



Health Care Reform: What Employers Are Considering

**SURVEY RESULTS
MAY 2010**

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About the International Foundation of Employee Benefit Plans

The International Foundation of Employee Benefit Plans is a nonprofit organization, dedicated to being a leading objective and independent global source of employee benefits and compensation education and information. Total membership includes 36,000 individuals representing 8,400 multiemployer trust funds, corporations, public employer groups and professional advisory firms throughout the United States and Canada. Each year, the International Foundation offers over 100 educational programs, including conferences and e-learning courses. Membership provides access to personalized research services and daily news delivery. The International Foundation sponsors the Certified Employee Benefit Specialist® (CEBS®) program in conjunction with the Wharton School of the University of Pennsylvania and Dalhousie University in Canada.

About the International Society of Certified Employee Benefit Specialists

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

About Research at the International Foundation

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

I. INTRODUCTION

Now that health care reform legislation has been signed into law, employers are trying to assess the expected impact and how to respond.¹ In May 2010, the International Foundation conducted a survey of employers in order to determine how they are reacting to the changes brought about by the new health care reform legislation and the strategies being considered.²

What actions are organizations likely to take and in what time period? Are they apt to implement changes to eligibility before they are required by law to do so? The survey offers benchmarks of how employers are responding to a host of health care reform challenges with particular emphasis on immediate considerations and approaches for complying with the new law.

Those asked to participate in the survey were single employer plans (including corporations) in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCEBS).³ Survey responses were received from 1,021 individuals including benefits professionals (68.7%) and human resources professionals (21.8%). These individuals have a tremendous amount of experience and insight regarding the health benefits arena; they are positioned to understand strategies that are currently working and are carefully reviewing their practices and policies in light of the new highly complex legislation.

The research sample includes respondents from a wide variety of industries, with manufacturing and distribution (20.9%), insurance (14%), and health care and medicine (13.8%) being the most prevalent. The total annual revenue of organizations represented ranges from less than \$1 million to over \$1 billion. Employers with \$1 million-\$99 million in revenue or over \$1 billion are the most prevalent (27.9% and 23.2%, respectively).⁴

This report has ten sections beyond this introduction. Sections II and III provide key findings and a demographic profile of respondents. Detailed findings are presented in Sections IV-X. Section IV explores changing medical plan eligibility requirements for dependents, while Section V examines the impact of legislation on the use and structure of high-deductible health plans. Employers' approaches to eliminating lifetime and restrictive annual limits and preexisting condition exclusions are discussed in Section VI.

Section VII focuses on the extent to which the elimination of restrictions, e.g., annual and lifetime maximums, is influencing employers' choice of funding methods. Section VIII examines the extent to which the newly passed health care reform bill (including the early retiree reinsurance program) is impacting employer-sponsored retiree health benefits. Communication and education initiatives about health care reform are reviewed in Section IX. Section X identifies the major health care reform requirements impacting plan costs and presents the views of responding employers concerning various aspects of health care reform legislation. Conclusions are presented in Section XI.

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

¹ On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Along with revisions contained in the Health Care and Education Reconciliation Act (HCERA), which the President signed into law on March 30, 2010, the "Affordable Care Act" establishes a comprehensive system of health care reform. Changes to the ways in which health care is accessed, delivered and financed have significant implications for employers and other stakeholders.

² Many of the Reform Act's provisions will not go into effect for several years; however, there are numerous provisions to address and comply with before the end of 2010. Examples include prohibiting lifetime limits, restricting annual limits and providing health coverage for adult children until the child reaches age 26.

³ *Single employer plans* are maintained by one employer or by related parties such as a parent company and its subsidiaries.

⁴ For questions about their primary medical plan, respondents were asked to refer to the plan in which the majority of their active employee participants in the United States are enrolled. The reader is cautioned that the limited sample size for some questions and the nonrandomized sampling methodology may restrict the extent to which findings can be generalized in some situations. Duplicates at the individual level were removed. In some instances, the percentages in single-response questions may not sum to 100% due to rounding. Also, percentages in exhibits displaying multiple-response questions may exceed 100%.

II. KEY FINDINGS

This section presents major survey findings regarding the timing of employers' compliance with provisions in the new health care reform legislation and the impact of the new legislation on plan coverage, funding, communications and health plan strategies.

Dependent Coverage

- Only one in five (19.5%) responding employers is planning to change primary medical plan eligibility requirements for employees' adult children up to age 26 before required to do so by law. Two-thirds of employers are not extending coverage to adult children up to age 26 until legally required. About 5% of respondents' plans currently meet legal requirements; 9% are not sure.
- Close to half (47.1%) of the surveyed organizations currently have no preexisting condition exclusions in their plans for children under age 19; accordingly, they have no exclusions to remove from their plans in order to meet the new requirements. Only 5.7% of respondents are planning to remove all preexisting condition exclusions for children under age 19 before they are required to do so in 2011.
- Almost half (45.5%) of responding employers are not sure how they are going to address cost-sharing for dependent coverage (for their primary medical plan) in light of health care reform changes. Adding new tiers to the cost-sharing structure is a strategy that one in ten employers plans to pursue.
- Over half (53.4%) of the responding employers are not sure if they will change the eligibility requirements for dependents on other benefit plans (e.g., dental, vision, life insurance, accidental death and dismemberment) to conform to the rules for medical plans (thereby maintaining the same definition of dependent children for all plans) or only apply the new rules to the primary medical plan. The latter approach would result in maintaining and communicating different sets of eligibility rules and not maintaining consistency.
- Approximately 42% of responding employers plan to extend dental plan coverage to adult children in order to match their medical plan requirements. About 32% of respondents plan to extend vision benefit coverage to adult children. Extending life insurance and accidental death and dismemberment coverage to adult children is less common (9.7% and 6.4%, respectively).

High-Deductible Health Plans

- More than two in five surveyed employers (42.8%) have adopted at least one high-deductible health plan (HDHP).⁵ Of those employers currently offering an HDHP, considerably more respondents offer an HDHP coupled with a health savings account (HSA) (68.6%) than linked to a health reimbursement arrangement (HRA) (27.5%).⁶
- One in five employers (21.1%) are planning to add or increase emphasis on HDHPs in the next 12 months; in contrast to one in ten employers (10.2%) planning to stay away from or drop HDHPs. Close to half of responding employers report that within the next 12 months, they are planning no changes in their HDHP offerings.

⁵ A *high-deductible health plan (HDHP)* is a lower cost insurance policy that features a higher annual deductible than that of a traditional health insurance arrangement. HDHPs were created to provide affordable coverage for health events that might wreak financial havoc on a household. With an HDHP, the insured pays for nearly all medical expenses until the annual deductible amount is reached. The deductible is usually at least \$1,000; then traditional health insurance coverage begins.

⁶ A *health savings account (HSA)* is a tax-exempt trust or custodial account created for employees and retirees who are covered under an HDHP. Contributions to the account can be made by the employer and/or the employee. The employee, not the employer, owns the account, which makes the account portable. A *health reimbursement arrangement (HRA)* is a tax-exempt arrangement established by and funded by employers for employees and retirees to use for qualified medical expenses. Money remaining in the account at year-end can roll over and be used to cover future medical costs, but the portability of the account is left to the discretion of the employer.

- Those employers planning to add or increase their emphasis on HDHPs are more likely to focus on account-based plans linked to HSAs (68.8%) than coupled with HRAs (24.2%), or HDHPs without an account attached (12.1%).

Approaches to Eliminating Limits and Restrictions

- Approximately 80% of total respondents report that their plans currently include lifetime maximum provisions on essential benefits.⁷ Of these, only 4.4% are removing lifetime maximums before they are required to do so; 85.6% are not making changes until required, and 10% are not sure. About 70% of total respondents report that their plans currently set annual maximums on essential benefits. Of these, only 3.6% are removing annual maximums before they are required to do so; 84.6% are not making changes until required, and 11.8% are not sure.
- Approximately half of total respondents have plans that include preexisting condition exclusions. Of these, only 4.5% are removing the exclusions before required to do so; 81.2% are removing these exclusions when legally required, and 14.3% are not sure.
- Twenty-two percent of total respondents offer primary medical plans that apply a waiting period greater than 90 days for coverage. Of these, only 8% are changing the eligibility requirement before they are required to do so; 69.6% are not making the change until required, and 22.3% are not sure.

Funding Approaches

- A large majority (64.1%) of surveyed organizations currently finance their health care benefits using a self-funded approach.⁸ Half of all responding employers currently use a self-funded approach with stop-loss coverage.
- As a result of health care reform legislation, approximately 16% of responding employers are making one or more changes in their approach for funding their primary medical plan. Only 2.9% of organizations already providing a self-funded plan are considering purchasing stop-loss coverage for the first time, and 5.9% plan to purchase additional stop-loss coverage.
- Just over one-third (34%) of respondents currently are fully insured. In light of the changes imposed by health care reform legislation, only 2% of survey respondents are considering becoming fully insured.

Retiree Coverage and Health Plan Benefit Strategies

- Approximately two in five (39.2%) responding organizations currently offer medical benefits to retired employees. Of these, approximately three in five employers (60.8%) plan to review their health plan benefit strategies for early retirees (55-64 years old) in the next 12 months; half intend to examine their strategies relating to retirees who are 65 and older.
- More than half (51.9%) of the responding employers currently offering medical benefits to retirees plan to apply for the temporary early retiree reinsurance program in the Affordable Care Act.⁹
- As a result of eliminating the deduction for expenses allocable to the Medicare Part D retiree drug subsidy, one in ten respondents currently offering medical benefits to retirees indicated that they may terminate their retiree prescription drug plan.

⁷ *Essential health benefits* include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

⁸ Under a *self-funded* scenario, the benefit plan sponsor essentially acts as its own insurer, determining what will be covered by the plan and paying claims directly. Some self-funded plans contract with an insurance company or other third party to administer the plan; most purchase stop-loss insurance as protection against catastrophic losses above a specific dollar amount.

⁹ The Affordable Care Act establishes a temporary reinsurance program for group health plan sponsors who cover early retirees (ages 55-64) who are not yet eligible for Medicare.

