

Planning For Health Care Reform: How Income Impacts Employee Health Benefits Participation

Contents

- What Makes This Study Different** 3
- Executive Summary** 4
- Introduction** 6
- Determining Susceptibility and Potential Impact** 7
 - Industry as an Indicator 7
 - Calculating Financial Impact 8
 - Additional Costs of Additional Coverage 8
- The Relationship Between Participation and Income** 10
 - Participation by Income Segment 10
- Extending Coverage to Lower-Income Employees** 12
- Exceeding the 9.5% Affordability Threshold** 13
 - Percent of Singles Above the 9.5 Mark 13
 - Health Exchanges and Employer Options 16
- Economics of a Public Exchange Versus Group Health Benefits** 17
 - Equivalent Coverage Value 17
 - Where Employers Might Offer Subsidies 18
 - When the Employer’s Plan Becomes Less Expensive 19
- Conclusion** 21
- About the Study** 22
- Research Methodology** 22
- About the ADP Research InstituteSM** 22
- About ADP[®]** 23

Note: To simplify the figures in this document some statistics were rounded to the nearest whole number.

What Makes This Study Different

In 2012, the ADP Research InstituteSM, a specialized group within ADP[®], conducted its inaugural study of health benefits within companies having more than 1,000 employees. Utilizing 2012 data for health and welfare benefits from approximately 300 U.S.-based client organizations, the ADP Research Institute is now releasing additional insights from this distinctive study.

The uniqueness of the study comes from the data available to the research team through ADP's extensive client base and, in particular, from companies that have allowed their aggregated and anonymous information to be included in the data set, including detailed information processed on behalf of those clients. The statistics capture information from large organizations that purchase benefits eligibility and enrollment administration services from ADP. Because this information includes exact employee base salary, eligibility, benefits elections and total premiums paid as reported within ADP's Health & Welfare systems, the ADP Research Institute has access to precise, detailed employee data — rather than the less accurate results compiled through voluntary surveys.

The firms selected for this data set represent mature companies with established track records of offering health and welfare benefits, providing an additional distinctive feature of the study. More importantly, where other studies rely on surveys and information gathered through Federal government agencies and private foundations, the ADP data set comprises actual benefits census data. The results and observations therefore arise from precise employee demographic information for approximately one million employees and over two million covered lives.

You can access the first set of insights at adp.com/healthbenefitsbenchmarks and explore how the composition of a company's part-time workforce will drive the effects of the Affordable Care Act (ACA) through its participation rates.

Executive Summary

Beginning in 2014, the economics of employer-sponsored group health insurance will change dramatically. The ACA broadens the definition of who qualifies for benefits under an employer health plan, with the potential to expand the pool of eligible U.S. workers in group plans by several million. Based on the data pool consisting of companies with 1,000 or more employees, the ADP Research Institute findings show that roughly 29% of all employees do not qualify for benefits today. The ineligible full-time employees within just this set of employers constitute more than five million employees. For many U.S. businesses, the ability to accurately forecast the cost of health benefits related to these changes will be critical for annual budgeting and workforce planning.

To help employers navigate their options under the ACA, the ADP Research Institute conducted research by leveraging its proprietary benefits dataset to address critical questions:

To what extent do income levels and affordability impact employee participation in health benefits today?

Study results established a clear relationship between an employee's W-2 wages and his/her subsequent participation in a health benefits plan. Eligible employees with W-2 wages greater than 400% of the Federal Poverty Level (FPL), (roughly \$45,000 for a single individual, under 2012 guidelines), consistently participate in health coverage 81% of the time. As incomes decline below 400% of FPL, however, health plan participation declines steeply, reaching a participation rate of only 37% for eligible single full-time employees earning between \$15,000 and \$20,000 per year.

What percentage of employees pay more than 9.5% of income (the affordability threshold defined under the ACA) to purchase health coverage?

Across the entire study population, approximately 8.6% of full-time employees who are single pay 9.5% or more of their W-2 earnings to obtain coverage. Of these 8.6%, only 1.0% are purchasing self-only coverage, while the remaining 7.6% have covered dependents.

How do employer contribution levels compare with premium subsidies potentially available through a Public Health Exchange?

Despite the significant number of employees who pay more than 9.5% of wages for health coverage, most employees would still pay smaller premiums (calculated as a percent of income) through their employer-sponsored plan than the premium subsidies (percent of income) available through a Public Health Exchange.

Is there an income threshold below which an employee might prefer to participate in a Public Health Exchange?

Direct comparisons of premiums between Public Health Exchanges and employer-sponsored coverage are not yet available. However, the comparison of employee premiums as a percent of W-2 wages suggests that employees earning \$22,340 or more per annum (200% of the FPL for a single wage earner in 2012) would likely obtain better coverage at lower cost through their employer's group health plan. For large, self-funded employers, extending affordable health coverage to lower-income employees is likely to be financially preferable as well, rather than paying tax penalties for employees who obtain coverage through an Exchange.

Affordability of coverage will likely remain an issue for employees with incomes in the 200-400% FPL range, regardless of source of coverage. New tax penalties levied on individuals and families who do not purchase health coverage (the so-called “Individual Mandate”) may help raise the participation rate of lower-income employees in 2014, but the outcome is unclear.

To what extent will newly eligible employees participate in employer-sponsored health plans? The answer is not entirely clear. Most of the

newly eligible employees will come from lower-wage, nonexempt positions where health coverage was not traditionally offered. At lower-income levels, health premiums may consume 5% to 10% (or more) of disposable income, and affordability may be a barrier. Given the choice, some individuals may also prefer to obtain coverage through a Public Health Exchange, if tax subsidies and premium credits are available.

The employee participation rate has immediate, practical financial consequences for employers. For particular people-intensive industries — such as Retail, Hospitality, Construction, and Business Services — unplanned increases in health premiums can put significant pressure on operating margins. In simplest terms, total annual health benefit costs are equal to covered lives multiplied by annual premiums. If an employer’s covered population increases by 50%, total health costs will also increase by 50%, independent from other trends such as medical expense inflation. Because many of these hourly and contingent workers are concentrated within specific industry sectors, the cost impact will vary enormously among employers. Some employers will see no cost increases, while others may experience an effective doubling of cost. On the flip side, employers who do not extend affordable coverage to newly eligible employees are potentially liable for significant tax penalties.

Ultimately, engaging and supporting lower-income employees to obtain health coverage will be a major challenge for policy makers and employers alike. Low-wage employees without an immediate health concern may resist participation in a health plan that consumes a significant percentage of income, while higher-income employees may resent potential reductions in coverage and higher premium contributions needed to extend affordable health coverage to a larger pool of employees. Higher participation rates may also lead to higher total annual health costs for employers. This puts employers in a very delicate position as they prepare to comply with ACA requirements in 2014.

