What to Expect in 2016

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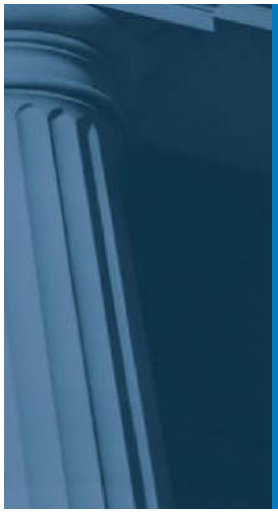
WHAT TO EXPECT IN 2016

The implementation of the Affordable Care Act (ACA) in 2010, is now almost complete. However, as we dive into 2016, there are many health insurance challenges and possible changes that could be headed our way. As much of what happened in 2015 continues to impact our industry in 2016, here are a few events that continue to shape and mold the health insurance industry that we discuss in detail throughout this guide:

- ☐ Mergers among large health insurance carriers
- ☐ Focus on the repeal or extension of the ACA's most contentious provisions like small group expansion, 30 hours considered full-time, medical loss ratios and the Cadillac Tax
- ☐ Employer preparation for new reporting requirements

This is an important year for health insurance carriers, brokers and our industry as an entirety. BenefitMall is your trusted advisor and we intend to bring you news, knowledge and resources to help you understand the path before us. Please allow this guide to serve as a collaborative effort to bring you everything you need to know about the ACA in 2016.



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AN ACA UPDATE

The ACA has significantly changed the health insurance industry yet, popularity of the law is still split. According to a recent Kaiser Family Foundation tracking poll, 43 percent approve of the law while 41 percent oppose it.

Some positive impacts of the ACA:

- In 2013, 13.3 percent were uninsured; that number has decreased to less than 10 percent as of today.
- Federal and state exchanges attracted more than 10 million enrollees during the 2016 Open Enrollment Period (OEP).
- $1.7 billion tax credits per month are going to more than 85 percent of exchange participants, giving them access to care – many for the first time.
- Policies are written on a guaranteed-issue basis with pre-existing conditions, no longer a deterrent to being insured.

Some negative impacts of the ACA:

- More than 9 percent of Americans are still without coverage.
- Cost sharing in the form of high deductibles and co-pays keep participants, who are now insured for the first time, from seeking care.
- While health care premium increases have slowed in the past few years, we saw more than 10 percent increases in many markets during this past OEP with higher increases predicted for 2017.

Small Group Expansion

Congress passed and President Obama signed into law the Protecting Affordable Coverage for Employees (PACE) Act in 2015. This act repealed the mandated small-group expansion and delegated the responsibility of determining the definition of a small group to individual states. Many states choose to recognize a small group as a business with up to 50 employees.

Open Enrollment and Exchanges

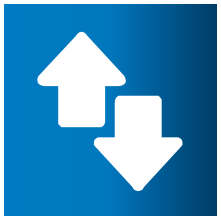
The effects on Americans

Open enrollment for state and federal exchanges just concluded for the third consecutive year resulting in more than 10 million Americans being enrolled in these exchanges. This number is half of the original 20 million projected when the law was first enacted. Among a number of reasons for the lower than projected enrollment is that more employers than expected kept employer-based benefits limiting the number of people that were exchange eligible.

The ACA has reduced the share of uninsured Americans to less than 10 percent through a combination of private insurance and Medicaid expansion. A few things to consider:

- Subsidies for low and middle-income people are often not sufficient to make coverage truly affordable.
- Premiums increased by a higher amount in 2016 than in previous years, further exacerbating the cost concerns.
- Young adults, who have not put a high priority on obtaining health insurance, now make up the majority of the uninsured.
- Deductibles and co-insurance among subsidized plans far exceed the premiums that many participants pay.
- Medicaid expansion has largely come to a standstill.

The effects on Carriers



Carriers differ in their opinions on the effects of the exchange. Due to its losses on exchange policies, UnitedHealthcare has already announced their exit from most states for 2017. Other carriers like Aetna and Anthem, recently affirmed that their individual business had performed in line with the projections. Centene, Molina Healthcare, Humana, HCSC, Kaiser Permanente and Cigna have all experienced losses, but also in line with projections.

