

EMPLOYER-SPONSORED HEALTH INSURANCE: RECENT TRENDS AND FUTURE DIRECTIONS

NIHCM FOUNDATION DATA BRIEF

OCTOBER 2013



KEY POINTS FROM THIS BRIEF:

- Employer-sponsored health insurance (ESI) continues to be the bedrock of coverage in the United States, but long-term trends reflect a steady decline in offer rates among smaller employers, lower enrollment rates among workers offered insurance, and a move away from coverage for dependents. As a result, the number and proportion of non-elderly people receiving insurance through an employer has trended downward for at least the past decade. [Page 2](#)
- These changes have occurred as escalating medical costs push health insurance premiums ever higher. By 2012, health insurance expenses amounted to nearly 8 percent of the overall private-sector payroll and were nearly 12 percent for public-sector employers. [Page 4](#)
- In the face of these rising costs, employers and health insurers have already been taking numerous steps to curtail spending growth. These initiatives include requiring greater cost sharing from plan enrollees, restricting eligibility for spouses, modifying benefit designs and making more wholesale changes to the types of plans offered, adding wellness and health management programs, and strengthening incentives for enrollees and providers to seek and deliver high value care. [Page 13](#)
- Against this backdrop, the ACA introduces sweeping changes to the U.S. health insurance system. [Page 5](#) While smaller firms and those with predominantly low-wage workforces may have less incentive to offer or retain coverage, any coverage losses will be modest because fewer workers in these firms currently have health benefits. Large employers, who provide most ESI currently, appear poised to stay in the game even with the one-year delay in the employer mandate but will continue changing the benefits they offer. [Page 9](#)
- It is all but certain that employers will continue to shift a greater portion of health benefit costs to employees and tighten eligibility rules for dependents. Increasing reliance on high-deductible health plans with savings options (HSAs and HRAs) within the ESI market also appears quite likely. [Page 13](#)
- Private exchanges are emerging very quickly as new insurance distribution channels and employers express high interest in moving to these markets in the next few years, most often providing a defined contribution that employees can use to purchase coverage of their choice on the private exchange. Some experts predict that private exchanges will soon be the dominant distribution channel for employer-provided coverage despite the availability of the public SHOP exchanges. [Page 16](#)

- Wellness and health management programs are widespread and growing in sophistication, with employers increasingly relying on financial rewards that require progress toward specific biometric goals. ACA provisions that permit even larger incentives have the potential to affect both the structure and cost of health benefits for millions of U.S. workers. [Page 17](#)
- Other strategies already being adopted by employers and insurers seeking to promote value in health care spending include high performance networks and centers of excellence, differential cost-sharing based on the value represented by the provider or the service, reference pricing, and improved transparency around cost and quality. Significant movement along these lines is expected to continue in the future. [Page 19](#)
- The ESI world is far from settled. The evolution of ongoing market trends and the impact of the new changes brought by the ACA both may be affected by larger environmental factors. Critical among these factors are trends toward self-insurance by smaller employers, the long-term viability of the public exchanges, state decisions about Medicaid expansion, legal challenges to the payment of subsidies on certain public exchanges and possible changes to the tax treatment of ESI premiums. [Page 20](#)

Employer-sponsored health insurance (ESI) remains the dominant feature of the U.S. health insurance landscape despite a long-term decline in the number of Americans with this form of coverage. In 2011 nearly nine in ten privately insured Americans under age 65 received their coverage from an employer.¹

In many ways, the Patient Protection and Affordable Care Act (ACA) seeks to build upon this foundation, with new marketplaces and tax credits to help the smallest employers and new penalties intended to compel larger employers to provide health benefits. Detractors of the ACA claim, however, that the law will spell the demise of employer-based coverage. In fact, the law contains numerous provisions that could work in either direction, and its overall impact on ESI is very hard to predict.

As full-scale implementation of the ACA gets underway in 2014 and its impacts are evaluated, it will be important to understand how the ESI market was already evolving in recent years in response to continually rising costs. In this brief, we examine these recent developments and consider what types of changes we are likely to see in the future, both as continuation of ongoing trends and as a result of ACA implementation.

ESI SNAPSHOT: RECENT TRENDS AND CURRENT STATUS

Overall Trends in Offer Rates, Take-Up and Coverage

Between 2000 and 2011, the portion of the U.S. non-elderly population having health insurance through an employer declined from 69.3 to 58.4 percent — representing a drop of more than 14 million in the number of people with such coverage.¹ This decline reflects the combined impact of several factors. To begin, fewer workers now have access to employer-sponsored coverage: between 2000 and 2012, the percent of private-sector businesses offering health insurance fell from 59.3 to 50.1 percent, and the percent of private-sector employees working in such establishments fell from 89.4 to 84.7 percent (Table 1). Second, although the percent of workers eligible for coverage in firms offering health insurance largely held steady at around 78 percent, take-up rates among eligible employees fell significantly — from 81.2 percent to 75.8 percent — as an increasing share of eligible employees decided not to enroll. The lower take-up rates translated into a decline from 64.1 to 58.9 in the percent of workers who enrolled in one of the health insurance choices available through their employers. At the same time there was a five percentage-point increase in the proportion of insured workers who opted for an individual, rather than a family, policy. This latter shift also works in the direction of reducing the

TABLE 1. CHANGES IN FACTORS AFFECTING EMPLOYMENT-RELATED HEALTH INSURANCE, 2000 TO 2012

	2000	2001	2002	2003	2004	2005	2006	2008	2009	2010	2011	2012
PRIVATE-SECTOR												
Number of private-sector employees (millions)	112.0	114.5	111.4	110.9	112.1	112.2	114.7	116.1	110.5	108.4	108.2	111.1
Percent of private-sector establishments offering health insurance	59.3	58.3	57.2	56.2	55.1	56.3	55.8	56.4	55.0	53.8	51.0	50.1*
Percent of employees working in establishments offering health insurance	89.4	88.8	88.3	86.8	86.7	86.9	86.9	87.7	87.6	86.5	85.3	84.7*
Percent of workers in establishments offering insurance who are eligible for coverage	78.9	77.9	77.1	78.5	78.4	78.5	77.5	78.1	79.5	78.2	78.0	77.8*
Percent of eligible workers who are enrolled (take-up rate)	81.2	79.8	81.0	80.3	79.8	79.6	78.3	78.7	76.9	76.5	76.1	75.8*
Percent of workers in establishments offering coverage who are enrolled	64.1	62.2	62.4	63.0	62.6	62.5	60.7	61.4	61.1	59.8	59.4	58.9*
Percent of enrolled workers opting for single coverage	46.2	46.3	47.7	47.3	47.3	48.6	48.9	50.2	50.0	51.3	50.2	51.3*
PUBLIC-SECTOR												
Number of state/local government employees (millions)	18.0	18.3	18.3	18.7	18.8	19.1	19.4	19.6	19.6	19.6	19.4*	NA
Percent of employees enrolled in private health insurance	65.1	68.3	65.5	66.2	66.0	66.8	65.5	65.8	65.4	67.0	66.3*	NA

Source: NIHCM Foundation analysis of data from the Medical Expenditure Panel Survey, Insurance Component, using the MEPSnet Query Tool available at http://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp. Data for 2007 are not available.

* indicates that the change over the observation period is statistically significant with 95 percent confidence. NA=not available.

number of people with employer-based coverage as fewer family members are obtaining coverage through the worker/primary policyholder.ⁱ Recent research indicates that the drop in dependent coverage has been much more pronounced for part-time workers and may be attributable to the larger declines in marriage rates for part-time vs. full-time workers.²

In contrast to the situation for private-sector workers, employment-based coverage among state and local government workers experienced a slight upswing between 2000 and 2011, with modest but statistically significant increases in employment levels and in the proportion of employees enrolled in private health insurance (statistics for federal workers and for 2012 are

not available). These changes are not large enough, however, to fully offset the insurance declines observed in the private sector. In addition, because the government workforce can often be adjusted only with some administrative delay, recession-driven reductions in state and local government employment (from the peak of 19.6 million workers during the 2008-2010 period) have continued past 2011, even as the economy has begun to

ⁱ While some of these spouses and dependents might obtain employer-based coverage through their own employment or another family member, the decline in the number of private-sector employers offering coverage would, in general, make this option less available. Additionally, there was a net decline in the number of private-sector workers over the period, arguing against an expansion in the number of people who were able to access health insurance through their own jobs rather than being included on another worker's family policy.

recover.³ These ongoing job losses are almost certainly associated with a loss of employer-provided health insurance among public-sector workers that is not captured in the timeframe shown in Table 1.

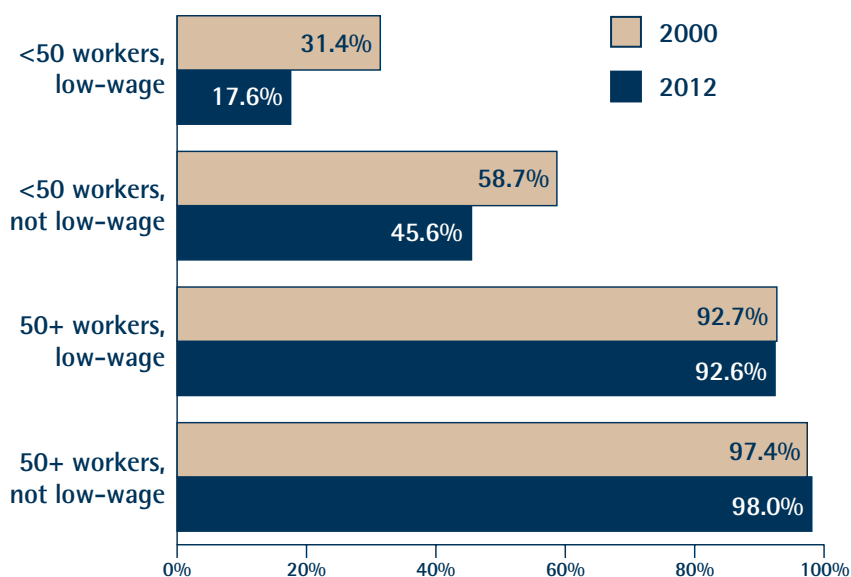
Health Coverage by Characteristics of the Employer

When private-sector businesses offer their workers health insurance, eligibility and take-up rates are very similar for small firms (fewer than 50 workers) and larger employers. As a result, coverage rates are also very similar among workers in firms offering coverage: 57.7 percent of workers enroll in small firms that offer coverage compared to 59.2 of workers in larger firms.⁴

There are, however, dramatic differences in health insurance offer rates by the size of the firm and by the composition of its workforce, and these differences have been growing more dramatic in the past decade (Figure 1). Only 31 percent of small firms with predominantly low-wage employees offered health insurance to their workers in 2000, and this figure had fallen to less than 18 percent by 2012. A similar decline occurred for small firms with higher-paid workforces, although the offer rates still exceed those seen in small low-wage firms. In contrast, offer rates among larger employers remained consistently very high throughout the period, with only small disadvantages seen for workers in predominantly low-wage large firms.