- A majority (56.8%) of responding employers are not sure whether they will offer Community Living Assistance Services and Support (CLASS) Act benefits, awaiting further clarification of premiums and regulations before they decide.¹⁰ Approximately 11% of employers indicate that they will consider offering CLASS benefits to employees, with or without other long-term care benefits.

Communication/Education Initiatives About Health Care Reform

- Responses are mixed concerning whether employers have noticed an increase in the number of participant contacts regarding health care reform legislation: half of responding employers report an increase in the number of contacts made by active employee participants, 44.4% state that there has not been an increase in contacts by this group while 6.1% cite an increase in contacts by retirees.
- For the most part, organizations have not started communicating with participants about health care reform legislation, but plan to take advantage of their annual enrollment period to begin their communications.
- Communication and education channels currently being used (or planned) to reach participants about the new legislation include e-mails to participants (50.5%), special written communication pieces (48.5%) and the organization's Web site (42%).

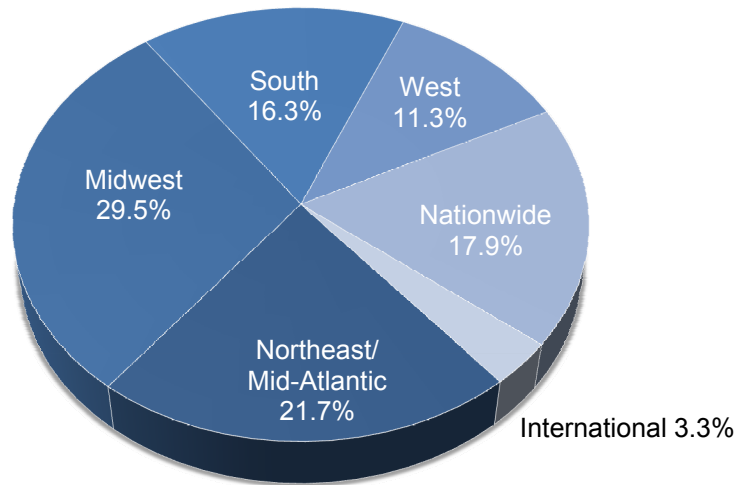
Top Provisions Impacting Plan Costs and Other Opinions on Health Care Reform Legislation

- Three-quarters of responding organizations identify extending coverage to adult children until they reach age 26 as the major health care reform requirement impacting plan costs, followed by additional W-2 reporting requirements (39.1%), the elimination of lifetime maximums (36.2%) and the elimination of annual limits on essential benefits (34.2%).
- Approximately 87% of respondents agree that their organizations will continue to offer health care benefits because they are critical to employee recruitment and retention and remaining competitive.
- The new law increases the level of financial incentives available to employees who participate in employer-provided wellness programs from 20% of health insurance premiums to 30%, effective in 2014. Approximately two-thirds of respondents agree that in 2014, their organizations will take advantage of this legal provision and offer increased employee rewards.
- Close to half of all respondents are focusing on redesigning their health plans so that by 2018, their plans will avoid triggering the excise "Cadillac" tax for high-value plans.
- One in ten respondents agree that the tax on the federal subsidy will result in employers dropping retiree prescription drug plans by 2013.

¹⁰ The CLASS program is a new voluntary federal program that differs from a traditional long-term care program in that it is meant to provide supplemental income to cover the extra expenses of living disabled in the community rather than pay amounts directly for caregiver or institutional care expenses. The intent of this program is to supplement and not replace private long-term care insurance.

III. DEMOGRAPHIC PROFILE OF RESPONDENTS

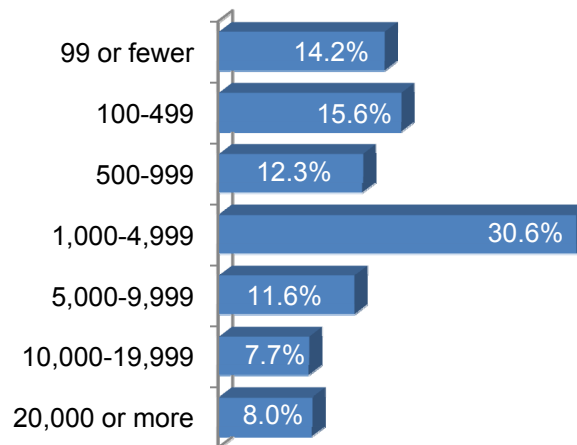
Exhibit 1: Region* (n=1021)



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

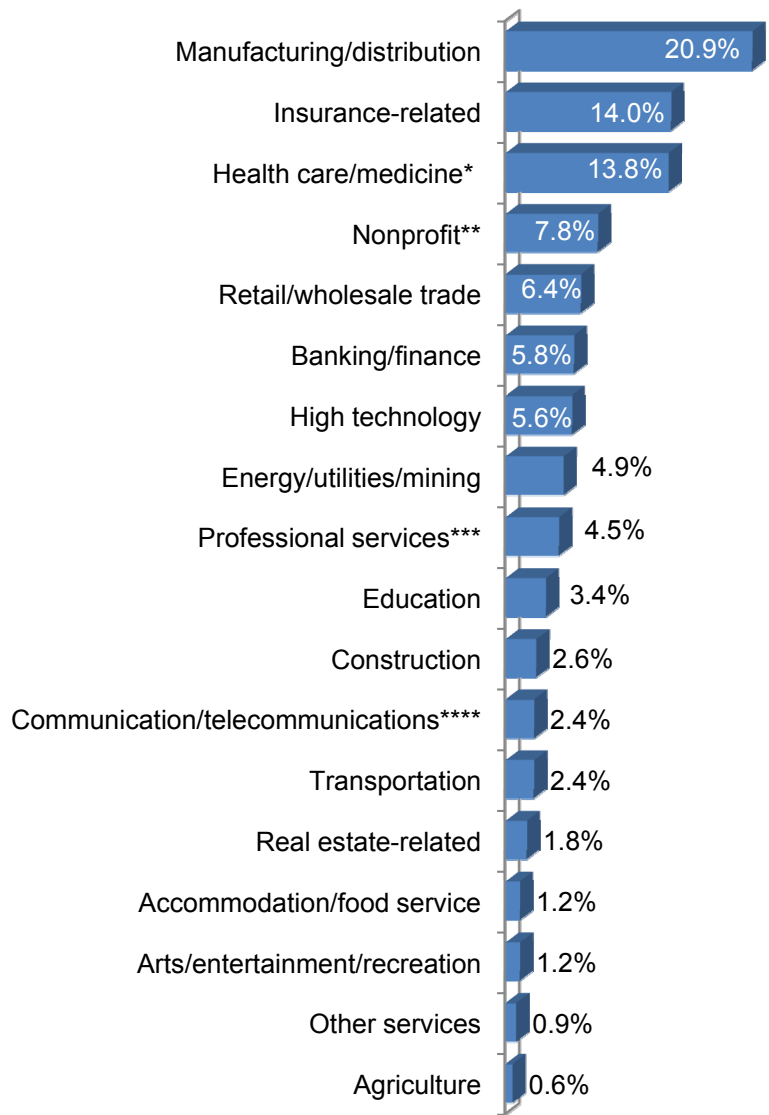
- Employers located in the Midwest (29.5%) or Northeast/Mid-Atlantic (21.7%) regions are more prevalent in the sample of employers than those located in other regions or having a nationwide or international presence.

Exhibit 2: Number of Employees (n=1021)



- Sampled organizations are dispersed across all employee-size categories. Organizations with 1,000-4,999 employees are almost twice as prevalent as other size categories.

Exhibit 3: Primary Industry (n=1021)



*Includes biotech, pharmaceutical, medical equipment and device manufacturing and sales.

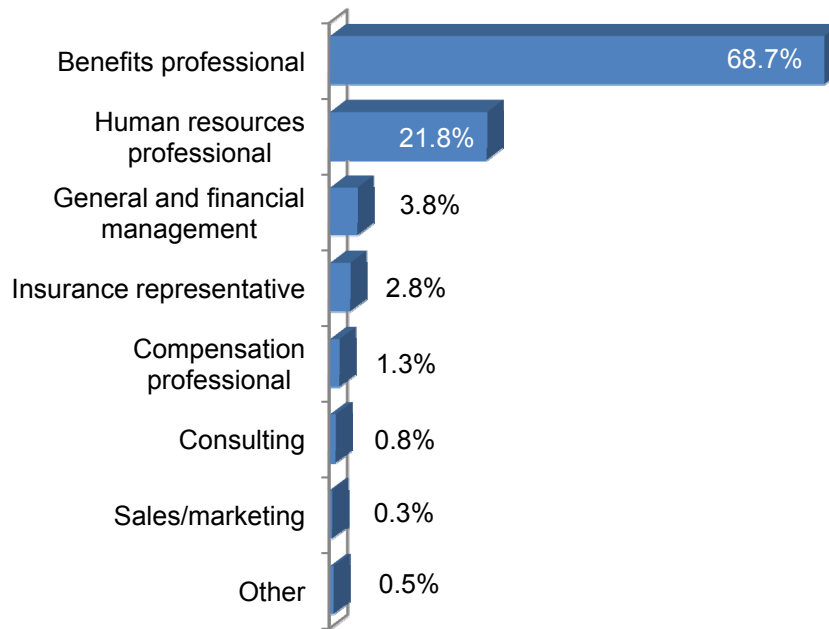
**Includes government entities as well as other nonprofit organizations.

***Includes consulting, engineering and legal services.

****Includes media, public relations and publishing.

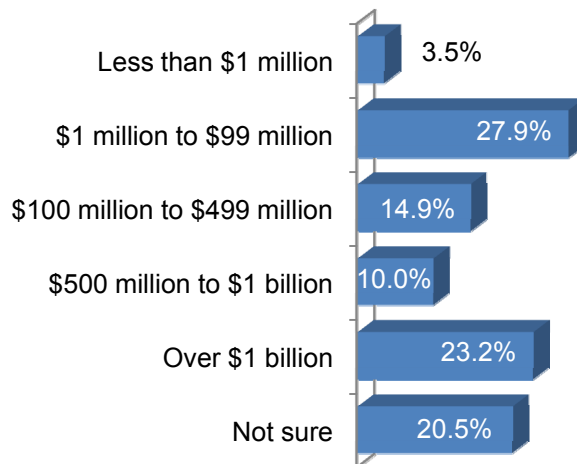
- The bulk of organizations in the survey sample are drawn from manufacturing and distribution (20.9%), insurance and related fields (14%), and health care and medicine (13.8%).

