2015 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 2015 by the International Foundation of Employee Benefit Plans, Inc.

ISBN 978-0-89154-760-0

Printed in the United States of America

RS150476

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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 the premier educational organization dedicated to providing the diverse employee benefits community with objective, solution-oriented education, research and information to ensure the health and financial security of plan beneficiaries worldwide. 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 and insurance companies and in other industry professions.

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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 26, 2015, the International Foundation of Employee Benefit Plans deployed its sixth 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 subsequent surveys focused on the actions employers took in 2011 through 2014.

2015 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 about plan design and funding, methods for communicating with employees, reactions to health insurance exchanges and the upcoming 2018 excise tax, cost-management initiatives and the potential impact on health care benefit costs.

Those asked to participate in the 2015 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 598 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 (16.4%) and manufacturing and distribution (14.6%) 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 to 2014 surveys were very similar to those in the 2015 survey. In several places throughout this report, comparison data is displayed by employer size and by years. We urge readers to exercise caution when interpreting comparison data from previous surveys because of the nature of the sample designs and potential nonresponse error. Due to rounding, some column percentages may not total 100%.

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' general status in response to ACA. Section IV focuses on employers' reactions to the health insurance exchanges. Section V discusses ways employers are communicating with their participants about reform. Strategies, actions and initiatives employers are adopting due to ACA are examined in Section VI. The cost impact of ACA is examined in Section VII. Section VIII discusses the demographic profile of respondents.

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

1. Electronic survey deployment began March 26, 2015 and was concluded April 14, 2015.
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 ACA's impact on single employer plans. Completed responses were received from 598 individuals representing single employer plans (including corporations). Attention is given to employers' status in response to ACA, plan design and funding, communication with employees, reactions to health insurance exchanges and the upcoming 2018 excise tax, cost-management initiatives and the potential impact on health care benefit costs.

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).

General Focus and Reactions to ACA

- Three in five respondents to the survey believe the law has had a negative effect on their organization. Among those who said their organization's view of the law has changed since enactment five years ago, more than three-quarters said that view has become more negative. Yet the vast majority of organizations remain committed to providing health insurance coverage despite these perceptions, increasing costs and the looming Cadillac tax.
- More than half of organizations describe their current status as compliant and developing some tactics or multiyear strategies to deal with reform. On the other end of the spectrum, about one in five organizations is just focused on attempting to keep compliant with each new provision going into effect. And 14% are compliant but taking a wait-and-see approach with strategy. What are these organizations waiting to see? A separate question revealed 93% of organizations are following ACA Supreme Court cases at least somewhat closely (18% are following very closely).

Health Insurance Exchanges

- Ninety-four percent of all surveyed organizations continue to provide health care coverage for all full-time employees in 2015 and, among that group, nearly all plan to continue coverage in 2016. There is a little uncertainty regarding employer-sponsored coverage five years from now; however, less than 5% say they are unlikely to continue coverage. Respondents overwhelmingly chose three reasons for maintaining coverage: to attract future talent, retain current employees and maintain/increase employee satisfaction and loyalty.
- Less than 5% of organizations provide coverage to full- or part-time employees through private health insurance exchanges. However, more than one in ten organizations that provide coverage to retirees aged 65 and older are doing so via private exchanges, and 17% more are considering doing so.

Communication

- Annual enrollment materials, e-mails, company websites, special meetings and specially written communication pieces are the most popular channels for communicating with employees about ACA.
- Confusion and lack of interest among participants are the biggest communication obstacles. One-third of organizations believe employee understanding of ACA is poor or very poor. On the other hand, two in five organizations believe ACA has increased their employees' engagement/interest in their health care. Nearly half of organizations have noticed an increase in the number of ACA questions active employees asked HR and benefits staff in the last 12 months. Last year, respondents said the most common ACA questions from employees were related to the health insurance exchanges. This year, employees most commonly are asking about benefit changes and whether they need to take actions (tax-related or otherwise).

Cost-Containment Strategies

- Implementation of health care cost-containment measures has increased, according to each of two previous ACA surveys. More than one-third of organizations now have increased out-of-pocket limits, in-network deductibles and/or participants' share of premium costs in response to ACA. More than one in five organizations have increased copayments or coinsurance for primary care, increased participants' share of prescription drug costs and/or increased the employee proportion of dependent coverage cost.
- One in five organizations has adopted or expanded wellness initiatives because of ACA, and another 17% plan to do so in the next 12 months. One in six has adopted or expanded wellness incentives because of ACA, and 15% are now offering the maximum allowable incentives under the law.
- Fifteen percent of organizations have adjusted hours so fewer employees qualify for full-time employee medical insurance. Other broad workforce adjustments remain less common. Five percent or fewer have reduced their workforce because of ACA costs, frozen or reduced pay raises/compensation, reduced non-health-care-related benefits, added workers to help with compliance or reduced hiring in order to stay under 50 employees.

Cadillac Tax

- The excise tax on high-cost group health plans (a.k.a. *Cadillac tax*) is considered the top ACA cost driver beyond 2015. Since 2011, a steadily increasing percentage of organizations has taken action to avoid triggering the excise tax—a trend likely to continue. More than one in ten organizations already have adopted changes to prevent them from triggering the tax, 21% are working on changes and 28% plan to act sometime prior to 2018. Only one-quarter said changes were not necessary either because they have no high-cost plans (23%) or because they plan to pay the tax (2%).
- The most common action taken to avoid triggering the excise tax is moving to a consumer-driven health plan (CDHP). In particular, more than one-quarter of all responding organizations have increased emphasis or added a high-deductible health plan (HDHP) with a health savings account (HSA) because of ACA, and an additional 14% are considering doing so. Nearly one in ten organizations has adopted a full-replacement HDHP because of ACA.

