HEALTH CARE REFORM

How will the Affordable Care Act delay affect employers?

PANELISTS

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TAYLOR serves as Regional Vice President, Southern Ohio Sales, for Mason, Ohio-based Anthem Blue Cross and Blue Shield in Ohio. He is accountable for the sales and renewal activities for Anthem Blue Cross and Blue Shield’s large group business. He and his team partner with clients to develop benefit strategies that are tailored to the unique cultural and financial goals of each client organization. Additionally, he has oversight for both employer and broker/consultant relationships. Taylor has been in the health benefits industry for more than ten years, in a number of roles. Prior to joining Anthem Blue Cross and Blue Shield, he served in the U.S. Army. Taylor attended the University of Maryland-Baltimore County (UMBC), where he obtained a bachelor’s degree in health policy and science before earning a master’s in health administration at Indiana University.

WILCOXON is a partner in the Employee Benefits & Executive Compensation practice group. She has significant experience advising employers and other benefit plan professionals on welfare benefit plan matters. She helps clients respond to increased plan costs and legal changes by analyzing various plan designs and associated risks; closely following legal developments and offering proactive advice; walking plan administrators through HIPAA privacy and security compliance and providing employee training; drafting and reviewing plan documentation and participant communications; consulting on benefit claims and appeals; and answering questions relating to COBRA, consumer-driven health plans, nondiscrimination requirements, cafeteria plan rules, taxation of benefits and other welfare benefit matters. In addition, Kim counsels employers on all aspects of retirement plans and executive compensation arrangements, including 401(k) plan design and administration, pension plan administration, 409A compliance, fiduciary counseling, and benefits issues in corporate transactions.

BOGDAN-POWERS, a Harvard graduate with a B.A. in History and Vice President of Employee Benefits Services with HORAN, leads the firm’s employee benefits team, developing customized solutions to meet the business goals and benefit objectives of its clients. She is responsible for client relations and works with the Account Management Team advising clients in the rapidly changing health care environment. Bogdan-Powers came to HORAN with 20 years experience in sales and marketing at Procter & Gamble Co. Her experience in the pharmaceutical division provided a comprehensive understanding of the health care system, including extensive collaboration with physicians, carriers and consumers.
A trio of local experts met recently with Cincinnati Business Courier editor Rob Daumeyer to discuss the coming impact of the federal Affordable Care Act – more commonly known as the ACA or simply Obamacare – on businesses and individuals.

This Roundtable discussion is designed to enlighten readers on several of the pertinent issues related to Obamacare. However, readers should note that for professional guidance on the implementation of ACA regulations specific to you or your business, you should seek advice from qualified professionals.

QUESTION: What are you spending most of your day on now regarding health care reform?

TAYLOR: My team is responsible for sales and retention for group business in the Southern Ohio region. That includes the Dayton metro area, as well as the Cincinnati metro area. Right now a lot of the time is being spent educating employers on their options, on the impact of health care reform to them and their employees. Ultimately, we are showing them options from a benefit perspective, that align with their strategy and with their cost and quality goals. We’re working to help clients understand what the Affordable Care Act (ACA) means to them and what their options are under this new federal law.

WILCOXON: I will say that my days now are considerably less stressful than they were before the delay. The delay that we’re going to talk about gave employers a little bit of breathing room. So it has gone from trying to advise employers about how to implement the ACA with very limited guidance to, now where we are, focusing on other aspects of the ACA. Rather than trying to decide to whom do we extend coverage (we’re beyond that initial stage), we’re looking at how this will impact our systems. We are working with clients to get them organized and ready for 2015. It’s definitely a different world now than it was a few weeks ago.

We are focusing mostly on three things. First, what exactly does the delay of implementation of some parts of the ACA mean for our clients in 2014? Second, we are looking at how the U.S. Supreme Court’s DOMA (Defense of Marriage Act) decision this summer will impact same-sex spouses. Third, we’re also working with clients to prepare for 2014 regarding wellness programs.

BOGDAN-POWERS: At HORAN we are advising our clients on their employee benefits and platforms. We have clients ranging in size from 2 to 10,000, so we have all sizes and all different rules apply. Like Kim, we spend a lot of our time on the strategy with our clients.

We are working with them to refine their short-term strategy for health care reform and on the long-term side, helping them decide how they want to handle benefits. On a daily basis, we are answering very specific questions that are overall health care related, but that also crossover to compliance, especially with ERISA (the federal Employee Retirement Income Security Act of 1974). We are in that time of year when a lot of things have to happen with notices and trying to integrate those. We get many specific questions.

