Navigating Obamacare

The Affordable Care Act is here, but it's still unclear whether Greater Madison employers will be able to afford health insurance benefits for employees five or 10 years from now. IB convened a panel of local industry experts to assess the ACA's long-term impacts.

Moderated by **JODY GLYNN PATRICK**, publisher emeritus | Photographed by **BILL FRITSCH**

GLYNN PATRICK: Given what's happened so far, including the multiple adjustments President Obama has made to the Affordable Care Act, what is your best guess about what will happen to health insurance premium costs going forward? Do you think medical costs, and therefore the premium costs they influence, will moderate in the long run?

TROCHLELL: There's a short-term dynamic and a long-term dynamic. In the short term, there will be a lot of variation in what employers actually see for themselves for those who are offering coverage in the small-employer market. And that's because we're transitioning from the pre-ACA plans and rating rules to the post-ACA, with more prescribed plans and rating rules. As employers go through that transition, they're going to see a lot of different things.

Employers don't care so much about the average cost increase. They think in terms of how it will apply to their business. I wouldn't be surprised, as employers go through the transition to the ACA plans, for some employers to see 50% rate increases and other employers to see 50% decreases. It's going to be all over the board. And the smaller the employer, and the more their demographic is different than the average, the more it'll be at one of the extremes. The larger small employers, if you will, will see less variation.

> The trajectory of health care reform is such that if by 2018, you can't accept and successfully manage financial risk, you're going to be a third-tier, cents-on-the-dollar, deeply discounted, fee-for-service, my-life-isn't-worth-living vendor to somebody else, and that's not going to be a good place to be. – **Dr. Frank Byrne, president, St. Mary's Hospital**

That's probably what will run through the media initially, that short-term dynamic. And maybe the employers that are seeing the big increases will be pretty vocal, and the ones that are seeing the substantial decreases will be less so. After employers have made the transition to ACA plans — and by the way, because of the transitional rules, this will still take a couple of years — there will be less variation than there is in today's market because everybody with the same carrier will generally see the same increase, and that's not the case today.

That doesn't really get to your question of long term, will the trajectory of the trend be different, but it does say that the variation will certainly be less. In terms of the insurance provisions and how they apply in Wisconsin, they won't do much to moderate the trends. What the providers are doing today in terms of becoming more accountable for the quality and cost of care, that will have more of a dampening effect on [the cost] trend than the insurance reforms that have taken place recently with the ACA.

BYRNE: Which is a great setup for what's happening on the provider side, and hopefully we'd agree that the previous status quo was clearly unsustainable. Fifty million uninsured, costs going up substantially, providers being paid just for doing things,

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OUR EXPERT PANEL

Clockwise from upper left:

Dr. Robert Turngren, president, Meriter Medical Group

Dr. Frank Byrne, president, St. Mary's Hospital

John Trochlell, vice president-actuarial and underwriting, WPS Health Insurance

Cheryl DeMars, president/CEO, The Alliance

John Healy, senior account executive and partner, M3 Insurance

Consumer-Driven Health Care Comes with Carrots and Sticks

Employers are allowed to engage in discriminatory treatment when it comes to health and wellness, but what about health and hiring?

The Affordable Care Act permits having employees, following a health-risk assessment, pay more toward their premiums if they smoke cigarettes, because their habits contribute more to the cost of health care. (They cannot be penalized if they enroll in a smoking-cessation program.)

Conversely, employees with good health habits and outcomes — such as good body mass index (BMI) scores — are rewarded by having employers pick up a greater share, sometimes the whole enchilada, of their health insurance costs.

But what about penalizing a broader range of people — including smokers, overweight people, and people with drug habits or drinking problems — when it comes to hiring? The subject was broached during IB's Industry Roundtable on Health Care, and panelists acknowledged it's one option that some employers now consider.

