Joint Small Business and Health Care Council
Agenda
June 7, 2013
9:00 – 11:00 AM

1. Welcome and Self Introductions
   Sponsor Welcome: Wells Fargo

2. Overview of Covered California and the Small Business Health Options Program (SHOP)
   Special Guest: David Zanze, President, Pinnacle Claims Management, Inc.

3. The Affordable Care Act: How Will It Impact Your Small Business’ Health Care Options?
   Special Guest Panelists:
   - Marciá Dávalos, Manager, Small Business Majority
   - Mark Wilbur, President & CEO, Employers Group
   - Joe Smith, Vice President, Small Business, Kaiser Permanente

Upcoming Chamber Events:
   - 2013 Small Business Awards & Training: Business Fitness
     Tuesday, June 11, 8 AM – 2 PM, Westin Bonaventure

Next Council Meeting:
Health Care Council
Monday, July 15
10:11:30 AM

A Growing Companies Program sponsored by
David Zanze
President
Pinnacle Claims Management, INC.

David Zanze has over 30 years experience serving as a leader and innovator in the health care industry. During his career, David has worked for a number of health care organizations and has expert knowledge in managing the business, operations, service and technology aspects of a health care enterprise. In addition to spearheading a variety of new services for providers, employers and consumers, he has also worked to develop and institute cost containment and health management features that are regarded by many as among the top management practices in the industry.

David brought his experience to a third-party administrator environment when he joined Pinnacle Claims Management, Inc. as President in 1996. Pinnacle is an all-inclusive TPA that offers competitive, cost efficient health benefit solutions to a diverse customer base. Pinnacle was recently appointed as the administrator for the Small Business Health Options Program (SHOP) by Covered California. As President of Pinnacle, David is personally involved with the implementation and ongoing needs for both the SHOP and each Pinnacle account. He places customer service as his number one priority.
Marcia Dávalos
Manager
Small Business Majority, Los Angeles

Marcia Dávalos manages Small Business Majority’s Los Angeles office, where she focuses on building relationships with small business owners and organizations across Southern California. Marcia is bilingual and also focuses her efforts on Small Business Majority’s Latino small business outreach work.

Prior to joining Small Business Majority, Marcia served as Director of Regional Networks for the Latino Coalition for a Healthy California, a statewide policy group working to improve the conditions, services and health of Latinos across California. She also has extensive experience as a community organizer and as deputy campaign manager for various campaigns and statewide ballot initiatives.

Dávalos grew up helping her family’s small business, which opened as a small mom-and-pop silver and leather shop in Los Angeles and grew to an internationally recognized manufacturer.
Mark Wilbur
President and CEO
Employers Group

Since joining Employers Group in 2007 as the youngest CEO in the association’s 116-year history, Mark Wilbur has brought an extraordinary level of innovation and leadership to transform the organization and re-establish it as the industry leader in human resources professional services; further, he has set new standards in member care and assistance. Mark has led the development of national strategic relationships to enhance member benefits and services. He has transformed EG’s online training offerings and has enhanced the technology infrastructure to respond to the ever-changing demands of running a business in the 21st century. Externally, he sits on many boards, including the Board of Directors for NAM (National Association of Manufacturing) and was the 2011 Chair for the Los Angeles County Business Federation (BizFed). In 2012, he served as the BizFed Institute Chair and is currently serving as the Co-Chair of the BizFed Healthcare Committee.

Before joining Employers Group, Mark was the Associate Dean of the Marshall School of Business at the University of Southern California (USC) for three years, leading many efforts from external affairs, corporate development and executive education, which included customized solutions for companies to help meet the critical needs of their employees and executives. Prior to USC, Mark was a Partner in Business Consulting at Arthur Andersen, developing solutions for clients across the U.S., Asia, and Europe. Mark’s professional experience and expertise are in strategic planning, business process design, customer relationship management, organizational change, customer service design and enhancement, as well as global operations and service integration.

Mark earned his BA and MBA from the University of Southern California (USC).
Joe Smith
Vice-President
Small Business California, Kaiser Permanente

Joe Smith is Vice-President, Small Business, California regions, and national leader, Small Group Line of Business (SG LOB), for Kaiser Permanente. Smith works with regional Marketing, Sales & Business Development and Small Group LOB leaders in all regions to improve and synchronize planning cycles, metrics, analytics, and other processes to manage the Small Group LOB. Smith and his team are also responsible for defining and developing the business processes and IT infrastructure required to implement Small Business Health Options Program (SHOP) exchanges in all regions in a manner that is effective, efficient, as consistent as possible, and leverages investments across the regions. He also oversees the identification and execution of other opportunities to improve and align exchange and non-exchange SG LOB marketing, sales, service, and administration in all regions.

