GA2016 presentation on the Affordable Care Act and the UUA Health Plan

The thoughts that follow are drawn from a presentation to the Association of UU Administrators at GA2016. As the UUA Health Plan prepares for the 2017 renewal and many congregations finish one fiscal year, evaluate spending levels for the next, and greet new staff for the beginning of another church year, we want to reflect on what the Affordable Care Act has been able to do, what it has failed to do, and how the UUA Health Plan intends to remain a force for responsible health insurance planning for the future.

Why is health insurance getting so expensive?

It's getting expensive – very expensive -- because the underlying cost of medical and drug services, something that insurance companies try to manage but do not control, is increasing at a crazy pace. From 2007 to 2016, the market basket cost of medical services for a family of 4 (2 adults, 2 children) has increased from$14,500 to $25,826 – a 78% increase, according to Milliman, a national actuarial firm and long-term business partner of the UUA Health Plan. The UUA Health Plan's rates have gone up 67% over the same period, despite serving an older population with fewer children than the national average.

The early projections for the rates increases that insurance companies will request for 2017 in the state-managed and federally run insurance exchanges – the "Health Insurance Marketplace"-- are in the 30% to 50% range, although few insurance commissioners will grant that level of increase.

What is the ACA doing to the insurance market, specifically to availability, benefits, pricing, and taxation?

During the 2016 Open Enrollment, the Health Insurance Marketplace, through a collection of state-run and federally-run exchanges, signed up 12.7 million people, including re-enrollments from 2015. 80% of those people got some level of premium support. Clearly, access is improving. The typical benefit was a "silver" plan, meaning that on average it covered about 70% of a family's medical care charges, leaving them to pay the other 30%. That's a big bite. A typical silver plan deductible was $3,000 per individual.

On the positive side, the premium tax credits that were available to 80% of participants, based on family income, and the closely related caps on out-of-pocket costs, also income-driven, offered significant relief to the lowest paid workers.

In addition, insurance companies have had to figure out how to keep plans "affordable". They use different strategies, but aside from the obvious one of raising deductibles and out of pocket limits, the favorite strategy is limiting networks – concentrating their

business with networks of second-tier hospitals, less expensive physicians, less expensive imaging centers. At the same time, they are changing drug benefits to tighten access to higher-cost drugs in their “formulary”. With specialty drugs making up 35% of prescription costs, this is a big deal.

So overall, the impact of the ACA has been to increase access to health insurance, while increasing premiums, increasing a family’s out-of-pocket costs, limiting access to top-tier hospitals and doctors, and restricting access to specialty drugs.

What’s more – and what is very important beyond what happens to pricing on the exchanges – the insurers’ reaction to the ACA’s requirements is being mirrored in the rest of the insurance marketplace – the group insurance marketplace -- which is dominated by employer plans, including plans like ours.

What does that mean for congregations?

Health insurance is not going to get cheaper. In the UUA Health Plan, we are trying to limit annual increases to less than 10%, and at the same time we struggle with the same market realities everyone else does. There is no magic bullet. Through the Church Benefits Association, our purchasing consortium, we continue to press Highmark for the best possible administrative fee pricing and best wholesale drug pricing; our enhanced clinical outreach program has begun to show better health outcomes and lower cost for our sickest members; our expanded free generic drug program is showing some promise for reducing overall prescription costs; adding reimbursement for urgent care centers at the same co-pay as regular office visits has reduced use of ERs; and we are discussing adding coverage for alternatives to traditional office visits. Through our relationship with Highmark, we get the benefit of all of the local Blue Cross plans’ efforts to change provider reimbursement methods, a strategy that offers long term promise.

- Congregations will need to carefully consider the health plans they offer, the way they calculate a fair contribution toward the cost, the ways in which they supplement the plans their employees choose with payments into Health Savings Accounts, whether or not to allow spouse/partner enrollment at all if the spouse/partner can get coverage through their own employer, and how to work with employees who are considering purchasing coverage on a state exchange.
- In 2017, congregations need to be looking at the range of plans they offer, and making certain that “silver” and “bronze” level plans are available to their employees. The UUA Health Plan offers both levels in addition to our Standard PPO, a “gold” level plan. At the same time, congregations need to consider basing their contributions toward the cost of employee coverage on the premium for a “silver” plan – our current High Deductible plan, rather than basing

contributions on the Standard PPO. In that scenario, employees could be allowed to buy up to a gold level plan by making additional contributions.

- Congregations that encourage employees to select a high-deductible plan – either “silver” or “bronze” may consider making monthly contributions to a Health Savings Account on behalf of participating employees, covering some of the additional potential out-of-pocket cost while still saving benefit money overall. The Health Plan Office would be happy to work with a congregation that wants to explore that strategy.
- While we do not recommend excluding a spouse/partner who can get coverage through their own employer, we have to recognize that the practice is becoming increasingly common and will soon be standard practice for the majority of employers if present trends continue in 2016.

Our concerns with restructuring benefits to allow the lowest paid staff to qualify for subsidies on the exchanges are discussed a little further on.

How is the ACA impacting past practices, such as paying employees for other coverage, using HRA’s to provide benefits, etc?

Despite our best efforts to publicize new ACA rules, (see previous Alerts #7 and #8) and widespread commentary from insurance brokers and advisors, congregations are still asking why they can’t continue a blanket policy of reimbursing staff for coverage they buy elsewhere. The penalties for non-compliance are so steep -- $100 per person per day – and the time since the rule was finalized and the grace period for compliance expired – one year ago on July 1, 2015, that congregations simply have to get better about compliance.