The much lower offer rates from small employers, combined with the concentration of the workforce among larger employers, mean that the vast majority of adults with employer-sponsored health insurance derive that coverage from a large employer (Figure 2). In 2011, one quarter of the 75 million non-elderly private sector workers with ESI was insured through a small employer (fewer than 50 workers), whereas just over half received their coverage from a very large firm

FIGURE 1. HEALTH INSURANCE OFFER RATES BY FIRM SIZE AND WAGES OF WORKERS, 2000 AND 2012



NIHCM Foundation analysis of data from the Medical Expenditure Panel Survey, Insurance Component.

(more than 500 workers). Thus, for the vast majority of workers now receiving employer-sponsored coverage, the ACA's impact on their coverage will depend on how larger employers react to the law's provisions.

The Impact of the Rising Cost of Medical Care and Health Insurance

The declining offer and enrollment rates described above have occurred as escalating medical costs have driven premiums for health insurance coverage ever higher. By 2013, the average yearly premium for coverage obtained through an employer had reached nearly \$5,900 for an employee-only policy and more than \$16,300 for family coverage.^{5,6} With employees' costs for medical coverage growing much more quickly than general inflation, hourly earnings and family income, some workers are inevitably priced out of coverage.

Health insurance costs also represent a meaningful and growing portion of employers' total labor costs (Figure 3). In 2012, private-sector employers were paying an average of \$2.23 per hour worked to purchase health insurance for their workers,

representing 7.7 percent of their total payroll expenses. These figures would be higher if calculated only for those firms actually providing health benefits. Health benefit costs incurred by state and local governments were approaching \$5.00 for each employee hour worked, or nearly 12 percent of payroll.

These rising costs not only reduce what the employer could otherwise pay workers in cash compensation, but have also been prompting employers to make a range of changes to their health benefits, including requiring greater employee cost sharing, modifying the types of plans offered, restricting eligibility for benefits, restructuring workforces, and adopting new incentives and programs to promote employee wellness and encourage value-seeking purchasing of medical services. Some (principally smaller) employers have also responded by dropping coverage altogether (see Figure 1).

These changes have been underway for a number of years, and it is against this backdrop that one must evaluate the impact of changes that may accompany full implementation of the Affordable Care Act. In the

sections that follow we enumerate the various provisions of the ACA expected to have a direct or indirect impact on employer-sponsored health insurance, describe ongoing developments in the employer-sponsored market and consider how the market is likely to continue evolving as the central provisions of the ACA come on line in 2014 and beyond.

ACA PROVISIONS AFFECTING EMPLOYER-SPONSORED HEALTH INSURANCE

SHOP Exchanges, Premium Tax Credits and the Large Employer Mandate

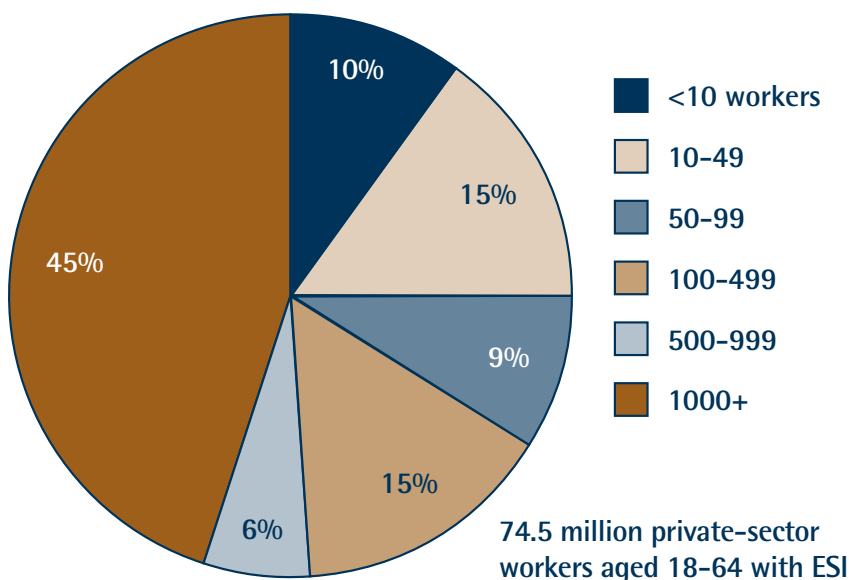
The ACA provisions most directly affecting ESI are the new Small Business Health Options Program (SHOP) exchanges, the small business premium tax credits and the large employer mandate. These provisions apply to employers differentially depending on the size of their workforce.

SHOP Exchanges. The SHOP exchanges are intended to be a centralized marketplace where employers can

easily shop for health insurance. Effective in 2014, all employers with up to 50 employees may access the SHOP exchanges in all states, and states have the option of expanding this access to employers with up to 100 workers. In 2016, the expansion to 100 workers will become mandatory in all states and beginning in 2017 states may permit even larger employers to purchase their coverage through the SHOP exchanges. Unless otherwise restricted by the jurisdiction (as in Vermont and the District of Columbia), employers of all sizes will remain free to purchase coverage outside of the SHOP exchanges.

In May 2013 HHS published final regulations delaying mandatory implementation of the "employee

FIGURE 2. DISTRIBUTION OF NON-ELDERLY PRIVATE-SECTOR WORKERS WITH ESI BY FIRM SIZE, 2011

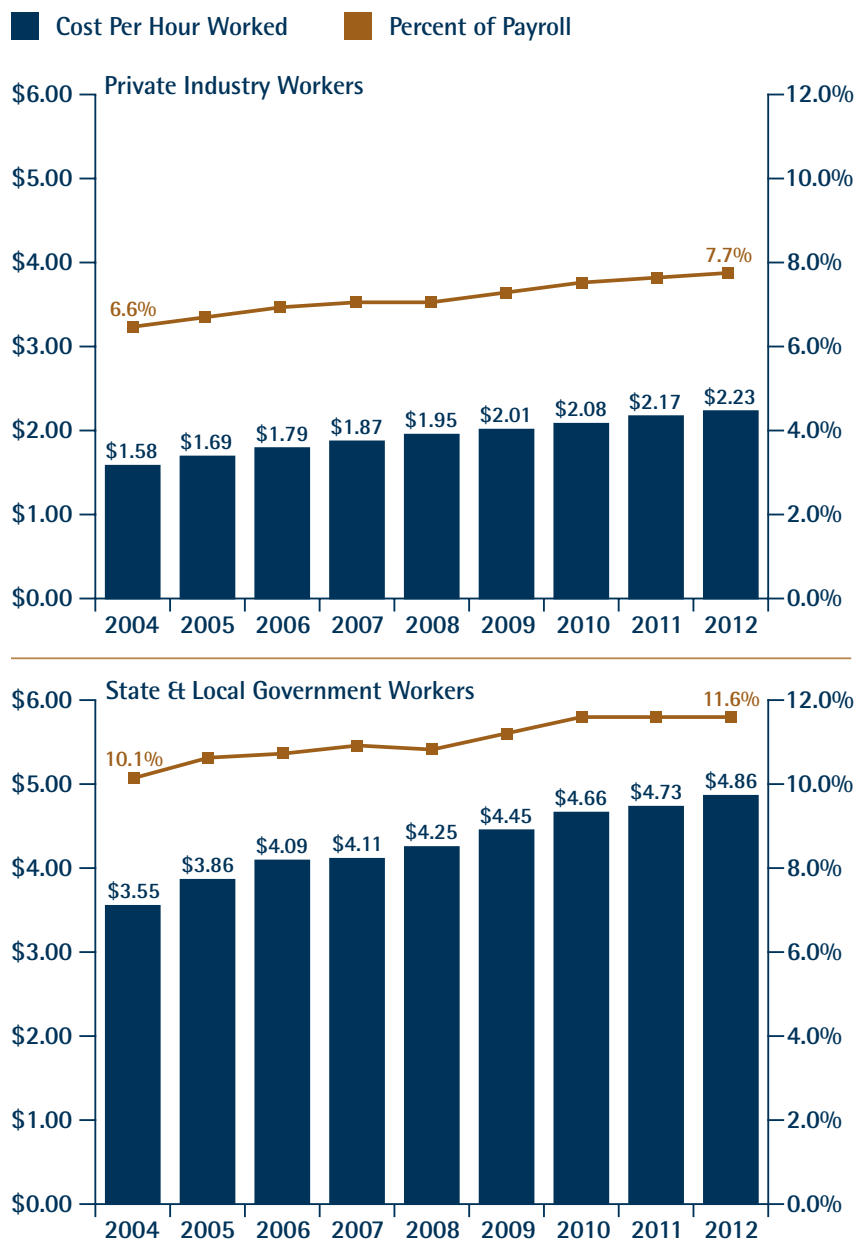


NIHCM Foundation analysis of data presented in Figure 12, Fronstin P. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2012 Current Population Survey." EBRI Issue Brief No. 376, September 2012.

choice" model within SHOP exchanges until 2015. As originally envisioned, SHOP exchanges were to allow employees multiple plan choices, usually within parameters established by their employers such as selecting any qualified health plan (QHP) offered at the actuarial value, or metal, level chosen by the employer.

With the delay, SHOP exchanges are now required only to permit employers to select a single QHP for their employees during the initial year of operation and the federally facilitated SHOP exchanges will use this more limited (employer choice) model. State-based SHOP exchanges remain free to go beyond this minimum standard and current evidence indicates that most state-based exchanges will be implementing a variety of employee choice models in 2014, including models permitting the choice of any plan offered on the exchange.^{7,8}

FIGURE 3. GROWTH IN COST OF HEALTH BENEFITS, 2004-2012



Source: December quarterly data from the Bureau of Labor Statistics, National Compensation Surveys.
<http://www.bls.gov/ncs/ect/#tables>

Premium Tax Credits for Small Employers. The small business premium tax credits offset a portion of an employer's premium expenses and are specifically targeted to help the smaller, low-wage firms that have increasingly struggled to offer health insurance. Employers with fewer than 25 full-time equivalent (FTE) workers and average annual wages under \$50,000 qualify for the credit if they contribute at least half of the premium costs for employees enrolled in qualifying health plans. The full credit is available to firms with up to 10 FTE workers and average wages up to \$25,000 and is phased out as the number of workers approaches 25 FTEs and wages increase to \$50,000. FTE computations are based on a 40-hour workweek. Available since 2010, the credits have enabled small employers to recoup as much as 35 percent of their premium costs, depending on the firm's for-profit/non-profit status and the size and average wages of its workforce. Beginning in 2014, the full credit will increase to a maximum of 50 percent of premium expenses for health plans purchased through the SHOP exchanges, but may be claimed only for two consecutive tax years.