QUESTION: What is the general state of knowledge in the business community in relation to the ACA? It appears to me that very few business owners are as well versed on this critical topic as they really need to be.

BOGDAN-POWERS: We’ve tried to break it down into a couple of areas because everyone is across the spectrum on this. What we did is conduct a full series of education seminars that were face-to-face. We broke it down into tight topics, so we’re finding that the big overview, we are past that. We need to get into specifics.

We also send information on e-mail on a regular basis regarding legislative updates. And every time we are in front of a client we are doing a presentation or some sort of education around health care reform.

QUESTION: So employers are past the initial introductions?

BOGDAN-POWERS: Yes, they are past the overview. They’re looking for the specifics. I would say they are very strong on the overview and we have a lot of opportunity to help them on the specifics.

WILCOXON: I would agree with that, but it also depends whom within the organization you’re talking about. The folks who are administering benefits on a day-to-day basis are definitely looking for the specifics. They’re in the weeds. They’ve been dealing with this for years.

But then you’ve got the higher level executives who know about this, know about the broad concept, and know it’s going to impact them. But don’t necessarily know all the details. They’re not in the weeds. So you have to tailor your presentation or your advice depending on the level of knowledge that people have.

TAYLOR: I think the understanding of ACA ranges from confused to the highly consulted. Those who have a lot of consultation are in a much better place, but when you think about that wide spectrum, especially in the individual and small-group markets, it ultimately comes down to them reviewing what products are they going to be able to choose from and how much will it cost.

We have not really been able to date to provide just what that is going to be because so much of what that market is going to be revolves around the exchange platform that hasn’t fully materialized yet.

On the other end of the spectrum are employers who are well consulted. They have a sense of where they need to go, but they’re anxious for continuous finalization of rules and regulations, which have been slow and, I suppose, steady.

But as we get closer to Oct. 1, and then ultimately, January, there are still a lot of unresolved questions from the administration. I think those folks are anxious to know what am I going to be judged against October 1 and January 1, what are my responsibilities.

QUESTION: The play-or-pay penalties are delayed now until the start of 2015. What are those penalties and what do they mean for businesses?

WILCOXON: The play-or-pay penalty will apply to an employer that is determined to be an applicable large employer, so generally that is one that has more than 50 employees. If that employer doesn’t offer a sufficient level of affordable health care coverage to all of its full-time employees, it will be subject to a penalty if any of its employees goes to a state marketplace, obtains coverage and is eligible for a premium tax credit that brings down the cost of that coverage through the state exchange program or marketplace.

The amount of the penalty depends on whether the employer has offered coverage to at least 95% of its full-time employees.

If the employer has offered coverage to at least 95% of its full-time employees and their children, and any full-time employee goes to the exchange and becomes eligible for the subsidized coverage, then the penalty is $3,000 times the number of full-time employees who actually go to the exchange and qualify for the tax credit.

That is what we call the smaller penalty (or the “B” penalty) because it’s based solely on the number of full-time employees who get that subsidized coverage.

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– Marcus Taylor
If the employer fails to offer coverage to at least 95% of full-time employees and their children, then the penalty is $2,000 times the employer’s number of full-time employees. Regardless of whether the full-time employee is eligible for coverage, is offered coverage, enrolls in coverage, whether they go to the state exchange, it is $2,000 times all the full-time employees.

That’s the big one. Some people call it the sledge hammer penalty or the “A” penalty.

TAYLOR: May I add something to that? I think she described the penalties well, but to put a little more color around some of those provisions, that minimum essential coverage that she talked about that must be offered to a minimum of 95% of their employees, it must meet a 2014 provision for a group health plan.

Some companies now offer a limited benefit plan or mini-med plans or they offer accident-only or chronic illness plans. Those types of health care insurance plans don’t meet the test anymore, so when you’re talking about a minimal essential plan that’s offered to 95% of your employees, it can’t be those things. It’s more the comprehensive types of coverage that will apply to the broader market in 2014.

The second part that she spoke about related to the so-called “B” penalty. It really is a two-prong test. The first one is around minimum-value coverage. That basically means that not only does the employer have to offer this minimally essential coverage, but that at least 60% of the cost of health care services based on the average consumer, are to be borne by the plan and not by the employee. That is important.

The second-prong to that is the affordability test, which says that in addition to that 60%, the employee contribution portion of that health care cost can’t exceed 9.5% of that employee’s household income. So that final section actually becomes a third prong on the penalty structure.

