12-24-2014

The Effects of the Affordable Care Act on Large Employers and the Impact on the Human Resources Function

Maksim Spivak
Cornell University, ms437@cornell.edu

The Effects of the Affordable Care Act on Large Employers and the Impact on the Human Resources Function

Abstract
[Excerpt] The purpose of this paper is to explore how Fortune 500 companies have been affected by the passing of the Affordable Care Act (ACA). More importantly, this paper will explore what strategies companies have adopted, and what the legislation means to the following stakeholders: company boards, executives, managers, employees, the Human Resource function, and the Benefits staff.

Keywords
HR Review, Human Resources, Affordable Care Act, Healthcare, Insurance, High-Deductible Healthcare Plans

Disciplines
Benefits and Compensation | Health Policy | Human Resources Management | Insurance | Labor Relations

Comments

CORNELL HR REVIEW

The Effects of the Affordable Care Act on Large Employers and the Impact on the Human Resources Function

Maksim Spivak

The purpose of this paper is to explore how Fortune 500 companies have been affected by the passing of the Affordable Care Act (ACA). More importantly, this paper will explore what strategies companies have adopted, and what the legislation means to the following stakeholders: company boards, executives, managers, employees, the Human Resource function, and the Benefits staff.

History of Employer Provided Healthcare

To understand healthcare in the United States, it is important to take a look back at how employers became responsible for funding healthcare to a large part of the country. The concept of healthcare insurance is fairly recent, originating in the 1930s. Prior to that, the lack of knowledge and limits of medical science limited the amount that doctors could charge. This changed in the 1920s when there was significant growth in the value proposition of doctors. Services began to cost more than many could afford.

The first health insurance product, Blue Cross and Blue Shield (BCBS), became popular in the 1930s. The shortage of labor during World War II and the early 1940s changed health insurance in the United States. Employers began to offer insurance as an important component of compensation packages, and the government provided tax incentives for the employer and employee to provide the benefit.

Initially, BCBS served as a non-profit organization that charged a standard premium. However, as new for-profit insurers entered the market, they developed risk models and premiums based on age, gender, health status, and pre-existing medical conditions. Up to the adoption of the ACA, this became the prominent methodology of determining premiums for individuals.

During the 1940s through the 1960s, medical technology utilization skyrocketed. In combination with government support, the proliferation of unions, and many new healthcare insurance products, the healthcare system that continues today was established. In 1965, the government passed the Medicare bill to care for the elderly. State administered Medicaid programs came soon after to tend for the poor and those who did not have access to private health insurance plans. The rest of the population was now in the hands of employer funded and employer facilitated healthcare plans. The ACA has largely reaffirmed this phenomenon through many of its provisions, such as the 95% rule (offering coverage to 95% of full-time staff by 2016), affordable coverage rule (premiums cannot be more than 9.5% of W2 wages), and penalty structure for employers

not providing adequate insurance options (substantial annual penalties for companies based on all FT employees if ACA provisions are not met).

Background on the Affordable Care Act

The self-reported census in 2010 indicated that 16% of the population, or 49 million people, in the United States were uninsured. About 40 million were between the age of 18 and 64. A 2011 study by the American College of Physicians found that there were 2.1 million hospital stays for the uninsured accounting for 4.4% of total aggregate inpatient hospital costs in the United States. Overall, the United States spent 17.9% of GDP on healthcare. The out of control healthcare spending, along with the high number of uninsured in the United States, brought on the ACA.

On March 23, 2010, after a bitter war at all government levels, President Barack Obama signed a comprehensive health reform to expand coverage, control healthcare costs, and improve the health delivery system. The law focused on: individual mandate, employer requirements, expansion of public programs, premium and cost-sharing subsidies to individuals, premium subsidies to employers, tax changes, health insurance exchanges, benefit design, changes to private insurance, modification of states' roles, cost containment, improving quality and health system performance, focus on prevention and wellness, expansion of long-term care, and other provisions.

How the Affordable Care Act has Already Affected Employers

As part of an exercise by Cornell University's Center of Advanced Human Resources Studies, we surveyed 29 large ($5 billion in revenue) companies that operate in the United Stated to learn more about the effects of the ACA on their businesses. The companies in the study included those with union and non-union employees. Over 93% of member firms asked were willing and interested in participating in the discussion. The high interest and the seniority of the Human Resource team members that participated, showed how important the topic is to companies' operations.