A recent Goldman Sachs Group Inc. analysis of state filings for 30 not-for-profit Blue Cross and Blue Shield insurers found that their overall companywide results were "barely break-even" for the first half of 2015 and that the group would post an aggregate loss for the full year – the first since the late 1980s. As expected, the individual exchanges appeared to be a "key driver" for the faltering corporate results, and the medical-loss ratio for the Blue insurers' individual business was 99 percent in the first half of 2015 – up from 91 percent at that point in 2014, and 82 percent for the first six months of 2013.

The future of the ACA being tied heavily to the success of the individual exchanges, key issues to focus on are:

- In 2015, 24 million people were eligible for advance tax credits (subsidies) that could be purchased on individual exchanges.
  - Ten million of these individuals were already enrolled in March 2015 in exchange plans through either their state or federal marketplace.
  - By June of 2015, this number dropped to 8.6 million indicating a significant disenrollment rate.
  - Attracting the remaining subsidy-eligible participants is increasingly difficult as policies are still too expensive and cost sharing provisions make it unaffordable even when people actually have coverage.

Premium pricing pressures will continue to persist:

- A recent McKinsey report showed an aggregate $2.5 billion loss among carriers in the 2014 individual marketplace.
- Only 36 percent of health plans showed gains in the individual market in 2014.
- Avalere Consulting, Robert Wood Johnson Foundation and The Urban Institute collaborated on an income study of subsidies. Findings show that the poorest are buying Obamacare policies, and the vast majority of the rest are not – even if they are subsidy eligible.
- Only 20 percent of those earning between 250 percent and 300 percent of the poverty level have enrolled so far with even less success at higher incomes.

Small Business Health Options Program (SHOP) Exchanges

While the federal and state exchanges for individual consumers have exhibited moderate success, the SHOP Exchanges have shown the complete opposite. At the end of 2015, less than 15,000 employer groups were enrolled through a SHOP Exchange compared with more than 10 million enrolled through individual exchanges.

Reasons often cited for lack of enrollment in SHOP Exchanges include:

- Extension that allowed the re-enrollment into existing plans through 2016 – also referred to as grandmothering.
- The inadequacy and confusion of employer tax credits.
- Lack of composite rating.
- Exchanges lack the ability to offer multiple plans among multiple carriers.
- Underwriting and pricing rules inside or outside the exchanges are identical.

Co-Ops Struggle Financially

A brief history of ACA Co-Ops:

- In the original plan, the government was to provide grants to at least two of these new Co-Op organizations in each state.
- The grants were changed to loans to keep the overall cost of the ACA under its spending limits.
- At of the end of 2014, only 23 of the potential Co-Ops were formed.
- Now, more than half of the original 23 Co-Ops have failed and are in various stages of winding down or, are in receivership by CMS and their respective Insurance Departments.

Known as "risk corridors," the intention was to help cushion insurers that end up with sicker customers and bigger medical claims than they had anticipated. Co-Op's in particular were heavily dependent on these payments to stabilize their risk pools given their size and relied on the availability of these funds as part of their initial pricing strategy.

The facts:

- The Health and Human Services Department (HHS) announced on October 1, 2015, that it would only afford to pay insurers participating in the federal and state-run exchanges just 12.6 percent of the nearly $3 billion they were owed under a temporary provision of the health care law.
- According to a recent government audit, only one out of the 23 Co-Ops made money in 2014 and as a group, lost $376 million.
- In total, Co-Ops fell more than 100,000 enrollees short of their projections.
- Ultimately, more than $900 million in initial loans may never get repaid.

Employer Reporting

Beginning this year, the Employer Mandate extends to all groups with 50 or more full time equivalent (FTE) employees. These employers will now be required to make an offer of affordable coverage to 90 percent of all employees – an increase from 70 percent in 2015. The challenge that is affecting these employers is now the issue of reporting. The U.S. Department of Treasury and the Internal Revenue Service (IRS) will oversee and administer the employer reporting requirements. While the IRS initially set the effective date to January 1, 2014, the requirement was delayed to January 1, 2015, with the initial reports needing to be filed in 2016.

Section 6055

Requires health insurance issuers, certain employers, and others that provide minimum essential coverage to individuals to report to the IRS information about the type and period of coverage, and furnish the information in statements to covered individuals.

Section 6056

Addresses the reporting requirements for employers who provide coverage through large group health insurance. The Affordable Care Act added section 6056 to the Internal Revenue Code, which requires applicable large employers to file information returns with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offered. (For a definition of applicable large employer, see question 5, below.) Under the regulations implementing section 6056, an applicable large employer may be a single entity or may consist of a group of related entities (such as parent and subsidiary or other affiliated entities).The regulations provide for a general reporting method and alternative reporting methods designed to simplify and reduce the cost of reporting for employers subject to the information reporting requirements under section 6056.