Large Employer Mandate. Employers with 50 or more FTE workers will be required to offer full-time (FT) employees affordable coverage meeting minimum standards or pay a "shared responsibility" penalty if any of their FT employees receive subsidized coverage in an individual exchange. Originally set to take effect in 2014, the mandate now will not be enforced until January 2015. For the purpose of this provision, current regulations define full-time employees as those who work at least 30 hours per week. The annual penalty will be \$2,000 per FT worker (after the first 30 workers) in cases where the employer offers no coverage. If the employer offers coverage but at least one FT employee qualifies for an exchange subsidy because the offered coverage is unaffordable to that employee or fails to provide the minimum required value, the annual penalty will be \$3,000 for each FT worker receiving a subsidy, up to the total penalty that would have applied if the employer offered no coverage.

The employer mandate has generated considerable speculation about how employers are likely to react and the possible ramifications for staffing and hiring decisions. For example, some have posited that small employers currently below the 50-FTE threshold will curtail hiring plans or otherwise rethink their staffing structure in order to remain exempt from the mandate.^{9,10} Others anticipate that larger employers will limit part-time workers to no more than 30 hours per week in order to avoid the mandate and, indeed, there have been numerous reports of public and private-sector employers considering moves in this direction.^{11,12} It is an open question whether these projections will become reality as ACA implementation proceeds and employers anticipate and respond to the mandate. A recent bipartisan bill introduced in the Senate would adopt a 40-hour threshold for defining full-time work¹³ and could gain traction if the practice of limiting part-time workers to less than 30 hours becomes widespread.

Beyond these obvious changes to the ESI landscape, the ACA contains myriad other provisions that will affect employer-sponsored coverage. As a package, the provisions translate into much improved access to insurance, a richer set of benefits and important new consumer protections, but they also bring the possibility of higher insurance prices for many employers and individuals.

Health Plan Taxes and Fees

One source of upward pressure on premiums will come from the new health insurance industry fees and taxes levied in the ACA, which will generally be passed on to purchasers of health insurance (Table 2). The most important of these is the tax that health insurers must begin paying in 2014 on certain net written premiums above \$25 million. Proceeds from this tax will be used to pay for premium subsidies in the individual exchanges. Set to raise \$8 billion in 2014, the tax will increase each year so as to generate \$14.3 billion in 2018 and will be indexed to the growth in premium costs thereafter. The Joint Committee on Taxation (JCT) has estimated that this tax will increase average premiums for affected plans by 2 to 2.5 percent, translating to a hike of \$350 to \$400 in average premiums for a family plan in 2016.¹⁴ Because self-insured health plans (used predominantly by larger employers) are exempt from this tax, it is the smaller employers with fully insured health plans that will feel its burden disproportionately. If midsize and increasingly smaller employers begin to self-insure (as discussed in greater detail below), the burden on remaining fully insured plans will increase since the tax is set to raise a specific revenue amount each year. For employers with fewer than 50 FTE workers, who face no penalty if they do not offer health benefits, these cost pressures may increase the likelihood that they stop providing coverage.¹⁵ The U.S. House of Representatives has advanced a bipartisan bill to repeal this tax, but further action on this front is uncertain given the need to find a large revenue replacement and the strong aversion in both parties to entertaining legislative fixes to the health reform law.¹⁶

Another important assessment on health plans will support the transitional reinsurance program that is designed to protect insurers operating in the uncertain risk environment of the individual exchanges from 2014 to 2016. This fee will add \$63 to the cost of insurance for each covered life in the first year of the program and will decline in the following two years.¹⁷ A second time-limited tax is the small annual assessment that will be collected through 2019 to fund comparative effectiveness research by the new Patient Centered Outcomes Research Institute.

User charges imposed to support the federal and state exchanges may also take a toll. Beginning in 2014, health insurers offering plans in a federally facilitated

TABLE 2. MAJOR HEALTH PLAN TAXES AND FEES UNDER THE AFFORDABLE CARE ACT

TYPE OF TAX	DESCRIPTION
Premium Tax (Health Insurance Tax)	Beginning in 2014, health insurers must pay an annual tax on premium revenue above \$25 million from fully insured plans. Employers with self-insured health plans are exempt from this tax, but it applies to most private managed care plans serving the Medicaid and CHIP populations. The tax is set to raise \$8 billion in 2014, rising each year to reach \$14.3 billion in 2018 and increasing thereafter by the rate of growth in premium costs.
Reinsurance Fee	In 2014–2016, all fully insured and self-insured plans must pay a fee to support the transitional reinsurance program designed to provide risk protection for insurers offering coverage in the individual exchanges. The fee will be set to raise \$12 billion nationally in 2014, \$8 billion in 2015, and \$5 billion in 2016 (plus administrative costs). The estimated cost per covered life is \$63 for 2014, and will decline accordingly in the two subsequent years.
Comparative Effectiveness Research Fee	Beginning with the first plan year ending on or after October 1, 2012, and continuing for seven consecutive years, fully insured and self-insured plans will be assessed an annual fee to fund the Patient Centered Outcomes Research Institute. The fee is \$1 per covered life in the first year, rises to \$2 in the second year and is adjusted for medical inflation for later years.
Federally Facilitated Exchange User Fee	Beginning in 2014, issuers offering health plans on a federally facilitated exchange will be assessed a fee equal to 3.5 percent of the monthly premium of each offered plan. As state-operated exchanges develop their plans for establishing a sustainable funding base for 2015 and beyond, this fee may be adjusted so it is in line with any state exchange user fees.
Excise Tax on “Cadillac” Health Plans	Beginning in 2018, fully insured and self-insured plans whose premiums exceed specified thresholds will be assessed a tax equal to 40 percent of the excess premium. The thresholds are currently set at \$10,200 for single coverage and \$27,500 for family coverage; they will be updated for medical inflation and other risk factors to derive the 2018 levels and for general inflation after that.

exchange will be charged a fee equal to 3.5 percent of the premium to cover exchange administrative costs. User fees are also proving to be a common approach for states seeking a sustainable funding base for their state-operated exchanges.¹⁸ The extent to which these fees will be passed on to insurance purchasers will depend on whether the exchanges are able to relieve insurers of administrative functions they would have otherwise had to perform on their own.

The so-called “Cadillac Tax” has a potentially very large impact on revenue raised, premium costs and plan benefits. Beginning in 2018, health plans with premiums above specified thresholds will have to pay a tax equal to 40 percent of the excess premium. Because the

thresholds will be indexed to general inflation, whereas premiums have historically grown more quickly, a growing number of plans will face this tax over time unless steps are taken to cut plan costs. Recent CBO projections assume that employers will respond by scaling down health benefits to keep premiums below the threshold, but still predict that this tax will generate \$80 billion in new revenues between 2018 and 2023.¹⁹

In addition to these taxes paid directly by insurers (and policyholders), new taxes on pharmaceutical companies and medical device manufacturers are expected to increase prices for their products. As these higher prices are reflected in higher claims costs, insurance premiums are likely to rise as well.

Other ACA Provisions

Many other provisions in the ACA will also affect the cost of health insurance as well as change the ways insurance can be accessed, the type of coverage that can be offered, and the incentives to obtain or provide coverage. Requirements to provide essential health benefits and meet minimum actuarial value thresholds, first dollar coverage of preventive services, restrictions on deductibles and total out-of-pocket costs, and elimination of annual and lifetime caps on the dollar value of benefits all provide important consumer protections and enhance the package of benefits — but also place upward pressure on premiums. The minimum loss ratio provision requiring insurers to spend 80 to 85 percent of premiums on medical care and quality improvement activities and mandatory review of certain requested premium increases are intended to mitigate upward pressure on premiums and further protect consumers. Key consumer protections come from the guaranteed issue requirement, which eliminates exclusions for pre-existing conditions, and new limits on waiting periods that may be imposed before full coverage takes effect. By facilitating coverage in the individual market for people who have pre-existing health conditions, these provisions eliminate the advantage to pooling risk at the employer level that has historically made employer-sponsored coverage more feasible and attractive.

New rating rules that eliminate premium variation based on health status and gender and restrict age variation to a 3:1 ratio will also have potentially large impacts on premiums in the individual and (to a lesser extent) small group markets. In contrast to the insurer taxes and various benefit enhancements and consumer protections, however, which will tend to increase premiums across the board, the impact of the rating rules will vary depending on the characteristics of the individual and the firm. Much concern has been expressed about 'rate shock' for younger, healthier individuals (particularly males) and for small firms with similarly low-risk workforces, but it is important to realize that other populations will benefit from the new rating rules. Specifically, employers with older, sicker, or largely female workforces (and individuals with these characteristics) should see premiums that are lower than they otherwise would have been without the rating changes. The impact also will vary by state

depending on the rating restrictions that were already in force prior to the ACA: firms and individuals in states with few prior restrictions will experience the largest changes when the ACA goes into effect and visa versa.²⁰ Employers with more than 100 workers and those that self-insure are exempt from these rating provisions. Thus, predicting the possible effect of new rating rules on ESI requires a nuanced approach that considers how specific types of employers and workers will be affected.

Employer decisions about offering health benefits are also likely to be influenced by their perceptions of whether their employees have reasonable access to coverage from other sources. As noted earlier, the ban on pre-existing condition exclusions will make the individual market a more feasible alternative than it is currently and could lead some employers to eschew coverage (especially smaller employers who are not subject to the mandate). Medicaid expansion will provide an alternative for workers up to 138 percent of FPL in states that opt to expand; ESI coverage could fall to the limited extent that people at this income level currently have employer-sponsored coverage. Similarly, if individual exchanges are viewed as functional and stable, some employers may be less inclined to provide coverage, particularly for their lower-wage workers who could benefit from the premium subsidies available in the individual exchanges.ⁱⁱ Lastly, the individual mandate should increase workers' demand for health insurance; although the penalty for going without coverage is low initially, it becomes more meaningful over time and would be expected to increase take-up rates among workers who are offered coverage by their employer.

ONGOING DEVELOPMENTS AND POSSIBLE NEW DIRECTIONS RELATED TO THE ACA

The Prevalence of Employer-Sponsored Health Insurance

The totality of the ACA provisions present a complex web of new incentives that may affect employers' decisions about whether and to whom to offer coverage and may influence employees' decisions

ii Employers considering offering different benefit opportunities to different groups of workers based on income must be careful about violating the Public Health Service Act, which prohibits discrimination in favor of highly compensated individuals in insured group health plans.