For many U.S. businesses, the ability to accurately forecast the cost of health benefits related to these changes will be critical for annual budgeting and workforce planning.

The employee participation rate has immediate, practical financial consequences for employers.

Introduction

How does employee income affect participation in group health plans?

Until 2010, this esoteric question was studied primarily by health economists and actuaries. With the passage of the ACA in 2010, however, the answers have practical significance to any employer with 50 or more full-time employees or their equivalents.

As employers review options for offering group health coverage in 2014 and beyond, the financial implications and tax liabilities related to participation rates must now be considered.

The “Shared Responsibility” requirements of the ACA provide that:

1. Most individuals must obtain a minimum acceptable level of health coverage, either through an employer-sponsored group plan, individual coverage, or certain other sources, or potentially be liable to pay penalties in the form of an additional tax.

2. Employers with 50 or more full-time employees, or their equivalent, are separately liable for specific tax penalties. These penalties are determined by:

- a. Whether the employer offers a group health plan with minimally acceptable standards of coverage,
- b. Whether the coverage offered meets a minimum test for affordability, and
- c. Whether one or more full-time employees receive a subsidy to purchase coverage through a Public Healthcare Exchange.

The impact of these tax penalties will vary significantly among employers, dependent upon industry and workforce models.

Determining Susceptibility and Potential Impact

Industry as an Indicator

For some employers, the impact of the ACA tax penalties will be negligible. This could be because the majority of associates participate in group health plans today. In companies where total labor costs make up only a small fraction of revenues, absorbing increased benefits costs might also be easier and therefore of less concern.

For specific types of employers, however, the financial impact of penalties and remediation alternatives from ACA can be sufficiently large enough to materially impact corporate financial performance.

This is particularly true for industries with:

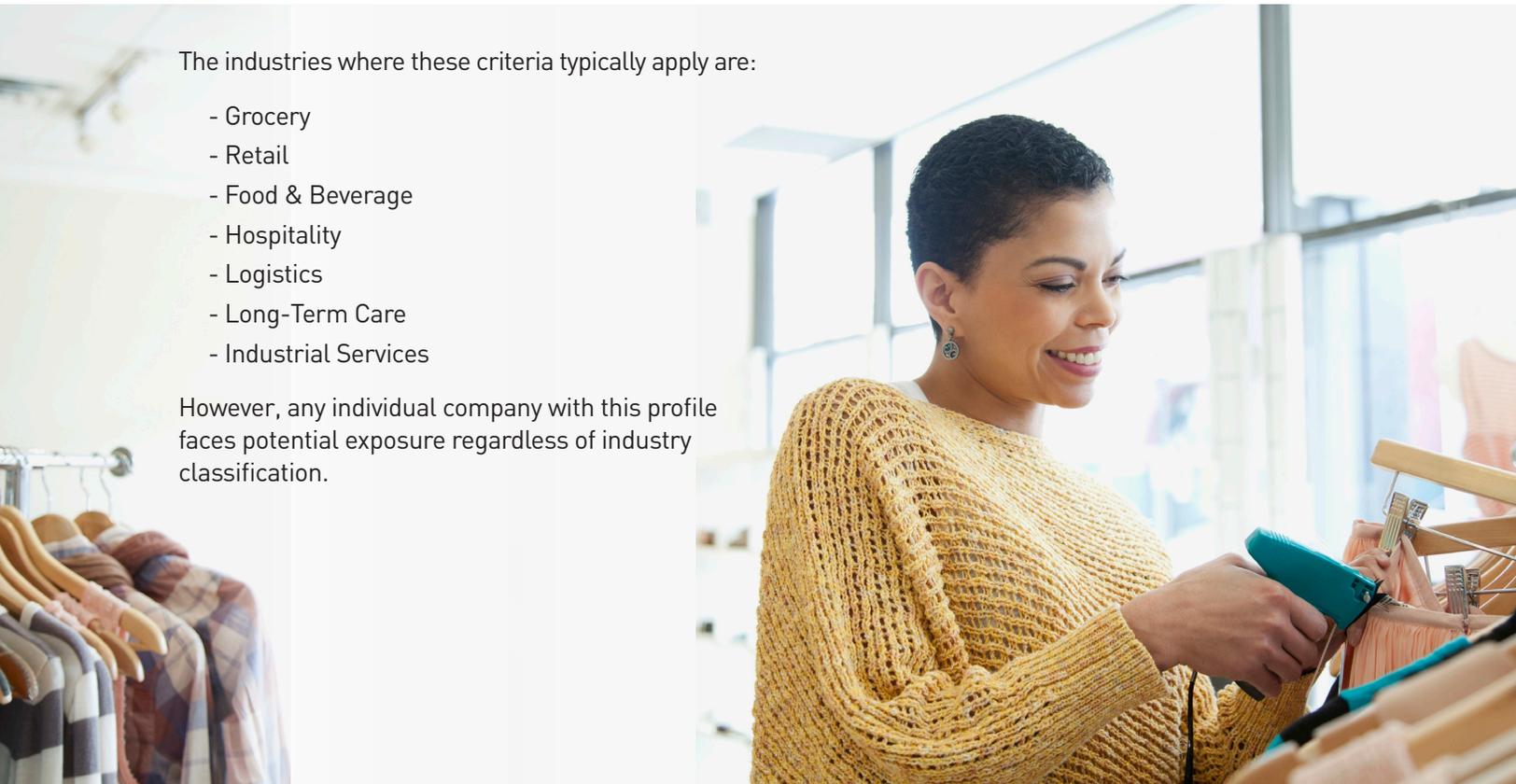
- High labor costs as a percentage of total revenue
- Narrow profit margins and customer sensitivity to price increases
- Workforces that have a high proportion of nonexempt, full-time employees who do not elect health benefits today, but may do so rather than pay tax penalties beginning in 2014
- Workforces with a high proportion of part-time employees who could be reclassified as eligible for health coverage beginning in 2014

The financial impact can be sufficiently large enough to materially affect corporate financial performance.

The industries where these criteria typically apply are:

- Grocery
- Retail
- Food & Beverage
- Hospitality
- Logistics
- Long-Term Care
- Industrial Services

However, any individual company with this profile faces potential exposure regardless of industry classification.



Calculating Financial Impact

Is the potential for financial impact enough to warrant action?

To illustrate the potential, consider an employer who does not offer minimally acceptable coverage but has at least one employee who purchases subsidized coverage through an Exchange. The tax penalty is \$2,000 per full-time employee, less the first 30. As simple as that calculation is, it translates into nearly \$2 million per year for an employer with 1,000 full-time employees when any one employee purchases subsidized coverage through an Exchange.

