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Critical Conversations in Health Care

Health exchange pricing is key to budgeting for reform

Staff *South Florida Business Journal*

D-Day is nearing for health care reform: On Oct. 1, the prices for health care insurnace exchanges are expected to be unveiled.

The exchanges will provide a supermarket of insurance choices for consumers. with policies starting on Jan. 1. The time frame makes it difficult to make early decisions on 2013 budgets.

Our Critical Conversations panel had a lively discussion about the insurance exchanges, an array of new taxes, the impact of industry consolidation and how the government is ready to bring the hammer down with financial penalties;

The panel was moderated by Editor Kevin Gale and the following transcript was written and edited for clarity by Senior Reporter Brian Bandell.

Q: Where are we at with the implementation of the Affordable Care Act?

A: Ralph Swanson, senior VP of **PNC Bank's** health care market in Florida: What we are seeing at PNC among providers we work with is they have been spending the last few years gearing up and they are upgrading their systems and being more automated. The big focus is automation and preparing for the requirements.

Jeffrey Kramer, CPA, **Goldstein Schechter Koch:** Implementation is well underway. It has been around for three years as of now. Has anybody had the chance to get through the act? Of course not. It is 986 pages and 10 different provisions. You have the individual mandate so you have to buy health insurance or pay a tax. There is the employer mandate, which says if you are a large employer you must buy health insurance for employees or pay a tax. There are the exchanges to help buy insurance for low-income families and there is Medicaid expansion. There was a 10 percent tax on tanning salons that was an unusual part of the act. Adult dependent children up to the age of 26 can get insurance under their parents' plans. There was a medical loss ratio that requires insurers to pay out a certain amount of premium dollars as benefits. Small business tax credits and

accountable care organizations happened under the act. It is underway and it's an enormous change in how health care is delivered.

Maureen Shea, EVP and CFO, Right Management: We are one of the small groups under 50 so there isn't as much intensity for us because we won't be required to provide employer health coverage, but there are requirements we must be prepared for. When the act was implemented my HR rep and my insurance agent became best friends. Make sure you have good counsel from your lawyer and your banker and your insurance company to make sure you have a good hold on the laws that are coming down.

Jim Repp, senior VP, AvMed HealthPlans: The majority of what has taken place is insurance reform. The medical loss ratio is a provision that says insurance companies must spent 80 cents on the dollar in the small insurance market and 85 cents on dollar in the large group market on medical costs or quality initiatives. So we get a cap for how much we get rewarded for creating efficiencies and better results. Our gains are capped but our losses are still unlimited. If you looked at that model as an entrepreneur, maybe you should get into something else like the ice cream business. In 2014 it is about expanding access through exchanges and subsidies to buy coverage. There are changes to how we can underwrite and rate business, including the collapsing of age bands from a 5-to-1 ratio, so older people are five times the rate of younger people, down to a 3-to-1 ratio. So the younger people get increases and the older people get decreases. That impacts affordability and enrollment for the most important people to get into the pool.

Stephen Spiegel, franchise owner, **Cold Stone Creamery:** It is hard to make any decision until you know exactly what is out there. The last time we got together we talked about exchanges, which will become public on Oct. 1. On Jan. 1 we would have to put them in place with the mandate. It put a lot of pressure on small businesses. I'm happy they pushed it [the employer mandate] to 2015. That makes me breathe a sigh of relief. I have about 90 employees now and most of them are part-time. The full time employees are less than 50. I wasn't mandated to offer health insurance, but what concerns me is what the competition is doing. We are all fighting for the same employees and I want to keep my managers. Now the younger people must pay more for insurance to subsidize the older people. What will happen Jan. 1 when my managers have to pay more money for their private health insurance? I am waiting to hear what rates will look like and I won't know until Jan 1.