That pre-employment drug test or physical examination will likely take on new meaning as employers scramble to control their costs, and the ACA appears to have set a precedent with wellness. One can quibble about whether to call these measures penalties or incentives, but they appear to be here to stay in what's called a health-contingent wellness program. In 2014, the ACA allows employers to add 30% more to the rate for someone who doesn't meet a minimum standard, explained John Healy, senior account executive and partner with M3 Insurance.

"Health-contingent wellness programs are becoming extremely popular, and those are definitely the wave of the future," Healy stated. "It won't be too long, I don't believe, before many employers will offer those types of programs or have those programs in place."

To address the question about whether someone who's ill, obese, or has diabetes can be discriminated against, Healy says they are given an alternative minimum standard that does not allow employers to penalize them if their ill health prevents them from meeting the minimum standard.

From what Healy has witnessed, employers are not as interested in getting money back from people who don't meet the minimum standard; employers are more interested in improving the health of these employees. "So at least annually, they give those people options to improve their scores so that they can pay less," he noted. "The idea is to improve the health of the individual before they get to an acute situation." **— Joe Vanden Plas**

and the more they did, the more they got paid. Frankly, financing health care in this country on the Robin Hood method, where we charge the people who can pay more to cover the people who can't pay, that's not sustainable.

We committed to proving the volume of the care we're providing and controlling costs in every possible way. While we're not done by a long shot, from 2009 to 2013 we used an actuarial benchmark to show that we have bent the cost curve substantially below the predictions in our system that Milliman and PricewaterhouseCoopers made.

In real 2013 dollars for Dean Health Plan patients, we saved about $68 million by moving things to the outpatient setting, by moving things to a lower-cost setting, by putting in shared decision-making in the care processes. We've made substantial changes in every element of our system to manage our costs better and bend the cost curve. I don't think costs are going to go down, but we can't have the rate of increase that we've had.

GLYNN PATRICK: There was a lot of discussion about whether we need all of these clinics. Is the urgent care clinic the answer — this urgent care clinic that's a step between waiting so long for an appointment and going to a hospital emergency center, where care is more expensive?

BYRNE: It's that and much more. It's not just having urgent care as opposed to the ER, the clinic as opposed to urgent care. It's having Epic MyChart, which we all have in this community, to interface with your provider and get answers. It's having primary care home models, which many organizations in our community have developed so that you can have same-day scheduling and same-day appointments, rather than going to the ER.

We will acknowledge that the hospital ER at 11 at night is not a good place to get care for your chronic diabetes. It's a great place if you have a life-threatening illness and so forth, and we'll take care of you if you show up, but for your diabetes control, your asthma control, those sorts of things, there are much better venues. It's disease management; it's team-based care. There was an article in a national business newspaper last week about the new doctors that will see you now, and it's really a team that includes a doctor, a pharmacist, a social worker, a psychologist, a nurse, and a physician assistant.

TROCHLELL: Dr. Byrne mentioned initia-

tives that started in 2009. That was before the Affordable Care Act was signed. A lot of the work being done that affects long-term trends, especially on the provider side, actually predates the Affordable Care Act.

DEMARS: Notwithstanding its name, it seems as though the primary purpose of the Affordable Care Act was really to increase access to insurance, and the work of bending the cost curve is largely the business of physicians and hospitals, employers and consumers, not regulators.

HEALY: To answer the original question, in the long term, there's going to be more of a leveling of the plans offered. Frank talks about the delivery of health care, which is obviously part of the law, but over the long term, in order to maintain an affordable plan, employers are going to gravitate toward that 70% level, the silver level, if you think about the metal tiers, because they can't afford gold and they can't afford platinum. There's going to be a lot of cost sharing that goes into this, so is it going to be an affordable plan?

John [Trochlell] mentioned that he's seen some employers with lower costs. So far, I haven't seen too many with lower costs. Almost every small employer has had an increase in cost, and I'm talking in the high 90s percentile. So long term, it's very difficult to tell. It really depends on how successful they are in getting younger people into these exchanges. So far, they haven't been very successful with that.

LESS BANG FOR THE BUCK?