BOGDAN-POWERS: Here is where this has helped the employers, where it impacts them the most. In terms of the play-or-pay, very few of them were going to be broadly impacted. Where it affects them is really two things; for those that had some employees where they didn’t offer benefits at the 30-hour mark, outside of small group, you can choose the amount of hours to decide to make someone eligible. When the reform comes in, it will be set at the 30-hour mark.

That has relieved some employers of certain subsets of their population that they don’t offer benefits at the 30-hour mark. That has been a huge piece to figure out how to count them and determine who are they. The expense of that has been delayed so they can prepare for it better.

The second group of employers that this really impacts is the one that has a significant percentage of employees whom they don’t cover today. If you think of a staffing agency or a restaurant business, or think of some of these businesses where they have a workforce that might have a higher turnover or play a different role, their business model is built on them having

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At Anthem Blue Cross and Blue Shield we understand you don’t have time to read the entire Affordable Care Act (ACA). After all, it’s thousands of pages. That’s why we brought together all the information you need in one helpful website: makinghealthcarereformwork.com.

We’ll help you understand the ACA and how it impacts your business. The site is full of tools and resources to help you make decisions, including:

- **ACA Decision Support Tool.** Use this interactive tutorial to learn the basics of ACA and its impact on you and your business.
- **ACA Financial Calculator.** Estimate your costs for offering health benefits to your employees.
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**DISCUSSION, FROM PAGE 3C**

An administrative staff that has benefits and a very big staff who doesn’t have benefits — whether they are contract workers or temporary workers. Those groups had a major issue in having to offer insurance.

They have some time now with the delay to figure out their business model. They need to evaluate if they can charge their clients a surcharge and what does that look like.

What we have seen in our employer groups are the 30 hours and these groups that have a high employee base outside of their administrative staff as part of their business model.

**TAYLOR:** Just one thing to add to that. If you read about some of the staffing agencies and the cost impact of this, they go from 1,000 eligible to suddenly they have to cover all these part-time and other employees, and they are jumping from 1,000 eligible to 10,000 eligible come January 1, 2014. It has huge cost implications because it’s not built into their bottom line, their income structure right now.

The other thing about the employers mandate is that — and correct me if I’m wrong — this is one of the few provisions that also impacts grandfathered plans. Many of the things we’ll discuss today in terms of provisions for 2014, are targeted for non-grandfathered plans. This provision applies to all plans. The employer mandate or as it is known the play-or-pay mandate has the broadest brush of all the provisions.

**QUESTION:** What is the consultation with a client like that? Do you have to just get to that level and explain to the business owner that this is your entire business model that will be affected by ACA?

**BOGDAN-POWERS:** I think there are two levels at which we’re trying to look. First, we’re trying to work with them and survey those employees who they don’t cover to truly understand where they are getting insurance today. Many of them may not need insurance from their employer. They could be covered by a spouse’s plan. They might have other areas of insurance. We have to help the client figure out what the exposure is and that takes time.

The second piece we’ve looked at is to say - how the market will emerge on this although it’s highly controversial today - are there minimal essential coverage plans that are acceptable to the government? These would have to cover the minimal essential benefits and allow the individual to pass their mandate, while also allowing the employer to provide an option for those who really can’t afford “affordable” coverage.

**WILCOXON:** To paint a picture of that, you really have to understand the Affordable Care Act as this interconnected web of provisions because everything works together. The first thing you have to understand is the individual mandate, where the law says individuals have to have coverage or they will be subject to their own penalty. So they have their own play-or-pay penalty, which was not delayed.

The reason we have that provision in the law is so the insurance companies would be willing to waive their pre-existing conditions limitations and provide guaranteed access (to allow everybody to be eligible). So we needed to have a trade-off to increase the risk pool-the individual mandate, in addition to requiring people to have coverage, part of the law was to make coverage more available, so we’ve got the insurance exchanges. And in order to make it more affordable, so we have this premium tax credit to subsidize the coverage that you can get through the exchange. Now, the premium tax credit is only available to people with a household income within a certain threshold and who are not eligible for minimum essential coverage, which is employer-provided coverage (that’s not limited mini-med, dental-only, vision-only), Medicare, Medicaid, TRICARE, Children Health Insurance Plan (CHIP) and certain others.

In order to be eligible for this credit, they can’t be eligible for this minimum essential coverage, or if they are eligible for employer-provided coverage, then that employer-provided coverage either does not provide minimum value or is not affordable. Minimum essential coverage is what an individual has to have to avoid their own penalty. And it’s when an employer has to offer the big sledgehammer penalty (the “A” penalty).

Then you’ve got the minimum value coverage, which is where the plan covers at least 60% of the cost. If an employer offers minimum value coverage, then an employee who is eligible for the coverage will not be eligible for the tax credit. So that person could not trigger the employer’s penalty. Employers are trying to decide if they should offer minimum value coverage to help reduce their liability for penalty. In most cases, most employer plans offer minimum value right now.