"...there is clearly a tremendous amount of uncertainty about how employers and employees will respond to the set of opportunities and incentives under [the ACA]... there is uncertainty regarding many other factors, including the future growth rate of private insurance premiums and the number of individuals and families who will have income in the eligibility ranges for Medicaid, CHIP, and exchange subsidies. Moreover, the models ... are generally based on observed changes in behavior in response to modest changes in incentives, but the legislation enacted in 2010 is sweeping in its nature."

—Congressional Budget Office. "CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance." March 2012 (page 2).

about accepting offered coverage. The questions are many and definitive answers are few at this point. Will the premium tax credits and SHOP exchanges help smaller firms maintain or begin to provide health coverage? After considering what is best for their bottom line as well as for their workers, will large employers "play" or will they "pay"? Will these firms try to make different arrangements for different categories of employees (e.g., lower wage vs. higher earners)? Will employees be more prone to demand and accept employer-offered coverage because of the individual mandate, and will employers respond to this employee demand by providing coverage? How will premiums change for specific firms and individuals, and how will these changes affect decisions to offer or accept employer coverage? Clearly, answers to these questions will be known only once the ACA changes take effect. What is more, the answers are likely to evolve over time as employers and workers continue to adjust to new dynamics.

Despite the difficulty of answering these questions, there have been numerous estimates and other predictions of how the ACA will affect employer-sponsored coverage. The most rigorous of these assessments are based on detailed micro-simulation models that draw upon multiple databases and a complex set of assumptions about employer and employee behavior and the many other factors that may affect ESI offer and take-up rates.

Figure 4 shows the results of micro-simulation modeling conducted by the Congressional Budget Office (CBO) in collaboration with the JCT. In March 2012, using mid-range assumptions judged to be most reasonable, CBO and JCT predicted that 5 million fewer people would have ESI in 2019 as a result of the ACA, a decline of just over 3 percent from the 161 million expected to have employer coverage in that year if the ACA had not been passed.²¹ This net decline represents 11 million fewer people receiving an ESI offer and 3 million who are offered coverage but obtain coverage through different sources, counterbalanced by 9 million individuals newly joining the ranks of those with ESI.

Recognizing the inherent uncertainty in this modeling, CBO and JCT considered four alternative sets of assumptions. The first and third alternatives posit that, relative to the mid-range assumptions, firms are less likely to offer coverage in response to employee demand and more likely to drop coverage when they have more workers who could obtain less expensive coverage through the exchanges or Medicaid; more extreme versions of these assumptions are used in scenario 3. These behavioral assumptions predict larger declines in the number of people covered by ESI than were predicted under the mid-range assumptions. Alternative scenario 2 moves in the opposite direction, with employers assumed to be more likely to offer coverage to help their workers satisfy the individual mandate and less likely to drop coverage even if some portion of their workforce could

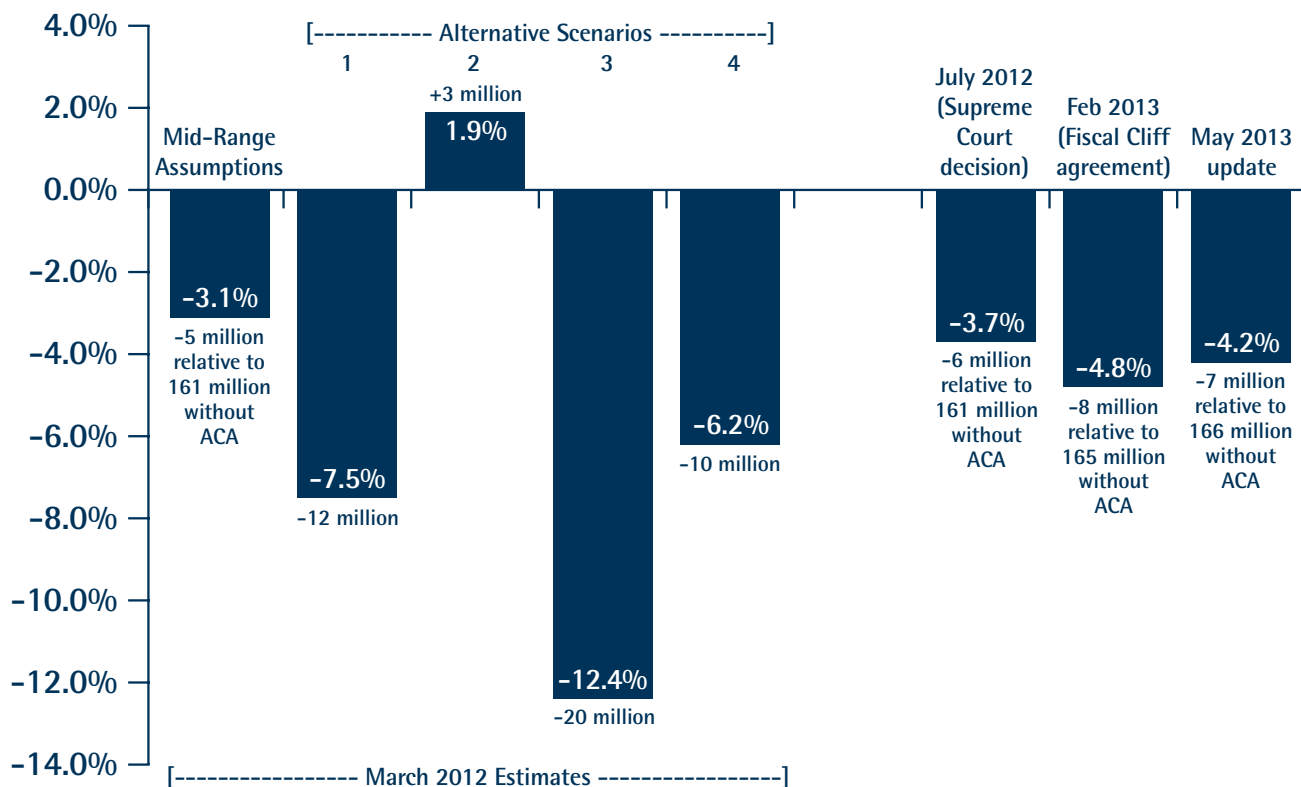
obtain coverage less expensively from other sources. If these assumptions capture employer behavior accurately, more people will be covered by ESI in 2019 than would have been the case without the ACA. Finally, alternative scenario 4 assumes significant workforce and/or benefit restructuring that causes more lower-paid workers to lose ESI, doubling the estimate of ESI losses if such restructuring does not take place.

Subsequent updates to these projections reflected new policy developments, data and modeling refinements. The June 2012 Supreme Court decision making the ACA's Medicaid expansion voluntary is expected to have very little new impact on ESI coverage,²² but the January 2013 fiscal cliff agreement is predicted to cause additional erosion in ESI coverage because the lower marginal tax rates will reduce ESI tax advantages.²³ Projections from May 2013 reflect updated assumptions about state Medicaid expansion decisions and modeling refinements regarding household marginal tax rates and are in line

with the earlier estimates.¹⁹ Micro-simulation models conducted by a range of other independent analysts in recent years have projected impacts of similar magnitude, with some anticipating modest declines in ESI in the near term and others predicting an increase in ESI coverage as a result of the ACA.^{24,25,26}

The newest policy development with the potential to affect ESI coverage is the one-year delay in enforcing the ACA's large employer mandate that was announced in early July 2013. CBO has estimated that this change will reduce ESI coverage by about 1 million people in 2014, relative to the levels that had been projected for that year in its May 2013 baseline. About half of those who would otherwise have had employer coverage in 2014 are expected to obtain insurance through the exchanges or through Medicaid/CHIP.²⁷ Updated estimates from the Urban Institute micro-simulation model predict an even smaller decline in ESI coverage due to the employer mandate delay. Specifically, that

FIGURE 4. CBO ESTIMATES OF THE ACA IMPACT ON ESI COVERAGE IN 2019



NIHCM Foundation analysis of estimates published by CBO in March 2012, July 2012, February 2013 and May 2013. Full citations provided in the text.

model predicts a 2.9 percent increase in the number of people with ESI if all provisions of the ACA were fully implemented (relative to no ACA) and a 2.8 percent increase if all provisions other than the employer mandate are in effect — a net loss of fewer than 100,000 individuals as a result of having no employer mandate.²⁸

These models and other economic analyses recognize that many factors weigh into employers' decisions about providing health insurance and note that ESI has dominated the private health insurance market for many decades even in the absence of employer mandates. In addition to the very significant tax advantages to providing and obtaining coverage through the workplace, health insurance can help employers maintain a healthy and productive workforce and assist in employee recruitment and retention. As long as the labor market is sufficiently competitive, employers not offering health coverage would need to "gross up" cash wages in order to attract and keep good workers.²⁹ Thus rational employers would not act based solely on the gross comparison of savings in benefit costs vs. penalties under the mandate. One analysis that adopted this broad lens (but conducted before the mandate delay) concluded that four of every five workers now covered by ESI are working for employers that will continue to have an economic incentive to provide coverage. The picture differs for workers in small firms not subject to the mandate and for low-wage firms whose workers could qualify for exchange subsidies; however health coverage in these firms is already limited, so any ACA-related declines in ESI for these employers would also necessarily be limited.³⁰

Surveys that ask employers about their intentions can provide yet another indication of how ESI might change when all provisions of the ACA go into effect, although responses to hypothetical questions are an imperfect predictor of future actions and the surveys typically consider only coverage losses while ignoring possible new offers of insurance.²⁵ Nonetheless, the balance of evidence from recent surveys indicates that most employers remain committed to providing health benefits for active workers in the near term, with the larger employers — who are currently providing the bulk of health insurance for workers — exhibiting the strongest commitment to health benefits.^{31,32,33} Employers

are less sanguine about the longer-term future, with one annual survey showing that the percent of midsize and large employers that are very confident they will provide health benefits for the next decade has fallen from 73 percent in 2007 to 26 percent in 2012.³⁴ There is also some evidence that employers will be closely watching their competitors and might reconsider their plans to maintain coverage if their leading competitors or other industry leaders eliminate coverage.

At this point, then, the general consensus appears to be that ESI coverage may decline somewhat over time as the ACA is implemented but that widespread changes are not anticipated in the near to medium term. Any such decline would continue the downward trend that has already been in evidence for at least the past decade. ESI losses are likely to be concentrated among smaller firms that face no penalty and employers with a large proportion of lower-wage workers who could qualify for subsidized coverage (to the extent that these firms currently provide coverage). Uncertainty about the employer response increases for longer-range projection periods.