Offering coverage to all employees might not be a panacea for this problem either. The employer who does offer coverage may be liable for penalties if an employee cannot afford the health coverage offered. In that case, the employer would pay \$3,000 for each employee who purchases subsidized coverage through an Exchange.

In determining whether an employer is liable for a penalty, affordability is generally defined as whether the employee's premium contribution exceeds 9.5% of the employee's household income.*

Additional Costs of Additional Coverage

Assuming that an employer can avoid tax penalties altogether by offering affordable coverage to all employees, an employer must, nonetheless, account for the additional costs associated with extending health coverage to a larger number of employees. ADP data shows that the average employer contributed \$7,225 per enrolled employee for health coverage in 2012. Currently, a significant percentage of lower-wage employees do not elect health coverage due to cost, even when this coverage is available. This could change, however, as individual tax penalties — the so-called “Individual Mandate”— take effect beginning in 2014 for individuals who do not purchase health coverage. The ability to estimate future rates of participation in employer-sponsored health coverage has become a critical variable to estimate and manage future health benefits costs. (See ADP Research Institute's previous document on this subject: adp.com/healthbenefitsbenchmarks.)

For the employer attempting to anticipate and manage their exposure to penalties, several critical questions arise.

Q | **Is there an income threshold below which an individual is unlikely to purchase health insurance whether from their employer or from a Public Healthcare Exchange? If so, how many employees do I have under that threshold?**

This set of individuals might present less of a liability if they do not trigger the penalties by going to a Public Healthcare Exchange for coverage.

Q | **How many employees today pay more than 9.5% of wages to obtain health coverage?**

This number could define how much of the employer's current benefits offering may need reconsideration.

*Several “safe harbor” methods exist by which an employer may determine whether the coverage they offer will be determined to be affordable. See IRS Proposed Regulations, 78 Federal Register 218, January 2, 2013.

Q | Are there certain groups of employees who would be better off obtaining coverage through a Public Healthcare Exchange?

If so, the employer can weigh the cost of the penalty against the cost of trying to provide something of value to the employee.

These questions will impact employers' health coverage decisions for 2014 and beyond. Companies may decide to adjust plan designs and premium options to optimize participation rates and balance their overall costs.

The results of the ADP Research Institute study show definitively that \$45,000 per year is a critical threshold for individual income when it comes to predicting employee participation in employer-sponsored health insurance.

- **Above \$45,000 per annum, single employees elect group health coverage roughly 81% of the time. This 81% rate of participation remains flat regardless of further increases in income.**

- **Below the \$45,000 threshold, participation in health coverage declines in accordance with income. Participation bottoms at 37% for individuals with base pay between \$15,000 and \$20,000.**

It is remarkable how close this \$45,000 threshold is to 400% of the 2012 FPL* for a household unit of one. Individuals earning less than 4 times the FPL are far more price sensitive to the cost of health coverage than those earning more. The threshold identified in this study will help reveal to companies which individuals may require additional financial support to encourage their participation in a health plan and when it is cost-effective to do so.

This study also shows that 8.6% of all single employees pay more than 9.5% of their base pay to obtain health coverage, including 1% who have self-only coverage. Simple extrapolations from the data suggest a similar ratio for married households.

Finally, the ADP Research Institute compared employee premium contributions (as a percent of income) with the potential premium contributions required to purchase coverage in a Public Healthcare Exchange. The data shows that, up to 200% of FPL, single employees might pay less for coverage through a Public Exchange for self-only coverage — in part because of the subsidy provided. However, employees at higher income levels would benefit far more by retaining their current employee group health plan.

When factoring in the additional advantages of self-funded group health, tax shields for employer and employee premium contributions, and the higher actuarial values associated with group-sponsored health plans, the data suggests that most large employers will continue to offer group health benefits rather than send their employees to an Exchange.

*FPL = \$11,170 in 2012. Thus 4 times FPL = \$44,680 for a single household; \$92,200 for a family of four.

The Relationship Between Participation and Income

Can a relationship be identified between income and the rates of participation in an employer’s group health plan?

The ADP Research Institute examined the behavior of 310,000 full-time, nonunion employees whose marital status was identified as single. This population was chosen because ADP has exact records of base pay and employee health premium contributions — and because this data could be representative of the individual’s full “household” income. Employees may have other sources of income, of course, but base pay is an effective proxy for total household income, especially for such a large sample size.

Participation by Income Segment

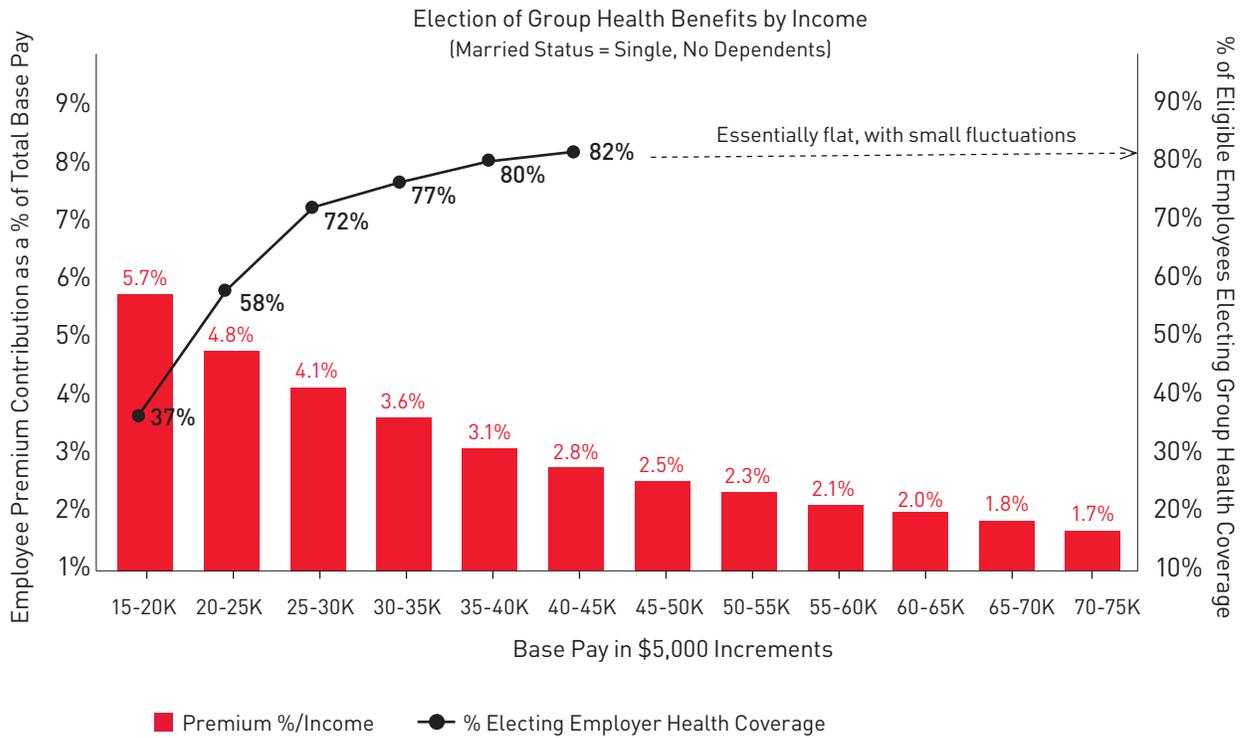
The employee data were split into income segments at \$5,000 intervals. Employee premium contributions were also computed as a percentage of base pay for individuals who elected the health coverage.