As Valerie hinted, there are some plans that are coming out now that are sometimes called ‘skinny plans’ or ‘thin plans’ that offer very minimal coverage - for instance, covering only preventative care services at 100%. That would be considered a minimum essential coverage plan under the rules that we currently know, so it would avoid the sledgehammer penalty. It would allow the individuals to avoid their own penalty, but it’s not minimum value. So somebody who is only offered the ‘skinny plan’ could go to the state insurance exchange and be eligible for the tax credit.

Employers are struggling to understand: Do we cover these people? Do we offer them coverage, do we not offer them coverage? That’s one alternative available - to accept the “B” penalty, provide the coverage to avoid the “A” penalty, and allow their employees to go to the exchange and be eligible for the tax credit (assuming they are otherwise eligible).

**QUESTION:** Employers need to give notice to their employees about the state market place, also known as exchanges. What do employers need to do provide and is there any difference across state lines in a community like Greater Cincinnati and Northern Kentucky?

**WILCOXON:** Thankfully, there is not. Employers need to say three things in the notice. First, they need to say that marketplaces exist and generally here’s what they do. Second, they need to say that if the employer’s plan does not offer minimum value, that the individual could be eligible for that tax credit through the exchange. Third, if the individual goes to the exchange and gets the policy, then they are likely not going to have a contribution from the employer. The employer is not going to pay for them to go to the exchange. The employer likely would subsidize a good
chunk of their health coverage and that's a tax-
free benefit. So the notice must explain that if 
the individual goes to the exchange and gets 
that policy instead the employer’s policy, they lose 
on the tax-free employer’s contribution as well 
as their own premium (their own amount that 
the employer pays will not be tax-free if they go 
through the exchange).

Those are the only three things that the law 
requires be in the notice.

TAYLOR: And those notices have to be 
provided for current or existing employees by 
October 1. Then for any new hire on or after 
October 1, within 14 days of starting

WILCOXON: The notices don’t have to 
confirm whether the employer’s plan provides 
minimum value – they just need to say that 
the employer may get the credit if the plan doesn’t 
provide minimum value. So employers won’t 
have to know or communicate by October 1 
whether the plan will provide minimum value 
in 2014. But employers may get questions from 
their employees once the employees receive the 
notice.

BOGDAN-POWERS: And that’s exactly 
the key, the questions from their employees. 
They want their firm numbers so they know 
what they’re putting in their notices, and that’s 
the challenge. So we are working with our em-
ployers to say let’s work a timeline between now 
and the last week of September. Many of our 
employers can distribute notices electronically 
if the employee base has computers for part of 
their work. So for some of our employers that 
is how they are going to distribute, so they can 
go right up very close to the time line.

WILCOXON: We have a lot of employers 
who distribute their ERISA notices electronically. 
The U.S. Department of Labor has a certain 
standard. You can send out those notices elec-
tronically, if under this safe harbor you have ac-
cess to a computer as an integral part of your 
job. But we also have employers who say that 
they don’t meet that safe harbor, but still feel 
comfortable distributing electronically because 
they think people are going to get this. That is the 
standard: Are people going to get these notices? 
But with the exchange notice, we have to meet 
that safe harbor, so there may be employers out 
there who send electronic summary plan descrip-
tions or other ERISA notices who may have to 
look at providing this in hard copy.

QUESTION: Marcus more and more em-
ployers are choosing self-funded insurance plans. 
Why are they doing that?

TAYLOR: Quite honestly it’s to avoid and 
hedge themselves against some of the cost im-
pacts and benefit impacts of ACA for fully-ins-
sured plans. It included anything from premium 
tax through the insurer fee, which we as an indus-
try pass directly to our fully-insured clients. That 
runs all the way down to smaller companies of 
two to 30 to what is considered the small group 
market. They are trying to avoid the impact of 
modified community rating and the unknown 
around what that means.

I think what Val could share with you as well 
that a well-designed ASO plan that aligns well with 
that employer’s ability to control costs and have 
a wellness strategy in place, could actually allow 
employers to reap the benefits of those activities. 

If they are under that fully-insured structure, 
especially going into 2014, particularly if they 
are a small group, then they lose any benefit of 
any of those activities. So, by being self-funded, 
while they have things that will impact them, 
they should have a few less. It also allows them 
to retain benefit control and control over what 
sort of plans they want to offer. There’s a lot 
more flexibility. That’s why we see employers 
looking at it.