Exhibit 4: Role/Relationship to Health Plan (n=1021)



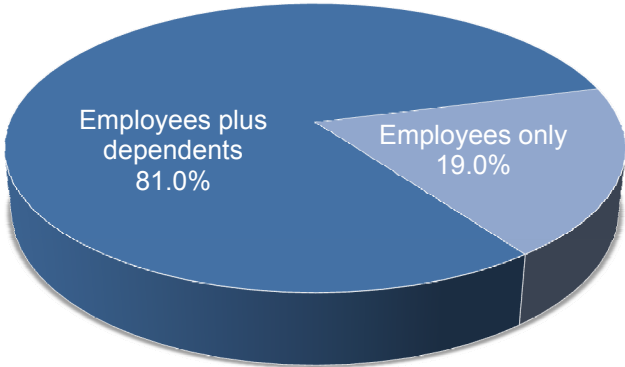
- Most health plan representatives completing the survey serve as benefits professionals (68.7%) or human resources (HR) professionals (21.8%).

Exhibit 5: Most Recent Total Annual Revenue (n=1021)



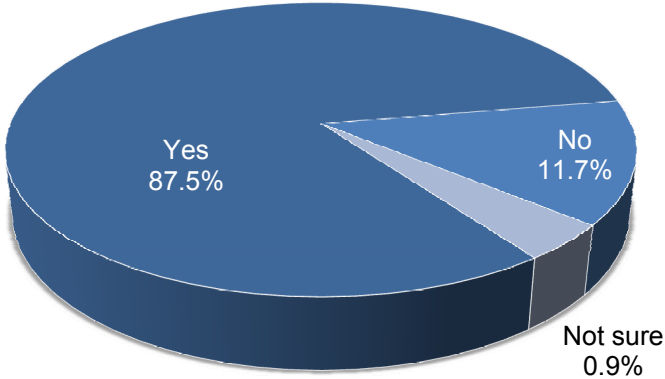
- All but 3.5% of organizations have total annual revenue greater than \$1 million. Employers with \$1 million to \$99 million in revenue or over \$1 billion are the most prevalent (27.9% and 23.2%, respectively).

Exhibit 6: Offer Medical Benefits to Full-Time Employees (n=1021)



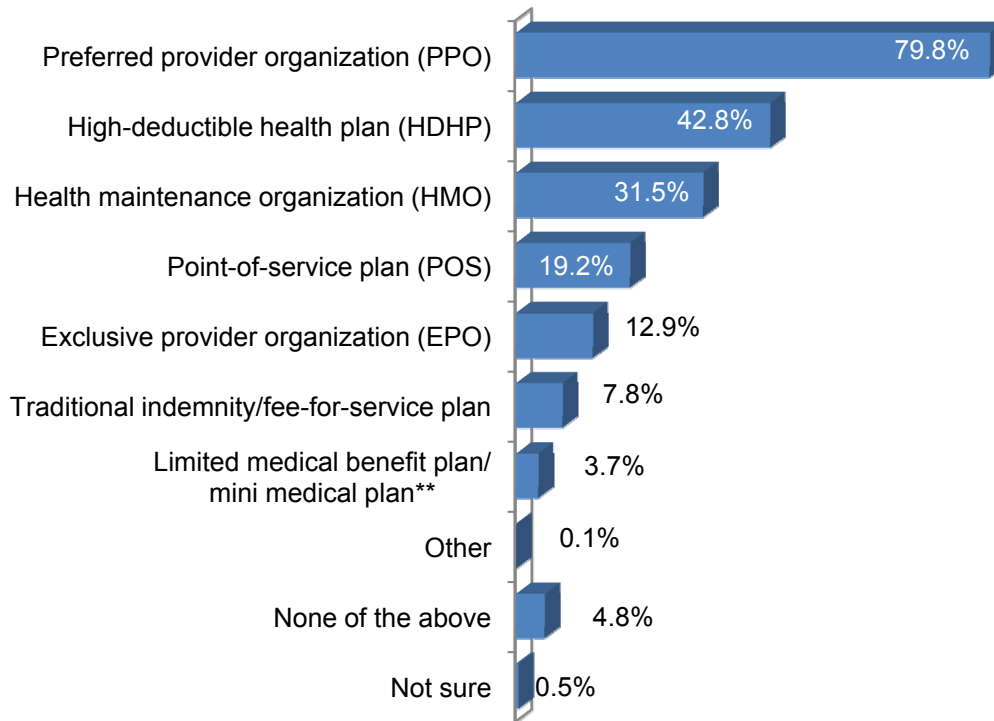
- All respondents offer medical benefits to full-time employees. Eighty-one percent of surveyed employers provide medical benefits to full-time employees plus dependents, while 19% offer medical coverage to full-time employees only.

Exhibit 7: Offer Medical Benefits to Employees Working 30-39 Hours Weekly (n=1021)



- Close to nine in ten responding organizations currently offer medical benefits to employees who work 30-39 hours on average per week.

Exhibit 8: Types of Medical Plans Offered* (n=1021)



*Respondents were asked to select all that apply.

**Reduced set of benefits for lower premium.

- Approximately four in five responding employers have a preferred provider organization (PPO) plan.
- More than two in five employers have adopted at least one high-deductible health plan (HDHP).¹¹ These plans are reviewed more closely in Section V.
- Other medical plans widely offered include a health maintenance organization (HMO) option (31.5%), a point-of-service plan (19.2%) and an exclusive provider organization (12.9%).

¹¹ A *high-deductible health plan (HDHP)* is a lower cost insurance policy that features a higher annual deductible than that of a traditional health insurance arrangement. HDHPs were created to provide affordable coverage for health events that might result in financial havoc on a household. With an HDHP, the insured pays for nearly all medical expenses until the annual deductible amount is reached. The deductible is usually at least \$1,000; then traditional health insurance coverage begins.

Exhibit 9: Health Care Benefits Offered to Active Employees (n=1021)

Prescription drug coverage	
Offered as part of medical plan	94.0%
Offered as a separate plan	5.3%
Do not offer	0.7%
Not sure	0.0%
Dental benefits	
Offered as part of medical plan	9.1%
Offered as a separate plan	88.6%
Do not offer	2.3%
Not sure	0.0%
Vision benefits	
Offered as part of medical plan	23.2%
Offered as a separate plan	64.5%
Do not offer	12.1%
Not sure	0.1%

- Close to 100% of surveyed employers offer prescription drug coverage either as part of the medical plan (94%) or as a separate plan (5.3%).
- Responding employers are considerably more likely to offer dental benefits through a separate plan (88.6%) than as part of the medical plan (9.1%).
- Nearly two-thirds of surveyed organizations offer vision benefits through a separate plan; close to one-quarter offer vision coverage as part of the medical plan.

Exhibit 10: Benefits Offered to Active Employees and Dependents (n=1021)

Dental benefits	
Offer to employees only	2.0%
Offer to employees plus dependents	95.8%
Do not offer	2.2%
Not sure	0.1%
Vision benefits	
Offer to employees only	2.9%
Offer to employees plus dependents	83.6%
Do not offer	13.2%
Not sure	0.2%
Life insurance	
Offer to employees only	24.9%
Offer to employees plus dependents	72.5%
Do not offer	2.4%
Not sure	0.2%
Accidental death and dismemberment (AD&D) insurance	
Offer to employees only	52.8%
Offer to employees plus dependents	40.1%
Do not offer	6.6%
Not sure	0.6%
Long-term care insurance	
Offer to employees only	10.1%
Offer to employees plus dependents	26.1%
Do not offer	63.3%
Not sure	0.6%

- Benefits commonly offered to both active employees plus dependents include: dental benefits (95.8%), vision benefits (83.6%) and life insurance (72.5%); less frequently, employers provide these benefits to active employees only.
- Employers are more likely to provide accidental death and dismemberment (AD&D) insurance to active employees only (52.8%); coverage for employees as well as their dependents is less prevalent (40.1%).
- Only 36.2% of respondents report that their organizations offer employer-sponsored long-term care insurance; 26.1% offer coverage to employees as well as dependents, and 10.1% provide coverage to employees only. These results are not surprising when compared to the findings of another International Foundation survey on voluntary benefits, which found that long-term care insurance is frequently a voluntary (employee-paid) product that is currently offered (or planned to be offered within 12 months) by half of the survey respondents.¹²

¹² International Foundation of Employee Benefit Plans. *Top Trends in Voluntary Benefits: Survey Results*. Cosponsored by *Employee Benefit News*. 2009.

IV. DEPENDENT COVERAGE

This section examines the extent to which employers are expanding coverage for dependents before they are required to do so. Employers' cost-sharing initiatives also are analyzed.

For plan years beginning on or after September 23, 2010, a group health plan is required to extend coverage to an employee's dependents up to age 26 regardless of factors such as a young adult's marital status, student status, residency, financial dependence on the primary enrollee or eligibility for other coverage. In addition, the coverage will not be taxable to the employee or dependent. Generally, the dependent coverage extension requirement applies to existing group health plans as of the first plan year that begins on or after September 23, 2010. For calendar year plans, which are the most common, the effective compliance date is January 1, 2011. It is estimated that of the nation's 29.5 million young adults (ages 19-25), 2.37 million potentially would enroll in a parent's plan.¹³

In order to continue coverage for graduating students, insurers and employers have been encouraged to adopt this provision before the date required by law. Some insurance companies have reported that they will allow children graduating in spring or summer 2010 to remain on their parent's individual plans rather than dropping and reinstating them when the new law takes effect. For group plans, it is the employer's decision whether to let young adults remain in the plan or rejoin before the mandatory implementation date.