Figure 1 shows the full results. Selected findings include:

\$15,000 - \$20,000	Full-time eligible employees, with base pay between \$15,000 and \$20,000, elected health coverage only 37% of the time. Among those in this income category who did elect health benefits, the employee contribution to premiums averaged 5.7% of total pay for self-only coverage, and 7.2% of total pay across all singles, including those with dependent coverage.
\$20,000 - \$25,000	Participation in health coverage increased to 58% for individuals with reported base pay between \$20,000 and \$25,000, while premium contributions declined as a percentage of base pay.
\$40,000 - \$45,000	The participation rate reaches 82% at the threshold segment of \$40,000-\$45,000 in pay, with group health premium contributions averaging 2.5% of pay for self-only coverage, and 4% of pay across all singles, including those with dependent coverage.
\$45,000+	Participation rate levels off at roughly 81% for all income segments, where base pay is greater than \$45,000.

Source: ADP Research Institute

FIGURE 1. Participation Rates and Premiums as a Percentage of Income



Source: ADP Research Institute

Above \$45,000 the participation rate for group health benefits remains fixed at roughly 81%. Premium levels do not account for the remaining 19% who choose not to elect coverage. For employers offering health coverage to lower-income associates today, these figures may look familiar.

Results suggest significant price sensitivity toward the cost of health benefits below a particular income level.

Extending Coverage to Lower-Income Employees

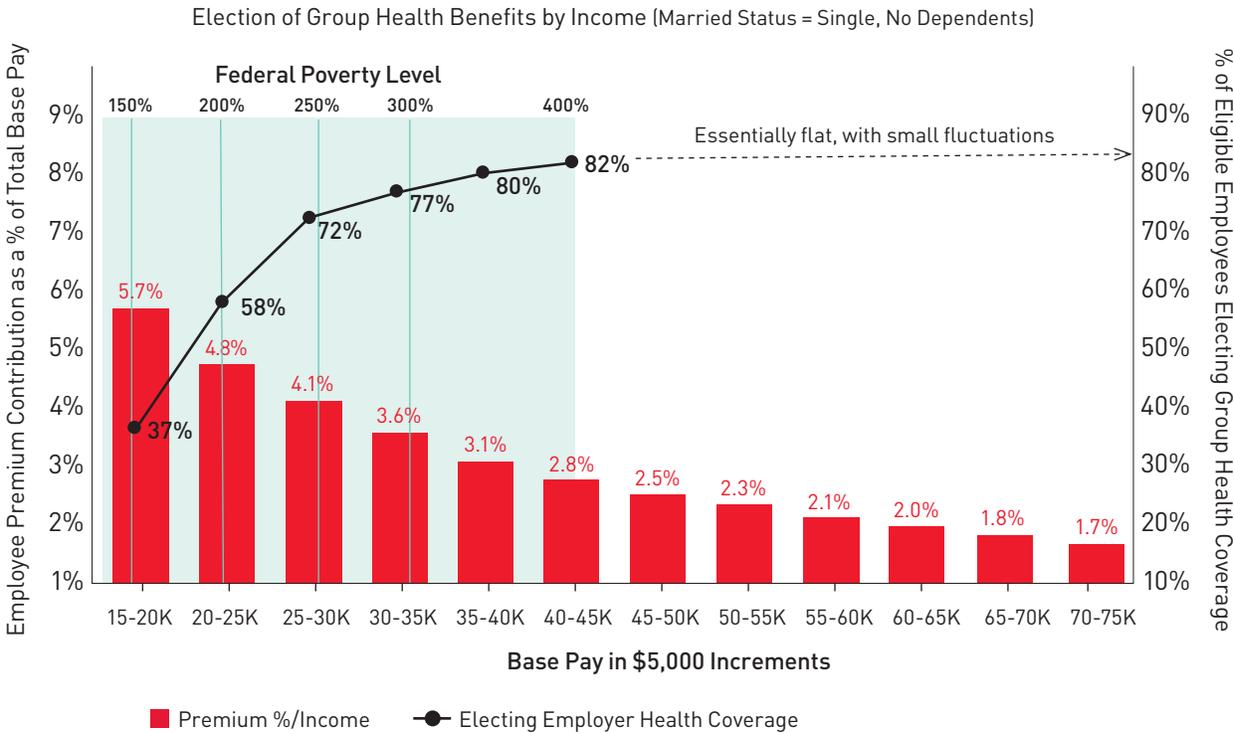
For employers who decide to extend health coverage to more of their lower-income and/or part-time associates, low participation rates are likely to remain a major issue.

The ACA requires that an individual obtain health coverage or potentially face a tax penalty. In 2014, the penalty is generally the greater of \$95 per individual (up to a maximum of \$285 per family) or 1% of household income, rising to the greater of \$695 per individual (up to a maximum of \$2,085 per family) or 2.5% of household income in 2016. Still, the penalty is small enough that some lower-income individuals may be tempted to decline coverage altogether.

How these income levels compare with the FPL guidelines will also be of interest. In 2012, the FPL for the 48 contiguous states and the District of Columbia was \$11,170. The ACA provides subsidies to individuals with incomes up to 400% of the FPL. These subsidies help pay for the health coverage through an insurance Exchange.

Figure 2 shows how the results tie into the employees who are eligible for subsidies by overlaying key FPL thresholds onto the prior graph from Figure 1.

FIGURE 2. FPL Accurately Captures Price Sensitivity



Source: ADP Research Institute

The results suggest, at least for individual coverage, below 400% of the FPL describes accurately the income range of individuals demonstrating price sensitivity when purchasing group health benefits. This means **400% of the FPL and below is an effective reference point for employers**, when studying their own employee populations.