Cost Impact

- Two-thirds of organizations have conducted an analysis to determine how ACA will affect 2015 health care plan costs. Among all organizations, 82% expect the law will increase their organization's health care costs this year, with most projecting a 1% to 6% increase. The median cost increase is 3% among organizations that know their exact 2015 cost change because of ACA. However, ACA-related costs are hitting smaller employers much harder than larger ones. General ACA administrative costs and costs associated with reporting, disclosure and notification requirements are the top ACA cost drivers for 2015.
- Employers are not anticipating a brighter future; one-third expect 2016 to be the year that will produce the greatest cost increases because of ACA. One-quarter expect 2018—when the excise tax on high-cost group health plans takes effect—to be the year producing the greatest cost increases. One in six expects costs to increase the most this year (2015), and just 13% of employers believe the greatest cost increases are behind them.

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III. General Focus and Reactions to ACA

This section of the survey report examines employers' general response to and strategies concerning ACA. Organizations are at various stages in assessing the impact of and developing approaches to health care reform. As shown in Exhibit 1, more than half of organizations describe their current status as compliant and developing some tactics (36.8%) or multiyear strategies (20.4%) to deal with reform. Exhibit 2 shows larger employers are more likely to have multiyear ACA strategies compared with smaller employers. On the other end of the spectrum, 17.1% of organizations are just focused on attempting to keep compliant with each new provision going into effect. And 14.3% are compliant but taking a wait-and-see approach with strategy. What are these organizations waiting to see? Exhibit 3 reveals 92.5% of organizations are following ACA Supreme Court cases at least somewhat closely (17.8% are following very closely). Organizations following the ACA Supreme Court cases very closely were asked to share details about how that monitoring process works and what they were looking and hoping for. Many mentioned they rely on attorneys, brokers, consultants and the International Foundation to stay up to date with these cases. Some said their HR/benefits staff monitors internally on a daily basis via e-mail updates, articles, legal blogs, meetings and webinars. Several remarked they are hoping for a repeal verdict and changes to the law, viewing the Supreme Court as the "last chance to fix our problems." A few said their organization is involved in lobbying efforts surrounding the law and court cases. Several others mentioned the court cases' impact on their ability to think strategically long-term. Many just want clarity: "I just want them to make up their minds and let me know what I have to do."

Three in five respondents (59.5%) believe ACA has had an overall negative effect on their organization thus far (46.3% somewhat negative; 13.2% very negative) (Exhibit 4). About three in ten (28.3%) describe ACA's effect on their organization thus far as neutral, and 12.2% say the effect has been positive. Looking toward the future, more than two-thirds of respondents (70%) predict ACA will have an overall negative effect on their organization (50.8% somewhat negative; 19.2% very negative). One in five (17.7%) forecasts a neutral effect, while 12.2% believe the effect will be positive. Looking back, about half of organizations (46.4%) say their organization's view of ACA has changed since enactment and, among that group, more than three-quarters (77.6%) said that view has become more negative (Exhibit 5). The biggest ACA challenge for most organizations is administration issues (56.9%) even more so than costs (20.6%) (Exhibit 6).

EXHIBIT 1

Current Focus Regarding ACA*

	(n = 598)
Attempting to keep compliant as each new provision goes into effect	17.1%
Compliant but taking a wait-and-see approach with strategy	14.3%
Compliant but just beginning to get a handle on how ACA will affect our plan(s) in the future	11.4%
Compliant and developing some tactics to deal with implications of reform	36.8%
Compliant and have a multiyear approach to deal with implications of reform	20.4%

*Respondents were asked to select the one statement that best describes their organization's current focus.

EXHIBIT 2

Compliant and Have a Multiyear Approach to ACA by Employer Size

	(n = 598)
0-50	9.5%
51-499	22.5%
500-4,999	21.4%
5,000-9,999	24.2%
10,000+	39.2%

EXHIBIT 3

Following Supreme Court Cases Related to ACA

	(n = 562)
Very closely	17.8%
Somewhat closely	74.7%
Not at all	7.5%

EXHIBIT 4

Effect of ACA on Organization

	Thus Far (n = 598)	Future (n = 598)
Very positive	3.0%	2.8%
Somewhat positive	9.2%	9.4%
Neutral	28.3%	17.7%
Somewhat negative	46.3%	50.8%
Very negative	13.2%	19.2%

EXHIBIT 5

Change in View of ACA Since Enactment Five Years Ago

	(n = 598)
Yes, we view it more positively now	10.4%
Yes, we view it more negatively now	36.0%
No change	53.7%

EXHIBIT 6

Biggest Challenge Regarding ACA

	(n = 562)
Administration issues	56.9%
Cost issues	20.6%
Plan design issues	10.9%
Communication issues	10.0%
Other	1.6%

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IV. 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 2015, larger employers (100 or more full-time employees) face penalties (generally $2,000 per employee) if they do not offer minimum essential coverage to their employees and any of their employees receive a subsidy to obtain coverage through a health insurance exchange. Employers with 50 to 99 employees are allowed a transitional year; penalties will go into effect beginning in 2016. Full-time employment is defined as 30 or more hours of work per week. The vast majority of surveyed employers (94%, or 562 total respondents) offer medical benefits to employees who work more than 30 hours on average per week (Exhibit 7). The remaining survey results focus primarily on this group providing medical benefits.

Survey results show nearly all surveyed employers will continue to provide employees with health insurance next year in 2016 (Exhibit 8). Only 1.6% will continue coverage but encourage some employees to seek coverage through the exchanges, and just 0.2% plan to drop coverage for all employees.

Exhibit 9 reveals some uncertainty regarding employer-sponsored coverage five years from now; however, most organizations say they are somewhat likely (10.7%), very likely (52.2%) or definitely will (33.2%) continue coverage. Less than 5% say they are unlikely to continue coverage five years from now. Respondents overwhelmingly chose three reasons for maintaining coverage: to attract future talent (78.7%), retain current employees (74.8%) and maintain/increase employee satisfaction and loyalty (53.4%) (Exhibit 10).

