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THE VIEWSLETTER

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THE RESHAPING OF THE ACA

The Affordable Care Act (ACA) was the signature legislation of the Obama administration. It significantly changed health care delivery and payment systems. The ACA rules enabled more and more Americans to buy health insurance. However, the law was controversial from the start. Initially, it did not have strong public support.

On his first day in office, President Trump signed an executive order indicating his plan to repeal the ACA. During almost all of 2017, the administration focused on this goal. Even with a Republican President and Republican majorities in the House and the Senate, the administration could not repeal it.

That does not mean the ACA couldn't be changed. The Trump administration took a number of actions that materially altered the ACA going forward. Many of these changes affect the long-term sustainability of the individual insurance market. Some may ultimately affect employer-sponsored health plans.

ZEROING OUT OF THE INDIVIDUAL MANDATE

The Tax Cuts and Jobs Act of 2017 zeroed out the ACA's individual mandate penalties. That mandate required taxpayers to either obtain health coverage or pay a tax penalty. In 2019 the penalty amount will be $0. This means the individual mandate remains a part of the ACA but there will be no tax penalty for those who do not obtain coverage.

In addition, the Trump administration expanded some individual mandate penalty exemptions for 2018. The IRS website describes these exemptions at https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-exemptions. The website does not include the latest exemption since the Centers for Medicare and Medicaid Services (CMS) just recently enacted it. This exemption removes the penalty for those lacking insurance if they live in a county with no insurers or just one insurer or if the only coverage available covers abortion and that violates an individual's religious beliefs.

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Interestingly, the IRS decided to include a mandatory question on health care coverage on tax returns for the 2017 tax year. The tax return was deemed incomplete unless that question was answered.

Eliminating penalties may affect employers' plans. At the first open enrollment in 2019, employers may see some employees drop their coverage if they no longer have to pay a tax penalty for not having coverage.

CHANGES TO ESSENTIAL HEALTH BENEFITS (EHBS)

Individual and small group plans must cover ten categories of essential health benefits. While states determine their own essential health benefits, the ACA dictates the plan options they can use to determine a benchmark plan. The Trump administration just made the 2020 rules for determining EHB benchmark plans more flexible. States will be able to change EHB benchmark plans annually. They will also have the following options:

- Choose an EHB benchmark plan any state uses in the 2017 benefit year
- Construct a custom EHB benchmark plan that incorporates all ten required categories of benefits by replacing any current category with the benefits offered under any other benchmark plan
- Select a set of benefits that will become the state's EHB benchmark plan. There are rules that will apply to building a state benchmark plan.

With these broader interpretations of EHBs, health plans may offer less comprehensive coverage in 2020 and still meet ACA rules.

From an employer standpoint, this change may allow small group insured employers to offer more cost-effective benefit plans.

For most employers with either large insured plans or self-funded plans, EHBs can't have annual or lifetime dollar maximums. Cost sharing for these benefits must also accumulate toward the ACA out-of-pocket statutory limit. More latitude on EHB benchmarks may make plans less restrictive and help control health plan costs. Plans may now be able to introduce annual or lifetime maximums on certain benefits. Remember, however, large insured plans will typically defer to the state plan for the EHB benchmark. Self-funded plans are free to use any state's EHB benchmark plan.

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DID YOU KNOW

Common elements of a wellbeing plan that employers say have a positive impact on health care cost are health assessment data, health screening data and engagement.

Health care cost *(percent of employers who say these activities have a positive impact)*

- Health assessment - 88%
- Health coaching - 76%
- On-site walking paths - 54%
- Free or subsidized fitness trackers - 41%

Health screening data *(percent of employers who say these activities have a positive impact)*

- Wellness competitions - 83%
- Group walk/run events - 59%
- On-site walking path - 53%
- Nutritional counseling - 50%

Health assessment data *(percent of employers who say these activities have a positive impact)*

- Workplace standing/walking workstations - 59%
- Nutritional counseling - 56%
- Stress management programs - 48%
- Off-site fitness class subsidies - 32%

Engagement *(percent of employers who say these activities have a positive impact)*

- Wellness competitions - 83%
- Smoking cessation programs - 77%
- Organized group run/walk events - 69%

Source: A Closer Look: Workplace Wellness Trends, International Foundation of Employee Benefit Plans

ELIMINATING COST-SHARING REDUCTION PAYMENTS

In September 2017, President Trump eliminated cost-sharing subsidies to insurance carriers in the Marketplace. These subsidies reduced the out-of-pocket cost for anyone with a silver level Marketplace plan who earns less than 250% of the Federal Poverty Line (FPL). Those in that income bracket would get higher actuarial valued silver plans, which had lower out-of-pocket costs at the point of service. The ACA requires individual insurance carriers to offer the better benefit silver level plans for lower income individuals. The ACA did not require the government to fund higher-level benefits.

