The Affordable Care Act (ACA) has had its fair share of challenges. The 2012 presidential election, the Supreme Court review and the difficult rollout of the federally facilitated public exchange are a few noteworthy examples. In this article, the authors take a look at the impact of ACA through an employer lens, considering its aftereffects in many traditional areas of benefits management and some new ones.

Plan Design—Turning Up Consumerism

It is a stretch to say the world of copay plan designs is dead, but ACA has accelerated the adoption of consumer-directed health plans (CDHPs), including account-based plans and standalone high-deductible plans. Plan sponsors are looking to these models as a strategy to promote greater consumerism in their employees, lower costs and provide a platform to reward healthy behaviors. With the 2018 Cadillac tax facing many employers, the opportunity to lower total health care costs has been top of mind, and CDHPs are clearly part of that strategy for a growing number of companies. The PricewaterhouseCoopers (PwC) Health and Well-Being Touchstone Survey provides some illustrative data highlighting this shift. In 2010, 13% of respondents indicated high-deductible plans had the highest enrollment among their plan options. By 2014, this number doubled to 26%, surpassing enrollment in health maintenance organizations (HMOs) and point-of-service (POS) plans (Figure 1).

While CDHP adoption among plan sponsors continues to
increase, plan sponsors also are looking to use plan design to drive the right behavior and value from the health care system. In value-based insurance design (VBID), the plan design is structured to encourage or discourage the use of specific health care services based on whether there are clinical benefits relative to their cost. The most common examples have been found in prescription drug plans where certain drug categories require lower cost sharing to promote medication adherence, typically for chronic conditions such as diabetes and asthma. Using the PwC Touchstone survey as a barometer of change in this area, we also see a dramatic increase in the number of employers considering value-based design elements as a strategy to manage costs and improve quality, increasing by almost double between the years 2011 and 2014 (Figure 2).

Plan Eligibility and Cost Sharing—Revisiting the Role of Dependents and Health Habits

With the advent of broader access to coverage, one of the most dramatic impacts of ACA has been the increased focus on employer-provided dependent coverage. With new taxes levied on self-insured plans tied to covered lives (employees and dependents), such as the Patient-Centered Outcome Research Initiative (PCORI) and the Transitional Reinsurance Program (TRP), the need to trim dependent rolls grows. Add in the need to manage total health care costs to avoid or delay the excise tax in 2018, and it is no surprise plan sponsors are taking a harder look at who is enrolled in their plans and modifying contribution strategies accordingly.

While employers frequently have looked for strategies to reduce costs through newer plan designs, two clear trends in plan participation and cost sharing are evident: Employers are looking at ways to take costs out of their plan through spousal surcharges or by removing dependents with access to other coverage options.

For example, last year a major national employer announced it would be eliminating spousal coverage for employees when the spouse has access to coverage through his or her employer. In rolling out this strategy, the company cited its need to provide affordable coverage to its employees and the increasing costs associated with health reform.

The use of other surcharges—applied to employees or dependents—is also on the rise and applied to those with poor health habits (e.g., smokers). ACA has helped to broaden the ability for employers to apply such incentives related to health behaviors.

Worksite Wellness—Doubling Down on the Investment in Health and Well-Being

With the 40% excise tax on high-cost health plans looming in 2018, the need for bending the cost curve has never been greater. And while less than one in five believes these programs are currently very effective at mitigating health care costs, nearly 90% are likely to increase their efforts in the health and wellness arenas. In fact, increasing company efforts related to wellness and health management is the most commonly cited strategy in reaction to ACA.

Central to those efforts are increased efforts to promote employee engagement in these programs. While four out of five already use incentives to promote those programs, incentives increasingly will move beyond participation in...
health care reform “lookback”

FIGURE 2
Employers Considering Use of Value-Based Insurance Design


TABLE
Impact of State and Federal Fees, Taxes and Mandates Pre- and Post-ACA

<table>
<thead>
<tr>
<th>Prior to ACA (and current)</th>
<th>Insured</th>
<th>Self-insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>State premium taxes</td>
<td>X</td>
<td>No</td>
</tr>
<tr>
<td>State benefits mandates</td>
<td>X</td>
<td>No</td>
</tr>
<tr>
<td>Insurer risk/profit charges</td>
<td>X</td>
<td>Less</td>
</tr>
<tr>
<td>Post-ACA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health industry tax</td>
<td>X</td>
<td>No</td>
</tr>
<tr>
<td>PCORI fees</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reinsurance fees</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Federal benefits mandates</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Excise tax on high-cost plans (2018)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The majority of the attention for ACA has been on the health insurance reform elements such as mandating essential health benefits, eliminating preexisting condition clauses, expanding access to the uninsured and setting medical loss ratio thresholds. Perhaps the most remarkable of the changes associated with the law are the trends in health care delivery, and many plan sponsors have been at the forefront of these efforts. The days of determining the value of a provider network based purely on discounts or access measures are numbered. Plan sponsors are looking for network strategies that reduce the unnecessary variation in costs and poor quality that are found among broad PPO networks while also implementing solutions that align the delivery of care with their population health needs and strategies.