Employer Reporting Bill

In December 2015, Senators Warner (VA) and Portman (OH) introduced S. 1996 "The Commonsense Reporting Act of 2015" before the Senate. Specifically, the legislation addresses the final regulations released last March regarding the reporting requirements under Section 6055 and 6056. Under these requirements, employers and insurance carriers are required to gather numerous pieces of data on a monthly basis and report them annually to the IRS and individuals. The information reported is intended to verify compliance with the individual and employer mandates, and administer advanced premium tax credits (APTC) and cost sharing subsidies under the state and federally facilitated insurance exchanges.

The most relevant pieces of the legislation would:

- **Create a voluntary prospective reporting system:** Permits employers to voluntarily report to the IRS general information about their health plan for the current plan year, which will help increase the accuracy of eligibility determinations for exchange tax credits. Under this bill, state and federally facilitated exchanges will access information securely through the Data Services Hub.

- **Streamline the reporting process:** Eases reporting burdens for employers who use the voluntary prospective reporting system by requiring Section 6056 reporting statements only for those employees for whom the employer has received notification that the employee or their dependents received an APTC rather than issuing reporting statements for the entire workforce.

- **Modernize transmission of information to individuals:** Allows for electronic transmission of employee and enrollee statements rather than requiring this information be provided only by paper statements sent through the mail.

It will take time for these bills to move through the committee process. With bills now in both houses of Congress and with many bi-partisan sponsors, these bills will need to be watched closely.

Employers are actively seeking a simple solution to produce reports that include as much data as possible from their existing systems in order to decrease the manual labor needed to comply with these government mandates. Many are finding that their payroll providers have most of the data that is needed. But, even when combined with an employer's benefits administration system, many will still find that some portion of these forms will require manual input.

BenefitMall's allCompliance™ helps to minimize these manual tasks by incorporating the following:

- ☐ Variable Employee Monitoring
- ☐ Reporting Dashboard
- ☐ Affordability Monitoring
- ☐ Integration with HR/Payroll Tools
- ☐ Dedicated Customer Support
- ☐ IRS Form Reporting
- ☐ IRS Form E-Filing
- ☐ Audit Logs

The Cadillac Tax

All employer-based health plans with annual benefit values more than $10,200 for individuals and $27,500 for families was to be subject to a 40 percent tax for every dollar above those thresholds beginning in 2020.

However, given the political pressure to act, a two-year delay of this tax was included in the year-end budget bill this past December. Many are optimistic that with a new President in 2017, the tax could eventually be repealed in its entirety.

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Repeal of the ACA

After withstanding more than 50 repeal votes, the health care law was faced with a new challenge as 2015 came to a close. House Republicans have consistently voted to repeal the ACA either in whole or part. Senate Republicans have failed to move any of these measures forward. In mid-December of 2015, Republicans in both chambers celebrated a small victory as Senate Republicans pushed through H.R. 3762, Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, the first ACA repeal to be passed in the Senate. While this vote demonstrates a unified party ahead of the 2016 elections, President Obama threatened to veto the bill which ultimately occurred this past February.

Had it been put into law, the bill, H.R. 3762, would have:

- Repealed the ACA's mandate requiring individuals to purchase health insurance and employers to provide it.
- Repealed the Cadillac Tax on premium health care plans.
- Prohibited Medicaid reimbursements for Planned Parenthood services for one year.
- Increased the Community Health Center Fund by $235 million/year for two years.

2016 LEGISLATIVE INITIATIVES

With a Republican led House and Senate in 2015, there was some movement on a variety of reform bills – most notably, the repeal of the ACA's small group expansion provision and delay of the Cadillac Tax. But there were many other initiatives that were introduced that are each working their way through the legislative and regulatory process in 2016:

Access to Professional Health Insurance Advisors Act would amend the Public Health Service Act to exclude remuneration paid for licensed independent insurance producers from administrative costs for purposes of calculating the medical-loss ratio of a health insurance plan. This is commonly referred to as the "MLR Broker Commission Bill."