There are two simple rules for congregations to follow when they think about reimbursing employees for coverage the employees get elsewhere. First, if the payment is being made to reimburse them for an ACA-qualified group insurance plan that they get through a spouse/partner, or are carrying over from a past employer (a retired teacher’s group plan, for example), then the funds are tax free and legal, under current IRS regs; if they are being used to purchase individual coverage, they are not legal and can subject the congregation to excise tax penalties. Second, there is a small employer exemption: the ACA rules do not apply to employers with “fewer than 2” (IRS language) employees in their health plan as of January 1 of a calendar year. The interpretation of who is covered by the plan is still being debated, and has not been clarified by the IRS. The consensus opinion of the attorneys we work with, who represent most of the religious denominations in the US, is that the determination of size is based on the number of employees eligible for coverage, whether or not they enroll, and whether the coverage is health insurance, an HRA, or a premium reimbursement arrangement. The

only time that it is safe to use the “one employee” exception is when there actually is only one employee on the 1st of January.

HRA’s – Health Reimbursement Arrangements have their own set of rules. Essentially, to be legal the HRA has to be integrated with an ACA-qualified ***group*** health plan that the employee is enrolled in currently; otherwise, the contributions are illegal.

What changes are we seeing among UUA Health Plan participating congregations?

- Freestanding HRA’s – ones not connected directly to a qualified health plan – and most reimbursement for individual – not ***group*** – coverage employees get elsewhere, have nearly disappeared.
- Congregations are giving a lot more thought to basing their premium contributions on a silver-level plan, like our high-deductible plan, rather than paying 80% of a gold-level plan. This is where the Health Insurance Marketplace is, and it’s where employers in the private sector are headed. Some congregations are even considering basing contributions on a bronze-level plan, which the UUA also offers. In other words, congregations are reducing their health insurance costs while allowing employees to buy up to a better plan if they want.
- At the same time congregations are moving employees toward high-deductible plans, they are slowly adopting the idea of contributing to Health Savings Accounts, to help employees pay a portion of out-of-pocket costs. The net cost to congregations can still be lower.
- We have seen congregations consider restructuring their contribution arrangements to make it possible for their lowest paid staff to qualify for subsidized care on the exchange. This can be a difficult balancing act in terms of the perceived inequity of cutting contributions for low-paid staff. Some congregations have even considered dropping employer-sponsored insurance altogether, sending their staff to the exchange for coverage.

What are the potential pitfalls of relying on the Exchanges? There are four pitfalls to watch for:

- The Health Insurance Marketplace – the collection of state a federal exchanges – is not stable. 2017 is predicted to be the year of a serious shaking out among insurance companies. United Health has already announced plans to drop out of nearly all markets. Other insurers may follow. After the 2016 year, when rate increase were highly variable state-by-state, we expect most insurers to be looking for rate increases between 30% and 50% -- insurance commissioners will not grant increases that large, but the

trend is clear. And the deficit between needed rate increases and what's granted by insurance commissioners will further destabilize the market.

- To reduce losses on exchange policies, insurance companies will continue to raise out-of-pocket limits, narrow their networks, and further restrict access to care, including access to specialty drugs.

- Employees who get coverage through an Exchange plan must buy the coverage with after-tax income, losing the significant tax break that comes with employer-sponsored plans. In addition, it can be difficult for employees that have reasonably priced employer plan options to actually qualify for a tax subsidy, so the whole strategy of moving staff to exchange plans requires very careful analysis by the congregation.

- Congregations that do try to move employees toward Health Insurance Marketplace coverage have to be very careful NOT to tie the salary increases they would grant to employees to replace premium contributions to the actual employee decisions on whether or not to buy insurance, or the level of insurance to get. Tying salary increases to actual insurance decisions could subject the congregation to excise tax penalties.

A moral imperative to live up to our UU values

When the UUA was about to launch our own health plan in 2007, UUA President Bill Sinkford at GA in 2006, speaking to the UU Ministers Association, to congregational presidents, and to district leadership framed the effort as a moral imperative to cover the hundreds of congregational staff who had no health insurance with a plan that offered quality, affordable coverage that reflected UU values. The emphasis that year was to get people covered with real health insurance, instead of leaving hundreds with no coverage or terribly inadequate policies. The UUA Health Plan has been enormously successful in meeting that goal.

As we head toward 2017, the moral imperative of quality, affordable, values-based coverage for all is still there, but the emphasis has shifted. The Affordable Care Act has created an opportunity for nearly everyone to have health insurance – but not all health insurance is created equal. The UUA Health Plan was one of the first in the country to guarantee coverage to same-sex couples and to offer coverage for transgender benefits. We were years ahead in offering full parity for mental health benefits, and a year ahead of everyone in offering full coverage for women's health benefits. In our Standard PPO plan, we offer one of the most generous hearing aid benefits in the country, because we believe it's the right thing to do. We are one of the few

organizations offering supplemental coverage for the expenses of treating children with learning disabilities. The list goes on -- we live our UU values in our health plans. Our challenge here in the UUA Health Plan Office – and our challenge to congregations – is not to give up on the progress we've made. No insurance plan available on a state exchange – and none available from United Healthcare or CIGNA or Aetna or Anthem is going to offer the kind of coverage we offer. And no other plan is going to be able to match the personalized service and the personal commitment of every member of the Office of Church Staff Finances.