Exceeding the 9.5% Affordability Threshold

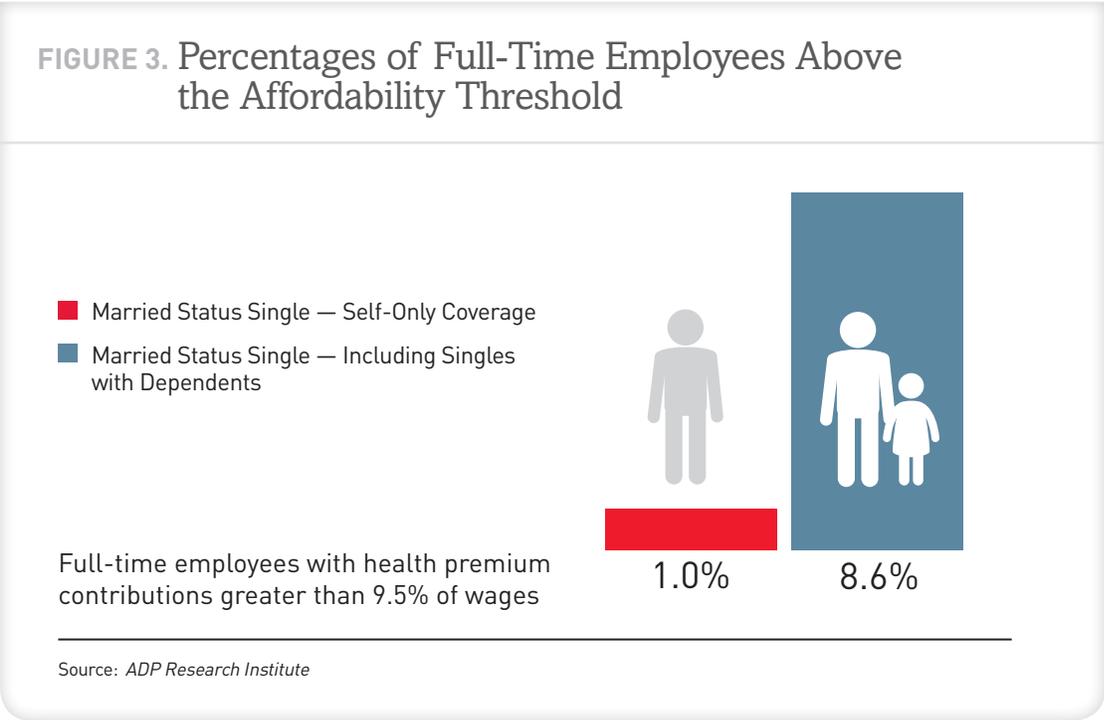
Knowing how many employees fall into the category of paying more than 9.5% of their income for health coverage would also be useful for employers.

A key provision of “Shared Responsibility” requires employers with 50 or more full-time employees (or equivalents) to offer an affordable health plan to their employees with minimally acceptable coverage — or potentially pay tax penalties. The law establishes the affordability threshold as 9.5% of an individual’s household income, but employers can rely on “safe harbors” that set affordability for employees based on each employee’s wages.

For larger employers, the affordability threshold identifies the employees most likely to be eligible for tax credits in a Public Exchange. In the specific case where the 9.5% threshold is exceeded for self-only coverage, and the employee receives a subsidy to purchase health insurance through a Healthcare Exchange, the employer becomes liable for a penalty of \$3,000 per employee, beginning in 2014. Clearly, employers would have an interest in estimating the number of employees who currently pay more than 9.5% of their income for health coverage. Armed with that insight, an employer can begin developing policies to reduce exposure to the penalty tax.

Percent of Singles Above the 9.5 Mark

To consider the impact of the 9.5% rule over a large employee population, the ADP Research Institute reviewed income levels and employee-paid premiums across the entire ADP data set. For purposes of this study, unmarried, nonunion, full-time employees were chosen specifically because their reported base pay may be a reasonably accurate proxy for total household income.



Of 212,718 single participants who elected health coverage, 8.6% (18,195) of those individuals paid more than 9.5% of their base pay to cover health premiums. Assuming these individuals have no other sources of income besides base pay, the 8.6% provides an outer limit on the universe of employees who would be eligible to receive subsidized coverage through a Healthcare Exchange in 2014. However, only 1% of single participants paid more than 9.5% of income for self-only coverage — the criteria established by the IRS to trigger a tax penalty to employers.

WHAT ABOUT MARRIED COUPLES?

The ADP Research Institute also examined premium-to-income ratios for married individuals. However, the analysis of married benefits-eligible populations is problematic given that 77% of all married, working-age couples have dual incomes. The ADP benefits database does not capture spousal income. However, some inferences can be offered.

Results show that 16.0% of married individuals paid more than 9.5% of base pay to obtain health coverage, roughly double the percentage for unmarried employees.

Assuming each dual-income household earns, on average, twice as much as a single household and that typical family coverage is somewhere between 2-3 times more expensive than single coverage, the total number of married individuals above the 9.5% premium-to-income threshold is estimated to be between 8% and 12% of total employees.

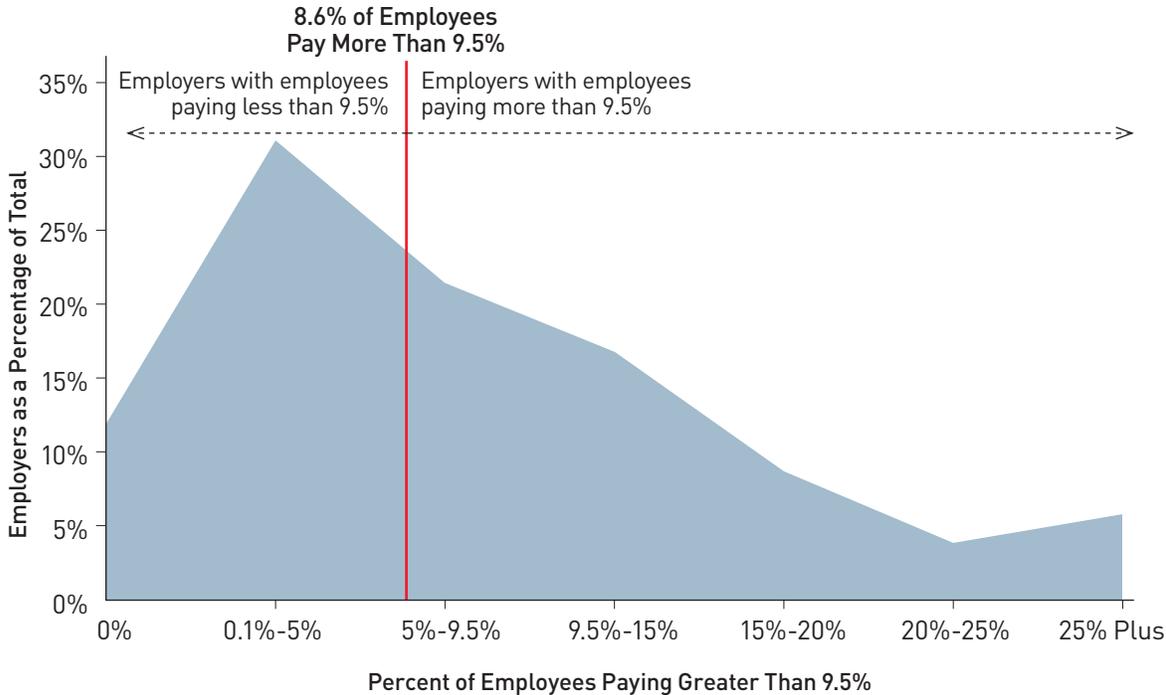
Without exact tax returns for married couples, a precise number cannot be established. Actual results could vary significantly based on total household income and cost of family coverage.