Restrictions on Hours of Part-Time Workers

Highly publicized reports that some prominent private sector and government employers plan to limit hours for part-time workers in order to avoid providing health benefits have raised concern about what this will mean for workers and whether this phenomenon is likely to become widespread. In fact, any move to more part-time work would continue trends that have been underway since before the drafting of the ACA began.² Workers most at jeopardy for reductions in their hours would be those who work slightly more than 30 hours per week, who earn less than 400 percent of FPL (and thus would trigger employer penalties if receiving subsidized coverage on the individual exchange) and who are not already offered health insurance. Workers whose schedules fluctuate or who normally work fewer than 30 hours each week would also be subject to formal limits on their hours but less prone to actual reductions in hours worked. The University of California at Berkeley Labor Center has estimated that some 2.3 million workers are at risk of reductions in hours, with the largest concentrations in the restaurant and retail

industries.³⁵ These workers would face reduced earning potential but would not be losing ESI coverage since they are not currently covered through their job; many would likely turn to the public exchanges to purchase subsidized coverage.

The one-year delay in the employer mandate has put this issue temporarily on the back burner, but has also given employers an additional year to make strategic staffing decisions in anticipation of the 2015 start of the mandate. Only time will tell whether a significant number of large employers decide to cut hours for part-time workers. At least one prominent employer has backed away from announced plans to restrict hours when faced with significant negative public reaction, and other observers point to the higher administrative costs and other downsides of a heavy reliance on part-time staffing.^{11,12,36,37} It is also worth noting that current non-discrimination laws may make it tricky to restructure workforces in this way. ERISA prohibits "discriminating against an employee for the purpose of interfering with the employee's attainment of a right to which s/he would be entitled" under the employer's group health plan³⁸ and might be used to challenge reductions in hours that cause some employees to lose benefits.

Strategies to Reduce Health Spending and Encourage Higher Value Purchasing

While most employers now providing health benefits appear inclined to continue to do so – at least until they see how the many ACA changes play out and how their competitors react – they will not be standing still. For at least the past decade, employers have been responding to the rising cost of providing health coverage by requiring greater employee cost sharing, trimming benefits and making even more wholesale changes to the types of plans they offer.⁵ These trends are expected to continue in coming years, especially as the Cadillac tax on high-premium plans provides added impetus to bring down the costs of employer-sponsored coverage. A recent survey of midsize and large employers found, for example, that 58 percent of respondents were confident that they would trigger the Cadillac tax if they make no changes to their benefits, and 80 percent intend to take cost-cutting steps to avoid the tax.³³ In fact, the CBO's May 2013

estimate that the tax will generate \$80 billion in revenue by 2023 is some \$58 billion lower than its estimate made just a few months earlier and reflects the recent slowing in health insurance premium increases and acknowledgement of the fact that employers are already making big changes to their benefits to rein in costs.^{39,40} Key developments are described below.

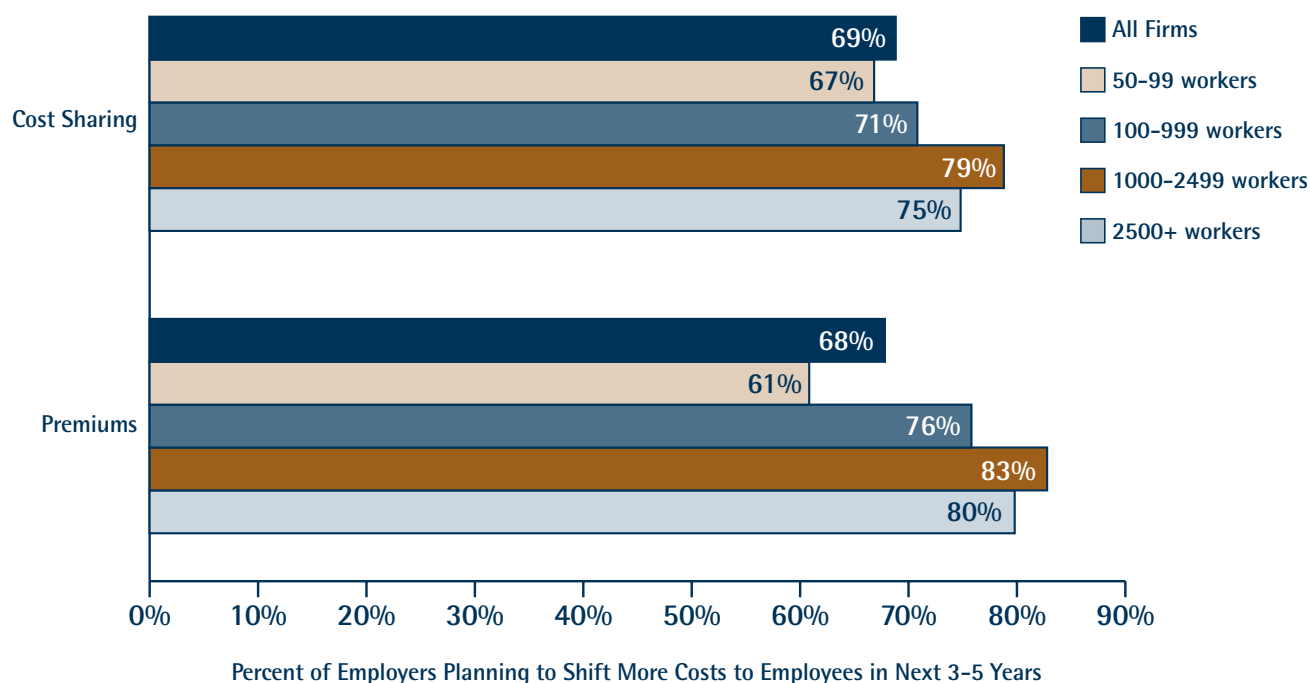
Greater Employee Cost Sharing

Employers are increasingly relying on greater employee cost sharing as a core strategy to manage benefit costs. For example, nearly 80 percent of covered workers now face an annual deductible for single coverage, up from 55 percent in 2006, and the average deductible amount has nearly doubled from \$584 to \$1,135 over this period. Across firms of all sizes, the proportion of covered workers with single-coverage deductibles of at least \$1,000 has nearly quadrupled, rising from 10 percent in 2006 to 38 percent in 2013. Smaller firms (<200 workers) have consistently been more likely to use high deductibles, with nearly six in ten covered workers in these firms now enrolled in plans with single-coverage deductibles above \$1,000, and nearly one in three in plans with deductibles exceeding \$2,000.⁵

And employers expect to continue moving in this direction. A 2012 survey of firms with more than 50 workers found, for instance, that approximately 70 percent plan to increase employee premium contributions and/or cost sharing in the next three to five years, and the likelihood of taking these actions was uniformly high regardless of the employer size (Figure 5).

There is also evidence that employers are more interested in protecting coverage for their workers than for dependents. For example, 63 percent of midsize-to-large employers anticipate increasing the premium contribution for dependent coverage in 2013, compared to 55 percent expecting to do the same for workers with self-only policies.³³ Another survey of employers with more than 1000 workers found that one in five currently assess a spousal surcharge and another 13 percent planning to do so next year.³⁴ Among very large employers (more than 5000 workers), 14 percent reported using spousal surcharges in 2012, and 4

FIGURE 5. EMPLOYERS' RELIANCE ON GREATER EMPLOYEE COST SHARING



Source: "2012 Deloitte Survey of U.S. Employers: Opinions about the U.S. Health Care System and Plans for Employee Health Benefits." July 2012.

percent denied coverage to spouses altogether if they had access to health insurance from another source.³² UPS and Kroger are two large employers that have recently announced that they will begin restricting spousal coverage in 2014.

Consumer-Directed Health Plans

Another way of shifting additional costs to employees is through the use of consumer-directed health plans (CDHPs). Also referred to as account-based health plans (ABHPs), these plans typically combine a high-deductible health plan with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) that can be used to cover out-of-pocket expenses. HSAs are funded by the employee and optionally by the employer using pre-tax dollars, and any unspent account funds at the end of the year belong to the employee. Employees must enroll in a qualifying high-deductible health plan in order to make tax-advantaged contributions to an HSA, but may enroll in a qualifying high-deductible health plan without contributing to an HSA; thus, these high-deductible plans are often termed "HSA-eligible" or "HSA-qualified" plans. For 2014, IRS rules stipulate that

HSA-eligible plans must have a deductible of at least \$1,250 for self-only coverage (\$2,500 for family coverage) and limit an enrollee's out-of-pocket costs for in-network care to no more than \$6,350 (\$12,700 for family). In contrast to HSAs, HRAs are funded solely by employer contributions and the employer may reclaim any residual funds remaining at year's end. Enrollment in a high-deductible plan is not required with an HRA, although these products are often paired. CDHPs also are usually combined with consumer support tools to help enrollees make more informed choices about their health care utilization and spending.

There has been very rapid growth in the use of CDHPs since they first came on the market, with steady increases in both the likelihood that an employer will offer one of these plans and the proportion of the workforce enrolled. Data from a prominent annual survey of U.S. employers indicate that larger employers are more likely to offer a CDHP but that employers of all sizes have seen an increase in use of these plans. By 2013, 20 percent of all workers with employer-sponsored health insurance were enrolled in a CDHP

(defined as a high-deductible health plan with an HSA or HRA savings option); this enrollment growth has come at the expense of preferred provider organization and point-of-service (PPO/POS) plans and HMOs (Figure 6). Data from other employer surveys are consistent with this picture.³² The annual insurer surveys conducted by America's Health Insurance Plans also confirm these trends, showing consistent growth in enrollment in high-deductible/HSA plans, particularly within the large employer market segment.⁴¹

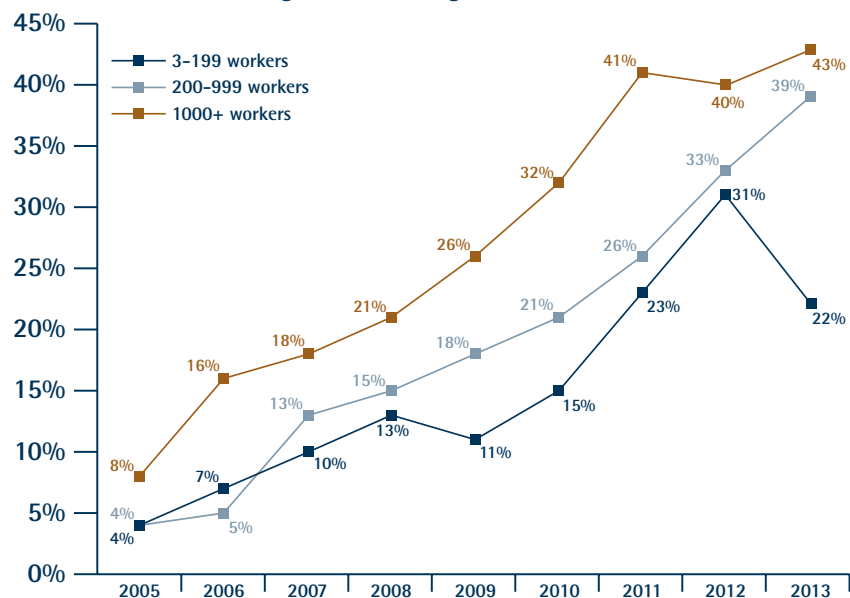
Further expansion is highly likely in the coming years, as well. Over 60 percent of midsize and large companies, for example, expected to offer an ABHP in 2013 and 80 percent expect to do so by 2015.³³ Employers also report rising interest in actively encouraging enrollment in these plans, such as by making the CDHP the default plan option, providing a greater premium subsidy to employees who select this option, contributing (more) to HSAs and HRAs, offering supplemental benefits to CDHP enrollees, and engaging in targeted communication efforts to promote the value of these plans to employees.^{34,42} The lower premiums and typically slower rate of premium growth for CDHPs are also expected to continue fueling interest in CDHPs, especially as employers try to keep employee premium costs affordable and avoid the Cadillac tax and as employees try to limit their own premium outlays.