BOGDAN-POWERS: I think in the 
Southwest Ohio market, speaking from an 
employer point of view, it’s a very competitive 
market for carriers. So you have a lot of price 
competition within the fully-insured market, as 
a result there really hasn’t been a lot of drive 
necessarily to take a lot of risk. Once you go 
self-funded, you are the insurer. You are taking 
the risk. You owe the cash for the claims. There 
hasn’t always been that risk-reward. We have 
a lot of traditional groups, even if you just go 
over to Indiana, that would not be fully-insured, 
they’d be self-funded. 
The trigger is what Marcus is talking about. 
There is a 1.8% premium sales tax in Ohio that 
you save. There is a 2.3% tax that is now with 
health care reform, which is permanent and is 
going to increase over the years. So, those two 
taxes have given people the trigger to look and 
say that the premium tax has always been there.

And now health care reform has given that trigger 
to say in now the time to look. When we counsel 
clients there are criteria though.

The triggers are great, but you need to have 
a stable or growing workforce. You need to have 
good cash flow. And you need to have really 
financial, CFO-type control, whoever that is, 
involved in the benefit-risk decisions in order 
to afford it.

There are pieces that have to happen, so there 
are certain companies that we would have to 
say this is probably not for you because you are 
becoming the insurer and it can affect the cash 
flow of your business in ways that you may not 
be prepared for. We do analysis of our clients to 
help them understand those pieces.

It’s an exciting time for an employer because 
many employers who may not have full access 
to their data will get it, so they can implement 
wellness. That’s what Marcus was referring to 
earlier. They have data showing them where 
they want to focus. And, quite frankly, where 
they have really good years where their claims 
come in lower than expected, they get to reap 
the benefits of that. They also have the years 
– and they have protections for it – when the 
claims are higher and they have to pay higher. 
It gives them a little bit more control on how 
they design things.

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TAYLOR: And I’ll just add that self-funding isn’t new. 10 years ago, I think if we looked at what we’re doing now, we were still trying to find ways to bring rates down and increase participation within the plan. And that’s where we are today. Out-of-pocket maximums are now at $2,000 for a single and $4,000 for a family, which is a big win for employees, because this gives them a clear understanding of what they can expect to pay for their health care. However, it’s important to note that these numbers are just a starting point, and they can vary depending on the plan and the carrier. And that’s where we find ourselves today.

DISCUSSION, FROM PAGE 5C

On a daily basis, we are answering very specific questions that are overall health care related, but that also crossover to compliance, especially with ERISA (the federal Employee Retirement Income Security Act of 1974). We are in that time of year when a lot of things have to happen with notices and trying to integrate those. We get many specific questions.

— Valerie Bogdan-Powers

Wilcoxon: And it may be difficult to coordinate if you have different vendors for your different benefits. So if you have one administrator for your medical benefits and another for your prescription drugs, you now have to start talking to one another so they can integrate. Right, we’ve got some transition relief, so we don’t have to do that for 2014. But in 2015, they’ll have to integrate. But that will be a challenge as well.

TAYLOR: They hit on a ton of them. I’ll just add a couple more in the small group market. There are now limits on what you can charge from a deductible standpoint. And that’s $2,000 for a single and $4,000 for a family, which could have a significant impact on the aforementioned high deductible health plans where a lot of plans in the small group market are well beyond $2,000. They may have been $5,000 at a single or even $10,000. Now we’ve got to bring those back down and what happens is if you lower the deductible, the premium is going to increase. So that is pretty significant. Also in the small group market you have rating limitations around modified community rating. We’ve lost some of the variables that we can rate for as an insurer that allows for a broader spectrum of costs. Additionally, guaranteed issue is now in place for all segments, including large group. And so a carrier can’t deny coverage for lack of participation or not meeting contribution guidance or that sort of thing.

QUESTION: Play-or-pay is delayed so what is going into effect, January 1, 2014?

WILCOXON: There are some plan design requirements that will go into effect in 2014. Beginning in 2014, plans can no longer impose any pre-existing condition limitations. Waiting periods to get into the plan can’t be any more than 90 days. Plans can no longer impose any annual or lifetime dollar limits on essential health benefits. And then, depending on whether you’re a grandfathered or non-grandfathered plan, there may be additional requirements.

So a grandfathered plan is a plan that was in effect on March 23, 2010 (which was the date that the law was originally passed) and hasn’t been modified in certain respects since that time. If you have modified your plan and lost your grandfathered status, a few other things that go into effect would include the use of an out-of-pocket maximum that has specific requirements. Before this, you could have an out-of-pocket maximum in your plan, which said an individual has to pay up to X many dollars under the plan, and then the plan will cover everything at 100%.