The 23 respondents that said they were unlikely to provide coverage to all full-time employees in five years were asked to rate the likelihood of offering a financial subsidy if coverage is dropped and the most likely cause for discontinuing coverage. Most organizations (65.3%) say they would be at least somewhat likely to provide a subsidy, and the most common reason given for possibly discontinuing coverage is the cost becoming too high (65.2%) (Exhibits 11 and 12).

Exhibit 13 shows that among the two in five responding organizations (41.3%) offering retiree health coverage, 9.9% plan to discontinue it next year and an additional 15% are unlikely to continue coverage. Among the two in five responding organizations (40%) offering health coverage to part-time employees, just 4.4% are unlikely to continue coverage for this group next year (Exhibit 14).

Regarding private exchanges, 10.8% are currently using this option for retirees aged 65 and over, 5.2% have this in place for future retirees, and 5.2% are using them for early retirees (ages 55-64) (Exhibit 15). An additional 19.4% are considering private exchanges for early retirees, 19% are considering for future retirees and 17.2% are considering for retirees aged 65 and over. Only 1.8% of organizations currently use private exchanges for their part-time employees, but 10.2% are considering this option. Only 3% of organizations use private exchanges for their full-time employees, but 12.3% are considering this option. An open-ended question was asked to the small number of employers providing coverage to full-time employees via private exchanges about their experience and motivation for moving to a private exchange. The most common themes were increased choice and reduced costs.

EXHIBIT 7

Currently Provide Health Care Coverage to All Full-Time Employees

	(n = 598)
Yes	94.0%
No	6.0%

EXHIBIT 8

Approach to Health Care Coverage Next Year (2016)

	(n = 562)
We will continue to provide employer-sponsored coverage for all full-time employees	98.2%
We will continue to provide coverage but encourage some employees to seek coverage through the exchanges	1.6%
We will drop coverage for all employees and direct them to the exchanges	0.2%

EXHIBIT 9

Likelihood of Offering Coverage Five Years From Now

	(n = 562)
Definitely will	33.2%
Very likely	52.2%
Somewhat likely	10.7%
Somewhat unlikely	3.4%
Very unlikely	0.5%
Definitely won't	0.0%

EXHIBIT 10

Main Reasons to Continue Coverage*

	(n = 539)
To attract future talent	78.7%
To retain current employees	74.8%
To maintain/increase employee satisfaction and loyalty	53.4%
To avoid paying penalties	14.3%
To maintain tax advantages (e.g., tax deductions, no increase in payroll taxes, etc.)	14.1%
To maintain/increase productivity	13.7%
Other	3.9%

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

EXHIBIT 11

Likelihood of Offering Subsidy if Coverage Is Discontinued*

	(n = 23)
Definitely will	4.4%
Very likely	26.1%
Somewhat likely	34.8%
Somewhat unlikely	26.1%
Very unlikely	4.4%
Definitely won't	4.4%

*Respondents committed to continuing coverage were not asked this question.

EXHIBIT 12

Likely Cause for Discontinuing Coverage*

	(n = 23)
The cost of providing coverage becoming too expensive	65.2%
Exchanges are proving to provide adequate health coverage for individuals	17.4%
Other organizations in our industry discontinuing coverage	13.0%
Other organizations in our geographic area discontinuing coverage	4.4%
Employees voluntarily moving to the exchanges	0.0%
Other	0.0%

*Respondents committed to continuing coverage were not asked this question.

EXHIBIT 13

Likelihood to Continue Retiree Coverage Next Year*

	(n = 232)
Definitely will	26.7%
Very likely	29.3%
Somewhat likely	19.0%
Somewhat unlikely	10.3%
Very unlikely	4.7%
Definitely won't	9.9%

*Only the 41.3% of respondents whose organizations currently have some form of retiree coverage were asked this question. Respondents were asked their likelihood of continuing coverage through 2016.

EXHIBIT 14

Likelihood to Continue Coverage for Part-Timers Next Year*

	(n = 225)
Definitely will	44.4%
Very likely	40.0%
Somewhat likely	11.1%
Somewhat unlikely	2.2%
Very unlikely	2.2%
Definitely won't	0.0%

*Only the 40% of respondents whose organizations currently offer coverage for part-time employees were asked this question. Respondents were asked their likelihood of continuing coverage through 2016.

EXHIBIT 15

Provide Coverage Through a Private Exchange*

Coverage for full-time employees	(n = 562)
Yes	3.0%
No, but considering	12.3%
No	83.6%
Not sure/not applicable	1.1%
Coverage for part-time employees	(n = 225)
Yes	1.8%
No, but considering	10.2%
No	87.1%
Not sure/not applicable	0.9%
Coverage for retirees aged 65 and over	(n = 232)
Yes	10.8%
No, but considering	17.2%
No	67.2%
Not sure/not applicable	4.7%
Coverage for early retirees (ages 55 to 64)	(n = 232)
Yes	5.2%
No, but considering	19.4%
No	72.0%
Not sure/not applicable	3.5%
Coverage for future retirees	(n = 232)
Yes	5.2%
No, but considering	19.0%
No	65.5%
Not sure/not applicable	10.3%

*Only respondents whose organizations currently offer coverage for part-time employees were asked about private exchanges for that group, and only respondents whose organizations currently offer coverage for retirees were asked about private exchanges for each of the retiree groups.