Q: Entrepreneur Magazine recently reported results of a survey that said two-thirds of respondents say they have no understanding at all of the insurance exchanges. Twenty percent of respondents said they have a fuzzy understanding of the exchanges and only 18 percent say they can explain what an exchange is with confidence. What has been finalized on this topic?

A: Repp: The delay really doesn't affect the exchanges. The exchanges are still moving forward. I won't speculate whether they will all be ready or not. Florida is somewhat unique in that we made the decision not to have a Florida-specific exchange and not to participate in the federal exchange, so we will have a federally-facilitated exchange run by [Health and Human Services] and the federal government with very little insight on the

needs of Floridians. The only way to get federal subsidies based on income level is through exchanges. Subsidies are available for people below 400 percent of the federal poverty level, so a family of four making less than $90,000 they will have access to subsidies to help them pay for health care premiums. What we have heard is there will be a tremendous amount of promotion and advertising geared to creating awareness for health insurance exchanges. Those decisions could impact your own plan, whether they peel off and go into the exchange.

Kramer: I don't think anybody really understands what the exchange is. It's like a supermarket for buying health insurance. It will be an opportunity for consumers to shop for health insurance with pretty clear information. The government is trying to package insurance to make it easier for consumers to buy. In the old days we had defined benefit pension plans and we transitioned to the 401(k), where the employees controlled benefits. It's the same way in health care. Instead of the employer controlling health insurance, we will see a transition from employer-sponsored plans to the employees and individuals controlling more of their coverage.

Shea: For 20 years we had Florida Blue. We had great retention and we paid 80 percent of the coverage. For us there wasn't pressure to have employees shop on exchanges.

Q: How have health care challenges impacted the local provider businesses?

A: Swanson: There are three main provisions affecting providers. One is the government going from a cost-based model of reimbursement to a quality-based model. There is a big requirement to manage quality outcomes. The other big requirement is going from paper to electronic medical records. And lastly, government payers are cutting reimbursements to finance the growth in coverage of lives. Providers are trying to be as efficient as possible to handle these challenges and to be as automated as possible to coordinate with other providers and manage care. There is less of building new hospital bed towers and more investing to be more efficient. The administrative costs of processing claims is such a big cost component in the health care industry that when you can reduce that cost by 20 percent, it has a big impact.

Repp: It is also driving greater transparency and greater understanding of what costs and treatments are. But the flip side is clinical technology continues to drive costs up. Medical cost inflation is driven heavily by improvement in medical technology, and there are questions about whether it is improving quality. We need to do a better job showing that these new technologies improve outcomes. There is an opportunity to consolidate data. It produces better outcomes if all of your providers know what they are doing. We are far from that.

Q: What has been the impact of consolidation in the health care industry on the cost and accessibility of health care insurance for businesses?

A: Repp: Break consolidation into two categories. There's the horizontal type that is limiting choice and reducing the number of providers as they buy each other up. When it occurs it can drive costs up 15 to 20 percent. If a marketplace has four hospital systems

and they merge down to two hospital systems, that drives increased costs in the marketplace because of the leverage to negotiate with the payer community. There is also vertical integration with hospitals buying physician practices. In the long term it can be effective because you are sharing data across the system. If you have inpatient, outpatient and emergency room care under one umbrella, you can be more efficient and reduce costs and reduce duplication of services.

Kramer: I'm seeing a lot of consolidation and I think it's a good thing. It's putting the management of health care into the hands of a lot of good people. In doctors' practices, we were seeing a lot of small groups, now we have much more qualified people managing the business side of medicine. A large group can afford to hire a good manager with an MBA, an attorney and a technical person.

Shea: For liability insurance in a large group there could be cost effectiveness in having a large group that an individual doctor can't get.

Q: Is there pressure for smaller doctor groups to join up together to adapt to the reforms?

A: Swanson: It's a good analogy to banks. There were once 15,000 banks in the country, and with consolidation, there are a lot less now. Doctors are saying the costs of going electronic are high and the requirements are complex, so they join a larger health care group and concentrate on practicing medicine. There will be increased fixed costs and you need to spread those among a larger population of patients.