The Obama administration subsidized insurance carriers to make up for the benefit differentials. However, the Trump administration eliminated those subsidies in September 2017. Insurance carriers then increased Marketplace plan rates to make up for the discontinued subsidies. On average, premiums increased by 20 percent.

Interestingly, the government ends up paying higher premium subsidies because of this funding change. The Congressional Budget Office (CBO) estimated the government would spend more if the President discontinued cost-sharing subsidies. The reason is that 85 percent of those receiving coverage in the Marketplace receive federal premium subsidies under the ACA. Taxpayers eligible for subsidies pay a limited percentage of their household income. The government pays the remainder of the premium. For most people with Marketplace coverage, the federal subsidies cover the premium increase caused by discontinued cost-sharing subsidies.

YOUR QUESTIONS

Q: Our organization has an aggressive incentive to encourage employees to get an annual physical. Employees get a discount on their employee contribution for health insurance that equals 20 percent of gross single cost for coverage. The employees receive the incentive when they submit a form from their doctor confirming they had an annual physical. I have seen many articles saying this approach will no longer be permitted in 2019. I have started to plan for 2019 and I am not sure whether we should continue this incentive.

A: The articles refer to the result of a recent case before a court in the District of Columbia (DC) – AARP v. EEOC. The case concerns the final wellness regulations incorporated into the American with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). The ADA rules apply to employee medical exams. The final ADA rules had a number of requirements, but limited the incentive for getting health exams to 30 percent of the single cost for coverage. The court case found the EEOC did not fully evaluate whether the 30 percent incentive would still make an exam voluntary. The court recently ruled the EEOC has to issue new final regulations regarding the 30 percent allowed incentive or it would vacate the final rules in 2019. If the EEOC does not issue new final regulations by 2019, the EEOC ADA rules for wellness plans return to the rules in place before final rules were issued. This means the ADA allows voluntary exams, but does not define voluntary. There is a safe harbor for exams related to a group health plan. The problem is that there is no clear definition of what is considered related to a group health plan. If you want to maintain an aggressive incentive for an employee to get an annual exam, you should consult with an attorney to understand potential issues if it runs afoul of the vaguely defined ADA rules.

PENDING REGULATIONS ON SHORT-TERM MEDICAL PLANS

The federal government has proposed regulations expanding the use of short-term medical policies. Short-term medical policies are individual health insurance plans designed to fill a short-term need for insurance. The Obama administration allowed these policies to last for only three months. No renewals were permitted and the coverage was not considered Minimal Essential Coverage (MEC) to meet the insurance requirement under the individual mandate.

The Trump administration has issued proposed rules that will materially change how short-term medical polices are offered. The changes include:

- Policies can be written for 12 months and individuals can re-apply for coverage
- Policies can have pre-existing condition limitations

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- Policies are not required to cover essential health benefits
- Insurance carriers can medically underwrite applicants

These rules have not yet been finalized. If they are finalized as proposed, they will create a substantially lower cost coverage option that healthy people might take. In that case, the carriers offering ACA coverage in the Marketplace will see good risks leave and sick individuals stay. These changes will likely drive rates higher at a faster pace and may prompt some carriers to leave the individual Marketplace.

The ACA affected employers in many ways. Although the Trump administration was unable to fully repeal the ACA, it has managed to change a number of regulations. The zeroing out of the individual mandate will impact insurance carriers in the Marketplace. Many of the changes recently introduced will likely weaken the ACA Marketplaces. It will be interesting to see whether individual insurance carriers continue to participate in the individual market with fewer tools to manage their risk pools.

In 2019, states may take independent actions to strengthen their own individual insurance markets. Many states have proposed creating a reinsurance program to protect insurance carriers in the individual market from high dollar claims. Some states are actually looking at instituting individual mandates at the state level. New Jersey is expected to pass a state law requiring residents to have health insurance or risk a state tax penalty.

TREND TIDBITS

2018 - 3rd Quarter Trend Average Estimates from Michigan and National Carriers

$ PPO Plans - MI increases at 7.4%; National at 7.2%

$ HMO Plans - MI increases at 7.0%; National data not available

$ Prescription Plans - MI increases at 11.0%; National at 11.0%

$ Dental PPO Plans - MI increases at 3.5%; National at 3.5%

Source: Average Trend of the Predominant Carriers Operating in Michigan and Nationally

The next two to three years will be telling in terms of maintaining a sustainable individual market in states. The Trump administration will continue its efforts to weaken the ACA. However, some states may step in to make sure insurance carriers will continue to participate in the individual market and maintain a viable individual market in their state. MMA

THE EVOLUTION OF REFERENCE-BASED PRICING

Reference–based pricing started out as a cost-control measure. Health plans identified elective procedures with widely varying costs. They would then pay claims for procedures like hip and knee replacement surgeries and imaging services such as MRIs using a reference price.