It is important to note, however, that this 8.6% rate is a composite average over 300 separate ADP clients. In practice, individual companies will have percentages that vary significantly above or below 8.6%. Figure 4 illustrates this result. The graph shows the percentage of employers who fall above and below the 8.6% composite rate. For roughly one-third of all employers in the study, the 9.5% rule impacts less than 5% of their workforce. For these employers, compliance with affordability thresholds is not likely to generate significant additional cost. At the opposite end of the scale, however, roughly one-third of employers have 15% or more of their workforce paying premiums above the 9.5% affordability threshold. For 5% of employers in this study, at least one out of every four of their covered employees pays more than 9.5% of W-2 wages for health coverage. Clearly, the cost impact of affordability thresholds for employer-provided health insurance will vary greatly from employer to employer.

For that reason, ADP recommends that all employers precisely calculate the percentage of their own employees who meet this criterion. The 8.6% serves as a benchmark for employers to use as a point of comparison with their own workforce data — and to illustrate the potential impact on a company.

FIGURE 4. Distribution of Employers with Employees Paying Greater Than 9.5% of Income Toward Health Premium



Source: ADP Research Institute

Health Exchanges and Employer Options

The next question then is: What portion of the 8.6% will leave the employer's health plan in 2014 to obtain coverage through a Public Healthcare Exchange?

Employers are not subject to penalties for employees who leave unless the employee actually receives subsidized coverage through a Healthcare Exchange. Given that the cost and quality of these Exchanges will vary widely from state to state, it is difficult to answer this question in advance.

Still, employers have several options to reduce this migration. The employer may offer:

- A very low-cost default coverage option, such as a catastrophic coverage plan with a 60 or 70% Actuarial Coverage Valuation that provides minimally acceptable coverage.
- Private subsidies for lower-income associates. The employer could offer \$500 - \$1,000 supplements to lower-income employees to put their premium contributions below the 9.5% threshold. This would be financially better for the employer than paying a nondeductible \$3,000 tax penalty. The employee's premium contribution to this would also be shielded from FICA and income tax.



Adding to this uncertainty, the 8.6% statistic only accounts for lower-income employees who already enroll in employer health coverage today. What happens in 2014 when employees are also liable for tax penalties if they do not obtain adequate health coverage? Within the ADP sample population, 30% of benefits-eligible unmarried employees have incomes within the \$15,000 - \$30,000 range. If their participation rate increased to the norms of higher-income individuals, we would expect a 40% increase in enrollment for this lower-income segment. For that reason, we believe that 8.6% understates the issue.

Economics of a Public Exchange Versus Group Health Benefits

Are employees better off maintaining health coverage through their employer, or migrating to a Public Exchange?

The ACA specifies that individuals with incomes less than 400% of the FPL* are eligible for specific subsidies to assist with the payment of health insurance bought through a Public Exchange. These subsidies are characterized by the percent of income required for the individual to pay insurance. For example, a single individual earning 133% of the FPL, approximately \$14,855 per year, would be expected to pay no more than 3% of total household income, or \$446 per year, for coverage on the Exchange. Such an individual might arguably benefit from purchasing coverage on the Exchange rather than participating in their employer's group health plan, where they may pay 8% to 10% of their income.

Equivalent Coverage Value

There are some considerations to the contrary. Government subsidies will be set according to the price of the second-least expensive "Silver" plan offered within a given state. In other words, the government will provide subsidies to purchase insurance with an Actuarial Coverage Value of 70%. In some cases, the government will provide additional subsidies to pay for out-of-pocket health expenses of a higher-tier plan. Above an FPL of 250%, however, the purchaser would be expected to pay the additional premiums for a Gold or Platinum plan out of their own pocket, or tolerate the higher out-of-pocket and coinsurance typically found with a Silver plan. For debt-constrained individuals earning more than 250% of FPL and having a low tolerance for out-of-pocket health costs, the employer's group health plan might be a better value.

NEW HEALTHCARE TERMINOLOGY: ACV

The Affordable Care Act (ACA) will introduce new healthcare terminology to consumers. The ACA requires Exchanges to offer plans with Platinum, Gold, Silver and Bronze designations. These correspond to Actuarial Coverage Values (ACVs) of 90%, 80%, 70% and 60% respectively. A plan with an ACV of 90% expects to cover 90% of the total allowed cost of benefits.

PLAN TYPE	Actuarial Value	Deductible	OOP* Maximum	Coinsurance	Premium Differential**
Platinum	90%	\$250	\$2,000	15%	14%
Gold	80%	\$500	\$4,000	35%	13%
Silver	70%	\$1,500	\$5,000	45%	Base line
Bronze	60%	\$2,000	\$7,500	50%	-17%

* Out-of-pocket

** Assumes no change to purchasing behavior

Source: *Health Exchanges: Impact of Health Plan Benefit Changes on Cost and Utilization*, Milliman, May 2011.

This is a simple illustration. In practice, two Gold plans could have different deductibles, coinsurance, and out-of-pocket maximums.

The typical employer group health plan has an ACV of roughly 82% or just above a Gold plan¹. Government subsidies for state-sponsored Exchanges, however, are set for the second-least expensive Silver plan with that state Exchange. Consumers moving from an employer plan to the Exchange might find the deductibles and coinsurance of a Silver plan to be unacceptable. Therefore, government subsidies may seem less generous if the equivalent plan is 13% more than the employer's plan.