The expansion of eligibility for adult children up to age 26 also applies to grandfathered plans; however, coverage need not be offered by a grandfathered plan (until 2014) if the adult child has access to other employer-sponsored health coverage.¹⁴ Plans that are grandfathered will not lose that status because they comply or implement the new coverage early.

Beginning in plan years six months after the date of enactment, a group health plan may not impose any preexisting condition exclusions on children under 19, i.e., employers are required to remove preexisting condition exclusions, if any, for children up to age 19. This provision will be expanded in 2014; group health plans will be completely prohibited from imposing any preexisting condition exclusions.

¹³ *Federal Register*, May 13, 2010, Volume 75, Number 92.

¹⁴ A *grandfathered plan* is one in existence when the law was enacted, i.e., group health plans in effect on March 23, 2010, are considered grandfathered plans. Grandfathered plans have delayed effective dates for certain changes. Losing that status would mean the plan would have to comply with additional provisions in the law. Interim final rules for plans to retain grandfather status were jointly issued by the Departments of Labor, Health and Human Services, and Treasury during the week of June 14, 2010. These rules significantly limit employers' ability to restructure health benefit plans, increase cost-sharing or change contribution levels if employers seek to retain grandfather status.

Exhibit 11: Changes to Eligibility Requirements of Medical Plan for Dependents (n=1021)

Extending coverage to adult children up to age 26 (required in 2011)	
Changing before required	19.5%
Not changing until required	66.5%
No change needed, plan already meets legal requirements	5.4%
Not sure	8.6%
Extending coverage to adult children up to age 26—regardless of the availability of other employer-sponsored coverage (required by grandfathered plans in 2014)	
Changing before required	13.5%
Not changing until required	67.9%
No change needed, plan already meets legal requirements	4.8%
Not sure	13.8%
Removing all preexisting condition exclusions for children under age 19 (required in 2011)	
Changing before required	5.7%
Not changing until required	39.9%
No change needed, plan already meets legal requirements	47.1%
Not sure	7.3%

- Only one in five responding employers is planning to change primary medical plan eligibility requirements for employees' adult children up to age 26 before required to do so by law. Two-thirds of employers are not extending coverage to young adult children up to age 26 until legally required.
- Only 13.5% of respondents plan to expand eligibility for employees' adult children up to age 26 (if the adult child has access to employer-sponsored health coverage) before legally required to do so (required for grandfathered plans in 2014).
- Close to half of the surveyed organizations currently have no preexisting condition exclusions in their plans for children under age 19.
- Only 5.7% of respondents are planning to remove all preexisting condition exclusions for children under age 19 before they are required to do so in 2011.

Exhibit 12: Cost-Sharing for Dependent Coverage* (n=1017)

Do not plan to increase cost-sharing for dependent coverage	24.4%
Increase the premium contributions (cost-sharing) for family coverage**	19.6%
Increase the dependent premium contributions (cost-sharing) for all children**	11.3%
Plan to add new tiers to the cost-sharing structure	10.7%
Increase the dependent premium contributions (cost-sharing) for children age 19 up to age 26***	10.5%
Plan to structure premiums based on income	2.9%
Plan to drop dependent coverage**	0.3%
Other	1.1%
Not sure	45.5%

*For primary medical benefit plan. Respondents were asked to select all that apply.

**Further guidance released after the survey was conducted stated that grandfathered health care plans will not be able to significantly raise copayments or deductibles, or significantly reduce benefits, or they would forfeit their grandfather status.

***Further guidance released after the survey was conducted stated that this option is not legal.

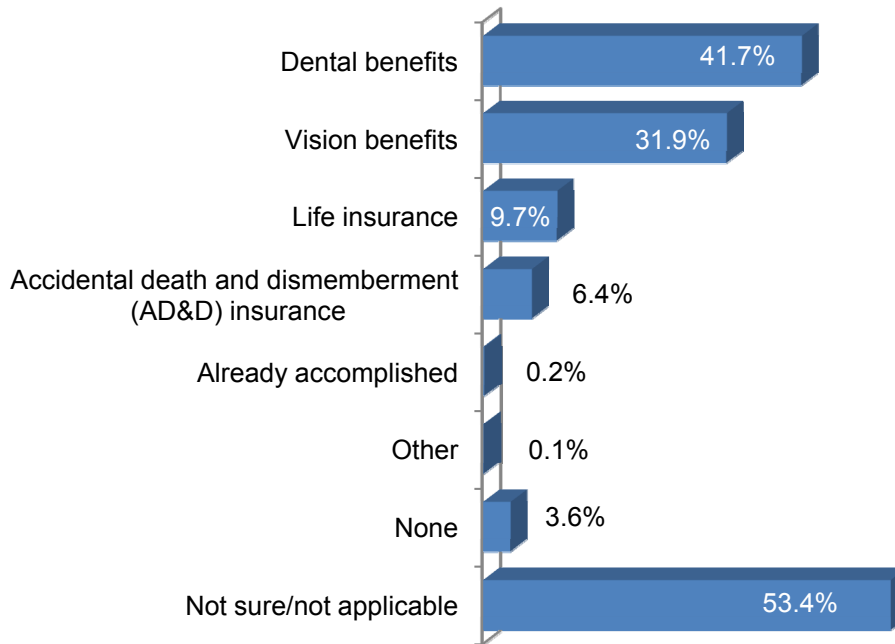
- Almost half (45.5%) of responding employers are not sure how they are going to address cost-sharing for dependent coverage (for their primary medical plan) in light of health care reform changes.
- Approximately one-quarter of respondents do not plan to increase cost-sharing for dependent coverage.
- About one in five surveyed organizations plans to increase the premium contributions (cost-sharing) for family coverage, followed by 11.3% intending to increase the dependent premium contributions (cost-sharing) for all children. These health care plans need to proceed with caution as further guidance released after the survey was conducted stated that grandfathered health care plans will not be able to significantly raise copayments or deductibles, or significantly reduce benefits, without forfeiting their grandfather status.¹⁵
- If allowed, 10.5% of respondents would increase the dependent premium contributions (cost-sharing) for children age 19 up to 26. However, further guidance stated that this option is also not legal.¹⁶ A group health plan cannot vary its terms or employee contributions based on a child's age, except if the plan covers children age 26 and older. Benefits and employee contributions must be applied equally for those under age 26. Plans, however, can have tiered pricing based on the number of family members covered.
- Adding new tiers to the cost-sharing structure is a strategy that one in ten employers plans to pursue. (One organization plans to utilize a ten-tier rating structure.)

¹⁵ Federal Register. June 17, 2010.

¹⁶ Federal Register. May 13, 2010, Volume 75, Number 92.

The survey asked employers if they will change the eligibility requirements for dependents on other benefit plans (e.g., dental, vision, life insurance, accidental death and dismemberment) to conform to the rules for medical plans (thereby maintaining the same definition of dependent children for all plans) or apply the new rules only to the medical plan. The latter approach would result in maintaining and communicating different sets of eligibility rules and not maintaining consistency.

Exhibit 13: Changes to Eligibility Requirements of Other Plans for Dependents (n=1021)



*Respondents were asked to select all that apply.

- Almost 42% of responding employers plan to extend dental plan coverage to adult children in order to match their medical plan requirements.
- About 32% of respondents plan to extend vision benefit coverage to adult children.
- Extending life insurance and AD&D coverage to adult children is less common (9.7% and 6.4%, respectively).
- Over half (53.4%) of responding employers do not provide these benefits or have not decided whether they will change the eligibility requirements for dependents on other benefit plans to match the eligibility requirements of their primary medical plans.

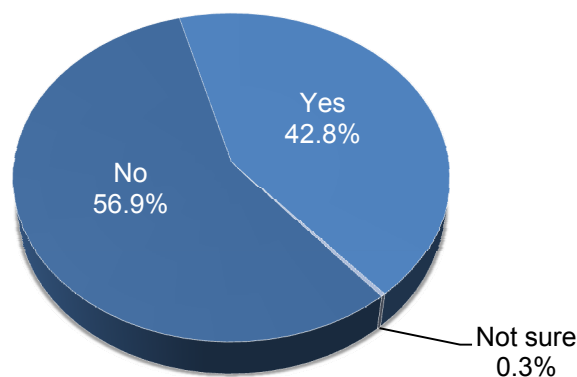
V. HIGH-DEDUCTIBLE HEALTH PLANS

It is still unclear as to how some of the provisions of the health care reform legislation will affect high-deductible health plans (HDHPs) and the accounts associated with them.¹⁷ Effective January 1, 2011, the health care reform law ends the tax-advantaged treatment of over-the-counter drugs by limiting the amounts paid from HSAs, medical FSAs and HRAs to prescribed drugs or insulin. Another provision going into effect in 2011 is an increase in the tax penalty on HSA withdrawals that are not used for qualified medical expenses from the current 10% to 20%. Effective in 2013, FSA contributions will be limited to \$2,500 per year indexed annually to the Consumer Price Index.

Other provisions potentially impacting HDHPs and associated accounts include the requirement that all insurance policies provide a minimum actuarial value of at least 60% for the benefits covered, first dollar coverage for preventive care services and the excise “Cadillac” tax.¹⁸ For example, preventive services must be covered without any cost-sharing (e.g., copayments, deductibles). Most HDHPs currently choose to provide first dollar coverage of preventive care services; however, in 2010, all HDHPs will be required to do so. For HDHPs, the excise “Cadillac” tax on high-value plans will apply to the benefit value of employer-sponsored coverage (including the value of a group health plan and contributions to employees’ FSAs, HRAs and HSAs) as of 2018.

The survey contrasts employers’ current offerings of HDHPs with changes employers anticipate making in the next 12 months.