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V. ACA Communication

Section V examines employer communication and employee engagement with ACA. Most employers (73.5%) use annual enrollment materials to communicate with employees about ACA (Exhibit 16). E-mails sent to employees (52.9%), a company website (37.7%), special meetings (27.1%) and special written communication pieces (26.5%) are also popular channels of communication. Larger organizations are more likely to communicate via company websites and written communication pieces, while smaller organizations are more likely to communicate at meetings or via e-mail. Participant confusion (53.4%) and lack of interest (46.4%) are the biggest obstacles to communicating about ACA (Exhibit 17). Some of the common themes among "other" responses submitted were employees having negative reactions toward the law and challenges communicating electronically.

Exhibit 18 shows how ACA interest among employees has increased in the last 12 months. Nearly half of organizations (45.1%) have noticed an increase in the number of ACA-related questions human resources and benefits staff have received from active employees. Very few organizations (5.9%) have seen a decrease in questions about ACA in the last 12 months. Respondents say the most common questions from employees are regarding benefit changes, whether they need to take actions and how ACA affects their costs (Exhibit 19). Questions about exchanges and whether the organization will drop health coverage are also common.

Exhibit 20 shows that about one-third of organizations (34.4%) rate their employees' understanding as poor or very poor (26% and 8.4%, respectively). On the other hand, two in five organizations (39.1%) believe ACA has increased their employees' engagement/interest in their health care (Exhibit 21). Smaller employers are more likely to report that they and their participants are having difficulty keeping up with the law. Smaller employers are also more likely to be receiving a growing number of questions from employees about ACA and noticing increased employee engagement/interest in their health care compared with larger organizations.

EXHIBIT 16

ACA Communication Initiatives*

	(n = 562)
Communicate during annual enrollment period	73.5%
E-mail sent to employees	52.9%
Organization website	37.7%
Special meeting(s)	27.1%
Special written communication piece(s) either in payroll inserts, sent to employees'/retirees' homes or distributed by some other means	26.5%
Communicate implications of reform throughout the year	21.9%
Regular organization newsletter	13.5%
Social media (e.g., Facebook, Yammer, Google+, LinkedIn, Twitter, YouTube, blogs)	3.2%
Other	2.3%
No communication about ACA changes	6.8%

*Respondents were asked to select all that apply.

EXHIBIT 17

Obstacles to Communicating With Participants*

	(n = 562)
Confusion among participants	53.4%
Lack of interest among participants	46.4%
Participants are having difficulty keeping up with each new piece of the law and regulations	30.3%
Have not experienced obstacles communicating with participants	28.5%
Organization is having difficulty keeping up with each new piece of the law and regulations	23.1%
Other	2.9%

*Respondents were asked to select all that apply.

EXHIBIT 18

Change in Number of Employee Questions due to ACA*

	(n = 562)
Increased significantly	10.9%
Increased somewhat	34.2%
Stayed the same	49.1%
Decreased somewhat	3.9%
Decreased significantly	2.0%

*Change in the number of questions by participants to the human resources/benefits staff in the past 12 months.

EXHIBIT 19

Most Common Employee ACA Questions*

	(n = 562)
How will our benefits change? Is this benefits change because of ACA?	41.8%
How does the law affect me? Do I need to do anything (tax-related or otherwise)?	39.9%
What will this cost me? Why are my costs going up?	35.1%
Is the organization planning to drop coverage?	25.8%
How do the exchanges work? Am I eligible? Are they free? Could I qualify for a subsidy? How does exchange coverage compare with my current coverage?	24.4%
Can my child stay on the plan longer?	19.2%
Are we dropping spousal/dependent coverage?	13.5%
Will I have an average of 30 hours per week and qualify for benefits in 2015?	10.5%
How does the law impact the future of the organization?	9.8%
Do I have to get coverage if I don't have it now? I need to sign up for benefits now, because I will be penalized by ACA—When will there be an open enrollment opportunity?	8.5%
Other	5.0%

*Respondents were asked to select the top three most common ACA questions their employees have been asking.

EXHIBIT 20

Employee Overall Understanding of ACA

	(n = 562)
Very good	3.2%
Good	8.5%
Average	47.5%
Poor	26.0%
Very poor	8.4%
Not sure	6.4%

EXHIBIT 21

Change in Employee Engagement/Interest in Their Health Care due to ACA

	(n = 562)
Increased significantly	4.8%
Increased slightly	34.3%
No change	55.9%
Decreased slightly	0.5%
Decreased significantly	0.4%
Not sure	4.1%

VI. 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 in response to ACA (Exhibit 22). Fifteen percent of organizations have adjusted hours so fewer employees qualify for full-time employee medical insurance. Other broad workforce adjustments remain less common. Five percent or less have reduced their workforce due to ACA costs, frozen or reduced pay raises/compensation, reduced non-health-care-related benefits, added workers to help with compliance or reduced hiring in order to stay under 50 employees.

Respondents were asked whether their organizations increased or planned to increase participant cost sharing to contain costs. More than one-third of organizations now have increased out-of-pocket limits (40.6%), in-network deductibles (36.8%) and/or participants' share of premium costs (34.5%) in response to ACA (Exhibit 23). More than one in five organizations have increased copayments or coinsurance for primary care (27.6%), increased participants' share of prescription drug costs (27.2%) and/or increased employee proportion of dependent coverage cost (23.8%). Among the most common cost-management plans for the next 12 months, an additional 13.4% plan to increase the employee portion of dependent coverage cost, and 10.7% plan to increase copayments or coinsurance for primary care. Exhibit 24 shows the implementation of health care cost-containment measures has increased, compared with each of two previous ACA surveys.

When asked about other plan design/utilization changes spurred by ACA, one in five (20.3%) organizations has adopted or expanded wellness initiatives, and another 16.7% plan to do so in the next 12 months (Exhibit 25). One in six (17.1%) has adopted or expanded wellness incentives because of ACA, and another 14.6% plan to do so in the next 12 months. One in ten organizations (10.3%) has adopted or expanded disease management initiatives, and smaller proportions have added or expanded the use of low-cost "skinny plans" (5.9%) and/or dropped spousal coverage (4.6%).