Yet another factor that will contribute to higher CDHP enrollment is the increasing employer interest in using a "total replacement" model in which the

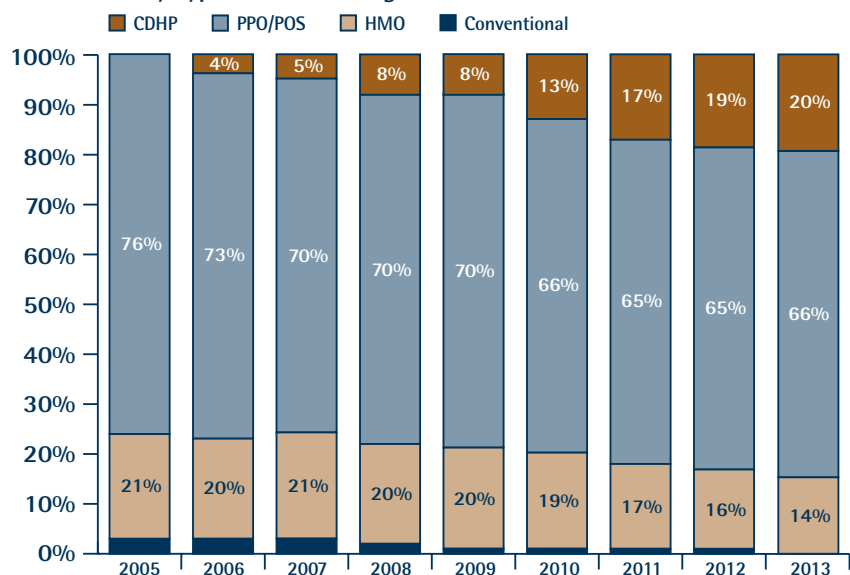
CDHP is the only plan offered. While offering CDHPs as one of several plan choices still remains the dominant approach, especially among larger firms, there is evidence that more limited options may be on the

FIGURE 6. GROWTH IN CDHP OFFER RATES AND ENROLLMENT, 2005–2013

CDHP Offer Rates Among Firms Offering Health Benefits



Enrollment by Type of Plan Among Covered Workers



Source: Kaiser Family Foundation/Health Research and Educational Trust, "2013 Annual Survey of Employer Health Benefits," (Exhibits 8.3 and 5.1).

horizon for more workers. For example, 37 percent of midsize and large employers expressed interest in adopting a total replacement CDHP strategy in the next three to five years,⁴² and 23 percent of large self-insured employers believe they will have such a strategy in place in 2014, almost double their 2013 level.³⁴

Since passage of the ACA, there has been concern in some corners that the growing use of CDHPs would be stopped in its tracks because the law's minimum actuarial value requirement, deductible limits, minimum loss ratios and other benefit requirements would make it very difficult to design a high deductible plan able to satisfy all requirements simultaneously. Decisions about how contributions to HSAs and HRAs would be treated when calculating actuarial value were one key to whether these concerns would become reality. Actuarial values would be pushed downward if these contributions were not considered, but would tend to be inflated if all contributions were counted as health benefits. Final regulations stipulate that all employer contributions to HSAs and a portion of their contributions to HRAs (generally reflecting funds that the employee would be expected to use for cost sharing in the year) will be treated as spending on health benefits, raising the actuarial value of these plans and putting them more easily within reach of the 60 percent minimum actuarial value. The regulations also provide added flexibility by allowing for a two percent margin around target actuarial levels. Simulations by Towers Watson indicate that more than 90 percent of people enrolled in an account-based health plan in 2010 were in plans with an actuarial value of at least 65 percent, even without treating employer contributions to the savings account as a health benefit.⁴³ In addition, the ACA permits deductibles above the maximum specified in the statute if this is necessary to meet actuarial value requirements, and government guidance for possible safe harbor plan designs that will satisfy minimum actuarial value standards includes plan specifications consistent with high-deductible plans.⁴⁴ It thus appears that early concerns about the obsolescence of high-deductible plans and CDHPs in the world of employer-sponsored health insurance are unlikely to materialize.ⁱⁱⁱ

iii In contrast, because HSA contributions by individuals are not counted when calculating a plan's actuarial value, high deductible plans in the individual market may have a harder time satisfying the 60 percent actuarial value minimum.

Private Exchanges and Defined Contributions

A fast emerging development within the world of employer-sponsored health insurance is the surge of interest in private exchanges where employers and their employees can shop for coverage. Often — but not always — employers considering private exchanges are simultaneously looking to cap their health benefit spending by providing employees with a defined contribution that can be used to purchase coverage from the array of options offered in the exchange. Employees choose the plan that best suits their needs, using their own funds to “buy up” to a higher premium level if they wish to do so.

Private exchanges offer a number of potential advantages to employers and employees. Employers who wish to step back from the day-to-day work of administering benefits can reduce their HR expenses by relying on the exchange for these tasks. The use of defined contributions lets employers cap their benefit expenses and control future liabilities. For multi-state employers, private exchanges offer the possibility of a single national marketplace instead of the state-specific SHOP exchanges. Private exchanges may also offer a much wider range of benefits and services than public exchanges — including dental, life and other types of insurance and even non-insurance offerings such as wellness products. Using front-end decision support tools provided by the exchange, employees have the chance to customize a comprehensive benefit package that is responsive to their individual needs. The availability of tailored and comprehensive benefits can also help employers to be more competitive in the labor market.

The landscape for private exchanges is complex and evolving very rapidly. Some exchanges are “single carrier” models developed by a specific health insurer and offering a range of products from that insurer alone. Others are “multiple carrier” models organized by benefits consultants, brokers or other third-party vendors and offering plan options from multiple insurers. Existing exchanges are also targeting a variety of specific market niches, such as employers of different sizes, retirees, Medicare enrollees, and self-insured firms. Recent market analysis by Oliver Wyman counts more than 30 private exchanges and more than 10 technology providers.⁴⁵ Continuing evolution and

market maturation is expected in the coming years, especially as the public SHOP exchanges become operational and their impact becomes clearer.

Employers seem ready to embrace private exchanges and the shift to defined contributions for their health benefits. Nationally, Mercer reports that 56 percent of employers will consider a private exchange for active or retired workers.³² Sears Holding Corporation and Darden Restaurants have already made this move, together affecting some 135,000 active employees, and Walgreens soon will do the same for 160,000 workers. IBM and Time Warner have just announced plans to move their U.S. retirees to private exchanges next year. Other employer surveys report low current use of private exchanges, but echo the projections of strong growth for private exchanges and defined contributions in the next few years.^{31,34,42,45} On the other hand, some economists argue that rational employers who recognize that they must compete for workers based on the total (wage and benefits) compensation package are likely to realize few advantages from moving to a private exchange.⁴⁶

The interaction between private exchanges and the public SHOP exchanges remains an unknown and some market experts predict that private exchanges will eventually dominate the group market. Delayed implementation of the employee choice model in the federally facilitated SHOP exchanges may make private exchanges more attractive to small employers in those states in 2014, and inertia could cause them to stay with this choice in later years. However, most state-based exchanges will be implementing an employee choice model immediately, often with defined contribution options,⁷ and this flexibility may counteract some of the allure of private exchanges. Additionally, small low-wage firms may access the premium tax credits only if they purchase coverage through a SHOP exchange. At the same time, Connecticut has announced it will be using an existing private exchange as its SHOP exchange, and other states are expected to make similar choices.⁴⁷ CMS is also leveraging existing private exchanges to facilitate enrollment in the federally facilitated public exchanges.⁴⁸ One recent simulation has predicted that by 2018 more Americans will obtain their health insurance via a private exchange than through a

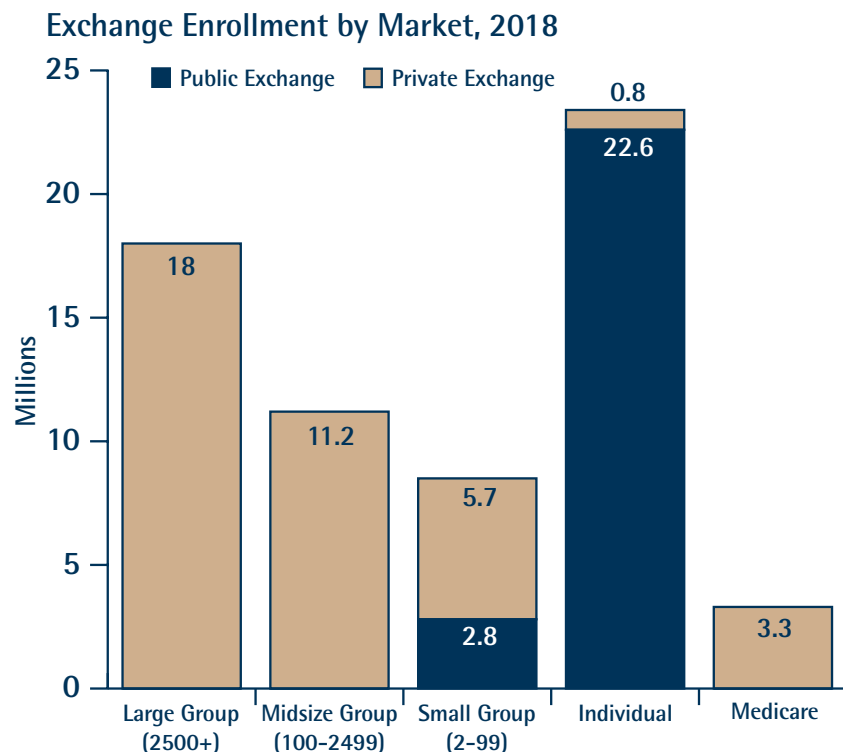
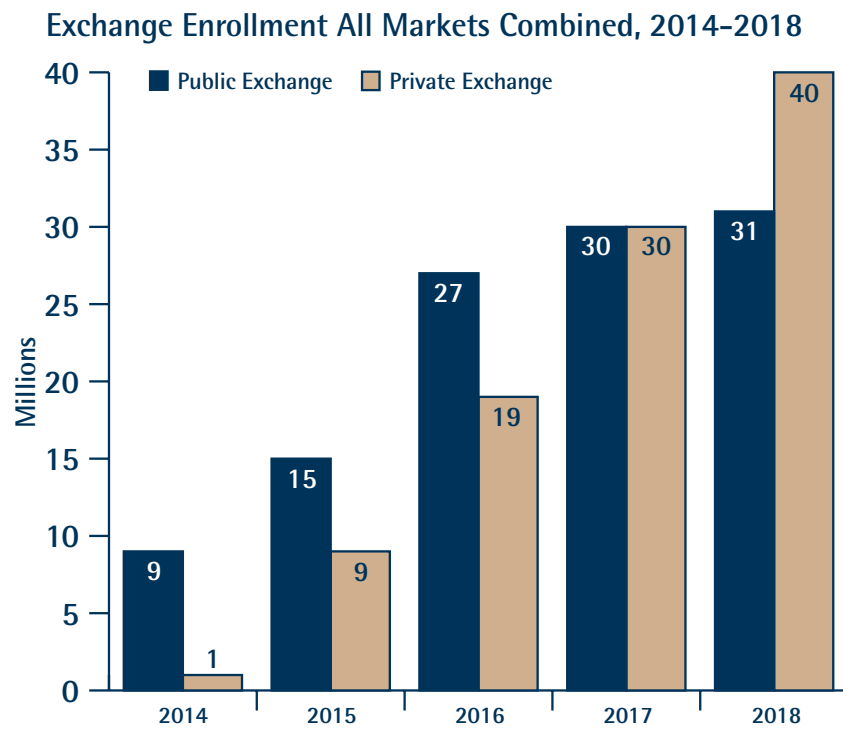
public exchange.⁴⁹ A second study came to the same conclusion and showed this result is expected even in the small group market, which will have had the longest period of access to the SHOP exchanges (Figure 7).⁴⁵