This bill defines "independent insurance producer" as an insurance agent or broker, insurance consultant, benefit specialist, limited insurance representative, and any other person required to be licensed under state law to sell, solicit, negotiate, service, effect, procure, renew, or bind policies of insurance coverage or offer advice, counsel, opinions, or services related to insurance.

Employee Health Care Protection Act would permit a health insurance issuer (carrier) that had health insurance coverage in the group market on any date during 2013 to continue offering that coverage through 2018 outside of a health care exchange established under the ACA. The act treats that coverage as a grandfathered health plan for purposes of an individual meeting the requirement to maintain minimum essential health coverage.

Equalizing the Playing Field for Agents and Brokers Act would direct HHS to establish a toll-free customer service support help line to enable certified health insurance agents and brokers to seek assistance regarding qualified health plans offered in the federal health insurance marketplace.

Save American Workers Act would amend the Internal Revenue Code to change the definition of "full-time employee" for purposes of the employer mandate to provide minimum essential health care coverage under the Affordable Care Act from an employee who is employed on average at least 30 hours of service a week to an employee who is employed on average at least 40 hours of service a week.

Small Business Health Relief Act would repeal provisions of the Internal Revenue Code that: (1) impose fines on large employers (those with 50 or more full-time employees) who fail to offer their full-time employees the opportunity to enroll in minimum essential health insurance coverage, and (2) require large employers to file a report with the Department of the Treasury on health insurance coverage provided to their full-time employees.

The bill would also deem high deductible health plans to meet essential health benefits coverage requirements if the enrollee has established a health savings account; amend the Public Health Service Act to repeal the limitation on premium rate variance by age in the individual or small group market; repeal the prohibitions on payments for over-the-counter medications from HSAs, MSAs, and FSAs; repeal the $2,500 annual limit on employee contributions by salary reduction to a health flexible spending arrangement under a cafeteria plan; and allow a health plan to maintain its status as a grandfathered health plan regardless of any modification to cost-sharing, employer contribution rates, or covered benefits.

THE FUTURE OF SMALL EMPLOYER COVERAGE

Small businesses, the segment that has seen the fewest ACA regulatory and legislative changes, may be going through the biggest change of all this year. Rating and underwriting enhancements under the ACA have impacted small businesses; however, they have yet to feel the effects of the Employer Mandate and its compliance and reporting requirements. There are nearly 30 million small businesses, employers with 2 to 50 employees, in our nation, making up 96 percent of US businesses. Of those small businesses, 54 percent of these employees are provided health care coverage by their employers.

Small Business Health Insurance Research

Beginning in the later part of 2011, BenefitMall completed a comprehensive study of the group marketplace with a specific focus on the 2 to 50 employee segment. Breaking down the segments further, BenefitMall's research predicted the following:

- **25-49 Employees:** This segment would not be directly impacted by health care reform given the lack of penalties and incentives for this particular group. Overall, the segment may shrink due to persistent affordability issues.
- **10-24 Employees:** This segment would see little value in tax credits, as was expected, indicating only a moderate decline; however, the segment might shrink in the long term as exchanges are established in favor of individuals.
- **2 to 9 Employees:** Our primary research showed that this segment would be more enthusiastic about reform, but still saw few benefits from tax credits, as they would not be a strong enough incentive. In the long run, declines could accelerate as low-wage workers migrate to federal and state exchanges as individuals.

Overall, our 2011 research indicated that there was minimal interest across all group segments in "dumping" health insurance coverage. There was also little difference among small and large employers:

- Six percent of small employers (those with 2 to 49 employees) were likely or highly likely to drop coverage.
- Four percent of all employers (those with 2 or more employees) were likely or highly likely to drop coverage.
- Of the six percent of employers likely or highly likely to drop coverage, 60 percent expected to do so in the first two years after the law passed.

Overall, we concluded at that time that reform was expected to significantly reduce the percentage of uninsured through government programs (especially Medicaid Expansion) and individual coverage assisted by the Individual Mandate. All other consumer segments, including the 25 to 50 – employer market, was projected to experience net growth under health reform.

A recent Kaiser Family Foundation and the Health Research & Educational Trust Annual Survey provides some insight into the accuracy of our 2011 predictions. According to their recent report:

- Average family insurance premiums for groups of three to 200 employees rose 12.4 percent from $14,098 in 2011 to $15,849 in 2014.
- The average dollar contribution paid by employees in groups of three to 200 grew 11.4 percent from 2011 to 2014, indicating that employee contributions have remained relatively stable.
- The percentage contribution paid by employees among all group sizes was 29 percent for family coverage and 18 percent for single coverage. These percentages were consistent for both plan types from 2011 to 2014.
- The percentage change of small business owners offering employer sponsored coverage was dependent on employer size.