Starting in 2014, employers are 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.[3] An incentive of as much as 50% is permitted to prevent or reduce tobacco use. One in seven organizations (14.6%) has already begun offering the increased incentives, and an additional 29.2% are considering doing so (Exhibit 26).

More than one-quarter of surveyed organizations (27.8%) have conducted dependent eligibility audits or plan to do so in the next 12 months as a result of ACA (Exhibit 27). Another 26% have conducted or plan to conduct claims utilization, while 18.6% have conducted or plan to conduct health care claims audits.

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 four years—moving from 44.6% in 2011 down to 16.9% in 2015 (Exhibit 28). Because they are able to make only limited health plan

3. Prior to 2014, the allowed incentive level was 20%.

changes, employers can find it challenging to maintain grandfathered status.[4] More than one in five employers with a grandfathered plan (22.1%) anticipate their plan will lose this status in 2016 or sooner (Exhibit 29).[5]

The Treasury Department and Internal Revenue Service (IRS) have published rules implementing 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 30). Nearly all surveyed organizations (96.8%) currently meet the minimum value requirement, and 92.9% meet the affordability requirement. More than nine in ten organizations (92%) meet both test requirements. (Most others said they were not sure, as opposed to confirming they were not meeting the requirements.)

As shown in Exhibit 31, ACA has not prompted plan funding changes for a large majority of responding employers (89.5%). Some employers that use 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.[6] A small portion of organizations (8.4%) has added stop-loss insurance because of ACA.

Starting in 2018, ACA 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 still a few years away, Exhibit 32 shows that 34% of responding organizations have already started working to redesign their primary health plan to avoid triggering the tax. Since 2011, a steadily increasing percentage of organizations has taken action to avoid triggering the excise tax—a trend likely to continue. Larger organizations are more likely than smaller organizations to have started working to redesign their health plan to avoid triggering the tax (Exhibit 33). Smaller organizations are more likely to say changes are not necessary because they do not have a high-cost plan. Exhibit 34 shows that just over half of organizations are on pace to trigger the tax—20.8% are currently working on changes, 28.3% plan to act sometime prior to 2018 and 2.5% plan to pay the tax in 2018. More than one in ten organizations (13.2%) already have adopted changes to prevent them from triggering the tax. Fewer than one-quarter said changes were not necessary because they have no high-cost plans (23.1%).

Exhibit 35 shows the most common action being taken or planned to avoid triggering the excise tax is moving to a CDHP (52.9%). Other common actions being taken or planned to avoid the tax include: reducing benefits (36.9%), shifting costs to employees (35.7%), dropping higher cost plans (31.4%) and adopting wellness initiatives (28.3%).

Among all responding organizations, more than one-quarter (27.1%) have increased emphasis on or added an HDHP with an HSA because of ACA, and an additional 14.4% are assessing the feasibility of adding this option (Exhibit 36). Lower proportions report they are increasing emphasis on or assessing the feasibility of adding an HDHP with a health reimbursement arrangement (HRA) (13.3%) or an HDHP with no account (10.5%). Larger organizations are generally more likely to be increasing their emphasis on HDHPs compared with smaller organizations (Exhibit 37). Exhibit 38 reveals nearly one in ten organizations (8.5%) has adopted a full-replacement HDHP because of ACA and an additional 18.7% are considering doing so.

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4. 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.

5. In 2014, survey respondents said the top advantages of maintaining grandfathered status were the exemption from the requirement to provide preventive care coverage with no cost sharing or annual limits and the exemption from implementing the appeals process.

6. 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.

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 22

Workforce Adjustments due to ACA*

	(n = 562)
Reduction in hiring to get/stay under the 50-employee ACA threshold for small employers	
Have done	1.1%
Plan on doing in the next 12 months	0.2%
Adjusting hours so fewer employees qualify for full-time employee medical insurance requirement	
Have done	15.0%
Plan on doing in the next 12 months	4.3%
Adding workers to help keep compliant with ACA	
Have done	4.8%
Plan on doing in the next 12 months	3.6%
Reduction in workers due to costs directly associated with ACA	
Have done	4.3%
Plan on doing in the next 12 months	1.8%
Froze or reduced pay raises/compensation	
Have done	5.0%
Plan on doing in the next 12 months	2.0%
Reduced non-health-care-related benefit offerings	
Have done	3.4%
Plan on doing in the next 12 months	3.0%

*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 23

Cost-Containment Measures due to ACA*

	(n = 562)
Increase out-of-pocket limits	
Have used	40.6%
Plan on using in the next 12 months	8.0%
Increase in-network deductibles	
Have used	36.8%
Plan on using in the next 12 months	9.8%
Increase participants' share of premium costs	
Have used	34.5%
Plan on using in the next 12 months	9.8%
Increase copayments or coinsurance for primary care	
Have used	27.6%
Plan on using in the next 12 months	10.7%
Increase participants' share of prescription drug costs	
Have used	27.2%
Plan on using in the next 12 months	8.9%
Increase employee proportion of dependent coverage cost	
Have used	23.8%
Plan on using in the next 12 months	13.4%
Modify/add tiers to cost-sharing structure	
Have used	15.3%
Plan on using in the next 12 months	9.1%
Increase voluntary (employee-pay-all) benefit offerings	
Have used	10.1%
Plan on using in the next 12 months	7.3%
Structure premiums based on income	
Have used	8.0%
Plan on using in the next 12 months	4.5%