Exhibit 14: Offer High-Deductible Health Plan (n=1021)

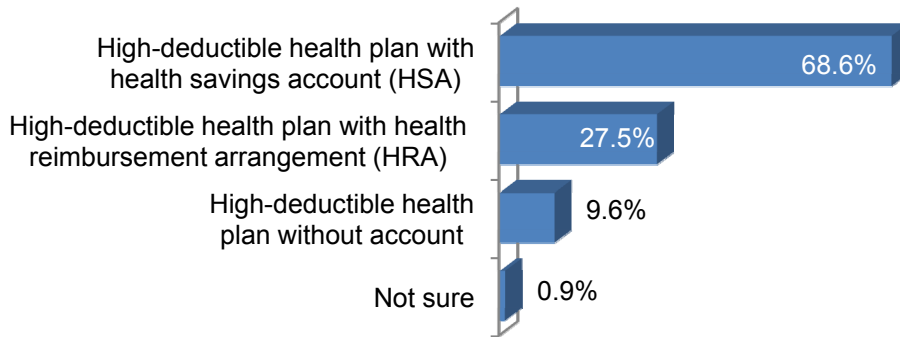


- More than two in five employers have adopted at least one HDHP. A majority of employers do not currently offer an HDHP. Employer size had no significant impact on whether employers have adopted an HDHP.

¹⁷ A high-deductible health plan (HDHP) is a lower cost insurance arrangement that features a higher annual deductible than that of a traditional health insurance arrangement. HDHPs were created to provide affordable coverage for health events that might result in financial havoc on a household. With an HDHP, the insured pays for nearly all medical expenses until the annual deductible amount is reached. The deductible is usually at least \$1,000; then traditional health insurance coverage begins. An HDHP may be offered with a *health savings account (HSA)* or a *health reimbursement arrangement (HRA)*. An HSA is a tax-exempt trust or custodial account created for employees and retirees who are covered under an HDHP. Contributions to the account can be made by the employer and/or the employee. The employee, not the employer, owns the account which makes the account portable. An HRA is a tax-exempt arrangement established by and funded by employers for employees and retirees to use for qualified medical expenses. Money remaining in the account at year-end can roll over and be used to cover future medical costs, but the portability of the account is left to the discretion of the employer. A *flexible spending arrangement (FSA)* is an account that reimburses employees for expenses incurred for specific tax-qualified benefits.

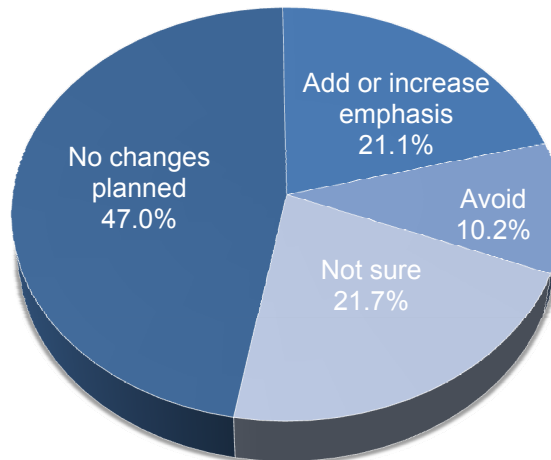
¹⁸ Health care reform legislation uses a different definition for a plans’ actuarial value than the American Academy of Actuaries. For purposes of the legislation, a plan’s actuarial value would be measured only by comparing the percentage of covered benefits paid by the health care plan relative to an identical plan with zero cost-sharing (i.e., no deductibles, copays or coinsurance). It is not clear whether a plan’s actuarial value would include employer or individual contributions made to the individual’s HSA.

Exhibit 15: Types of High-Deductible Health Plans Offered (n=437)



- While both health savings accounts (HSAs) and health reimbursement arrangements (HRAs) are tax-exempt accounts used to pay qualified medical expenses, they differ in ways that influence their appeal and popularity. Of those sampled employers currently offering an HDHP, considerably more respondents offer an HDHP linked to an HSA (68.6%) than coupled with an HRA (27.5%).
- Only one in ten respondents currently provide an HDHP without an HSA or HRA attached to it.

Exhibit 16: Changes in High-Deductible Health Plan Offerings* (n=1021)

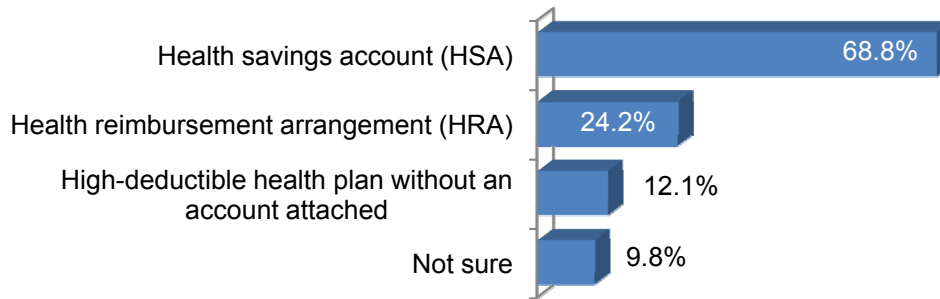


*Within the next 12 months.

- One in five employers is planning to add or increase emphasis on high-deductible health plans in the next 12 months, in contrast to one in ten employers planning to stay away from or drop high-deductible health plans. Employers planning to step up HDHPs may consider offering them to retirees as well as current employees.¹⁹
- Close to half of the respondents report that within the next 12 months, they are planning no changes in their HDHP offerings.

¹⁹ Towers Perrin, *2010 Retiree Health Care Cost Survey*. December 22, 2009.

Exhibit 17: Changes in High-Deductible Health Plan Arrangements (n=215)



*Within the next 12 months.

- Those employers planning to add or increase their emphasis on HDHPs are more likely to focus on account-based plans linked to HSAs (68.8%) than coupled with HRAs (24.2%), or HDHPs without an account attached (12.1%).

VI. APPROACHES TO ELIMINATING LIMITS AND RESTRICTIONS

This section of the report examines the extent to which employers are changing eligibility requirements on their primary medical plan before they are required to do so by removing lifetime and annual maximums on essential health benefits and all preexisting condition exclusions and changing the eligibility waiting period so it does not exceed 90 days.²⁰

For plan years beginning on or after the date that is six months following enactment, group health plans (including grandfathered health plans) may not impose lifetime limits or unreasonable annual limits on the value of essential benefits for any plan participant or beneficiary.²¹ For plan years beginning on or after January 1, 2014, group health plans (including grandfathered health plans) may not impose any annual limit on essential benefits.

For plan years beginning on or after the date that is six months following enactment, group health plans (including grandfathered health plans) are not allowed to impose any preexisting condition exclusions for eligible children under age 19. In the future this mandate will be expanded; for plan years beginning on or after January 1, 2014, group health plans may not impose any preexisting condition exclusions for any individual. Waiting periods of more than 90 days are prohibited for plan years beginning on or after January 1, 2014.

Exhibit 18: Changes to Eligibility Requirements of Medical Plan for Employees

Removing lifetime maximum on essential health benefits (n=810)	
Changing before required	4.4%
Not changing until required	85.6%
Not sure	10.0%
Removing annual maximums on essential health benefits (n=713)	
Changing before required	3.6%
Not changing until required	84.6%
Not sure	11.8%
Removing all preexisting condition exclusions (n=511)	
Changing before required	4.5%
Not changing until required	81.2%
Not sure	14.3%
Waiting period will be changed so it does not exceed 90 days (n=224)	
Changing before required	8.0%
Not changing until required	69.6%
Not sure	22.3%

²⁰Essential health benefits include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

²¹A grandfathered plan is one in existence when the law was enacted, i.e., group health plans in effect on March 23, 2010, are considered grandfathered plans. Grandfathered plans have delayed effective dates for certain changes. Losing that status would mean the plan would have to comply with additional provisions in the law. Interim final rules for plans to retain their grandfather status were jointly issued by the Departments of Labor, Health and Human Services, and Treasury during the week of June 14, 2010. These rules significantly limit employers' ability to restructure health benefit plans, increase cost-sharing or change contribution levels if employers seek to retain grandfather status.

- Approximately 80% of total respondents (810 organizations) report that their plans currently include lifetime maximum provisions on essential benefits. Of these, only 4.4% are removing lifetime maximums before they are required to do so; 85.6% are not making changes until required, and 10% are not sure. About 70% of total respondents (713 organizations) report that their plans currently set annual maximums on essential benefits. Of these, only 3.6% are removing annual maximums before they are required to do so; 84.6% are not making changes until required, and 11.8% are not sure.
- Approximately half of total respondents (511 organizations) have plans that include preexisting condition exclusions. Of these, only 4.5% are removing the exclusions before required to do so; 81.2% are removing these exclusions when legally required, and 14.3% are not sure.
- Twenty-two percent (224 organizations) of total respondents offer primary medical plans that apply a waiting period of greater than 90 days for coverage. Of these, only 8% are changing the eligibility requirement before they are required by law to do so; 69.6% are not making the change until required, and 22.3% are not sure.

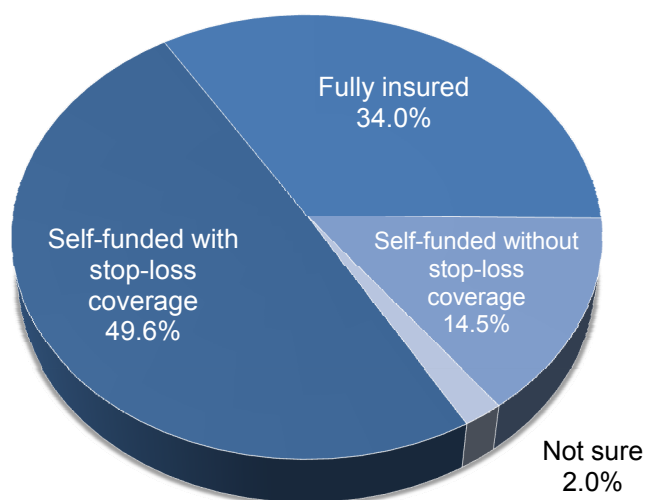
VII. FUNDING APPROACHES

Employers have been self-funding benefit plans for over 25 years, with the expectation that self-funding arrangements will provide both management and financial advantages, e.g., offer greater flexibility in managing benefit plans, reduce administrative expenses, avoid state-mandated benefits and capture favorable claims experience.²² Organizations pay claims as they are incurred, allowing them to invest and receive returns on unused funds. Employers using a self-funding method of financing may choose to limit potential aggregate medical claims exposure by purchasing stop-loss insurance that would make payments if claims exceeded a certain predetermined amount for the entire group.²³

It is generally perceived that certain provisions in the new health care reform law will lead to a significant escalation of employers' health care costs, e.g., required expanded child coverage, the prohibition of annual limits and lifetime maximums on essential health benefits, and the removal of preexisting condition exclusions. (See Exhibit 32—Top Provisions Impacting Plan Costs.) At the same time, the bill subjects self-funded medical plans to a host of new requirements, even for plans that were in existence when the act became law. Further clarification of these requirements is needed.²⁴

The survey sought to determine if there are any changes in the direction employers will take in financing their primary medical plans as they evaluate the complex legislation.