The conversations with the executives resulted in the following main findings:

1. The ACA has directly resulted in 1-5% increase in plan costs for companies. All companies indicate that increase cost has been highly visible. The increases came from a wide range of sources including:
    a. Indirect effects in the administration, understanding and provision of the ACA clauses.
    b. Government imposed fees such as the Reinsurance fee ($63 per member per year), Patient Centered Outcomes Research Trust Fund ($2 per member per year).
    c. A requirement to provide coverage for children up to 26 years of age has added a significant number of members at many companies. While these patients are usually low-risk and low-cost, the sheer increase is from the previous industry standard that required coverage for children up to 19 if not enrolled in college and 23 if enrolled in college. Some companies

reported that both parents and children were employed at their company, and that in such cases the children would utilize their parents' coverage rather than their own since a dependent premium is less than a primary member premium.

d. Removal of lifetime limits and restrictions on annual spends have been removed causing some companies to pay more for employees requiring expensive and chronic coverage.
e. Elimination of preexisting conditions for all enrollees, which affected the 6-month look back period that employers used to have to deny coverage for certain conditions (under the Health Insurance Portability and Accountability act of 1996).
f. Elimination of recessions, or the ability of an insurance plan to deny coverage retroactively, now produces new administrative costs for insurance companies and forces employers to complete due diligence quicker.
g. New internal claims, appeals and external review processes need to be established in accordance with rules and regulations. For companies with light benefits staffing, this was a particularly difficult and fiscally strenuous task.
h. Coverage of emergency and preventive services was offered by many employers but not in all plans. Mandatory coverage of these items has increased premiums for many of the plans.
i. Some aspects of wellness programs have resulted in an increase. While most companies have robust programs, the requirements of specific services such as smoking cessation and birth control products had to be reassessed. Companies that offered incentives for wellness programs were also required to assess their programs to make sure they adhered to the regulations.

2. High-deductible healthcare plans (HDHP) are the fastest growing option at many of the companies. The HDHP plans allow companies to lower premiums and to instill an aspect of consumerism into healthcare choices made by their employees. The HDHP limits have been established at $1,250 as the minimum deductible and $6,350 as the maximum out-of-pocket (OOP). While HDHP plans are growing in adoption and acceptance, the limits on Flexible Spending Arrangements (FSA) have been set at $2,500 and the Health Savings Accounts (HSA) at $3,300 for single coverage. As premiums are not included in the OOP, the consumer must select an HDHP plan that is right for them while considering the need for an FSA or HSA account. While Health Reimbursement Arrangements exist as well, this option is not as popular due to a lack of tax-advantages.

3. Human resource executives are also changing their overall benefits strategies as a result of the ACA:

a. Benefits plans are being projected for 3-5 years versus considerably shorter periods of 1-2 years in the past.
b. Finance arms of companies are working closely with HR and Benefits on healthcare cost and strategy. Line items in healthcare expenses face more

scrutiny than in the past, largely due to the looming 40% excise tax on plans that have a value of over $10,200 for self-only coverage and $27,500 for family coverage. The excise tax, commonly referred to as the Cadillac tax, is designed to reduce the opulent benefits offered to many in the corporate world and attacks excessive spending on healthcare, which is driven by the lack of thoughtful marginal spending by consumers.

c. Companies are shifting at attacking trend (increase of healthcare costs on annual basis) versus a previous emphasis innovation due to a limited amount of resources.

4. The ACA has affected business lines and has forced many business managers to rethink hiring strategies as a result. The delineation between seasonal workers, full-time and part-time workers, has affected human capital strategies of many firms. Management, who are generally the ones benefitting from luxury plans, are not concerned about their benefits being affected but are concerned about their business changes.

5. Companies are hesitant in adopting disruptive healthcare models, such as allowing all their employees to enter the public or private exchanges. Some are even reluctant to reduce or remove the excessive Preferred Provider Organization (PPO) and Health Management Organization (HMO) options that are currently offered at their firms. The complications are due to perceptions of healthcare by the employees, union contracts and by the reluctance of some benefit managers to see a benefit in adding HDHP options. While the CAHRS research indicated that companies prefer to take the middle ground when it comes to healthcare strategy – some are taking an aggressive stance (companies that are not part of CAHRS). According to Aon Plc., a London based global human resources solutions business, one-third of United States employers plan to move healthcare coverage to a private exchange in the next few years. Walgreens, Sears, Petco and Darden Restaurants are large companies that have already taken the leap.

The companies in the CAHRS study all planned to continue offering healthcare benefits to their working populations. All stated that they planned on keeping the momentum in the wellness and preventive space. Benefits realized that now is a great time to move forward with intense wellness programs due to the spotlight on the ACA, healthcare and premiums. While many companies struggled to quantify the benefits of their programs, it was easy to see that companies that were proactive a long time ago and continued their push on educating their employees and offering proper services benefited from much lower trends. The dynamic labor force, which is constantly changing on a global scale, makes it difficult for even the best HR-focused companies to quantify wellness and preventive initiatives. Employee behavior, varied demographics, previous experiences, family relations and even geography provide many variables into the equation, and make even the most advanced regression analysis nearly impossible.