*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 24

Cost-Containment Measures Taken due to ACA by Year*

	2013 (n = 879)	2014 (n = 624)	2015 (n = 562)
Increase out-of-pocket limits	13.8%	32.4%	40.6%
Increase in-network deductibles	14.9%	29.6%	36.8%
Increase participants' share of premium costs	18.0%	30.3%	34.5%
Increase copayments or coinsurance for primary care	12.7%	23.6%	27.6%
Increase participants' share of prescription drug costs	11.7%	18.9%	27.2%
Increase employee proportion of dependent coverage cost	10.4%	20.4%	23.8%
Modify/add tiers to cost-sharing structure	6.9%	10.9%	15.3%
Increase voluntary (employee-pay-all) benefit offerings	4.3%	8.0%	10.1%
Structure premiums based on income	2.6%	3.4%	8.0%

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

EXHIBIT 25

Changes in Plan Design/Utilization due to ACA*

	(n = 562)
Adopt/expand wellness initiatives	
Have done	20.3%
Plan on doing in next 12 months	16.7%
Adopt/expand the use of financial incentives to encourage healthy behaviors	
Have done	17.1%
Plan on doing in next 12 months	14.6%
Adopt/expand disease management	
Have done	10.3%
Plan on doing in next 12 months	10.7%
Add/expand use of low-cost "skinny plans" that do not meet the ACA definition of "minimum value"	
Have done	5.9%
Plan on doing in next 12 months	3.4%
Drop spousal coverage	
Have done	4.6%
Plan on doing in next 12 months	3.9%

*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 26

Offering Increased Wellness Incentives*

	(n = 562)
Yes	14.6%
No, but considering	29.2%
No	53.9%
Not sure	2.3%

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

EXHIBIT 27

Audits/Analysis Conducted due to ACA*

	(n = 562)
Health care claims utilization analysis	
Conducted	15.3%
Plan on conducting in the next 12 months	10.7%
Dependent eligibility audits	
Conducted	15.0%
Plan on conducting in the next 12 months	12.8%
Health care claims audits	
Conducted	8.5%
Plan on conducting in the next 12 months	10.1%

*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 28

Portion of Plans With Grandfathered Status by Year

2011 (n = 1,134)	44.6%
2012 (n = 927)	34.3%
2013 (n = 879)	27.3%
2014 (n = 624)	17.8%
2015 (n = 562)	16.9%

EXHIBIT 29

Outlook for Maintaining Grandfathered Status

	(n = 95)
Will lose in 2015	6.3%
Will lose in 2016	15.8%
Do not expect to lose grandfathered status in the next two years	53.7%
Not sure	24.2%

EXHIBIT 30

Currently Meeting ACA Test Requirements

	(n = 562)
Minimum value requirement (health plan pays at least 60% of allowed costs)	
Yes	96.8%
No	0.2%
Not sure	3.0%
9.5% affordability test requirement	
Yes	92.9%
No	2.3%
Not sure	4.8%
Percentage meeting both test requirements	92.0%

EXHIBIT 31

Change in Funding Approach*

	(n = 562)
No changes to plan funding approach	89.5%
Have become fully insured	1.6%
Have become completely self-funded with stop-loss coverage	4.5%
Have become completely self-funded without stop-loss coverage	0.2%
Already self-funded, but now purchased stop-loss coverage	1.6%
Already self-funded, but now purchased additional stop-loss coverage	2.3%
Already self-funded, but dropped stop-loss coverage	0.4%

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

EXHIBIT 32

Taking Action to Avoid 2018 Excise Tax by Year*

2011 (n = 1,134)	10.5%
2012 (n = 927)	13.9%
2013 (n = 879)	16.8%
2014 (n = 624)	24.5%
2015 (n = 562)	34.0%

*The total combines the group that is currently taking action with those that have already taken action.

EXHIBIT 33

Taking Action to Avoid 2018 Excise Tax by Employer Size

	(n = 562)
0-50	15.4%
51-499	35.0%
500-4,999	36.6%
5,000-9,999	36.9%
10,000+	38.7%

EXHIBIT 34

Organization Currently on Pace to Trigger 2018 Excise Tax

	(n = 562)
Yes, and we don't plan to make changes to avoid the tax (i.e., we plan to pay)	2.5%
Yes, but we are currently working on changes to avoid the tax	20.8%
Yes, but we plan to take action to avoid the tax sometime prior to 2018	28.3%
No, because we have already taken action to avoid the tax	13.2%
No, changes are not necessary to avoid the tax (i.e., have no high-cost plans)	23.1%
Not sure	12.1%

EXHIBIT 35

Specific Actions Taken to Avoid 2018 Excise Tax*

	(n = 350)
Moved to a CDHP (e.g., high-deductible plan)	52.9%
Reduced benefits	36.9%
Shifted costs to employees	35.7%
Dropped higher cost plan options	31.4%
Adopted wellness and preventive initiatives	28.3%
Added wellness incentives	23.7%
Added more affordable plan options	20.6%
Moved to a private exchange	3.1%
Other	2.0%
Not sure	14.9%

*Only respondents who indicated they are currently working on, plan on taking action or have taken action to avoid the 2018 excise tax were asked this question.

EXHIBIT 36

ACA's Impact on HDHPs*

	(n = 562)
HDHP with HSA	
Increasing emphasis/adding	27.1%
Assessing feasibility of adding	14.4%
Assessing feasibility of dropping	1.4%
Decreasing emphasis/dropping	0.5%
HDHP with HRA	
Increasing emphasis/adding	7.1%
Assessing feasibility of adding	6.2%
Assessing feasibility of dropping	0.7%
Decreasing emphasis/dropping	2.0%
HDHP with no account	
Increasing emphasis/adding	3.8%
Assessing feasibility of adding	6.7%
Assessing feasibility of dropping	0.3%
Decreasing emphasis/dropping	0.6%

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

EXHIBIT 37

Increasing Emphasis on HDHPs by Employer Size*

(n = 562)	0-50	51-499	500-4,999	5,000-9,999	10,000+	Total
HDHP with HSA	11.5%	21.2%	29.3%	35.4%	34.2%	27.1%
HDHP with HRA	5.8%	8.8%	3.9%	10.8%	11.8%	14.4%
HDHP with no account	3.9%	1.5%	5.2%	6.2%	6.6%	3.8%

*Responses represent organizations that are increasing emphasis on or adding HDHPs specifically due to ACA.