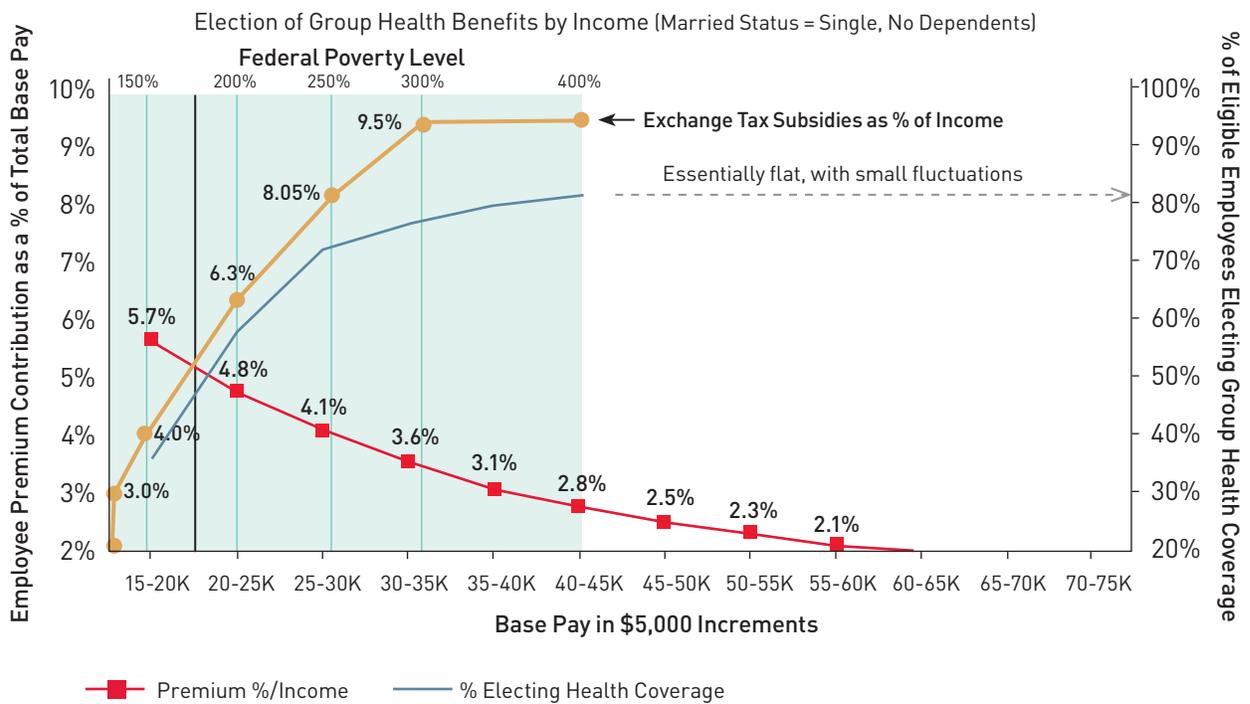
*FPL = \$11,170 in 2012. Thus 4 times FPL = \$44,680 for a single household; \$92,200 for a family of four.

¹ Source: *Health Exchanges: Impact of Health Plan Benefit Changes on Cost and Utilization*, Milliman, May 2011.

Where Employers Might Offer Subsidies

Superimposing these premium subsidies on top of ADP’s empirical data for premium contribution as a percentage of total wages reveals a clear pattern. Results are shown in Figure 5, below, where the red line (premium contribution as a percentage of income as measured by ADP) crosses the gold line, representing subsidies available to lower-income employees to purchase coverage at an Exchange.

FIGURE 5. Exchange Tax Subsidies as % of Income



Source: ADP Research Institute

Based on the available data, for single employees earning less than \$22,340 per annum (area left of the gold line), a Public Exchange is less expensive than group health benefits for self-only coverage.

When the Employer’s Plan Becomes Less Expensive

Employees earning above \$22,340 but less than \$45,000 per year (area to the right of the black line but within the highlighted space), however, will likely be able to obtain cheaper coverage through their large employer plan. These individuals are more likely, as reflected through the increasing participation rate, to be more price sensitive than employees with higher incomes. Employers concerned about participation rates may wish to offer additional subsidies or premium supports for employees in this lower-wage category. Above 400% of FPL, employee price sensitivity to health coverage declines to the point where subsidies for health coverage may no longer be needed. These observations are summarized in Figure 6 below.

FIGURE 6. Subsidized Exchanges Versus Group Health Coverage

	< 200% of FPL	200% - 400% of FPL	> 400% of FPL
Possible Preferences for Employees	PUBLIC EXCHANGE <ul style="list-style-type: none"> • Substantial cost differential • Additional tax subsidies to reduce out-of-pocket expenses 	EMPLOYER-SPONSORED COVERAGE <ul style="list-style-type: none"> • Better coverage at less expense • May not participate without employer subsidies • May prefer 29 hrs/wk with no plan versus 33 hrs with plan 	EMPLOYER-SPONSORED COVERAGE <ul style="list-style-type: none"> • Better coverage at less expense • Possible unfavorable reaction to Exchange coverage

Source: ADP Research Institute

Single employees with dependents, while constituting a small percentage of single employees, provide a useful research tool for modeling family coverage, because W-2 wages and cost of family premiums are precisely known. For example, our research shows that health premiums represented an average of 14.1% of income for single employees with dependents earning between \$20,000 and \$25,000 per year.

For a family of four, a Public Exchange is more likely to be cost-effective below 225% of FPL — slightly higher than an individual seeking self-only coverage. Because Federal poverty thresholds are higher for a family of four, this corresponds to an income of roughly \$52,000 a year. In other words, a family of four with an income less than \$52,000 per year may find a Public Exchange more cost-effective than an employer group health plan, while those earning more, would likely prefer the employer plan.

In general, families contribute a higher percentage of premium costs for health coverage than individuals. Because IRS “Shared Responsibility” penalties for affordability are set based upon self-only coverage, this could potentially accelerate the trends.