Smith joined Kaiser Permanente in 2006, taking on responsibility for the California regions’ Small Group business line, which represents nearly 700,000-members. Prior to joining KP, Smith led marketing for PacifiCare Health Systems’ Individual and Small Business segment and spearheaded the establishment of PacifiCare’s product development function. In addition, he served for eight years as a consultant for Price Waterhouse and Towers Perrin, working with numerous Fortune 500 customers.

Smith earned an M.B.A. from the University of California, Irvine, and holds a B.S. in Mathematics from Iowa State University.
What’s in Healthcare Reform for Small Businesses?

After a year of debate, in March 2010 Congress passed legislation that will fix the serious problems that small businesses, including the self-employed, face in the current healthcare system: skyrocketing costs and unpredictable premiums, lack of access to affordable coverage and choice among health plans, and administrative inconvenience and hassle. So what does this actually mean for small business owners?

The new law will be implemented over a five-year period (2010-2014) to avoid disruption to the existing system and make transitions as smooth as possible. The general approach is to build upon the existing employer-based health system that employers and employees are used to: insurance will still be purchased from private insurance companies as well as not-for-profit plans, and the private sector healthcare system of doctors, hospitals and other providers will be maintained. Medicare will still cover retirees and Medicaid will continue as it does currently to cover uninsured children and low-income adults, with new flexibility to cover more people.

Lower costs
The law will help reduce costs for small businesses by creating an insurance pool in each state, providing small business tax credits, promoting administrative and delivery system efficiencies and reducing long-term healthcare inflation.

Insurance pool
A health insurance exchange will create a pool of small businesses with up to 100 employees and the self-employed to leverage purchasing power. An exchange will enable insurers to offer lower premiums as a result of lower administrative costs and spreading risk across a larger population. Insurers will have to offer standardized benefit packages within the exchange, so competition will be based on price and quality, not benefit design. The larger pool will also dampen the annual volatility of premiums. Combined with insurance reform, the exchange will offer small business owners and the self-employed access to stable, affordable coverage year after year.

- **The law will create 50 state exchanges.** It will mandate creation of the exchanges by 2014, and allow businesses of up to 100 employees to participate (although states will have the option to limit to 50 employees). Beginning in 2017, states may allow employers with more than 100 employees to use the exchange, but are not required to do so.

- **Co-ops and national health plans:** The law will create, and fund with loans, state-based nonprofit co-ops—consumer-owned insurance alternatives that would compete with privately held insurance companies. In addition, each state exchange will also offer at least two multi-state health plans (one of which must be a nonprofit) negotiated by the federal Office of Personnel Management (OPM). OPM negotiates a variety of health plans for 8 million federal employees and families in all 50 states.

Small business tax credits
The tax credit is estimated at $40 billion from 2010 to 2019, an average of $4 billion per year over that 10-year time span; approximately 4 million small businesses will qualify in 2010 for the tax credit to offset employer health plan costs.
Beginning in 2010 and through 2013, businesses with fewer than 25 full-time employees that contribute at least 50% of the total premium will be eligible for tax credits of up to 35% of the employer contribution. The full credit will be available for businesses with fewer than 10 employees averaging less than $25,000 annual wages, and phase out at $50,000. Nonprofit organizations will qualify for tax credits of up to 25% of the employer contribution during this time period. Also, any state tax credit a small business owner receives for providing coverage will not reduce the amount of the federal tax credit.

Beginning in 2014, eligible small businesses purchasing coverage via an exchange will receive tax credits of up to 50% of the employer contribution if the employer provides at least 50% of the premium cost. Nonprofit organizations will qualify for tax credits of up to 35% of the employer contribution during this time period. Seasonal employees will not be counted when determining eligibility. A business can claim the credit for any two years in the future. The law explicitly excludes sole proprietorships and family members from the small business tax credits (but they can apply for individual tax credits).