Employee Wellness and Health Management Programs

Employers are also placing high importance on wellness and health management programs for their employees (and, in many cases, dependents) — both in the interest of improving workforce productivity and holding the line on health spending. Aon Hewitt's 2012 survey of midsize and large employers found that 63 percent of respondents sponsored some type of worksite-related health program,⁴² while the 2013 survey by Kaiser Family Foundation and the Health Research and Educational Trust reports a figure of 77 percent across employers of all sizes.⁵ Popular components of wellness programs, used alone or in tandem, include health risk questionnaires and/or biometric screening; tobacco cessation programs; weight management and nutrition counseling; lifestyle or behavioral coaching; gym memberships, on-site exercise facilities and/or physical fitness challenges; educational materials and other resources for healthy living; 24/7 nurse call lines; and programs to manage specific chronic conditions or complex care.

Employers are relying on a range of financial and other incentives to encourage employee engagement in their wellness programs. Rewards may include a lower premium contribution from the worker, a lower plan deductible, a larger employer contribution to an HSA or HRA, or gift cards, cash, or merchandise. Incentives can also be structured as penalties, such as a premium surcharge or higher cost sharing. While positive incentives tend to be favored over penalties, there is a growing move away from simply rewarding completion of a health risk assessment to expecting more active participation in program activities and progress toward achievement of specific biometric measures such as BMI, blood pressure or cholesterol levels. Thirteen percent of respondents to a survey of midsize-to-large firms reported, for example, that they were using biometric-based incentives in 2012, and more than 60 percent indicated that this strategy is planned or under consideration for adoption in the

FIGURE 7. PROJECTED GROWTH IN PRIVATE AND PUBLIC EXCHANGE ENROLLMENT



Sources: (top) Accenture. "Are You Ready? Private Health Insurance Exchanges Are Looming." May 17, 2013; (bottom) Lapsey H. "The New Supplier/Distribution Dynamics in the Employer-Sponsored Benefits Market – Private Exchanges and Provider Competition." May 29, 2013.

next three years.³³ Additionally, companies are increasingly interested in extending the financial incentives to covered spouses and dependents since these members account for a portion of plan costs and may influence employees' health behaviors. For instance, 59 percent of the nation's largest employers predicted that they would include spouses in their wellness programs by 2014, up from just 19 percent in 2011.³⁴

The rewards or penalties can be significant for an employee currently and have the potential to become much more important under ACA provisions that will take effect in 2014. Starting next January, employers will be allowed to offer wellness program rewards or impose penalties of up to 30 percent of the total cost of coverage and can incorporate a further 20 percent incentive for activities related to preventing or reducing tobacco use. Final regulations issued in May 2013 attempted to address concerns that these incentives could have the unintended effect of undermining the ACA prohibition against medical underwriting if employees who have difficulty participating in program activities or achieving target outcomes due to a medical condition end up paying more for health coverage. Under these nondiscrimination rules, employers must provide such workers with reasonable alternative means of satisfying program requirements so they can earn rewards or avoid penalties. While consumer advocates were generally pleased with these provisions, representatives of the business community worry about

the added administrative burden for employers, watered down performance standards, and decreased flexibility in program design.^{50,51}

Employers will also need to keep the ACA's affordability and actuarial value requirements in mind when they are designing their wellness-related incentive structures. Rewards that lower premiums can affect determinations of plan affordability while rewards that provide lower cost sharing can affect whether a plan meets the minimum actuarial value standard. For 2014, regulations allow employers to assume that employees will succeed in qualifying for all rewards available, effectively making offered plans more affordable and increasing their actuarial value. Starting in 2015, however, these calculations must assume that workers will earn rewards related to tobacco cessation but fail to earn rewards related to other wellness incentives — thereby raising the bar for a plan to be deemed affordable and of minimum actuarial value.

It remains to be seen how the increased financial stakes and requirements to meet affordability and actuarial value standards and ensure that wellness programs are not discriminatory will play out over the next few years. However, given the already widespread and growing use of wellness programs, it is clear that the ACA wellness provisions have the potential to affect both the structure and cost of health benefits for a very large portion of the U.S. workforce.

Other Strategies to Promote Value in Health Care Spending

Employers and insurers are pioneering numerous other strategies that use new plan designs, financial incentives, and data on prices and quality to encourage value in both the provision and purchasing of health care services. While not yet uniformly widespread, these strategies appear to be gaining in popularity and poised to spread rapidly within employer-sponsored plans.

High Performance Networks. After years of emphasis on broad networks and maintaining the widest possible set of provider options for enrollees, employers and health insurers are increasingly focusing on "high performance" networks as a central component of their quest for value. Common manifestations include

contracting with only a limited network of providers deemed to provide high value care, tiered network designs that permit a wider choice of providers but place the best performers in a preferred tier with lower cost sharing,⁵² and centers of excellence for specific types of surgery or for management of specific chronic conditions (often equated with patient-centered medical homes).

Mercer reports strong growth between 2011 and 2012 in adoption of these practices by very large employers, with use of narrow networks rising from 14 to 23 percent, use of surgical centers of excellence almost doubling (18 to 35 percent) and use of medical homes tripling (3 to 9 percent) in just two years.³² In its 2012 survey of midsize and large employers, Aon Hewitt found even higher uptake and signs of continued strong interest in these approaches: one-third of surveyed employers reported use of mandatory condition management or specialty networks for certain chronically ill enrollees, 42 percent are already using a high performance or specialty network, and approximately half are considering using one or more of these mechanisms in the next three to five years.⁴² Deloitte also predicts that employers will increasingly change their benefits to rely on narrower physician and hospital networks in the next few years, with the larger employers expected to make a more pronounced move in this direction.³¹ These trends are consistent with expectations and early evidence that health plans offered in the new public exchanges will be designed around tightly managed networks as insurers work to deliver high quality providers at competitive prices.^{53,54}

Value-Based Benefit Design. Concurrently, benefit designs that encourage patients to seek value for their health care spending are also proliferating. These incentives may be coupled with networks built around high performing providers. Walmart, for example, made news last fall when it announced that its covered associates would face no out-of-pocket costs if they use one of six designated centers of excellence for cardiac, spine and transplant surgeries.⁵⁵ Nationwide, 12 percent of large employers currently use differential cost sharing to encourage use of high performance networks and another 19 percent plan to do so next year.³⁴ More generally, value-based insurance design (VBID) uses different copayment levels based on the

perceived value of the service, such as low cost sharing for preventive care and drugs to manage chronic conditions and high cost sharing for lower-value services. Approximately 30 percent of large employers are using VBID now or plan to incorporate this feature into their benefit structures next year.³⁴

Reference Pricing. Reference pricing is another strategy that puts pressure on health care consumers to spend wisely since they will be responsible for costs incurred above the reference price. Highly publicized initiatives undertaken by Safeway and CalPERS in recent years illustrate how this strategy can encourage patients to select high performing providers that have agreed to provide the service at or below the reference price and spur high-cost providers to reduce their prices.^{56,57} Recent surveys of midsize and large employers show growing interest in reference pricing, with 20 percent of employers either using the strategy in 2013 or reporting plans to adopt it in 2014,³⁴ and 55 percent considering such a move in the next three to five years.⁴²

Transparency. The increasing emphasis on consumer engagement in health care decisions — whether through the growing use of high-deductible health plans or through other strategies designed to promote value-based purchasing — brings with it a need to arm consumers with good data on health care prices and quality. Approximately one in five employers with more than 50 workers view transparency around cost and quality data as a current core strategy for managing health care spending.³¹ Midsize to large employers are working with their insurers and, to a lesser extent, with independent vendors to provide this information to their employees, and they expect continued growth in this area in the next few years.^{33,34}

OTHER FACTORS TO WATCH

The evolution of these ongoing market trends and the impact of the many changes brought by the ACA both may be influenced by larger environmental factors. Critical among these factors are trends toward self-insurance by smaller employers, the long-term viability of the public exchanges, state decisions about Medicaid expansion, legal challenges to the payment of subsidies

on certain public exchanges, and possible changes to the tax treatment of ESI premiums.

Self-Insurance Among Smaller Employers and Regulation of Stop-Loss Insurance

Employers electing to self-insure for health coverage are exempt from most state insurance regulations, making self-insurance an attractive choice for employers able to accept the risk of incurring higher-than-expected claims. Not surprisingly, self-insurance is much more common among large employers who have more employees over whom to spread this risk: in 2012, 83 percent of private-sector firms with more than 500 workers were self-insured, compared to only 14 percent of firms with fewer than 100 employees.⁴

Self-funded plans will also be exempt from many of the ACA provisions that are expected to increase health insurance premiums. Most notably, self-funded health plans will not have to provide essential health benefits, abide by community rating, guaranteed issue and risk adjustment rules or pay the health insurance premium tax and other new state taxes imposed as a result of the ACA (such as insurer fees assessed to support the exchanges). These exemptions provide a powerful new incentive for smaller firms to try self-insurance, particularly if they are able to reduce their risk to manageable levels by purchasing stop-loss policies that cover claims incurred above certain thresholds or “attachment points.” Additionally, the ACA’s guaranteed issue provision enables small employers to revert to fully insured coverage at almost any time without a penalty if self-insuring turns out to be too risky.