You could say that the prescription drug company doesn’t count toward that out-of-pocket maximum that you have to continue to pay for that no matter what. Under the new rules, the prescription drug co-payments have to be included. Everything except premiums have to be included. And that out-of-pocket maximum can’t be larger than $8,150 next year for a single coverage and $12,700 for family coverage.

BOGDAN-POWERS: You know Kim, what is interesting is that we are just starting to feel the impact of what Anthem has released its renewals for January 1, which is when the majority of large groups renew the maximum out-of-pocket on how the plan has been designed — we’re finding that every plan is designed differently — it can have a significant impact. So if you’re in a high deductible plan it has really nominal to no impact because this is based on the high deductible health plan maximum. But if you’re in an HMO or an HMO plan we are finding that some of these plans are having significant increases or are going to have to change their maximum out-of-pocket, which sometimes, depending on the client, if they’re in a collective bargaining agreement or any other piece isn’t as easy as it appears.

WILCOXON: And it may be difficult to coordinate if you have different vendors for your different benefits. So if you have one administrator for your medical benefits and another for your prescription drugs, they now have to start talking to one another so they can integrate. Now, we’ve got some transition relief, so we don’t have to do that for 2014. But in 2015, they’ll have to integrate. But that will be a challenge as well.

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QUESTION: What is the impact of adjusted community rating? Who does it help the most and who does it hurt?

TAYLOR: We currently rate across a bunch of factors. So we can do a risk factor and look at the risk of a small group — two members to 50 — and make some observations, make some determinations that we had a wide range that we could rate a healthier group against a less healthy group. We could also look at a group size factor and also an industry factor, so if you work in a high-risk industry, one where people are on their feet all day and over time it leads to chronic pains. You used to be able to rate for those vs. someone who works in an office setting.

All three of those things go away completely. We lose those factors. We look at age and gender, right now we have an 8-to-1 range that we can rate based on age, that now goes down to 3-to-1. So again, with that restriction around it’s going to impact cost. And a new factor that’s been introduced into the small group rating equation is around tobacco and the fact that you can actually charge up to 50% more for tobacco users on top of your standard rates. But when you put all that together, there is less latitude and bandwidth around elderly vs. younger consumers. When you take away variables like looking at the actual risks of a person, looking at the impact of the fact that at different points in your lives males incur more costs than females and vice versa. When you take all those things away it adds up to significant rate impact in that small group block.

A lot of it depending on what you read and which side of the aisle you sit in this discussion, you’ll hear terms like rate shock being related to this modified community rating. I think our own Lt. Gov. and her office recently released some information that across Ohio because of ACA and a lot of things having to do with modified community rating we were expecting an average of costs across all carriers an increase of 41% of costs in that segment. And that is before subsidy. But it’s hard to calculate subsidy without having things finalized around the marketplace and the exchanges. But that message of 41% was a significant rate impact and one that you’ll consistently hear in the insurance industry.

BOGDAN-POWERS: I think for our employees, the groups under 50 that are going to community rating it’s been really difficult because they have been, quite frankly, trying to run their businesses and they want to have benefits for their employees because they’ve always been geared to that. Now they have to make pretty big decisions that they have to make prior to January 1. So we do have groups that are looking to renew at different times if they think they are going to be greatly impacted. That has a lot of implications with rules they have to comply with.

Those are typically groups that are community rated. You just have this line in the middle and all you are doing is hauling people to that line. So, if you’re above that line, great you save. If you’re below the line, you’re going to want to not have to go because really you can’t afford it in a lot of these businesses. We’re talking a 50% increase can bail a business for a year in their ability to stay in business, but also their ability to offer the types of benefits they want. And, quite frankly, it impacts their ability to hire and invest in their business. This is a hard time for us as we talk to our clients and try to separate our selves to help them understand every time we go in, here is the rule and here is the law, and here is our recommendation because it gets very emotional.

TAYLOR: And to Val’s point, this ties back to the previous questions about why more and more customers are looking at self-funding. They’re looking for alternatives or shelters from these things, for example, she mentioned early renewals. If I’m a company that typically renews in January, February, or March, if my carrier allows me to renew in December that allows me to delay these community rating provisions at least until December 2014, while the market settles or they look for other alternatives. Self-funding is another shelter that people look to. But professional employer organizations are another where they basically put their HR function out to a PEO entity and then that PEO entity has a number of other small companies under it but they operate as one because of that unifying entity as part of what they provide the employee benefits, so they get treated as a large group. It’s looking at alternative to try to escape all together or delay community rating. It’s a significant impact.
QUESTION: Kim, what does the recent U.S. Supreme Court decision on gay marriage mean for employer-sponsored health plans?