Cost containment
Cost containment provisions to bring down the overall inflation rate of healthcare costs include:

- Creating a small business insurance pool that will reduce costs by spreading risk, promoting healthy competition and lowering administrative overhead for businesses.
- Eliminating the cost shift that adds to the cost of everyone’s care when the uninsured receive care in the most expensive settings, such as emergency rooms.
- Providing additional choice in areas of the country where one or two insurance companies now have monopolies, and offering new alternatives to plans from existing private insurers—such as a system of not-for-profit co-ops and new multi-state health plans that will bring competition.
- Providing funding for enforcement to reduce waste, fraud and abuse in Medicare and Medicaid programs.
- Changing the way doctors and hospitals are paid by moving away from a system that rewards quantity of service to one that rewards the best outcomes for patients.
- Investing in prevention and wellness by requiring that prevention and screening services are offered at no charge and authorizes Congress to appropriate $200 million for small business wellness initiatives.
- Implementing an electronic medical records system to create efficiency.
- Simplifying the paperwork burden that adds tremendous costs and hassles for patients, providers and businesses today.
- Enabling states to lead medical malpractice reform with federal funding to back them up.

The CBO estimates that this law will reduce the government deficit by $142 billion over the next 10 years, and $1.2 trillion over the following 10—which should, in turn, reduce taxes and interest rates.

More choices
The law will increase the choice of health plans—including health co-ops and new multi-state health plans—through an insurance pool (exchange) offered to employees of small businesses, the self-employed and other individuals. In addition:

- A temporary Preexisting Condition Insurance Plan (formerly high-risk pool) has already been established under the new law, using $5 billion in funding. It will allow individuals (including the self-employed) who have been denied coverage due to a preexisting condition and who have
been uninsured for at least six months prior to applying for enrollment, to buy affordable comprehensive coverage. This will benefit many self-employed and small business employees who are currently excluded from coverage. Since being implemented, restrictions have eased and premiums have been lowered in the states where the plan is federally administered. Those who enroll in a Preexisting Condition Insurance Plan will be transitioned to the exchange in 2014 without a gap in coverage. For more information, visit https://www.pcip.gov/.

- The bill provides small businesses, including the self-employed, a new option for a simplified cafeteria plan to provide tax-free benefits to employees.
- Small business owners and employees will be able to access the state exchanges via the web to learn about and purchase insurance plans, and find out whether they are eligible for tax credits and/or subsidies to limit cost-sharing. The exchange website will also let people know whether they are eligible for any state or local public health programs, including Medicaid and CHIP. (For information about the exchange and other components of healthcare reform, visit the national website www.healthcare.gov.)

**Insurance reforms for small business and consumer protection**

The law includes insurance reforms that will prevent discrimination and improve access to affordable coverage for small businesses and their employees, as well as self-employed people:

- Prohibiting medical screening for health conditions and exclusion of coverage for preexisting conditions will ensure that no one is denied coverage for serious health conditions.
- Rating regulations that prohibit the use of health status or claims history in determining premiums will enable those with serious health conditions to obtain affordable coverage. Rates may only vary by age (limited to a 3-to-1 ratio), geographic area, family size and tobacco use.
- The law requires that insurers expend not less than 85% on medical coverage for large groups and 80% for the small group and individual market. It also provides for consumer rebates, and includes “sunshine” reporting requirements for insurers to justify rate increases.
- Lifetime limits are prohibited in 2010 and annual limits will be prohibited once the exchanges are set up. Any annual limits imposed before 2014 must be approved by the HHS secretary.
- Under the reform plan families will be able to keep their dependent children covered under their family health plan through age 26, effective September 2010 for the new plan year.
- The law establishes new processes for federal and state review of premium increases. Among other things, states may recommend that insurers not be allowed to participate in the exchanges due to unreasonable premium increases.

**Expanded coverage**

Insurance reforms, premium assistance and subsidies to limit cost-sharing for lower-wage employees and Medicaid expansion will increase coverage for nearly all Americans. Currently 83% of Americans have health insurance. The law will dramatically increase this number to 95%. Illegal immigrants are excluded from all health insurance programs under the law.
Employee tax credits
Every individual will be required to obtain health insurance. To help make this affordable, tax credits will be provided, on a sliding scale, to lower-wage employees; those earning up to $43,000 for an individual or $88,000 for a family of four may qualify for help.

- The annual fee for adults who don’t obtain coverage will be the greater of $325 in 2015 and $695 in 2016, and a sliding scale working up to 2% to 2.5% of income by 2016.
- The law provides exemptions for married couples with annual income below $18,700, financial hardship, religious objections and individuals deemed unable to pay for other specific reasons detailed in the legislation.

Financing
The law relies on several sources of revenue—in addition to reductions in Medicare expenses and other cost-saving measures—to offset the costs of expanded coverage, tax credits and premium assistance. In fact, it will not only be self-sustaining, but also, per CBO estimates, reduce the federal deficit by $142 billion between 2010 and 2019 and $1.2 trillion over the second decade.