Moving to self-insurance will be most attractive to small employers with younger and healthier workforces because the age banding and community rating rules are expected to increase premiums for these employers disproportionately, making their payoff to self-insurance potentially higher. In addition, firms with less healthy workforces may find it more difficult to self-insure because stop-loss insurance is underwritten for health status and certain high-risk employees may be excluded altogether (a practice known as “lasering”). If a more pronounced move to self-insurance occurs for small employers with younger and/or healthier workforces, the higher-risk employers that remain fully

insured will face higher average premiums. Even without such adverse selection, premiums will be pushed upward as more firms self-insure because there will be fewer fully insured groups contributing to the fixed revenue target that must be raised through the health insurance premium tax. The rising premiums brought on by a wave of self-insurance could undermine the stability of the SHOP exchanges and, if small firms drop coverage and send workers to the individual exchanges, raise the federal cost of premium and cost sharing subsidies.

In an ACA-mandated study of this issue, micro-simulations conducted by RAND projected no increase in self-insurance among small employers after the ACA is fully implemented in 2016 and therefore no associated adverse selection against the small group market.⁵⁸ This finding has been questioned, however, because it derives from a modeling assumption that available stop-loss policies have a much higher attachment point than policies believed to be currently available.^{59,60} Under an alternative assumption of widespread availability of affordable stop-loss coverage with much lower attachment points, RAND's model projects a substantial uptick in self-insurance by small firms. But even then the model finds little evidence of adverse selection: eliminating small firms' ability to purchase stop-loss coverage (thereby keeping most low-risk small firms in the fully insured market) reduces exchange premiums for the platinum plan by only 3 percent and has no significant impact on premiums for other levels of coverage. More recent modeling by researchers at Urban Institute reaches a different conclusion finding significant potential for adverse selection and market destabilization if small employers are able to purchase stop-loss coverage that effectively shields them from all or most risk, as regulations in most states would currently permit.⁶¹

Clearly, the availability of affordable stop-loss coverage with attachment points that meet the needs of smaller employers will encourage self-insurance in this market segment. At present, we have little systematic data on the types of policies now being sold to small employers⁶² and conflicting assessments of the prevalence of stop-loss coverage for small firms. A growing amount of anecdotal evidence indicates that these policies are being developed and marketed to smaller and smaller

firms,⁶⁰ but other work suggests that stop-loss coverage for small firms is currently very limited.⁶³ Most experts agree, however, that these trends may accelerate quickly in the future given the incentives within the ACA and if state insurance regulations continue to permit the low attachment points and other policy features that attract very small firms.

Regulation of stop-loss insurance varies significantly across states. Although the National Association of Insurance Commissioners (NAIC) adopted a Stop-Loss Insurance Model Act in 1995 to guide state regulation of this market, only a minority of states currently regulate stop-loss insurance and several states permit attachment points well below those recommended in the model act. More recently, the NAIC has been debating an update to the model act that would, among other changes, make stop-loss coverage less attractive to small employers by tripling minimum attachment points. These changes have been controversial, however, and have not yet been adopted although the NAIC continues to monitor the situation. Several states have also recently faced opposition to their attempts to implement or strengthen stop-loss insurance regulations.

Ultimately, regulation of stop-loss insurance must balance the dual interests of protecting the integrity of health insurance markets vs. responding to the concerns of small businesses, which may view self-insurance as their only viable path to offering affordable health insurance to their workers. The RAND simulations estimated, for example, that elimination of a stop-loss coverage option would reduce health insurance offer rates among small firms (< 100 workers) from 79 percent to 59 percent.⁵⁸ Coverage losses among firms with fewer than 50 workers could be even more worrisome since these employers are not required to offer coverage under the ACA. Given the political difficulties of navigating these competing interests and the fact that state insurance regulators are currently focused on myriad other activities related to ACA implementation, it is not surprising to find that many states are generally adopting a "wait and see" approach regarding possible reinforcement of stop-loss insurance regulations.⁶³ Their future actions bear watching as they could affect the ESI environment significantly.

Viability of the Public Exchanges

Many employers' decisions about offering health coverage will be influenced by their perceptions of whether the individual and SHOP exchanges offer affordable and attractive insurance options and a good consumer experience. Employers may be more inclined to send some or all of their workers to the individual exchange if these markets are seen as functioning well, whereas a robust SHOP exchange can help small employers to offer coverage. Views about exchange viability are likely to evolve over the next few years as both types of exchanges are rolled out and mature. Critical factors to watch include whether early operational glitches are resolved successfully and quickly, the number of insurers offering products and the range of plans and rates available, and the extent of any adverse selection emerging against the exchanges.

For individual exchanges, data now available for both the federally facilitated and state-based exchanges provide a cautiously optimistic picture on premiums and the amount of competition for 2014, although there will be appreciable price variation across and within markets, and some areas will have only a small number of offerers.^{64,65} Despite reports of heavy use of the exchanges on day one, considerable uncertainty remains about whether a sufficient number of people will enroll and – most importantly – what types of people will enroll. Adverse selection is of very real concern if the younger, healthier individuals (especially males) who are most likely to see large jumps in premiums under the ACA rating rules respond by foregoing coverage. While the availability of a catastrophic plan for those under age 30 and premium subsidies for those with incomes between 100 and 400 percent of FPL will help to mitigate the impact of any rate shock, the \$95 penalty for violating the individual mandate in 2014 will do little to keep the low-risk population in the market if their premiums spike. Other potentially destabilizing events would be the *en masse* addition of individuals now in state high-risk plans to the risk pool of the individual exchanges and large numbers of COBRA enrollees deciding to purchase coverage on the exchange instead.⁶⁶ Any significant and persistent problems with the roll out of the individual exchanges and/or

adverse selection leading to spiraling premiums and market instability will undermine employers' confidence in this channel as a viable place where their workers can obtain coverage.

In the SHOP exchanges, the decision to delay the mandatory employee choice model until 2015 may make this channel less attractive initially to small firms in states with federally facilitated exchanges, unless the firm is seeking to benefit from the premium tax credits. Beyond 2014, the SHOP exchanges could be threatened by increased self-insurance by smaller firms and the resulting upward pressure on premiums for fully insured firms remaining in the market, as described above. In addition, there is the question of how opening the SHOP exchanges to larger firms beginning in 2016 and the rapid development of private exchanges will affect the SHOP exchanges in coming years.

Medicaid Expansion

Another big wildcard that could impact ESI is whether states choose to implement the ACA's now-voluntary expansion of Medicaid eligibility to all adults with incomes below 138 percent of the FPL. As of August 2013, only about half of the states have committed to expanding Medicaid. In the remaining states, individuals in the 100-138 FPL segment will gain eligibility for subsidized coverage in the individual exchanges instead of through Medicaid. Beginning in 2015, large employers in non-expansion states will, therefore, be liable for a penalty if they have any full-time workers in this income segment and fail to provide them with affordable health insurance. Additionally, the inclusion of this income segment on the individual exchanges is expected to put upward pressure on premiums,⁶⁷ exerting a potentially destabilizing force on those markets. Thus, large employers seeking to avoid penalties and employers of all sizes that are continuing to provide coverage while waiting to see if the individual exchanges are viable alternatives for their workers may have somewhat stronger incentives to provide health insurance in states that do not expand Medicaid.

At the same time, people living below poverty in non-expansion states will be excluded not only from

Medicaid but also from the subsidized coverage available through the individual exchanges. While the rare employer having low-income workers in this situation might attempt to fill the void by providing coverage, the vast majority of these individuals will go without insurance even if they are working, raising uncompensated care costs borne by the state's health care providers. To the extent these costs are passed on to privately insured patients, it will become more expensive for employers in non-expansion states to cover their workers.

Subsidy Availability in Federally Facilitated and Partnership Exchanges

Larger employers' decisions about offering health insurance might also be affected by the outcome of a legal challenge to the ACA filed in early May 2013. Petitioners are challenging the IRS interpretation of the ACA statutory language regarding the provision of health insurance tax credits in "exchanges established by the states." They argue that instead of the broad interpretation adopted by the Treasury Department to permit subsidies in all states, the literal reading of the ACA text precludes payment of premium subsidies in the states that have opted to have federally facilitated or partnership exchanges. If this challenge were to prevail, large employers in these states could drop coverage without risk of triggering the shared responsibility penalty that will begin in 2015, since none of their workers could receive subsidized coverage in the exchange being operated in their state.⁶⁸ On the other hand, some employers in these states might be prompted to maintain coverage since the individual exchanges will be much less viable alternatives for their workers if subsidies are not available.

Changes in the Tax Treatment of Premium Expenses

Finally, there is the possibility of tax reform. Under the current tax code, which excludes premiums for employer-sponsored health insurance from income and payroll taxes, there is a tremendous incentive to provide and obtain health insurance through the workplace. CBO estimates that the exclusion will lead to \$248 billion in lost revenue for the federal government in 2013 alone,⁶⁹ making it the largest of the "tax

expenditures" in the individual income tax code and a prime target of efforts to balance the federal budget and reduce the deficit. In recent years, numerous reform proposals have recommended limiting the ESI tax exclusion to policies costing less than a predefined threshold (e.g., the 75th or 80th percentile of ESI premiums), slowly phasing the exclusion out completely, or replacing the exclusion with a tax credit or deduction.⁷⁰ Some proposals coordinate the recommended changes with an elimination of the ACA's Cadillac tax since both target excessive health benefits.⁷¹ Given the complexity of changing the tax code, the political entrenchment around budget reform and what seems to be an improving budget outlook,⁷² it remains to be seen whether policymakers will tackle the thorny issue of tax treatment of ESI premiums in the next few years. Any changes they do make, however, have the potential to reset the incentives around ESI dramatically.

In sum, the next few years will be an interesting and dynamic time for employer-sponsored health insurance, marked by continuation of ongoing efforts to reduce the cost of coverage and improve the value of health spending as well as by a new set of opportunities and incentives put in place by the ACA. Developments on all fronts bear careful watching.

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ABOUT THIS BRIEF

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This document is the fifth in a series of briefs on topics relevant to our nation's high health care spending and health insurance. Earlier briefs provided an overview of health care spending in the United States (May 2012), examined government spending for health entitlement programs (June 2012), explored the concentration of health care spending within a small portion of the population (July 2012) and examined the drivers and impacts of rising spending for private insurance (January 2013).

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