GLYNN PATRICK: You mentioned going to a different level of coverage from the gold and the platinum. Are they trying to maintain their previous cost by doing that and finding that the dollar doesn't purchase as much? Is the employee actually getting less for that dollar as well?

HEALY: When you think about the cost sharing that's in a silver plan, the out-of-pocket cost is significantly higher than it is today. So I believe over the long term, in order to maintain an affordable plan, employers will need to gravitate toward that, especially in the small market. Larger employers have a lot more flexibility, and they have more effective methods to control costs — self-insurance being one of those. As John mentioned with the rating requirements that are part of the law, those are changing the dynamic for employers on the small-group side, and the rates are going up significantly right now.

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BYRNE: Don't you think the trend toward higher, like the silver or bronze, when it's a higher deductible, higher co-pay plans, which you're predicting under the Affordable Care Act, is simply an extension of a trend that we've seen for the last number of years of employers creating higher co-pays and deductibles or benefit buy-downs, if you will, to try and control their costs?

HEALY: Absolutely.

BYRNE: I've been accused of being a relentless optimist. There is a potential positive side to that, which we have seen already, and that is better-informed users of health care services because of the increasing financial accountability that I have as a patient or potential patient. Again, let me be clear, I'm not talking about the working poor and folks where if you raise their co-pays and deductibles, you're making them choose between food and shoes and health insurance or health care. That's a bad choice.

Multiple studies over many decades have shown that people who are underinsured or have no insurance seek care later and have worse outcomes. I'm talking about folks middle-class, and above perhaps, that are becoming more informed consumers because they have more of a financial stake in matters.

DEMARS: We're seeing consumers with an interest in and an appetite for better information on costs, particularly, but also on quality. It goes largely to high-deductible health plans and accompanying educational initiatives to help people understand the lack of correlation between cost and quality in health care — that high cost doesn't necessarily mean high quality, and low cost does not mean low quality.

TURNGREN: The system model of care, the patient-centered medical home, this is where care is going to change and evolve from what it was years ago. Even 10 years ago, a physician in an exam room with a patient was very isolated, so the model of care is going to change out of the primary-care realm. In the more acute-care realm, you see tremendous focus on cost reduction and the enhancement of quality. So you see bundles for hip and knee replacement, and you see bundles for coronary artery bypass surgery, etc., trying to prove the quality and trying to simultaneously reduce the costs in real dollars.

This is a response that started before the Affordable Care Act even started. I think everyone in the health care field understood that there had to be change. So I think it's starting now. Do I think it's the solution? No, I don't. It's a good first step. Where the real benefit will come is through the providers of care — physicians, hospitals, health systems — along with the employers and the individual people deciding and embracing some of these new models of care.

One of the principles of patient-centered medical home is patient engagement in their own care. But if we really want to get affordable care for all in our country, there's going to be another level that we'll shoot at in a number of years from now that will not be regulated. Well, it might be regulated, but it won't be just math and numbers and we're going to pay you less. It's going to be societal decisions about end-of-life care, about wellness and lifestyle, about the malpractice situation, which isn't much of a problem in Wisconsin. But in Illinois, places like that, it's a much bigger problem.

If you look at the pyramid of where the money is spent, it's spent on the very small number of people who have very bad illnesses right at this moment. Some of that is money well spent with intervention. Some of the end-of-life care, of course, that's debatable. So in 10 or more years, society will have to tackle some of these bigger issues, where the cost is. It's a big topic to discuss because you get into items like rationing of care and so forth.

HEALY: Consumer-driven health care is

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the trend we're talking about here. It's definitely a good trend, but that's an effect of the law. It's not the cause. The law is changing things from the types of plans that everybody has become very used to, especially in our community with all the competition that we have.

Is the law going to create a lower cost in the future? It depends on whether you're talking about pure premium or a combination of premium and the out-of-pocket cost, regardless of how educated they are and how much consumerism they bring to the encounter with the provider. If they're spending a lot more of their own money and premiums are going up, I don't believe the law is really doing what it was originally intended to, other than increasing access.