Q: Businesses were considering breaking down their business models to smaller entities to save on health care costs to avoid the mandate penalties of up to $2,000 per employee. What accounting practices have been firmed up for the health care reform that can aid or prevent this?

A: Kramer: There are a lot of things going on with the IRS with regard to this health act. This is as much a tax act as it is a health care act. When I read through it, I realized there are an awful lot of tax impacts. I identified 14 different tax items in the act. There is a misconception about the 50-employee rule. The reality is it's 50 full-time-equivalent employees, so you can't just hire 49-full-time employees and 20 part timers and not get impacted by the act because that is like having 60 employees. A full-time employee is working at least 30 hours a week, so two employees who each work 15 hours a week is like one FTE. Breaking into smaller companies to avoid the act won't work either because the IRS has rules for related companies where they are considered one company so it will be very hard to avoid paying taxes under the act.

One provision is net income tax. If you are a married couple with a lot of investment income, you will pay a 3.8 percent additional tax. A 0.9 percent Medicare tax will apply for higher income taxpayers. The individual shared responsibility tax provision applies if you don't have health insurance in 2014. It's the greater of a flat dollar or a percentage of income. It's $95 in 2014 and $695 in 2016 for an individual. For a family of four it applies to each person but children under 18 are half of that tax. In 2014 the percentage of

income is 1 percent. In 2015 it's 2 percent and in 2016 it's 2.5 percent. If it's family of four making $50,000 per year in 2014, they would pay a $500 tax for not having health insurance. In 2015 the tax would be $1,000. In 2016 the tax would be $2,085. That is a 4 percent tax and that's a pretty hefty tax for not having health insurance in 2016 so it will be interesting to see how that plays out in time.

The other big tax is the employer shared responsibility payment. The regulations were produced by the IRS. They were 144 pages and I found them very complicated and I read tax law all the time. Companies will have to pay a tax if they don't have health insurance for employees if they have greater than 50 FTEs. It's not a deductible penalty. The tax for the companies is calculated based on lesser of two factors, the number of employees and the employees that go to the insurance exchange and receive credits. If a company feels the employees shouldn't go to an exchange, the company can appeal. The tax will be the lesser of $2,000 times the number of employees greater than 30, or $3,000 times the number of employees buying coverage in exchange. Those are the play or pay rules.

Let's take three hypothetical companies. If you don't provide insurance the monthly penalty is $167 per employee per month and they go into the exchange. If you do provide insurance coverage, the Keiser Family Foundation says the average cost of insurance is $340 per month without a tax deduction. It's $250 with the tax deduction for individual coverage. So you either pay a $167 penalty versus $250 to provide health insurance to employees. If it's just a dollars and sense question, the companies will just send employees to the exchange, but other factors will play into this. If you send employees into the exchange, the employee may say pay me more money because I have to buy health insurance and that might equal the differential. For larger companies, if you pay the penalty you are still subsidizing your employees' insurance. That money goes to the government and it is subsidizing what the government is paying for your employees' health insurance.

Q: Will the government ratchet up that penalty over time?

A: Kramer: As of now I'm not aware of increases in this penalty over time.

Shea: Jeff and Jim, my insurance agent shared with me we would be receiving another tax on our health care premium in 2014 as an employer. He said it was between 6 and 8 percent.

Kramer: There are two taxes on insurance providers. One is a fee on all insurance companies in excess of $30 million in premium dollars. The amount is $8 billion in 2014 and $11.3 billion in both 2015 and 2016. That was part of the whole negotiation process of passing this act. There is an annual fee of several dollars for every insurance policy issued during the year.

Q: Audience question from Jim Patrick, health care investor: I want to know whether the provider tax incentive investments for new IT are still in effect and what are they.