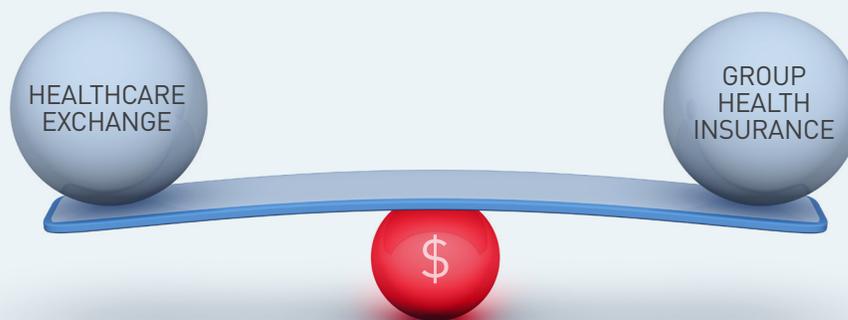
Before employers make decisions regarding premium structures, several critical differences between health coverage purchased through an Exchange with government subsidies versus group health coverage subsidized by an employer should be noted:

- Through an Exchange, individual coverage will be potentially more expensive for equivalent coverage than the premiums paid by a large, self-funded employer. Once an employer exceeds several thousand lives, self-funding becomes viable and creates a significant cost advantage over fully insured group products and individual coverage. Additionally, the risk pool of a private employer may be substantially healthier than the public-at-large, resulting in fewer claims year-over-year and, thus, better premiums.

- Government subsidies for Exchange coverage are based on the premiums of the second-least expensive “Silver” plan offered within a state Exchange (a Silver rating indicates an Actuarial Valuation of 70%). The typical group health benefits plan has an Actuarial Valuation of 82%² comparable to a “Gold” plan. In practice, this means the base plans within the Exchange will have substantially higher deductibles and co-pays. To purchase equivalent insurance to what their employer most likely offers, an individual would need to pay an additional 13%-to-15% more in premiums.³
- Very low-cost insurance, with minimally acceptable standards of coverage, could be potentially added by employers to meet the requirements under ACA and thereby avoid penalties.

Ultimately, each employer preparing for ACA has unique challenges associated with its particular workforce and business. Margin-sensitive companies with a high proportion of low-wage employees may need to offer a health plan with an Actuarial Valuation of no more than 60% to 70% in order to comply with ACA. Or, they may have all their employees move to a Public Exchange. Less margin-sensitive companies, focused on workforce competitiveness, may choose to extend existing group health coverage to an even greater spectrum of their workforce than they do today.

COMPETITIVENESS OF EXCHANGES



Will Exchanges be price-competitive with group health insurance? In the small-to-midsized employer market, the answer is not clear. Large employers, however, are likely to have some major cost advantages over Public Healthcare Exchanges due to self-funding arrangements for insurance.

Over the past several years, self-funding has increasingly demonstrated lower health-cost trends than full insurance and enjoys a roughly

5% cost advantage over standard, fully insured group insurance.

In addition, large employers are better positioned to pursue health management programs with financial incentives to encourage healthy lifestyles that reduce health risk.

For these reasons, most large employers may be able to anticipate offering better health coverage at lower cost for their employees.

Source: *Self-Insured Health Benefit Plans*, Deloitte, March 23, 2011.

^{2,3} Source: *Health Exchanges: Impact of Health Plan Benefit Changes on Cost and Utilization*, Milliman, May 2011.

Conclusion

Employers should be anticipating the potential for significant tax penalties as the ACA unfurls. To devise a plan to minimize this exposure, their companies can use the data in this ADP Research Institute study to determine the extent of their exposure by understanding the relationship between income levels and participation rates. Further, they can comprehend the drivers that would activate penalties and the options for addressing those situations.

Some industry profiles could indicate a more significant liability exposure. Hospitality and Grocery are just two such industries, but any organization shouldering high labor costs, narrow profit margins, or large numbers of employees currently without coverage should also take note.

Determining exposure would have been difficult in the past. But actual benefits-election data available through the ADP client dataset has been helpful in relating income segments to their election of health benefits coverage. Employers can now use this information to identify the parts of their employee population most susceptible to the Public Health Exchanges' offerings.

Some of the employee group coverage issues may be more easily addressed than others. Understanding a company's options and where those options might have merit can be considered through an understanding of the 9.5% affordability index and how the Public Healthcare Exchanges are structured to address the issue.

Even companies with smaller exposures will want to consider whether extending benefits to more of their workforce than before is a better option than paying the penalties. It is important to note, however, that doing so may not solve the problem. If the coverage offered is too expensive to be affordable for the employee population in question, employees may still resort to an Exchange.

About the Study

ADP offers a comprehensive health and welfare benefits solution among its broad spectrum of available products and services. Leveraging anonymous information from our client dataset allows us to draw insights into employee behavior with respect to benefits participation, demographics, and premiums paid by employees and employers.

This study is based on 2012 actual employee-level, aggregated data from ADP's health and welfare benefits clients of approximately 300 U.S.-based client organizations. All states and major industries are covered, as well as gender, age, and marital status. Each of the companies in the study has 1,000 or more employees, including both full-time and part-time workers. Due to the small dataset population of union employees, only nonunion employees are considered in this analysis.

Research Methodology

The ADP Research Institute conducted this cross-sectional analysis utilizing raw anonymous employee-level data from 2012. These static data were joined with ADP's client-level information to identify the associated industry for each employee. The employee base was evaluated in terms of eligible versus ineligible for health insurance, including an assessment of participation rates. Demographic analyses were then conducted by geography, industry, age, and gender. Premiums were analyzed from the perspective of number of dependents, annual compensation, and full-time versus part-time status. The "monthly premium" data allowed for segmenting the premiums by employee-only, employer-only, and both pay. (Most of the analyses focus on the premium segment where both pay.) By combining the participants with number of dependents, further analyses were conducted focused on total members covered.

About the ADP Research InstituteSM

The ADP Research Institute provides insights to leaders in both the private and public sectors around issues in human capital management, employment trends, and workforce strategy.

About ADP®

ADP, Inc. (NASDAQ: ADP), with about \$10 billion in revenues and approximately 600,000 clients, is one of the world's largest providers of business outsourcing solutions. Leveraging over 60 years of experience, ADP offers a wide range of human resource, payroll, tax and benefits administration solutions from a single source. ADP's easy-to-use solutions for employers provide superior value to companies of all types and sizes. ADP is also a leading provider of integrated computing solutions to auto, truck, motorcycle, marine, recreational vehicle, and heavy equipment dealers throughout the world. For more information about ADP or to contact a local ADP sales office, reach us at **1-800-CALL-ADP (1-800-225-5237)** or visit the company's website at **adp.com**.

ADP does not give legal advice as part of its services. This document provides general information regarding its subject matter and should not be construed as providing legal advice. This material is made available for informational purposes only and is not a substitute for legal advice or your professional judgment. You should review applicable law in your jurisdiction and consult experienced counsel for legal or tax advice.



IN THE BUSINESS OF YOUR SUCCESS®

The ADP logo, ADP and In the Business of Your Success are registered trademarks of ADP, Inc. ADP Research Institute is a service mark of ADP, Inc. All other trademarks and service marks are the property of their respective owners. Copyright © 2013 ADP, Inc.

adp.com/research

HR. Payroll. Benefits.