Other Studies on the Subject Show Significant Changes in Healthcare Benefits

According to a study conducted by RAND Corporation, a research organization that develops solutions to public policy challenges, enrollment in employer-sponsored plans

increased by 8.2 million between September 2013 and March 2014. The overall uninsured rate went from 20.5% to 15.8%. The survey also found that 3.9 million people gained insurance through federal and state marketplaces, while 1% of total population (1 million people) became uninsured. The reasons for the loss of insurance are unclear but can be attributed to possible cancelations or perception of high cost. However, the number is small in comparison to the entire population in the subject age group (18-64). Rand's data shows very similar results to those obtained by Gallup and the Urban Institute – organizations that have tracked the effect of the ACA on the number of people covered.

Aon's survey, mentioned earlier, took a look at 1,230 United States employers, which account for about 10 million workers, found that 5% of companies plan to drop coverage in the next 3 to 5 years. Aon's assessment of the current statistic is also 1%, the same as that of Rand, Gallup and Urban Institute. The Aon survey did indicate that 38% of employers plan to offer no benefits to part-time workers (below 30 hours per week) in the next 3 to 5 years. Aon also found that two thirds of employees want to make changes to the benefits that they offer for retirees. Large companies such as Time Warner and IBM have already moved their retirees to private exchanges. AT&T plans do so in 2015. According to Aon, 30% of companies that provide supplemental benefits to retirees have already moved the population to private exchanges. The companies surveyed in the CAHRS study did report positive results in their experience in moving retirees to exchanges. The benefits leaders stated that the retirees benefited because of customized solutions, cheaper rates and a larger number of coverage options.

Kaiser historical statistics show a large change in the amount of retiree benefits being offered. In 1988, 66% of companies with 200 or more employees offered coverage compared to 28% in 2013. Unionization highlights the decline even more, with 22% offering retiree coverage in a non-unionized setting versus 45% in a unionized setting in 2013. This is worrisome since the retiree healthcare subsidy benefit is trending steeply downward. Even the unions, which have historically been focused on retiree benefits, cannot, or refuse to, negotiate this for their members.

Outside of the elimination of retiree benefits and a shift toward HDHP plans, studies have shown that employers have cut back on options and increased pricing within the plans they offered. According to the New York Times, the Kaiser foundation has found that from 2009 to 2012 plans that have a deductible of more than $2,000 have doubled. Over a third of the plans that employees utilize have a deducible higher than $1,000. While deductibles and copayments have been rising for decades, the recent spike in increases is a result of 5-8% trends and the looming Cadillac tax in 2018. Some experts estimate that as many as 75% of plans will be effected by the tax unless significant changes are made. However, in the long run the elimination or downsizing of Cadillac plans is forecast to reduce excessive consumption of unnecessary healthcare spending and increase consumerism by individuals in those rich plans.

How the Affordable Care Act is set to Affect Employers in the Future

The ACA has significant potential to change how the employers provide and pay for healthcare, the function of the benefits administrator within a company, and how employees will consume healthcare.

1. Employers and healthcare coverage
    a. Options – As indicated by the survey data, the options that employers offer in terms of healthcare coverage will change for employees. HDHP plans with FSA or HSA will likely become prevalent and dominant in both union and non-union settings. Deductibles and copayments will increase to engage the consumer more and to lower up-front premiums. As the actuarial values of the plans decrease, through higher out-of-pocket expectations, trends will increase the premiums until healthcare costs are curtailed.
    b. Access – As the healthcare reimbursement model shifts to value-based care and quality payments, networks will decrease in size, potentially limiting access for some employees. As seen in Massachusetts, which adopted an early version of the ACA through what is called RomneyCare, waiting times are 45.5 days to see a family physician, versus 18 days nationwide. Combined with a shortage of doctors, access will become an important issue for many employers to manage. The market forces counteract each other in the case of access. More people become insured through ACA, hence increasing demand; more preventive services are now covered and offered by employers further increasing demand, while supply of doctors is reducing on a patient to doctor ratio. Economic theory infers this phenomenon would drive prices significantly higher. However, reimbursements are being lowered, and doctors and insurance companies are being squeezed through the ACA. Access, tight network and focus on quality will be a priority for benefits staff and exchange providers.
    c. Wellness and preventive care – The best way, but the least quantifiable, to reduce trend is to offer education and services in the area of wellness and preventive care. Companies that manage a robust program will be in a position to reap the benefits of lowered healthcare costs in the future and the avoidance of the dreaded, excise tax.

