moving to the exchanges	9.0%
Other organizations in our geographic area discontinuing coverage	4.8%
Not sure	1.6%

EXHIBIT 19

Reasons for Maintaining Coverage in 2014* (n = 428)



*Respondents were asked to select their top two choices.

VII. Grandfathered Plans

If an organization had at least one individual enrolled in a group health plan or health insurance coverage when the first health care reform legislation was 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.

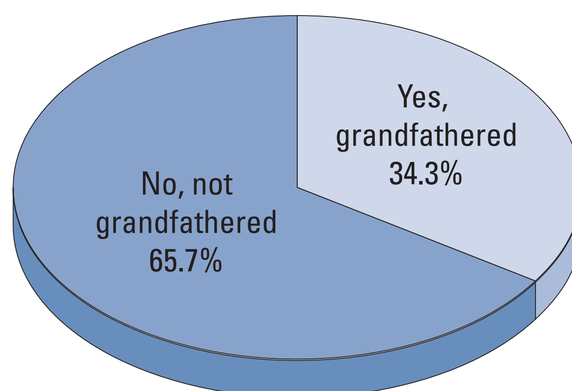
The primary health plan of more than one in three responding organizations (34.3%) is a grandfathered plan (Exhibit 20). This section analyzes employer perspectives on and the potential benefits of being classified as a grandfathered plan.

Because they will be able to make only limited health plan changes, it is likely maintaining grandfathered status will be a challenge for employers.[10] Nearly half of employers with a grandfathered plan (46.9%) anticipate their plan will lose this status in 2014 or sooner (Exhibit 21). In contrast, slightly more than one-third (35.2%) believe their grandfathered status is safe, at least until 2014.

Respondents were asked to identify up to two advantages of having their plans classified as a grandfathered plan. The top advantages chosen are exemption from the requirement for providing preventive care coverage with no cost sharing or annual limits (29.6%), exemption from implementing the appeals process (29.6%) and exemption from essential benefits requirements applicable in 2014 (28.9%).

EXHIBIT 20

Grandfathered Status of Primary Health Plan (n = 927)



10. 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 21

Outlook for Maintaining Plan Grandfathered Status (n = 318)

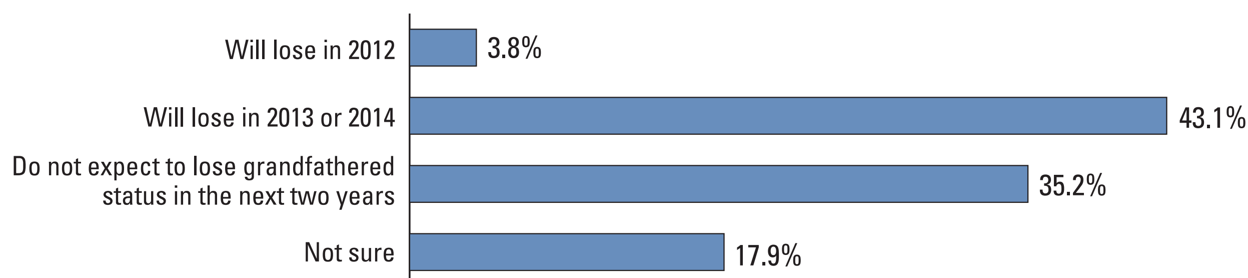


EXHIBIT 22

Top Benefits of Classification as a Grandfathered Plan* (n = 318)

Eliminate requirement to provide coverage for specified preventive care with no cost sharing or annual limits	29.6%
Exempt from implementing the appeals process required under PPACA, which includes external appeals	29.6%
Avoid essential benefits requirements applicable in 2014	28.9%
Avoid 60% actuarial value minimum benefit requirements applicable in 2014	14.2%
Exempt from requirements to cover emergency services at nonnetwork facilities without prior authorization and at the same cost-sharing levels as in-network facilities	11.6%
Avoid application of Internal Revenue Code Section 105(h) nondiscrimination rules to our fully insured plans	11.0%
Avoid premium rating structure limitations for plans with less than 100 employees, applicable in 2014	9.4%
Don’t see value/benefits of being classified as a grandfathered plan	18.9%
Other	2.5%

*Respondents were asked to select up to two.

VIII. Demographics

Individuals invited to participate in the 2012 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 968 individuals including benefits and human resources professionals, general and financial managers, and other professionals. Exhibits 23 through 26 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 (50.8%) state they have most employees enrolled in a preferred provider organization (PPO). Approximately one in five (21.3%) use some sort of high-deductible health plan (HDHP) as their primary medical plan—less than 1% use an HDHP without an account while 20.6% use an HDHP with a health savings account (HSA) or health reimbursement arrangement (HRA) (Exhibit 23).[11]

Exhibit 24 shows that organizations from all regions of the country participated in the survey. Employers located in the Midwest (27.4%) and Northeast/Mid-Atlantic (23.5%) regions are more represented than those located in other regions and those having a national or international presence. Surveyed organizations are dispersed across all employer-size categories (Exhibit 25). The bulk of responding organizations have 1,000-4,999 benefits-eligible employees (27.2%) or 99 or fewer participants (21.3%). As shown in Exhibit 26, a wide range of industries is represented by the responding organizations. The bulk of organizations are drawn from insurance and related fields (21.9%), manufacturing and distribution (15.2%), and health care and medicine (9.9%).

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11 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 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 23

Health Plan With Majority Enrolled (n = 968)

Preferred provider organization (PPO)	50.8%
High-deductible health plan (HDHP) with health savings account (HSA)	14.7%
Health maintenance organization (HMO)	11.2%
Point-of-service plan (POS)	6.3%
High-deductible health plan with health reimbursement arrangement (HRA)	5.9%
Exclusive provider organization (EPO)	3.9%
Traditional indemnity/fee-for-service plan	2.3%
High-deductible health plan without account	0.7%
Do not offer coverage	4.2%

EXHIBIT 24

Respondent Region* (n = 968)

Midwest	27.4%
Northeast/Mid-Atlantic	23.5%
South	16.4%
West	13.7%
Nationwide	16.3%
International	2.7%

*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 25

Number of Benefit-Eligible Employees (n = 968)

0-50	14.3%
51-99	7.0%
100-499	19.0%
500-999	10.8%
1,000-4,999	27.2%
5,000-9,999	8.8%
10,000-19,999	5.9%
20,000 or more	7.0%

EXHIBIT 26

Respondent Industry (n = 968)

Insurance related	21.9%
Manufacturing/distribution	15.2%
Health care/medicine	9.9%
Nonprofit	7.3%
Professional services	7.1%
Banking/finance	5.6%
Retail/wholesale trade	5.1%
Energy/utilities/mining	4.3%
Education	4.2%
Communication/telecommunications	2.9%
High technology	2.9%
Construction	2.7%
Accommodation/food service	2.6%
Transportation	1.8%
Multiple industries	1.5%
Real estate related	1.3%
Arts/entertainment/recreation	0.9%
Agriculture	0.2%
Other services	2.5%

Health Care Reform: 2012 Employer Actions Update is the third in a series of reports on the impact of health care reform legislation on 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 at www.ifebp.org for the latest health care reform news, analysis and additional resources.