WILCOXON: Well, it actually did a number of different things. The recent decision took a look at one aspect of DOMA (federal Defense of Marriage Act). The Defense of Marriage Act had two aspects. One said states do not have to recognize same-sex marriages that were validly performed in other states. So, in other word Ohio doesn’t have to recognize a marriage that was performed in Massachusetts.

The second aspect of DOMA said for purposes of federal law, whenever we see the word “marriage” or “spouse,” we’re talking about one man and one woman who are legally married under state law. The recent decision invalidated that second aspect. We can no longer define marriage or spouse as an opposite-sex couple for purposes of federal law. So many health plans are subject to ERISA, which is a federal law. ERISA does not require a plan to cover a spouse. ERISA does not, for health plan purposes, have any provisions that deal with marriages or spouses. There are a few, but generally not.

Self-insured plans that are not subject to state law but are subject really only to ERISA have had the freedom to kind of design their plan however they want with respect to coverage of same-sex spouses. If the plan has allowed for coverage of same-sex spouses, this decision makes no difference to their coverage options. If it prevented it, it makes no difference.

Now, eventually we may get to the point where treating same-sex spouses differently than opposite-sex spouses is going to be prohibited for many purposes. It may get to the point someday where we have to offer coverage to same-sex spouses. That is not in the current legal landscape. So currently if you have a plan that denies coverage to same-sex spouses this decision doesn’t change that.

If you’ve got an insurance plan (which are subject to state insurance laws) whether you cover same-sex spouses has been dependent on what the insurance law says about what has to be done in your insurance plan. We may see more changes with that as more states move toward recognizing gay marriage.

The key that is going to be different for employers right now is that if they did recognize same-sex marriage and they did offer coverage to same-sex spouses, the tax treatment changes. So now we can no longer define marriage as an opposite-sex couple for purposes of federal law. We can also no longer say that the spousal coverage for same-sex spouses is not exempt under federal tax law. So now we can provide tax-free coverage to same-sex spouses. When and how we do that is the question we’re dealing with right now. We haven’t had guidance yet from the IRS. We don’t know how to implement that.

In addition, COBRA rights regarding same-sex spouses. They didn’t have COBRA rights in the past. If the employee died the spouse didn’t have her or his own independent right to continue coverage after the death. Now they will have the opportunity to do that.

Similarly, special enrollment rights. If the couple got married and it was a same-sex couple, that marriage didn’t provide a federal right to add the spouse to coverage (assuming the plan allowed coverage). So for purposes of federal law (HIPAA, COBRA), “spouse” can no longer be defined as an opposite-sex couple and will be any spouse that is validly recognized under state law.

Now the next question is: Which state law? That’s also left to be determined. It could be the state law where somebody lives. It could be the state law where somebody got married.

QUESTION: Marcus, what is the difference between public and private exchanges? If a small business is approached by a private exchange, what should they keep in mind?

TAYLOR: As Kim mentioned earlier, “exchange” is synonymous with “marketplace.” I think there is a lot of mystery around the term or the idea of an exchange because we don’t have a lot of clarity around what our public exchange will look like. But to really simplify it, an exchange is just simply an online marketplace. It can also be telephonic, but if you have ever shopped on Amazon.com, you can think of how that works. If you’ve ever used Travelocity, then you’ve been on an exchange or a marketplace. It’s basically an environment where you can look at multiple options, benefit and plan options, and so it provides transparency around the cost and the components that make up those different benefit plan options. And then information is available on those options.

A public exchange, the one that is kind of the topic of these days, is one that is backed and sponsored by the government, whether it’s federal or state. And with that backing it also provides premium or tax subsidy. The difference between that and a private exchange is typically private exchanges are facilitated or run by HR consultants or insurance carriers and entities like that. They don’t have any subsidy attached to them and a lot of times the private exchanges as opposed to the public exchanges will offer the end-to-end benefit administration, so everything from the enrollment to making claims, things like that.

The thing that all exchanges need to have in common is strong decision support tools. So if you think about an e-Health.com you are asked what you do and don’t prefer about the other person. The same thing about health care applies. If you don’t mind higher costs, if you don’t mind paying your preventive coverage upfront, then you have those options. You have those preferences, those inputs, it goes through a number of algorithms based on information around the options that align with your preferences.