Exhibit 19: Medical Plan Funding (n=1021)



- A large majority (64.1%) of surveyed organizations currently finance their health care benefits using a self-funded approach.
- Half of total responding employers currently use a self-funded approach with stop-loss coverage; in contrast, 14.5% of responding organizations use a self-funded approach without purchasing stop-loss coverage.

Respondents were asked to indicate changes in funding approaches their organizations are considering to finance their primary medical plan in light of changes imposed by health care reform legislation.

²² Rosenbloom, Jerry S., editor, *The Handbook of Employee Benefits*. McGraw-Hill, 6th edition, 2005. Under a *self-funded* scenario, the benefit plan sponsor essentially acts as its own insurer, determining what will be covered by the plan and paying claims directly. Some self-funded plans contract with an insurance company or other third party to administer the plan; most purchase stop-loss insurance as protection against catastrophic losses above a specific dollar amount.

²³ Insurance coverage for capping the total claims experience of the group is known as aggregate stop-loss. An organization also might limit its liability using specific stop-loss, which sets a limit on the amount that a plan sponsor will pay for an individual case.

²⁴ Laverriere, Kenneth, "United States: Self-Insured Medical Plans After Health Reform." *Mondaq Business Briefing*, May 19, 2010.

Exhibit 20: Changes in Medical Plan Funding* (n=1012)

Become fully insured	2.0%
Become self-funded with stop-loss coverage	5.1%
Become self-funded without stop-loss coverage	0.5%
Already self-funded, but will now purchase stop-loss coverage	2.9%
Already self-funded, but will now purchase additional stop-loss coverage	5.9%
Do not plan to make any change to funding approach	60.9%
Other	0.6%
Not sure	23.4%

*For primary medical benefit plan. Respondents were asked to select all that apply.

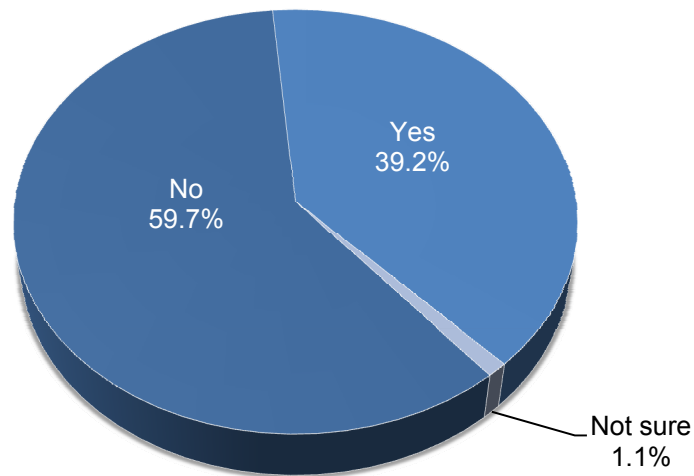
- Approximately 16% of responding employers are considering making one or more changes in their approach for funding their primary medical plan due to changes imposed by health care reform legislation; 60.9% do not plan to make any changes to their funding approach and 23.4% are not sure.
- A small proportion of respondents (5.6%) is considering changing to a self-funded medical plan, either with stop-loss coverage (5.1%) or without stop-loss coverage (0.5%).
- As a result of health care reform legislation, only 2.9% of organizations already providing a self-funded plan are considering purchasing stop-loss coverage for the first time, and 5.9% plan to purchase additional stop-loss coverage.
- In light of the changes imposed by health care reform legislation, only 2% of survey respondents are considering becoming fully insured.

VIII. RETIREE COVERAGE AND HEALTH PLAN BENEFIT STRATEGIES

Newly passed health care reform legislation includes a number of provisions that will affect employer-sponsored retiree health benefits. In particular, the bill will eliminate the federal income tax deduction for the 28% subsidy that an employer receives for providing creditable prescription drug coverage for retirees. In addition, the new legislation gradually closes the coverage gap in Medicare Part D prescription drug benefits over time and establishes a rebate for those Medicare Part D beneficiaries who reach the so-called “donut hole.”

This section examines the extent to which the legislation provides employers with an opportunity to review their health plan benefit strategies for retirees and apply for the reinsurance program for early retirees. Employers’ reactions to the removal of the favorable tax treatment of subsidies are also examined. Finally, employers’ intentions of creating a separate retiree medical plan and the likelihood of offering Community Living Assistance Services and Support (CLASS) program benefits are analyzed.

Exhibit 21: Medical Benefits Offered to Retirees (n=1015)



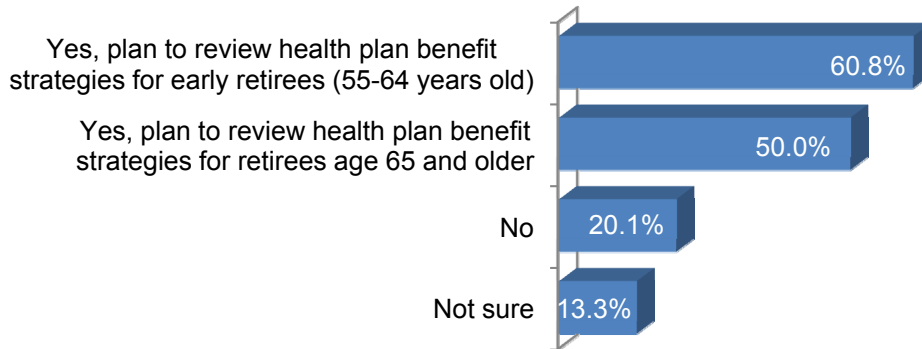
- Approximately two in five responding organizations currently offer medical benefits to retired employees; the majority (59.7%) do not offer these benefits to retirees.

Exhibit 22: Benefits Offered to Retirees and Dependents (n=1021)

Medical benefits for early retirees from age 55 to 64	
Offer to retirees only	2.3%
Offer to retirees plus dependents	35.7%
Do not offer to retirees	60.0%
Not sure	2.1%
Medical benefits for Medicare-eligible retirees	
Offer to retirees only	2.9%
Offer to retirees plus dependents	28.1%
Do not offer to retirees	66.6%
Not sure	2.4%
Life insurance	
Offer to retirees only	16.4%
Offer to retirees plus dependents	5.3%
Do not offer to retirees	76.0%
Not sure	2.4%
Dental benefits	
Offer to retirees only	0.8%
Offer to retirees plus dependents	18.6%
Do not offer to retirees	78.1%
Not sure	2.5%
Vision benefits	
Offer to retirees only	0.9%
Offer to retirees plus dependents	14.6%
Do not offer to retirees	81.8%
Not sure	2.7%
Long-term care insurance	
Offer to retirees only	1.3%
Offer to retirees plus dependents	4.5%
Do not offer to retirees	91.9%
Not sure	2.4%
Accidental death and dismemberment (AD&D) insurance	
Offer to retirees only	1.3%
Offer to retirees plus dependents	1.6%
Do not offer to retirees	94.5%
Not sure	2.6%

- Medical benefits for early retirees (from ages 55 to 64) and for Medicare-eligible retirees are currently offered by 38% and 31% of responding employers, respectively; these proportions refer to organizations covering retirees plus dependents and retirees only. More than one in five (21.7%) surveyed organizations offers life insurance to their retiree population, with coverage of retirees only (16.4%) more prevalent than coverage of retirees plus dependents (5.3%).
- Dental benefits are currently provided to retirees only and retirees plus dependents by 19.4% of the responding organizations; coverage for retirees plus dependents is more common than coverage of retirees only (18.6% and 0.8%, respectively).
- Vision benefits are more frequently offered to retirees plus dependents (14.6%) than to retirees only (.9%). Rarely do employer-sponsored plans provide long-term care insurance or accidental death and dismemberment insurance coverage for retirees plus dependents or retirees only.

Exhibit 23: Reviewing Health Plan Benefit Strategies for Retirees* (n=398)



*Within the next 12 months. Respondents were asked to select all that apply.

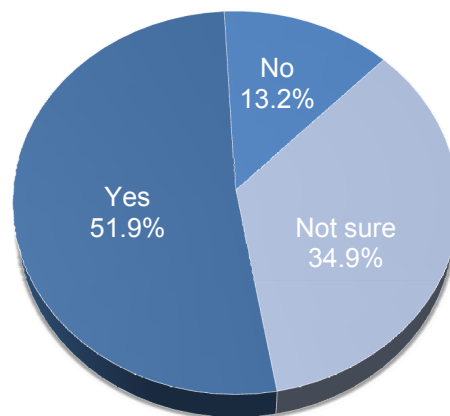
- Approximately three in five employers (60.8%) currently offering medical benefits to retirees plan to review their health plan benefit strategies for early retirees (55-64 years old) in the next 12 months.
- Half of the respondents currently offering retiree coverage intend to examine their strategies relating to retirees who are 65 and older.
- It is too early to tell whether recent health care reform initiatives will be a deterrent to employers offering retiree coverage, e.g., the loss of the tax-free nature of the Medicare Part D subsidy (retiree drug subsidy) in 2013.

The Department of Health and Human Services recently published regulations explaining how plan sponsors may apply for the early retiree reinsurance program in the Affordable Care Act. This act establishes a temporary reinsurance program for group health plan sponsors who cover early retirees (ages 55-64) who are not yet eligible for Medicare. The early retiree reinsurance program will provide reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and their spouses and surviving spouses and dependents. The program requires companies to use the assistance to reduce the cost of the plan.