2. The future of the function of the benefits teams at large companies is now in question. As evidenced by Aon and other survey companies, many employers have already shifted retirees to exchanges, and the rest of the employers that offer such benefits plan to do so shortly. For the general population, companies are considering exchanges in the next 3-5 years. The function of benefits teams at employers, which is to manage healthcare and retiree benefits, is positioned to be outsourced due to exchanges. The firms that specialize in the designing plans and those that are positioned to handle the regulations produced by the government efficiently will be more effective in managing benefits than internal departments. Employees are likely to benefit from the choice that is offered through exchanges. They will be able to pay according to several risk pools,

select levels of coverage, and have flexibility with plan options. The move to exchanges will likely either eliminate or reduce the benefits role.

3. The ACA changes and the focus on healthcare will likely change the way many employees consume healthcare. Through analytical programs, such as Castlight and insurance company provided tools, consumers will be able to budget and manage their spending on healthcare. As deductibles rise and transparency is increased, employees will treat healthcare consumption as they would with any other service. Healthcare insurance will become more of a payment system or plan instead of a carte blanche to negligently spend on healthcare. Employees should also start consuming more wellness and preventive services as those are now included and offered by all plans. Once a culture of spending time and effort on wellness now rather than later is established, consumers will realize the cost savings in future healthcare spend and quality of life.

What the Changes Mean to the Human Resources Function

The changes brought on by the ACA have already had significant effect on employers – through direct costs, such as fees and taxes, and indirect costs, such as administrative duties and reporting requirements. As the environment becomes more complex due to regulation and cost management, employers must outsource many of the benefits and reporting functions to organizations such as Watson Wyatt and Aon who are able to leverage economies of scale to deliver health exchange services and meet regulatory requirements.

In the immediate future, HR teams have to establish clear communication channels with the finance arm of the organization to effectively communicate what the healthcare changes mean to the company's employees and what the changes mean to the business lines. The strategy HR teams take have to become longer term and focused on reducing trend and reducing lead times to respond to regulatory changes.

The most significant change is the addition of a new role to the HR team – one of healthcare coach. As the ACA, the media and the medical community focus on quality and wellness, the employer will have an important role since the average employee spends 54% of their non-sleeping time on job-related activities each working day. Availability of wellness and preventive care is mandated, but the utilization can only be encouraged. Wellness and prevention are the keys to solving rising trend and our 17.9% of GDP problem. Since companies have taken on the role healthcare provider for most people, it is now their duty to also be the healthcare coach. Their employees and their shareholders demand it. א

Maksim Spivak is a student at Cornell University, pursuing an MBA at the S.C. Johnson Graduate School of Management and an MILR at the School of Industrial & Labor Relations.

Abelson, Reed. "High-End Health Plans Scale Back to Avoid 'Cadillac Tax'." The New York Times. The New York Times, 27 May 2013. Web. 12 May 2014.

"About the Charts." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, n.d. Web. 12 May 2014.

Carman, Katherine Grace, and Eibner, Christopher. RAND Corporation. 2014. Changes in Health Insurance Enrollment Since 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf, 11 May 2014.

Chen, Caroline. "More Employers to Move to Private Health Insurance Exchanges." Insurance Journal News. Insurance Journal, 19 Feb. 2014. Web. 12 May 2014.

"Health Insurance in the United States." Wikipedia. Wikimedia Foundation, n.d. Web. 11 May 2014.

Hemmings, Brandon; Fangmeier, Joshua; Udow-Phillips, Marianne. The Impact of ACA Taxes and Fees. August 2013. Center for Healthcare Research & Transformation. Ann Arbor, MI.

"How Did Healthcare Come about in the United States?" Stay Smart Stay Healthy RSS. N.p., n.d. Web. 11 May 2014.

Japsen, Bruce. "Doctor Wait Times Rise As Obamacare Rolls Out." Forbes. Forbes Magazine, 29 Jan. 2014. Web. 12 May 2014.

Lauter, David. "Study: Employer-provided Insurance Increasing." THonline.com. N.p., 13 Apr. 2014. Web. 11 May 2014.

Mangan, Dan. "Companies Push Retirees (and Soon, Workers) into Health Exchanges - NBC News." NBC News. NBC, 10 Sept. 2013. Web. 12 May 2014.

Miller, Mark. "Why Employers Are Shifting Retiree Health into Insurance Exchanges." Reuters. Thomson Reuters, 01 Mar. 0011. Web. 12 May 2014.

Spivak, Maksim, and Christopher Collins. "Effects of Affordable Care Act on CAHRS Member Firms." Center of Advanced Human Resources Studies, 20 Mar. 2014.

"Summary of the Affordable Care Act." Summary of the Affordable Care Act. Kaiser Family Foundation, n.d. Web. 12 May 2014.