EXHIBIT 38

Adopted a Full-Replacement HDHP

	(n = 562)
Yes, due to ACA	8.5%
Yes, but not due to ACA	16.6%
No, but considering	18.7%
No	56.2%

VII. Cost Impact

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. Two-thirds of employers (67.3%) have conducted an ACA cost analysis for 2015 (Exhibit 39). Larger employers are more likely to have conducted an analysis.

Exhibit 40 examines the costs of a specific group of respondents who said they knew their exact cost change due to ACA in 2015 and does not include respondents who estimated cost changes. Among this group, cost changes ranged from an increase of 30% to an overall decrease in costs resulting from ACA in 2015. The average cost increase among this group is 5.1%, and the median cost increase is 3%.

Exhibit 41 displays costs for all responding organizations—including respondents who estimated costs. Most organizations (82%) expect the law will increase their health care costs this year. About one in four (23.4%) estimates a cost increase of 1% to 2%. A similar proportion (22.6%) predicts an increase of 3% to 4%. Fewer than one in ten organizations (8%) estimate a cost increase greater than 10%. Costs associated with ACA appear to be hitting smaller employers much harder than larger ones—More than one-quarter of employers with 50 or fewer employees estimate a cost increase greater than 10%. Estimates of cost increases associated with ACA rose from 2012 to 2013, remained fairly consistent from 2013 to 2014 and declined slightly from 2014 to 2015 (Exhibit 42).

Respondents were asked to share their organization's experience with ACA-related health care cost changes for 2015. Several respondents mentioned the tangible cost burden associated with the different ACA fees and preventive coverage requirements, but some mentioned starting to accept these as part of the costs of doing business. Many more organizations this year seemed very concerned with tracking, reporting, disclosure, communication, payroll and administrative burdens.

Respondents identified general ACA administrative costs (55.7%) and reporting, disclosure and notification costs (37.5%) as the top ACA cost drivers for 2015 (Exhibit 43). When asked which future provisions would increase costs the most, respondents said the top three were costs associated with the excise tax on high-cost group health plans (19.8%), general ACA administrative costs (19.2%) and reporting, disclosure and notification costs (13.4%) (Exhibit 44).

Exhibit 45 reveals that one-third of employers (32.9%) expect 2016 to be the year that will produce the greatest cost increases due to ACA. About one-quarter (26.5%) expects 2018—the year of the Cadillac tax—to be the year producing the greatest cost increases resulting from ACA. One in six (16.2%) expects costs to increase the most this year (2015). Only 12.8% believe the year with the greatest ACA cost increases is in the past.

EXHIBIT 39

Conducted Analysis of ACA Costs by Employer Size (Yes Responses)*

	(n = 562)
0-50	42.3%
51-499	59.1%
500-4,999	70.7%
5,000-9,999	73.9%
10,000+	82.9%
Total	67.3%

*Other response options included: made no changes, were unsure or the question was not applicable.

EXHIBIT 40

Cost Impact due to ACA*

(n = 173)	Average	Median	Range
ACA cost impact	5.1%	3%	Decreased costs to increased 30%

*Respondents were asked about 2015 costs directly associated with ACA. Only organizations that knew their exact cost change were included in this table.

EXHIBIT 41

Cost Impact due to ACA in 2015 by Employer Size*

(n = 499)	0-50	51-499	500-4,999	5,000-9,999	10,000+	Total
Will decrease costs	2.2%	3.3%	0.5%	0.0%	1.6%	1.4%
No change	17.4%	13.9%	17.5%	21.4%	12.7%	16.4%
Increase costs 1-2%	2.2%	21.3%	25.9%	30.4%	28.6%	23.4%
Increase costs 3-4%	13.0%	21.3%	24.5%	23.2%	25.4%	22.6%
Increase costs 5-6%	19.6%	13.9%	17.9%	10.7%	15.9%	16.0%
Increase costs 7-10%	19.6%	13.9%	9.9%	10.7%	11.1%	12.0%
Increase costs more than 10%	26.1%	12.3%	3.8%	3.6%	4.8%	8.0%

*Respondents were asked about 2015 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 42

Cost Impact due to ACA by Year*

	2012 (n = 761)	2013 (n = 715)	2014 (n = 570)	2015 (n = 499)
Will decrease costs	1.6%	0.7%	1.4%	1.4%
No change	13.7%	11.0%	10.4%	16.4%
Increase costs 1-2%	31.1%	24.6%	24.7%	23.4%
Increase costs 3-4%	24.2%	22.8%	22.3%	22.6%
Increase costs 5-6%	11.8%	14.0%	15.4%	16.0%
Increase costs 7-10%	9.2%	10.1%	11.4%	12.0%
Increase costs more than 10%	8.4%	16.8%	14.4%	8.0%