- The health industry—drug companies, insurers and medical device manufacturers, all of which will be covering, and gaining new revenues from, more than 32 million new individuals—will pay new fees.
- Two sources of funding include (1) a tax on high-cost plans and (2) a fee on certain employers who don’t provide coverage and whose employees receive tax credits to purchase insurance through the exchange.
  - In 2018, a 40% excise tax will be imposed on that portion of the premium costing more than $10,200 per year for individuals or $27,500 for families. These are indexed for inflation. Costs will initially be paid by the insurer, but will likely be passed on to plan holders eventually. The tax is meant to discourage the use and purchase of high-cost/high-benefit plans. Economists, including the government scorekeeper, the CBO, project that employers would over time generally cease to fund health plans that exceed the 40% tax threshold and increase employee wages instead. To ensure that the tax hits everyone fairly there are adjustments for retirees and companies with older employees or high-risk occupations. Dental and vision are not counted as part of the benefit cost.

Employers will not be required to offer health insurance. Those employers with more than 50 employees who don’t provide coverage will have to pay a fee when an employee purchases insurance through the insurance exchange and qualifies for a tax credit.

- Employers with more than 50 employees that don’t offer coverage and have at least one full-time employee who receives a premium tax credit will have to pay a fee of $2,000 per full-time employee.
- There is a provision that subtracts the first 30 employees (e.g., a firm with 51 workers that does not offer coverage would pay an amount equal to 51-30, or 21, times the applicable per-employee payment amount).

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2013
Employer-Sponsored Health Care: ACA’s Impact

SURVEY RESULTS
I. Introduction

On March 19, 2013, the International Foundation of Employee Benefit Plans deployed its fourth survey in a series on how single employer plans are being affected by the Affordable Care Act (ACA). The surveys are in-depth studies of how single employers with health care plans are responding to the challenges and opportunities presented by ACA. The first survey, conducted in May 2010, emphasized employers' immediate considerations and approaches for complying with the new law. The second and third surveys focused on the actions employers were taking in 2011 and 2012.

2013 Employer-Sponsored Health Care: ACA’s Impact focuses on the most important health care reform issues facing employers this year. Topics addressed include employer concerns regarding plan design and funding, methods for communicating with employees, grandfathered plan status, reactions to health insurance exchanges, cost-management initiatives and the potential impact on health care benefit costs.

Those asked to participate in the 2013 survey were single employer plans (including corporations) in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCES). Survey responses were received from 966 human resources and benefits professionals, and industry experts. The surveyed organizations represent a wide base of U.S. employers from nearly 20 different industries. Insurance and related fields (18.6%), manufacturing and distribution (16.6%), and health care and medicine (11.3%) are most represented. Surveyed employers range in size from fewer than 50 employees to more than 10,000. The demographic characteristics of the respondents in the 2010, 2011 and 2012 surveys were very similar to those in the 2013 survey. In several places throughout this report, comparison data is displayed by employer size and previous survey years. We urge readers to exercise caution when interpreting comparison data from previous surveys due to the nature of the sample designs and potential nonresponse error.

This report has seven sections beyond this introduction. Section II provides key findings. Detailed findings are presented in Sections III through VIII. Section III discusses employers’ status in response to ACA and ways employers are communicating with their participants about reform. Cost implications of reforms, funding changes and cost-management initiatives are examined in Sections IV and V. Section VI focuses on employers’ reactions to the opening of the health insurance exchanges. Retiree coverage options are examined in Section VII. Employer perspectives on grandfathered plans are examined in Section VIII. Section IX discusses the demographic profile of respondents.

This survey is the fourth in a series of reports on the impact of ACA on single employer benefit plans. Readers are encouraged to watch for additional reports that help plan sponsors benchmark their benefit programs and practices against other plans.

1. Electronic survey deployment began March 19, 2013 and was concluded March 26, 2013.
2. Single employer plans are maintained by one employer or by related parties such as a parent company and its subsidiaries.
II. Key Findings

This section presents major survey findings concerning the impact of the Affordable Care Act (ACA) on single employer plans. Completed responses were received from 966 individuals representing single employer plans (including corporations). Attention is given to employers’ status in response to ACA, their communications with plan participants regarding reform, cost implications, cost-management initiatives, reactions to health insurance exchanges and grandfathered plan status.