Employers will have to determine how to assemble claims information to take advantage of a one-time, \$5 billion federal reinsurance program set up by the legislation that will reimburse employers for 80% of each claim between \$15,000 and \$90,000. The program begins June 23, 2010 and will end on the earlier of January 1, 2014 or when the program's \$5 billion appropriation is exhausted. Health and Human Services will accept applications in the order in which they are received and will deny incomplete applications. As demand will likely exceed supply, it is critical that applications be complete when submitted the first time.

The survey investigated the extent to which employers are planning to apply for this temporary reinsurance program.

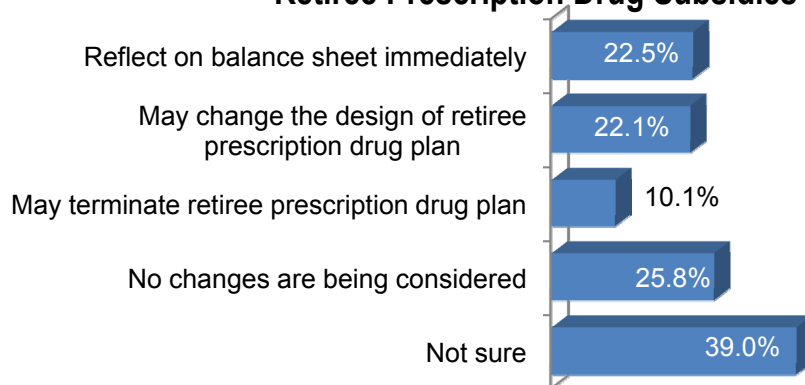
Exhibit 24: Early Retiree Medical Reinsurance Program (n=387)



- More than half of the responding employers currently offering medical benefits to retirees intend to apply for the temporary early retiree reinsurance program in the Affordable Care Act.
- About one-third of responding organizations offering retiree medical coverage have not decided whether their employment-based plans will apply for the new program.
- Employer size differences are of little consequence in determining which organizations will apply for the program.

Effective 2013, the act will eliminate the federal income tax deduction for the 28% subsidy that an employer receives for maintaining retiree drug coverage for Medicare-eligible retirees. The survey sought to determine the impact of removing the tax break on employers; the new provision requires employers to treat the subsidies as taxable income and could be a deterrent to the continued maintenance of employer-sponsored retiree drug coverage.

Exhibit 25: Reactions to Removal of Favorable Tax Treatment of Retiree Prescription Drug Subsidies* (n=267)

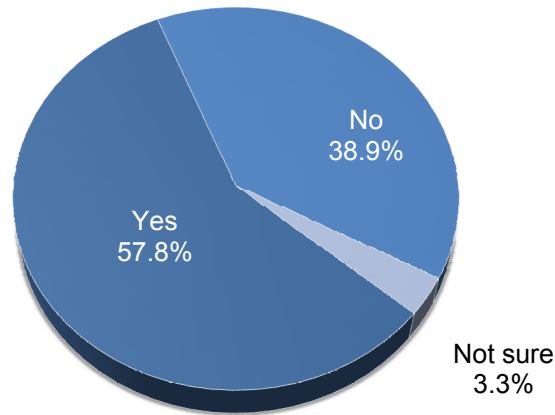


*Respondents were asked to select all that apply.

- Of the employers currently offering medical benefits to retirees, approximately 22% intend to reflect the accounting impact of the changed tax treatment immediately on their balance sheet; the same proportion may change the design of their retiree prescription drug plan.
- As a result of eliminating the deduction for expenses allocable to the Medicare Part D retiree drug subsidy, one in ten respondents currently offering medical benefits to retirees indicated that they may terminate their retiree prescription drug plan.
- Thirty-nine percent of respondents offering retiree medical coverage are not sure how they will react to the changed tax treatment, and about one-quarter of respondents report that no changes are being considered.

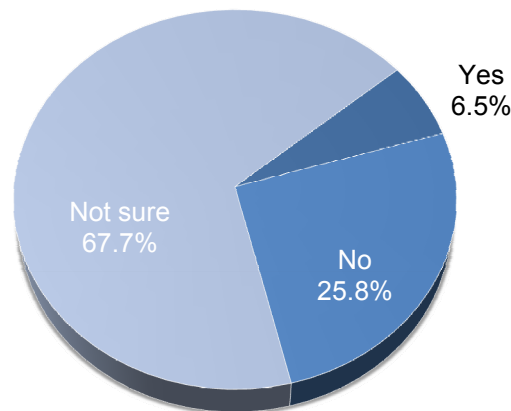
The survey examined the extent to which employers with a medical plan for retirees that is not currently separate from their plan for active employees intend to create a separate retiree medical plan for 2011 or later. This may allow plan sponsors to make changes to their medical plan for active employees that would not apply to their retiree medical plan, or vice versa. It is unclear at this point if separating the medical plan for active employees and retirees would jeopardize grandfather status. If this would not affect grandfather status, this may be a way to make changes to the plan and impact only a portion of the population, still maintaining grandfather status on the rest of the plan.²⁵

Exhibit 26: Presence of Separate Retiree Medical Plan (n=398)



- Nearly three in five surveyed employers currently offering medical benefits to retirees have a retiree medical plan that is separate from their plan for active employees.

Exhibit 27: Plans for Creating a Separate Retiree Medical Plan* (n=155)



*For 2011.

²⁵ A *grandfathered plan* is one in existence when the law was enacted, i.e., group health plans in effect on March 23, 2010, are considered grandfathered plans. Grandfathered plans have delayed effective dates for certain changes. Losing that status would mean the plan would have to comply with additional provisions in the law. Interim final rules for plans to retain their grandfather status were jointly issued by the Departments of Labor, Health and Human Services, and Treasury during the week of June 14, 2010. These rules significantly limit employers' ability to restructure health benefit plans, increase cost-sharing or change contribution levels if employers seek to retain grandfather status.

- Of those employers currently without a separate retiree medical plan, only 6.5% intend to create a separate retiree plan for 2011 or later. One-quarter of respondents do not intend to create a separate retiree medical plan.
- More than two-thirds of employers currently without a separate retiree plan are not sure if they will create such a plan.

Included among the many provisions of the new health care reform law is one creating the Community Living Assistance Services and Support (CLASS) program. Employee participants in this new voluntary federal program who become functionally limited can receive cash benefits to enable them to live in the community rather than in institutions such as nursing homes.²⁶

While employer participation is voluntary, employers are encouraged to participate in the CLASS Act. Employees of organizations that choose to participate will automatically be enrolled (although they may opt out) and pay for it through payroll deduction. Participants will need to contribute to the program for five years before being vested. The Secretary of Health and Human Services has until 2012 to finalize plan details and determine premium rates and benefits.

Exhibit 28: Likelihood of Offering CLASS Act Benefits (n=1016)

Will consider offering CLASS benefits to employees	6.0%
Will consider offering CLASS benefits to employees along with other long-term care benefits currently offered	2.8%
Will consider offering CLASS benefits to employees plus introducing a more comprehensive long-term care option	2.0%
Will not consider offering CLASS benefits	18.3%
Will not consider offering CLASS benefits because already offer long-term care benefits	14.2%
Not sure (e.g., need to understand premiums and what the regulations will require)	56.8%

- A majority of responding employers are not sure whether they will offer CLASS Act benefits, awaiting further clarification of premiums and regulations before they decide.
- Approximately one-third (32.5%) of respondents state that they will not consider offering CLASS benefits. They may already offer long-term care benefits or the program's automatic-enrollment feature could present major administrative challenges in certain industries; e.g., employers with high turnover would experience large numbers of employees leaving without ever vesting.
- Approximately 11% of employers indicate that they will consider offering CLASS benefits to employees, with or without other long-term care benefits.
- Employer size differences are of little consequence in determining which organizations will apply for the program.

²⁶ This new federal insurance program differs from a traditional long-term care program in that it is meant to provide supplemental income to cover the extra expenses of living disabled in the community rather than pay amounts directly for caregiver or institutional care expenses. The intent of this program is to supplement and not replace private long-term care insurance.

IX. COMMUNICATION/EDUCATION INITIATIVES ABOUT HEALTH CARE REFORM

The survey examined the extent to which employers have noticed an uptick in the number of contacts by participants regarding health care reform legislation, and whether they have begun a dialogue with their active employees and retirees in order to explain the impact reform might have on their organizations' benefits and to counter misinformation. Specific communication and education channels also are examined.

Exhibit 29: Contacts by Participants With Human Resources/Benefits Staff Regarding Health Care Reform Legislation* (n=1012)

Yes, increase in the number of contacts made by active employee participants	49.7%
Yes, increase in the number of contacts made by retirees	6.1%
No	44.4%
Not sure	4.9%

*Respondents were asked to select all that apply.