On your second question about what employer groups should be thinking about or how they evaluate a private exchange when they approach them – because now there are a number of them in the marketplace. I think first and foremost they should look at the entity that is backing that exchange and make sure that it’s reputable and has executed in other spaces relative to employee benefits. I think they should certainly take a look at the technology or the decision support tool. I think they should take a look at how much flexibility they are going to allow from a plan perspective. I think they should look at how many others are on this exchange already.

I would probably be hesitant to be the one or two employers on your private exchange. So you want to look at those types of things. And then I think the other thing is to look at the momentum of wellness within that, so depending on which exchange you’re dealing with some allow fully insured only. So if you’re a self-funded client, do you want to go back to a fully-insured arrangement? Some allow for both fully-insured and self-funding. Some allow for defined contribution, where you set a dollar amount and try to fix your risk as an employer. Those are some of the key things that I would look at if I were evaluating a private exchange solution.

BODGAN-POWERS: I think from the employer’s standpoint this will evolve over the next few years. I think you’ve seen some very, very large companies go in and actually some of the best practices that are coming out of that links to Marcus’ last point. The employer has to be really ready to dive into a defined contribution philosophy and if they’re in to the defined contribution philosophy and they want to drive consumerism to the employee to get the employee to become a consumer. And so those two pieces have to be part of it.

You typically don’t say you’re going to tweak a little bit, it’s an entirely different way of approaching how benefits can happen. There are a lot of neat things about it. In particular, it drives how individuals are able to choose what they want and the ability to apply the funding the way they’d like to apply it. Then comes the need for decision-making support, the education and all of those pieces and things we are still trying to connect for our clients.

The main question employers need to think about is are they really for that kind of strategy. We have some that are. Another question is how are you going to still maintain a momentum of wellness within that, because the employer ultimately is still written as a group, your own group. So you still have to motivate the wellness activity. That can’t just go away as part of this. Those are the pieces that we’re working through at this point.

WILCOXON: I think the other thing you have to think about is does the exchange offer individual insurance policies. Are they all offering group policies?

BODGAN-POWERS: I don’t think you’ll see that until they come out with guaranteed issue that comes out in January, but there are some (exchanges) that are being built right now.

TAYLOR: So none exist right now. I think going into 2014 you will see some pop up in every market probably. Of the ones that exist now, some go down to 100 employees beginning in January. Others you have to have a minimum of 5,000 or 5,000. So to Valerie’s point the really big employers are in the pool and testing the water.

BODGAN-POWERS: I’m not sure if this is where you are going, but the individual will have a choice between the public exchange and doesn’t have the opportunity to do it privately. There will be a lot more venues that individuals will be exposed to for buying insurance. There will be mall kiosks. There will be storefronts. There will be individual exchanges.

And there will be what is traditionally done, which is what is done today, and that’s a broker helping you through an agency. There are going to be a lot of options for the individual. The individual is really going to turn into a consumer in this.

WILCOXON: The big thing for employers is that if they allow their employees to go to this exchange and the employer can choose between a group policy and an individual policy, the employer can’t really make a contribution to that. There are rules that go along with this, but employers that have an individual policy option in the exchange really need to talk to somebody about that before they enter into that. Additionally, I have seen some exchanges that are offering all sorts of different types of supplemental insurance along with health insurance (disability insurance, home insurance, pet insurance, auto insurance). Those are going to be available to be paid for with pre-tax dollars. So if an employer is going to give employees money to go buy something on the exchange, they’re also going to need to think about the tax consequences of doing that.

QUESTION: What other points do you think we need to touch on?

BODGAN-POWERS: I do think there is one other piece of wellness plans that needs to be addressed. What is changing for 2014 is the amount. If people want to do what is called an incentive-based plan, where there are either rewards or penalties for people’s specific health outcomes instead of only participation, they can now raise those differentials to 30% in premium based on wellness. And it’s 50% for anything around tobacco, so that is a big piece for us. Today it is 20%, so we have a lot of employers who are moving from motivation-based participation-based to outcome-based. So you have to score within a certain range on a risk factor or have an alternative program that you have to complete to receive a premium differential.

WILCOXON: The key difference is that there is now a requirement to offer that alternative. So for example, if you had a BMI program where you had a certain premium amount if your BMI was under 30, anyone with a BMI that is 31 or over now has to be offered another alternative to achieve the premium discount. Whether it’s a walking program or an exercise program or an educational class or what have you, they need to be offered a separate way to qualify for the reward. Then they may need to be offered a subsequent alternative to that, depending on the alternative the employer chooses.

BODGAN-POWERS: They don’t have to necessarily improve their outcomes, but they then have to continue in the alternative programs. This is the direction we’ve been going the last two years and it’s going to kick in even stronger with these bigger differentials.
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