The reference price was set near the median of the amounts various providers charged in specific regions of the country. Health plans then also evaluated quality. Members were then told how reference-based pricing worked and given access to providers who would accept it as payment in full. Members who went to providers that did not accept the reference-based price would have to pay the remainder of the bill. These benefit structures provided strong incentives to use providers that would accept the reference-based price and strong incentives for providers to accept the reference-based price as payment in full.

These types of payment plans were more prevalent on the West Coast. They never garnered nationwide support, typically because health plans struggled to provide the support needed for members to use reference-based pricing effectively.

A new type of reference-based pricing is emerging as a way for self-funded plans to control cost. This strategy is going to directly involve employees in what is charged and what is paid for services.

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These plans tend not to partner with a PPO network for discounts. Rather, they set a reference price based typically on a percentage of the Medicare reimbursement rate for services. For example, the price may be set at the Medicare rate plus 35 percent. This is the maximum the plan will pay for services. A provider could choose to accept this amount as payment in full or bill your employee for the balance due.

Self-funded plans typically pair with a third party vendor to set the prices. It is fairly common for these vendors to step in and negotiate the amount due when the health care provider does not accept the reference-based price as payment in full. In many cases, they are able to convince the provider not to bill the patient for the balance.

Self-funded plans can structure the reference-based price on different types of services. Some will focus on high cost claims. Others may focus on facility

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Technical Corner

LEVERAGING TECHNOLOGY - COMMUNICATION

More and more employers are struggling to effectively inform employees of the benefits they offer. Most employers explain benefits primarily at open enrollment. Over the last decade, plan options have gotten more complicated, and the law requires more notices. As a result, communications have become lengthy and difficult to understand. Some employers decide on plan design late in the renewal process. As a result, they take the same approach to communication every year because they are strapped for time.

Most employers are frustrated with this communication cycle. However, you are in control and can break this cycle with planning and a commitment to evaluate what works, and perhaps what does not. To improve communications, employers should consider the following:

- Separate explanation from enrollment. Before open enrollment, send employees generic information on the types of benefits you offer and explain that they need to understand their options in order to make an informed enrollment decision.
- Consider using different media. Can you offer generic videos through your vendors? Health plans, HSA vendors, flexible spending account administrators, and even some benefit administration systems offer a library of professionally produced videos that can explain benefits.
- Encourage use of vendor apps. Almost all plan vendors offer phone apps to members. Over the next few days, notice how often people carry their phones with them. Most people have phones with them at all times. Phone apps provide information on the plan specific to the member; often they have electronic ID cards and allow employees to contact customer service directly from the app. They will help members at the moment they have questions or need help if you strongly encourage your employees to use the app.

Most employers have a mix of generations in their workplace. Although many younger employees already learn and communicate electronically through videos and phone applications, changing the way you communicate may now engage a different audience. Many older employees also embrace technology. If you make it easier to access and understand materials, you may have more success in communicating with and informing your employees.

To be effective in changing your communications, you need to plan your efforts long before the open enrollment season starts. In fact, you should review your communication plan annually and decide what worked and what didn't. Start focusing efforts on the media and messages that worked and change the messages that were not as effective. To succeed, you need to allow enough time to craft and implement a new open enrollment strategy. MMA

claims. Still others may focus on professional services. It is important to understand which types of services will be subject to the reference-based price system.

The appeal of these plans is that they offer complete transparency. They allow plans to control precisely what they are willing to pay for specific services. The concern is that there is no requirement that health care providers accept it as payment in full. This could mean employees are stuck paying a significant amount.

Many of the reference-based pricing vendors have successfully negotiated with providers and encouraged them not to bill the employee for the balance. Many employees are aware that health care providers may be willing to negotiate payments due. However, the employee is ultimately responsible.

Understand that if enough patients are covered by these plans, health care providers may not be willing to accept new patients with this type of coverage. Medicare pricing is very aggressive. Many providers already lose money caring for Medicare patients. Health care providers will lose even more under these types of pricing arrangements. As these arrangements increase in prevalence, expect health care providers to react to preserve their revenue.

Carefully analyze how these arrangements affect your cost and your employees. Most employers don't want employees struggling to pay a significant balance. In our tight labor market, these plans might affect your ability to recruit and retain key talent.

These arrangements are relatively new. If you decide to offer them, make sure you clearly educate your employees and they know whom to contact if they are balance billed. These plans are aggressive, but will cap health care expenditures. The question is, will health care providers choose to accept the reference-based price or will they insist your employees pay in full? MMA

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