The survey includes questions posed in the context of, “What are you doing with your plan as a result of ACA?” The reader is cautioned that some of the changes employers are making may not be directly influenced by health care reform, although they may be a by-product (i.e., if ACA is causing other costs to increase, employers may make changes to benefits not otherwise affected by health care reform to offset those increases).

Overall status and adjustments

- Most organizations have moved beyond a “wait and see” approach (90%). More than half of organizations are beginning to develop tactics to deal with the implications of reform.
- Most organizations (69%) think their understanding of ACA is good but not excellent—they believe they need to do more analysis.
- About two in five employers are increasing their emphasis on wellness initiatives and incentives due to the impact of ACA.
- A considerable portion of employers are increasing or considering increasing emphasis on high-deductible health plans (HDHPs), particularly with health savings accounts (HSAs) attached.
- About 10% of plans have adjusted their funding approach—typically, this involves the addition of stop-loss coverage.
- Most responding organizations report their plans meet the recently proposed minimum value (81%) and affordability (74%) requirements.
- Only about one-quarter of organizations remain grandfathered and, of those, less than half expect to keep their grandfathered status beyond the next two years.
- Most ACA communication to participants (73%) occurs during the annual enrollment period. About one in five organizations has noticed an increase in contacts made to their HR/benefits staff from participants regarding ACA.
- Organizations are communicating the implications of reform throughout the full year using e-mails (41%) and company websites (30%).
- Approximately 17% of organizations have already started to redesign their plans to avoid triggering the 2018 excise tax on high-cost health plans.
- Few organizations are changing their workforce hiring or reduction strategies as a result of ACA, but 16% have adjusted or plan to adjust hours so fewer employees qualify as full-time.
Cost impact

- About two-thirds of organizations have analyzed the ACA's cost impact (64%). A majority estimate the result will be a 3-4% or greater cost increase in 2013 due to ACA.

- Employers have implemented and plan to implement diverse cost-management initiatives in the next 12 months due to ACA—most commonly increasing participants' share of premium costs (43%), increasing the employee portion of dependent coverage costs (34%), increasing in-network deductibles (33%) and increasing out-of-pocket limits (31%).

- Few organizations are intending to drop spousal coverage or structure premiums based on income to cut costs.

- The requirement to offer affordable coverage to all full-time employees is the forthcoming ACA implication organizations are most concerned will increase costs. Extending coverage of adult children to the age of 26 is the provision already in place that has most significantly increased costs.

Providing coverage vs. the exchanges

- The vast majority of organizations (94%) say they definitely or very likely will continue providing coverage when exchanges open in 2014, primarily to retain and attract talented employees. Fewer than 1% of all organizations say they definitely will discontinue coverage when exchanges open in 2014.

- Of those considering discontinuing coverage, two-thirds say they are at least somewhat likely to provide a financial subsidy. The cost of providing coverage becoming too expensive is the top reason employers will consider discontinuing coverage at some point.

- Discontinuing coverage is viewed as a slightly more likely option for retirees than for full-time employees.

Comparisons by size

- Employers with more than 50 employees are more likely to be investing in wellness and prevention.

- Employers with 50 or fewer employees are generally making more employment-based decisions with hiring, reductions and reallocating hours.

- Employers with 50 or fewer employees are slightly more likely to discontinue coverage. The smaller the organization the less concerned it is about the actions of competitors.

- Smaller employers are less likely to have measured the cost impact of ACA on their organization, and more likely to estimate a higher cost impact.
Comparisons to previous years

- The portion of organizations that are still in "wait and see" mode has decreased from 31% in 2012 to less than 10% in 2013.
- In 2013, the portion of organizations that have modeled the financial impact of reform on their organization and the portion developing tactics to deal with implications of ACA have increased.
- Compared to 2010, the rise in HR/benefits staff contacts regarding ACA has slowed—perhaps due to the increased communication by organizations and more employee familiarity with the law.
- Estimates of cost increases directly associated with ACA have increased from 2012 to 2013.
- The portion of organizations stating they definitely will continue to provide employer-sponsored health care when the exchanges open in 2014 increased from 46% in 2012 to 69% in 2013. (In both years, the second most common response was "very likely" to continue to provide coverage.)
- In the past three years, the portion of organizations with grandfathered status has steadily dropped—45% in 2011 to 34% in 2012 and 27% in 2013.
- In the past three years, the portion of organizations redesigning their plans to avoid the 2018 excise tax on high-cost plans has steadily increased from 11% in 2011 to 14% in 2012 and 17% in 2013.