The report further outlined that groups with 3 to 50 employees, whether they offered coverage or not, saw a slight decrease in the total number of workers covered between 2011 and 2014 from 41 percent to 38 percent. The "take up rate" (defined as the percentage of eligible employees who elect coverage) during this same period actually remained steady at 77 percent.

- 45 percent of employers with 3 to 200 employees offered dental coverage in 2011 compared with 52 percent in 2014.
- For vision coverage during the same period, the percentage grew from 16 percent to 34 percent.

While we saw employer sponsored coverage only slightly decline over the past three years, the ACA has had a much more significant impact on the plans that employers offered. The percentage of covered workers in grandfathered plans dropped dramatically from 63 percent in 2011 to 35 percent in 2014. As costs continued an upward climb, employers have been forced to abandon their grandfathered status to keep premiums as affordable as possible.

%

After years of an increasing trend to high deductible health plans with savings options (e.g.; HSA, HRA), the mix of products purchased by the 3 to 200 employee segment has stabilized with:

- 46 percent selecting a PPO
- 24 percent choosing an HDHP option
- 17 percent choosing POS
- 13 percent in HMO plans

One common prediction among industry experts was self-insured plan growth. Instead, the actual percentage of covered workers in self-funded plans declined slightly from 16 percent in 2010 to 15 percent in 2014.

There is more to consider beyond just plan selection—deductibles and other cost sharing features continue to rise. In 2011, for all firms with 3 to 200 employees, 50 percent of covered workers were enrolled in a plan with an annual deductible of $1,000. By 2014, this percentage had grown to 61 percent for an average deductible of $1,217. While firms with more than 200 employees saw a similar rise, only 32 percent of employees in these large firms had an average deductible above $1,000 for single coverage in 2014.

It is important to note that these deductible amounts are averaged for all plan types (including HMOs and "in-network" services), which make them appear less than what most employees may experience.

At BenefitMall, while we expected that some of the very smallest employers would seek options in the individual market – which proved to be true – it happened to a lesser degree then we predicted. And, surprisingly, the 25 to 49 market is growing faster than anticipated with even more carrier and plan options for employers to choose from than before the ACA took effect.

In the 10 year period prior to the ACA, the percentage of employers offering coverage ranged between 59 and 69 percent. In fact, for the smallest of these groups (employers with only 3 to 9 employees), the current percentage of those employers offering coverage is statistically similar to what was observed in 2005 and 2006, suggesting that the economy may have a much greater historical influence than previously thought.

But the real threat to employer-sponsored coverage may not be the ACA with its exchanges and tax credits—it may simply be its costs. Health insurance is expensive, because health care is expensive. We know that the law has had a contributory inflation effect on premiums with little opportunity to reduce the overall cost of insurance.

Wellness Programs

Among the most probable near-term solutions to reducing costs are wellness initiatives. In fact, many organizations are now offering wellness benefits such as health risk assessments (questionnaires about lifestyle, stress or physical health) and biometric screenings (in-person examinations conducted by a medical professional) in the office. In addition, 31 percent of employers with health benefit programs also offer a financial incentive for employees to complete the assessments and 28 percent offer an incentive for employees to do the biometric screening.

Similarly, many employers offer wellness programs that include smoking cessation, weight loss programs or lifestyle coaching. Of the employers that offer wellness programs, 38 percent also give a financial incentive for employees to participate in or complete the program. These features reduce costs by ensuring employees stay accountable for their own health—rather than visiting a physician when an illness strikes. Wellness programs encourage employees to be proactive about their care.

CONCLUSION

In regard to the ACA, 2016 may not be the most eventful year, but brokers and business owners know that it will be one of the most critical. With three years of exchange experience, will we be able to answer the question of whether the ACA is working? How many more Co-Ops will fail and what carriers will want to participate in exchanges for 2017? How will 2017 premiums look? Up or Down?

These are the critical questions that will all be answered during the coming year. But, the biggest question of all might not be known until November. Who will be occupying the White House in 2017 and ***what will that mean for the ACA?***

The information supplied in this document is for informational purposes only. You and your client should consult with qualified Healthcare Reform personnel before making any decisions concerning ACA related issues.