STILL ALONG FOR THE RIDE?

GLYNN PATRICK: That's part of the question we're looking at today — the employer response to this. An employer has to make money or there's a certain point where they no longer are willing to employ people. Part of the question is, how can this be sustainable for a small business that doesn't have that bigger group and that finds itself in the middle?

One of the issues we've wondered about is the ride-along benefits. You employ people, you're used to providing insurance for them, and you also cover their families. Now you know that their spouse could go on an exchange. Are you going to continue offering spousal insurance? Now you're expected to care for a child longer. So is that going to be at the expense of a spouse or a domestic partner or someone else? What choices are available to employers, and what do you see them trending?

DEMARS: I'd say that employers are taking stock of all of those tradeoffs, looking at the higher cost that they're incurring and the strategies that they can implement to make that manageable. And things like looking at spousal coverage or other benefits are certainly part of the equation. It's also impacting workforce strategies. With full-time employees being defined at 30 hours a week, that is impacting how people are managing their staffing patterns.

HEALY: Attracting and retaining employees is obviously a very key thing, and it's a big part of what that question is really about. That's based a lot on industry, and it's based on location. You know, if you don't offer high-quality benefit plans in Madison or Dane County, it's going to be very difficult to attract and retain real quality employees. Now in an industrial setting in some other big city, you might be able to offer quite a bit less and increase the wages slightly and still get quality people. So it's a very difficult question to answer in that it's not a one-size-fits-all situation.

GLYNN PATRICK: Do you think we'll see more employers offering a cash-out to people to get their own insurance some other way? Or if they carried family before, give them an extra $200 in salary to apply toward their spouse's coverage in whatever way they choose to do it?

TROCHLELL: Yes, definitely, that will happen. To piggyback on something, there's a huge dichotomy that exists today that predates the Affordable Care Act in terms of health insurance offerings by employers to their employees between small groups and large groups. If you look at employers with 1,000 or more employees, about 99% of them offer health insurance. If you look at employers with 10 employees or less, it's probably 35%. That's a trend that's existed for a long time, and I don't see that completely reversing.

It could stabilize, but the positive news for small employers is that now employers that don't offer coverage to their employees have another avenue. And here's where the affordable part of the Affordable Care Act comes in. Those employees can go out and get their own coverage and, depending on their income, get a subsidy. Now those subsidies are funded by assessments on the entire insurance market — in particular, the employers.

So people can go out, and depending on their income, they can get free coverage. They can get highly subsidized coverage. The deductibles may be subsidized, depending on the percentage of the federal poverty rate that you're at. And so these employees now, for the first time, can get health insurance that is affordable relative to their family's income. It's just not through the employer. At the same time, small employers won't be penalized for not offering affordable comprehensive coverage to their employees.

BYRNE: We've had a couple of seminal events at this space already. First, IBM is changing its post-retirement coverage to defined contribution versus defined benefit, much as retirement plans went to the 401(k) defined contribution versus a defined-benefit program.

GLYNN PATRICK: They're also paying in the last month of the year so that you have to be there the entire year to pick up that benefit, which is new.

BYRNE: The other one is Walgreens, which is actually offering a defined contribution and allowing their employees to go out into the marketplace. Now those are two very big organizations, and that's where trends often start. Will it actually become a trend? How fast will it come into play?

TROCHLELL: There's no question that what's happened in the pension space is certainly creeping into the health insurance place, where employers want to get a fixed funding of these benefits. They don't want to be subject to these trends that are higher than their own income growth, and they want to be able to define that, fix it, and then get off the risk.

DEMARS: There is interest in that, and it sounds very appealing and pretty simplistic. What we're hearing employers talk about, too, is the question of how moving to a defined contribution style of health benefits through a public or private sector, typically a private-sector exchange, changes the underlying cost drivers. It doesn't necessarily, but it makes consumers more sensitive to the price. That's a good thing, but employers are looking for a better way, not just a different way, to fund health benefits and get after the real issues of controlling health care costs.