A: Kramer: There was a rebate issued for physician groups and other providers for implementing electronic health records. It was around $40,000 if they could define meaningful use. Many providers took advantage of that rebate when they implemented their electronic records systems. There was anticipation that physicians would have decreased reimbursement from Medicare if they didn't have electronic medical records. I believe the IT credit is still available but we are on the tail end of that credit.

Q: Ralph, are your clients pressured by this and the tax credits?

A: Swanson: Every time I meet with a health care CEO it comes up. A lot of focus with strategic planning is the technology requirements and being more efficient. That is why we see fewer capital project and initiatives to focus inward on efficiency and on consolidation. It's kept us busy financing that growth. Part of the equation as a provider is you get more reimbursement pressure and you get more covered lives. Medicaid expansion was supposed to increase the number of covered lives but that Medicaid equation in states like Florida isn't there.

Q: Audience question: Stephen, hearing about these taxes, what scenarios are you drawing up? You are an ice cream franchise guy not a health care guy so who do you look to to make decisions?

A: Siegel: There is a broker I have worked with a number of years and I speak to him every quarter. Jeff mentioned there will be full-time equivalents and it's still unclear what the rule is going to be. My problem is the clarity. This Obamacare law is sort of like the Bible, there are a lot of interpretations. I like certainty. I like to draw a budget the year before. I can't make any of these decisions until I know what my new costs are going to be. You don't know what the formula is until the formula comes out. I will start looking at everything again on Oct 1., but now there is so much uncertainty that I can't spend my time focusing and worrying about this.

Q: Audience question: I want to ask about preventive measurements. How long will it take in terms of determining medical necessity criteria to have a more uniform way to evaluate comparative effectiveness of treatments?

A: Repp: There are conversations about comparative effectiveness in the debate on health care reform and that quickly turned into arguments about death panels so politically it's challenging. Comparative effectiveness is an important component and one of the levers we have to use for the solutions in health care in this country.

Q: Audience question from Blair Adams with Adams Benefit Corp.: Jeff said according to the Keiser Family Foundation, the average monthly employee-only rate is $350. Because part of that premium is tax deductible for the company,

he stated the actual cost for the company is in the neighborhood of $250. The thing is the employer only has to pay 50 percent of the premium, so that's $175. Because that's tax deductible, it's really more like $123. If a company chooses to pay the fine, that's $2,000 per employee a year, or $167 per month. That's not deductible. The thing is that if one of your employees goes to the exchange, the company is fined $3,000 for everyone, or $250 per month. We run "pay or play" models almost every day and nine times out of 10 it makes the most sense to offer an affordable plan and let your employees decide what to do.

A: Kramer: It was the lesser of the two numbers. You have to look at $2,000 times the number of employees over 30 and the number who are in the exchange.

Repp: In terms of the long term, employers are still committed to providing health benefits to employees and they are concerned that the trend rate isn't sustainable. They are moving to a fixed defined contribution. We haven't seen a lot of interest in opting out completely and moving to exchanges. In this state only 35 percent of small employers offer coverage today. They will be interested in exchanges and other marketplaces.

Q: Will there be competitive aspect to recruiting where you have a choice of several job offers one with one having traditional benefits and the other will make me go to the exchange?

Shea: Companies that want high productivity and want to be competitive will offer the best package available so it behooves employers to provide the best benefits. Companies are also looking to do more with less. There is a push for greater profitability with less people.

Q: Audience question: Will the cost of providing health care in five years be less or more?

A:Shea: It's hard to predict, but the way we are going right now we have to have a lot of collaboration with our politicians and providers and employers. We really need health care reform and now it's highly government regulated. There is still a lot of bickering going on and, if you could get down to it, it would be better to work together. In the 35 years we've been proving health insurance it's never been less than the year before.

Kramer: There will be 35 million more people getting health care. There will be a shortage of primary care doctors and you will use retail clinicians to meet your needs.