The core elements of these efforts have focused on moving from a pay-for-volume world to a pay-for-value model and new delivery models, such as accountable care organizations and patient-centered medical homes, which are perhaps the more well-known. Many carriers are investing significant-
health care reform "lookback"

INCREASING FOCUS ON HEALTH CARE DELIVERY

- Accountable care organization (ACO)-covered lives are estimated to be over 20 million. Of the 626 ACOs tracked across the United States, 210 have commercial contracts and 74 have both government and commercial contracts. (Leavitt Partners).
- 37% of employers are considering or have already implemented a performance-based network.
- 26% of employers are considering or have already implemented direct contracting with providers (PwC 2014 Health and Well-Being Touchstone Survey).

FINANCING—NAVIGATING SHIFTING ECONOMICS
OF HOW TO FINANCE HEALTH CARE BENEFITS

With the advent of new taxes and fees, the economics of how benefits have been provided also have shifted. Most large employers traditionally have self-insured while many midsized and small employers have opted to be insured; with the advent of ACA, the economics have shifted even further toward being self-insured for midsized to large employers (table).

Insurance programs always have been subject to added costs relative to self-insured programs, including the costs associated with state premium taxes, state benefit mandates and additional insurer risk and profit charges. Many of the

FIGURE 3

Future Directions for Wellness Programs


Published in PwC's Health and Well-Being Touchstone Survey.
new federally imposed ACA taxes, fees and benefit mandates apply equally to insured and self-insured plans. However, the Health Industry Tax, which is imposed on insurance companies based on insurance premiums only, is resulting in additional assessments on insured plans of as much as 3% of premium. When added on to the prior “insured differential,” the total gap in costs is now 6-10%. With such a significant cost differential, this will influence financing decisions moving forward.

Benefits Delivery and Outsourcing—Private Exchanges as the Newest Next Generation

Finally, no benefits trend has been as visible and potentially transformational as the emergence of private exchanges. Coming in the wake of (and, in some instances, mirrored after) the ACA public exchanges (or “marketplaces”), the new approach to private exchanges is now seen by many employers as a key strategic alternative to managing their own benefit programs.

Some private exchanges are developing a point of view about “best practice models” that will help employers accelerate strategies they might do on their own. In fact, some more complex strategies may be expedited by a private exchange strategy including approaches that will facilitate a true managed competition model. While the current take-up rate in private exchanges is in its infancy, the interest is significant (Figure 4).

Like their public exchange counterparts, the assessment of private exchanges will continue to evolve as the
market matures and the evidence of their impact and effectiveness emerges. In any event, the impact of these new emerging technologies related to a greater choice, value-based design and an improved consumer shopping experience will have a continuing influence going forward.

Conclusion

The bottom line is that ACA has had the net impact of helping to “tip” the momentum in a number of major ways in benefits management strategy (Figure 5). While the direct impacts of ACA are still being determined and debated, there is no doubt that the indirect effects have been significant.

AUTHORS

Greg Mansur is a principal at PricewaterhouseCoopers and has more than 24 years of health care consulting experience working with plan sponsors, payers and providers to develop strategy, understand cost drivers, improve program performance and optimize operational effectiveness. He previously was a specialty practices leader in North American health and group benefits at Towers Watson, a director at Deloitte Consulting and managing director at Pace Healthcare Management. Mansur holds a B.S. degree in economics from California State Polytechnic University–Pomona and an M.P.H. degree from the University of California, Los Angeles–School of Public Health.

Michael Thompson is a principal in Global Human Resources Services at PricewaterhouseCoopers. He has over 25 years of experience in health care and employee benefits strategy development and implementation, design, financing, pricing, operations and analysis. Thompson consults with major employers and health plans on integrated health, wellness and consumerism, defined contribution retiree health, vendor performance management, human capital effectiveness and health care supply chain management strategies. Thompson is a fellow of the Society of Actuaries and is chairman of the Quality Initiatives Subcommittee of the American Academy of Actuaries. He holds a B.S. degree in mathematics from Union College.

International Society of Certified Employee Benefit Specialists

Reprinted from the First Quarter 2015 issue of BENEFITS QUARTERLY, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.

©2015 International Society of Certified Employee Benefit Specialists