Study of Multiemployer Plans — Current Affordable Care Act Issues

Segal Consulting conducted a study of nearly 300 multiemployer health plan clients to determine what changes, if any, the trustees have made since March 23, 2010, when the Affordable Care Act became law. (The last page provides information about the plans in the study.) This report highlights the key study findings. Benchmarking data like this can help trustees better plan for the future and make more informed decisions.

Closest “Metal” Value of Plans’ Primary Coverage

Individual health insurance coverage purchased through the federal Marketplace or a state Exchange must provide benefits at various actuarial levels: platinum (90 percent), gold (80 percent), silver (70 percent) and bronze (60 percent). To illustrate how the “metal” levels work, a platinum plan that has an actuarial value of 90 percent would be a plan that pays approximately 90 percent of eligible medical expenses. Trustees may wish to know how their multiemployer plan would pay claims based on this metal-value scale.

The chart below shows the “metal” levels of the surveyed plans’ primary coverage. For this study, Segal defined primary coverage as the plan with the largest enrollment. Segal determined the closest “metal” value according to the minimum-value calculations standards published by the federal government.
Grandfathered Status

Group health plans in existence as of March 23, 2010 are grandfathered, meaning that they do not have to comply with some of the law’s requirements. A plan will remain grandfathered for as long as the plan’s benefit design does not change beyond certain limits set by the federal government.* More than half of plans in the study are grandfathered under the Affordable Care Act.

A loss of grandfathered status can add new costs to the plan. However, remaining grandfathered has its own set of consequences, most notably strict limits on the ability of the plan sponsor to make plan design changes.

Looking Ahead to the Excise Tax

It is important for trustees to test their plan to see if and when it may exceed the excise tax threshold when the excise tax takes effect beginning in 2018. (The excise tax applies to both grandfathered and non-grandfathered plans.) Interestingly, a large percentage of all plan sponsors, regardless of whether they have done testing, are not currently considering changes to avoid the excise tax, as shown in the chart below.

* For information about changes that trigger the loss of grandfathered status, see Segal Consulting’s March 2013 Health Care Reform Insights, “The Consequences of Losing ‘Grandfathered’ Status.”
## Cost-Management Strategies

The bar chart below shows whether the plan trustees have implemented, are considering or have neither implemented nor considered specific cost-containment strategies since the Affordable Care Act became law.

<table>
<thead>
<tr>
<th>Cost-Management Strategy</th>
<th>Have Implemented</th>
<th>Are Considering</th>
<th>Have Neither Implemented Nor Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soliciting competitive bids for carriers and/or vendors</td>
<td>40%</td>
<td>15%</td>
<td>45%</td>
</tr>
<tr>
<td>Implementing more intensive pharmacy-management programs (e.g., increased use of step therapy and/or prior authorization requirements)</td>
<td>34%</td>
<td>23%</td>
<td>43%</td>
</tr>
<tr>
<td>Increasing copayments for any services</td>
<td>32%</td>
<td>13%</td>
<td>55%</td>
</tr>
<tr>
<td>Increasing deductibles</td>
<td>27%</td>
<td>13%</td>
<td>60%</td>
</tr>
<tr>
<td>Implementing more intensive medical-management programs (e.g., prior authorization and/or disease management)</td>
<td>18%</td>
<td>20%</td>
<td>62%</td>
</tr>
<tr>
<td>Increasing financial incentives tied to wellness (e.g., surcharges or bonuses)</td>
<td>8%</td>
<td>12%</td>
<td>80%</td>
</tr>
<tr>
<td>Moving to a narrower/limited/restricted provider network</td>
<td>7%</td>
<td>15%</td>
<td>78%</td>
</tr>
<tr>
<td>Making plan design changes in order to use a high-deductible health plan to be eligible to offer Health Savings Accounts</td>
<td>2%</td>
<td>5%</td>
<td>93%</td>
</tr>
<tr>
<td>Establishing on-site clinics</td>
<td>2%</td>
<td>5%</td>
<td>93%</td>
</tr>
<tr>
<td>Including any reference-based pricing (i.e., setting a maximum reimbursement for a medical procedure or test based on an external reference such as median provider pricing)</td>
<td>1%</td>
<td>6%</td>
<td>93%</td>
</tr>
</tbody>
</table>

The study found some regional differences in the implementation of cost-management strategies:

- Implementation of reference-based pricing was highest in the West.
- Implementation of both onsite clinics and wellness with incentives was highest in the Midwest.
- Implementation of narrow networks was highest in the Northeast.

The map graph on the last page shows how this study divides states into regions.

Trustees of 12 percent of plans have implemented or are considering other cost-management strategies, such as the following:

- Transitioning to an accountable care organization or patient-centered medical home model,
- Hiring a care coordinator,
- Increasing wellness and behavior communications,
- Implementing a telemedicine program,
- Modifying eligibility rules,
- Providing participants with pricing transparency tools, and/or
- Implementing a dependent audit program.
Changes to Eligibility for Coverage

A large majority of plans in the study have not changed coverage for spouses. The 34 plans that have changed spousal coverage have used a variety of strategies.

Among the relatively few plans in the study — 68 plans or 23 percent — that had a separate category or class of coverage for part-time workers when the Affordable Care Act became law, most have maintained that coverage.

Similarly, most plans in the study have maintained coverage for retirees. Among the 33 plans (11 percent) that did not maintain retiree coverage, very few made that change only for pre-Medicare-eligible retirees.

“A large majority of plans in the study have not changed coverage for spouses. ...Similarly, most plans in the study have maintained coverage for retirees.”
About the Plans in the Study

Number of Participants

- **1,016,195** Active participants
- **200,474** Both pre-Medicare-eligible and Medicare-eligible retirees
- **10,623** Pre-Medicare-eligible retirees only
- **1,650** Medicare-eligible retirees only

Industry Breakdown

- Construction: 64%
- Transportation: 7%
- Retail Trade and Food: 12%
- Service: 5%
- Entertainment: 4%
- All Other Industries: 6%

Reserves

The adjacent chart shows plans’ level of reserves. Reserves reflect plans’ continuation value on an incurred basis. Continuation value or “months in reserve” estimates the length of time that a plan can provide benefits to its participants if all income ceases.

- More than 12 months: 14%
- 6 to 12 months: 63%
- Less than 6 months: 23%

Region

- **West**: 17%
- **Northeast**: 43%
- **Midwest**: 29%
- **South**: 11%

Questions? Feedback? Contact Us.

For information about Segal’s extensive database of multiemployer health benefits and how it can be used to create custom benchmark reports, contact one of the following experts:

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