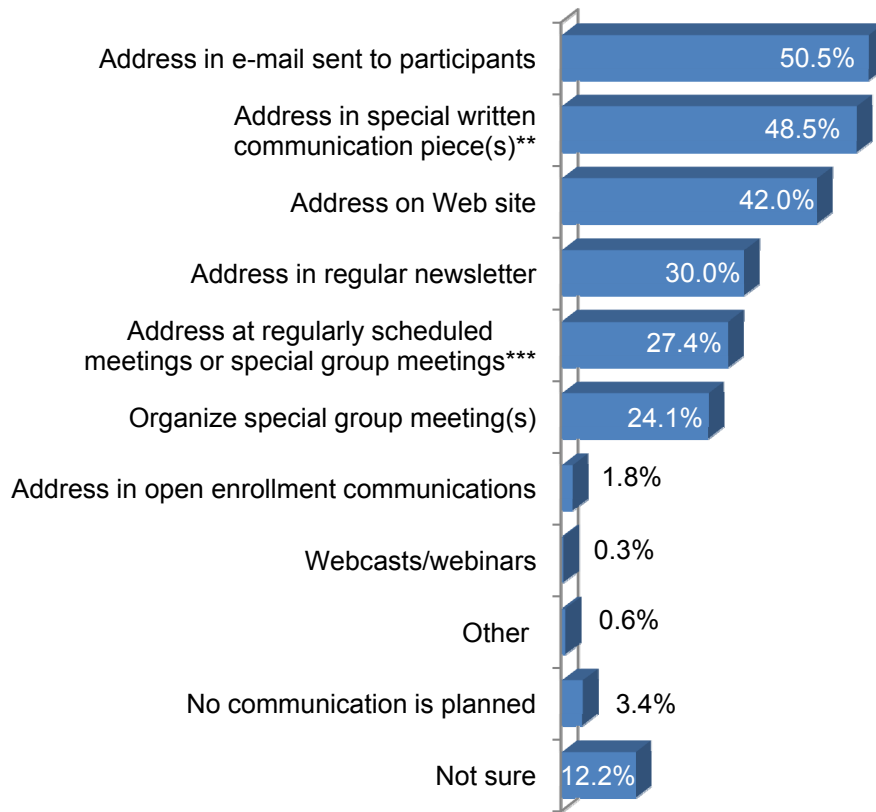
- Responses are mixed whether employers have noticed an increase in the number of participant contacts with human resources or benefits staff regarding health care reform legislation: half of responding employers report an increase in the number of contacts made by active employee participants while 44.4% state that there has not been an increase in contacts. A much smaller proportion (6.1%) cites an increase in contacts by retirees.

Exhibit 30: Communicating With Participants About the New Legislation (n=1012)

Yes, have already communicated to active employee participants	36.5%
Yes, have already communicated to retirees	2.2%
No	20.6%
No, but plan to start during annual enrollment	42.2%
Not sure	0.6%

- For the most part, organizations have not started communicating with participants about health care reform legislation, but plan to take advantage of their annual enrollment period to begin communications.
- Organizations already in contact with participants are much more likely to be communicating with active employee participants (36.5%) than with retirees (2.2%). It seems likely that much of their focus is on communicating with employees who have dependent adult children.

Exhibit 31: Communication/Education Initiatives About Health Care Reform Legislation* (n=1012)



*Initiatives that respondents have undertaken or plan to undertake in 2010/2011. Respondents were asked to select all that apply.

**E.g., open enrollment pieces, payroll inserts or pieces sent to participants' homes or distributed by some other means.

***E.g., open enrollment meeting.

- Communication and education techniques or channels currently being used (or planned) to reach participants about the new legislation include e-mails to participants (50.5%), special written communication pieces (48.5%) and the organization's Web site (42%).

X. COST IMPACTS AND OTHER OPINIONS ON HEALTH CARE REFORM

The last part of the survey asked respondents for their insights on the provisions of the new legislation that will impact plan costs the most and to express their opinions on the long-term sustainability of employer-sponsored health care benefits, the excise tax on high-cost health plans and a number of other issues growing out of the health care reform requirements.

Exhibit 32: Top Provisions Impacting Plan Costs* (n=1004)

Extending coverage to adult children to age 26	74.7%
Additional W-2 reporting requirements	39.1%
Elimination of lifetime maximums for all participants	36.2%
Elimination of annual limits on essential benefits	34.2%
Elimination of preexisting condition exclusions for children under age 19	10.9%
Administrative costs	0.8%
Ending of tax-advantaged treatment of over-the-counter drugs in HDHPs or FSAs	0.4%
No cost-sharing for preventive care	0.4%
Covering employees and dependents working 30-39 hours	0.3%
Mental health parity requirements	0.3%
Tax implications	0.3%
Effective taxation of retiree drug subsidy	0.1%
Pre-65 reinsurance program	0.1%
Other	0.5%

*Respondents were asked to select the two provisions of health care reform legislation (becoming effective 2011) that will impact plan costs the most.

- Three-quarters of responding organizations identify extending coverage to adult children until they reach age 26 as the major health care reform requirement impacting plan costs.
- The requirement mandating employers to report on form W-2 income statements in 2012 (reflecting coverage in 2011) the aggregate cost of employer-provided health care coverage is perceived by almost two in five respondents as a major driver of employers' health plan costs.
- Approximately 36% of employers identify the provision eliminating lifetime limits on the dollar value of essential benefits for any participant or beneficiary as one of the top reasons for plan cost increases.²⁷ The elimination of annual limits on essential health benefits is perceived by 34.2% of respondents as a major driver of plan costs.
- Eliminating preexisting condition exclusions for children under age 19 is cited by 10.9% of surveyed employers as a top cost driver.
- Close to 1% of the respondents referred to the additional administrative time and costs required for plan sponsors to comply with the new rules, including additional auditing, enrollment, monitoring, legal and actuarial procedures.

²⁷ *Essential health benefits* include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

Exhibit 33: Opinions on Health Care Reform Legislation (n=1004)

My organization will continue to offer health care benefits because they are critical to employee recruitment and retention

Strongly agree	45.1%
Agree	41.8%
Disagree	2.4%
Strongly disagree	1.0%
Not sure/not applicable	9.7%

It is important for my organization to remain competitive in our industry; therefore, we will continue to offer health care benefits

Strongly agree	43.5%
Agree	43.2%
Disagree	3.0%
Strongly disagree	1.0%
Not sure/not applicable	9.3%

In 2014, employers will be able to offer employees incentives of up to 30% (increasing to 50% if appropriate) of the cost of coverage for participating in a wellness program and meeting certain health-related standards. My organization will consider offering employees these incentives.

Strongly agree	16.9%
Agree	49.0%
Disagree	6.6%
Strongly disagree	2.4%
Not sure/not applicable	25.1%

By 2018, our health plan will be redesigned to reduce premiums and avoid triggering the excise “Cadillac” tax for high-value plans

Strongly agree	12.8%
Agree	34.7%
Disagree	9.7%
Strongly disagree	2.5%
Not sure/not applicable	40.3%

By 2013, our organization may drop retiree prescription drug plans because our organization will be taxed on the federal subsidy

Strongly agree	3.2%
Agree	6.7%
Disagree	9.6%
Strongly disagree	5.3%
Not sure/not applicable	75.3%

- Approximately 87% of respondents agree or strongly agree that their organizations will continue to offer health care benefits because they are critical to employee recruitment, retention and remaining competitive.
- The new law increases the level of financial incentives available to employees who participate in employer-provided wellness programs from 20% of health insurance premiums to 30%, effective in 2014. Approximately two-thirds of respondents agree or strongly agree that in 2014, their organizations will take advantage of this legal provision and offer increased employee rewards. These incentives will be in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided.

- Close to half of all respondents agree or strongly agree that by 2018 their health plans will be redesigned to reduce premiums and avoid triggering the excise “Cadillac” tax for high-value plans.
- One in ten of responding employers agrees or strongly agrees that the tax on the federal subsidy will result in employers dropping retiree prescription drug plans by 2013.

XI. CONCLUSIONS

In May 2010, the International Foundation of Employee Benefit Plans conducted a survey of employers to determine how they are reacting to the changes brought about by the new health care reform legislation and the strategies being considered. Those asked to participate in the survey were single employer plans (including corporations) in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCEBS). Responses were received from 1,021 individuals including benefits and human resources professionals, general and financial managers, and other professionals.

The study uncovered benchmarks of how employers are responding to health care reform challenges with particular emphasis on immediate considerations and approaches for complying with the new law:

- While employers believe that the new health care reform legislation will lead to increased plan costs, they remain committed to providing employer-sponsored benefits, believing that benefits are critical to employee recruitment, retention and remaining competitive.
- Most employers will wait to extend health care coverage to eligible adult children until they are required by law to do so.
- Half of responding employers are not sure how they are going to address cost-sharing for dependent coverage for their primary medical plan. Further guidance released after the survey was conducted shows that some of respondents' most frequently cited cost-sharing approaches may be illegal or result in plans forfeiting their grandfather status.
- Over half of respondents are not sure if they will change the eligibility requirements for dependents on other benefit plans (e.g., dental, vision, life insurance, accidental death and dismemberment) to conform to the rules for their primary medical plans, thereby maintaining the same definition of dependent children for all plans. Those who have decided to extend coverage to adult children for other plans are most frequently doing so for dental benefits and vision benefits.
- Most employers are not planning to make changes in their high-deductible health plan (HDHP) offerings. Organizations planning to add or increase their emphasis on HDHPs in the next 12 months most frequently will be focusing on account-based plans linked to health savings accounts.
- Small proportions of respondents are removing lifetime and annual maximums on essential benefits before they are legally required to do so; likewise, few employers with plans that include preexisting condition exclusions or waiting periods greater than 90 days are making changes before legally required to do so.
- Only a small proportion of organizations are changing their funding approach as a result of health care reform legislation.
- Employers that currently offer medical benefits to retired employees are putting a great deal of emphasis on reevaluating their medical strategy for retirees.
- A majority of employers who offer medical benefits to retirees will be taking advantage of the early retiree reinsurance program in the Affordable Care Act.
- For the most part, eliminating the deduction for expenses allocable to the Medicare Part D retiree subsidy will not result in employers deciding to terminate retiree prescription drug coverage.
- A majority of responding employers are not sure whether they will offer CLASS Act benefits, awaiting further clarification of premiums and regulations before they decide. Eleven percent of employers will consider offering these benefits to employees, with or without other long-term care benefits.
- Employers are recognizing the importance of communicating with plan participants about the new health care reform legislation. Most are choosing to do this during their annual enrollment period.

- Most employers identify extending coverage to adult children until they reach age 26 as the major health care reform requirement impacting plan costs, followed by additional W-2 reporting requirements, and the elimination of lifetime maximums and annual limits on essential benefits.
- Half of responding employers are focusing on redesigning their health plans to make sure that by 2018 their plans do not trigger the excise “Cadillac” tax for high-value plans.
- Employers will take advantage of the new financial incentives available to employees who participate in employer-provided wellness programs.

Health Care Reform: What Employers Are Considering is the first in a series of reports on the impact of health care reform legislation on benefit plans by the International Foundation of Employee Benefit Plans. Readers are encouraged to watch for upcoming studies and to monitor the Foundation’s Web site, www.ifebp.org, for the latest health care reform news, analysis and additional resources.