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WHAT'S AN EMPLOYER TO DO?

GLYNN PATRICK: What can help employers weather these times?

TROCHLELL: These times have the most variation and impact on small employers. The large employers are getting through this, more or less, business as usual. For the small employers, don't get caught up in all of the hoopla until you've sat down with your insurance professional and understand how it impacts you. They should ask questions about whether they are on an ACA-compliant plan. If not, when do they think they're going to have to move to an ACA-compliant plan? And then they can start analyzing the impact that will have on that particular employer. It's going to vary a lot.

Some employers will see substantial rate decreases. If you're a smaller employer with older employees, perhaps employees who have had health care conditions in the past, moving to the modified community rating [part of the Affordable Care Act] will reduce the rates for some of those small employers once they move onto an ACA-compliant plan. The flip side is that if you have a couple of younger males who are healthy, and that's all you cover in your health care plan, you're probably going to be in for

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> — Dr. Robert Turngren, president, Meriter Medical Group

some sticker shock.

Most carriers around this state have extended the pre-ACA plans for their small employers into the end of 2014. With the president's transitional policy, a lot of those plans are going to get extended into 2015. So a lot of the noise you're hearing right now is centered on the individual market because only a very, very small fraction of a small employer market has gone through this process yet. This is going to drag on for this year and probably next year before we start to hear about the canceled policies and the big rate changes for the small employers.

DEMARS: Unlike retiree benefits, employer success is inextricably linked to health, and therefore it's critical for employers to stay involved and invested in health benefit decision-making and design. In spite of all of the turmoil in the market, and there's a lot, I'm optimistic for many reasons. I see a boldness on the part of employers to try new things that I haven't seen before — significant strategies to really make a difference in health care.

Employers are putting together meaningful incentives for their employees to improve their health. They're also designing benefit plans that can work arm-in-arm with physicians who are working with patients on diabetes management and other chronic condition management.

In addition, the purchaser community in Wisconsin is coalescing like I've never seen before. Public-sector and private-sector purchasers, the state Medicaid program, Employee Trust Funds, and the employers represented by business coalitions are talking about common goals and strategies and ways to work together to not only improve care for our respective constituents, but for the community as a whole.

Finally, the improvements that I see in transparency of information and the result of better-quality, lower-cost care … those things are on the horizon.

TURNGREN: I would encourage employers to focus on aligning themselves with providers that are in a position to deliver value, which means very high quality and lower costs with an element of service and access. Focus on finding a provider that can deliver that, and then support employees in a long-term strategy around health and wellness, lifestyle and wellness, not necessarily just fitness, not just going to the gym, but wellness of the entire person as well as lifestyle.

HEALY: There needs to be a strategy, and I don't think the strategies are very short-term at this time. I think it needs to be a three- to five-year strategy, and they need to consider all the different stakeholders involved — employees, the systems they work with, the providers, and the type of plan designs they have. Their wellness is key not just from a health care cost perspective, but also from the health and productivity of the employee, and to actually make their business successful.

BYRNE: My advice to employers is get informed and stay informed because things are changing quickly. Form partnerships. We're grateful for the opportunity to work in partnership with The Alliance and many others. Work with your employees. We have continuous dialogue with our employees, not only about work, but also about the challenges in the business environment as a large employer. We have physicians helping us with supply costs. We have nurses, nursing assistants, pharmacists, and social workers talking to us about how we can improve care and manage costs and reduce costs as much as possible.

The trajectory of health care reform is such that if by 2018, you can't accept and successfully manage financial risk, you're going to be a third-tier, cents-on-the-dollar, deeply discounted, fee-for-service, my-life-isn't-worth-living vendor to somebody else, and that's not going to be a good place to be. So we want to work with the employers, the patients, and the families we're privileged to serve to solve this thing, and we're better positioned than any other community in the country to do that. IB