*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 43

Provision With Most Significant Cost Increases for 2015*

	(n = 562)
General ACA administrative costs	55.7%
New costs associated with reporting, disclosure and notification requirements (i.e., beyond previous years' costs)	37.5%
Increased Patient-Centered Outcomes Research Institute (PCORI) fees	32.9%
Costs associated with plan design changes related to ACA (including a plan redesign to avoid the 2018 excise "Cadillac" tax)	20.1%
Health insurance provider fees	18.2%
Costs associated with increased need for communication and resources spent interacting with participants regarding ACA	16.6%
Costs of now providing health insurance to individuals who previously were not offered coverage in order to comply with 2015/16 coverage requirement	13.7%
Costs of adjusting benefits to keep up with affordability requirement	12.3%
New costs associated with the age of 26 coverage requirement (i.e., new adult children have been added to the plan in 2013)	10.0%
Ongoing costs associated with no cost sharing for preventive care provision (i.e., beyond previous years' costs)	7.8%
Costs of adjusting benefits to keep up with minimum value requirement	7.5%
Up-front costs associated with adoption of new wellness and preventive care initiatives/incentives due to ACA	6.6%
Costs associated with a loss of grandfathered status triggering new ACA requirements	6.4%
Eligibility or claims auditing/analysis costs due to ACA	6.4%
Costs associated with changing funding approach due to ACA (e.g., becoming self-funded or purchasing stop-loss insurance)	2.5%
Costs of penalty for not providing "minimum essential" health coverage to full-time employees and dependents (i.e., $2,000 penalty)	1.4%
Costs associated with eliminating all preexisting condition exclusions for all enrollees	1.1%
Other	3.2%

*Respondents were asked to select the top three cost drivers.

EXHIBIT 44

Forthcoming Provision With Most Significant Cost Increases*

	(n = 562)
Costs associated with the excise tax on high-cost group health plans (aka "Cadillac tax")	19.8%
General ACA administrative costs	19.2%
Costs associated with reporting, disclosure and notification requirements	13.4%
Costs associated with plan design changes related to ACA	5.7%
Costs of adjusting benefits to keep up with affordability requirement	5.3%
PCORI fees	4.3%
Health insurance provider fees	4.1%
Costs of now providing health insurance to individuals who previously were not offered coverage in order to comply with 2015/16 coverage requirement	4.1%
Costs associated with a loss of grandfathered status triggering new ACA requirements	3.9%
Costs of adjusting benefits to keep up with minimum value requirement	3.4%
Costs associated with requirement to autoenroll new hires into a health plan	2.9%
Costs associated with increased need for communication and resources spent interacting with participants regarding ACA	2.5%
Costs associated with changing funding approach due to ACA (e.g., becoming self-funded or purchasing stop-loss insurance)	1.8%
New costs associated with the age of 26 coverage requirement (i.e., new adult children will be added to the plan in 2015 or beyond)	1.6%
Up-front costs associated with adoption of new wellness and preventive care initiatives/incentives due to ACA	1.4%
Ongoing costs associated with no cost sharing for preventive care provision	1.3%
Ongoing costs associated with eliminating all preexisting condition exclusions for all enrollees	1.1%
Costs of penalty for not providing affordable or minimum value coverage to full-time employees and dependents (i.e., $3,000 penalty)	1.1%
Eligibility or claims auditing/analysis costs due to ACA	0.7%
Costs of penalty for not providing "minimum essential" health care coverage to full-time employees and dependents (i.e., $2,000 penalty)	0.2%
Other	2.5%

*Respondents were allowed to select only one top future cost driver.

EXHIBIT 45

Year of Largest Expected Cost Increases

	(n = 562)
2014 or prior	12.8%
This year (2015)	16.2%
Next year (2016)	32.9%
2017	11.6%
2018	26.5%

VIII. Demographics

Individuals invited to participate in the 2015 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 598 individuals, including benefits and human resources professionals, general and financial managers and other professionals. Exhibits 46 through 49 present demographic characteristics of the respondents' organizations. Surveyed organizations were asked in which type of medical plan the majority of their participants are enrolled (Exhibit 46). More than half (52.5%) state most of their employees are enrolled in a preferred provider organization (PPO). More than one in four (27.5%) use some sort of HDHP as their primary medical plan—Less than 1% use an HDHP with no account, while 26.8% use an HDHP with an HSA or HRA.[9]

Exhibit 47 shows that organizations from all regions of the country were represented in the survey: Midwest (29.9%), Northeast/Mid-Atlantic (26.4%), South (24.7%) and West (18.9%). Surveyed organizations are dispersed across all employer-size categories (Exhibit 48). Most common were those with between 500-4,999 benefits-eligible employees (41.5%), followed by those with 51-499 employees (23.8%). As shown in Exhibit 49, a wide range of industries is represented by the responding organizations. Most frequent are those from insurance and related fields (16.4%), manufacturing and distribution (14.6%) and professional services (10.9%).

9. 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 46

Plan With Majority Enrolled

	(n = 598)
Do not offer coverage	1.3%
Traditional indemnity/fee-for-service plan	0.7%
Preferred provider organization (PPO)	52.5%
Health maintenance organization (HMO)	8.9%
HDHP with HSA	20.4%
HDHP with HRA	6.4%
HDHP without account	0.7%
Point-of-service plan (POS)	6.4%
Exclusive provider organization (EPO)	3.0%

EXHIBIT 47

Region*

	(n = 598)
Midwest	29.9%
Northeast/Mid-Atlantic	26.4%
South	24.7%
West	18.9%

*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 48

Number of Eligible Employees

	(n = 598)
0-50	10.5%
51-499	23.8%
500-4,999	41.5%
5,000-9,999	11.0%
10,000 or more	13.2%

EXHIBIT 49

Primary Industry	(n = 598)
Accommodation/food service	1.7%
Agriculture	0.3%
Arts/entertainment/recreation	1.0%
Banking/finance	4.2%
Communication/telecommunications	1.8%
Construction	2.7%
Education	5.7%
Energy/utilities/mining	4.9%
Health care/medicine	9.4%
High technology	5.0%
Insurance-related	16.4%
Manufacturing/distribution	14.6%
Nonprofit	10.0%
Professional services	10.9%
Real estate-related	1.3%
Retail/wholesale trade	6.2%
Transportation	1.5%
Other services	1.8%
Multiple industries	1.3%

2015 Employer-Sponsored Health Care: ACA's Impact is the sixth 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.