Beware of What You Wish for OR The Affordable Care Act and Me

Phyllis Mensh Brostoff, CISW, ACSW, CMC

"To follow what's happening with the new health care law right now, you have to understand that for all the deep divisions on the issue, there's actually a real bipartisan consensus about how the American health care system ought to be reformed. Or rather, there are two of them — a dishonest consensus among politicians and an honest consensus among people who study public policy for a living. ...Obamacare has an unwieldy, Frankenstein's monster quality in part because the law is trying to serve both consensuses at once... the White House's decision [to suspend the employer mandate] is a step toward honesty in policy-making. It takes us a little closer to a world where politicians of both parties actually level with the public, and acknowledge that employer-provided health insurance is an idea whose time has passed."

Oh, how fervently I wished for everyone in the US to have health insurance but not through their employer! I wanted Medicare for all – a national system already in place, paid for through payroll taxes, very efficient administratively (five percent overhead) and competing for business with the private system. That was my ideal scenario, but that was not to be. The only thing that could be wrestled through the Congress in 2010 was the Affordable Care Act. As it begins to go from the paper it was written on into implementation, it turns out it may not be very affordable. If most of a company's employees are comparatively low wage earners and it is a "large" employer (defined as having more than 50 FTE employees), it may cost more than anticipated.

Oh, how fervently I wished for everyone in the US to have health insurance but not through their employer! I wanted Medicare for all – a national system already in place, paid for through payroll taxes, very efficient administratively (five percent overhead) and competing for business with the private system. That was my ideal scenario, but that was not to be.

Our company, Stowell & Associates, started in 1983 providing only care management services to elderly and disabled adults. In 1985 one of our clients needed a special type of caregiver. We could not find a caregiver with these special skills among the existing home care agencies in our community. Our client, H, was chronically mentally ill, 55 years old, and desperately wanted to live on her own in a condo she owned. She had no friends and very little in the way of homemaking skills or experience. So we made the decision to go into "home care" and hired our first caregiver, Sherry, to work with H. To this day Sherry still works for the company. Over the years she has asked for a variety of benefits, i.e., training as a certified nurse's aide, in-service training opportunities to keep up her certification, health insurance, paid leave, and a 401-k. Over the years the company has added these benefits for our other full-time employees (those who work at least 30 hours a week). In 1988 the company joined the local Chamber of Commerce to access a chamber-sponsored health insurance plan, and after a few years, consolidated our insurance business through an insurance broker for all our insurance needs.

The company began expanding and growing in the 1990s. Currently we have about 150 caregivers, eight care managers, an executive director, a clinical director, schedulers, recruiters, and an accounting department. Combined staff are about 175, more than half of them working a minimum of 30 hours a week or more. This number of employees puts us squarely into the category of a large employer (50 or more FTE employees) that must provide affordable health insurance to our employees. In the past when reviewing our agency profile, we had little bargaining power and were considered a "bad" group from an underwriting point of view: too many woman (99 percent), too old (average age 50) and too low income

(averaging close to $13 per hour for our caregivers). This was a concern as we moved into understanding the regulations within the Affordable Care Act.

Based on medical underwriting standards and age tiers, the average cost per employee for a single plan had been about $820 per month. Only one-third (33%)of our eligible employees (full time, defined by working on the average 30 hours or more per week) actually enroll in the company's health insurance. Eighteen percent (18%) have other insurance. Twenty-one percent (21%) have government insurance, i.e., Medicare. Fifteen percent (15%) have no insurance coverage at this time because it is unaffordable for them. There are thirteen percent (13%) whose reasons for not having the company plan are unknown. The company currently pays sixty percent (60%) of the plan cost. On average an employee in the company-sponsored health plan pays $328 per month for individual coverage. Unfortunately those employees making approximately $13 per hour cannot afford the cost and remain uninsured– and it is two times the amount that is defined as "affordable" under the Affordable Care Act for a caregiver working an average of 30 hours a week ($20,000 per year).

According to the ACA and the way the math works, no plan can cost more than $1,900, or $158 a month, for our lowest paid full-time caregiver to be considered affordable by the ACA (9.5 percent of their gross wage). And to make matters worse for these hourly paid employees, Wisconsin's governor refused the Federal extended Medicaid benefit for single adults which would cover those with incomes up to 130 percent of poverty. However, Wisconsin will have a federal health insurance exchange because the governor refused to set up a state-run exchange.

From an administrative point of view, I want all of our employees to have health insurance. Office employees who have access to primary care can obtain preventative care. Caregivers can get help with health issues that might save them from work injuries. We have offered this benefit for more than 20 years, and it only seems fair that everyone have health insurance. Our client fees have reflected the ongoing insurance cost to us, so we do not anticipate increasing our fees.

There is a requirement within the Affordable Care Act (ACA) that has potential for affecting our company and employees. One interesting outcome of the ACA's requirement for community rating (i.e., underwriting can't be based on your group's health histories, just age, size of family, smoker/not, and location) is that our insurance premium may actually be reduced in 2014. Based on the demographics of our workforce, we have already been paying a higher rate for years. Employers having this number of employees or more with a lot of young workers are likely to be stuck with a large increase of premiums since premiums for younger workers may rise. This is not relevant to us.

Now that the employer mandate is suspended for a year, we won't be penalized if the cost is not "affordable." However, the cost of this insurance may still be too much for our lower wage employees. Our plan is that we'll probably add a second choice that will meet the "affordability" rule. We will not know what the 2014 rates will be until November of this year.

Most members of NAPGCM will not be in the position our agency is in because they are considered small employers. If they are not offering health insurance now, they and their employees can use the Marketplace (formerly called an "Exchange") to find insurance. It is designed to be an on-line tool that will look like the Medicare Plan Advisor or Expedia. Since all employees will, in theory anyway, be required to have health insurance, it would seem that all businesses will adjust fees to manage this expense. But, everything is still up in the air. Personally I think it will take at least five years before the ACA will be fully implemented and fully integrated into the fabric of the country. To repeat myself, I would have preferred just paying a payroll tax and including everyone in Medicare (or a Medicare-like system), but they didn't listen to me!

Reference

A Hidden Consensus on Health Care, by Ross Douthat, New York Times, July 6, 2013 http://www.nytimes.com/2013/07/07/opinion/sunday/douthat-a-hidden-consensus-on-health-care.html?ref=rossdouthat#comments

Most members of NAPGCM will not be in the position our agency is in because they are considered small employers. If they are not offering health insurance now, they and their employees can use the Marketplace (formerly called an "Exchange") to find insurance. It is designed to be an on-line tool that will look like the Medicare Plan Advisor or Expedia.

All articles published in the GCM Journal are the property of NAPGCM and protected by US and international copyright laws. Except as provided herein, no publication, reproduction, or reprinting of these articles is allowed without the express written permission of NAPGCM.

Affordable Care Act (ACA) Overview

Purpose of Affordable Care Act (ACA): increasing access to health insurance so that, in theory, everyone has access to affordable health care.

Consumer Protections in ACA: Prohibition against pre-existing conditions limiting access to insurance, continuation of coverage of adult children to 26, guaranteed issuance, subsidies for individuals between 100 percent - 400 percent of Federal poverty level, no more than 90-day waiting period before obtaining coverage.

Definitions

Employer Mandate: "Applicable large employer" is defined as having employed 50 or more individuals who worked on the average 30 hours or more a week in the prior calendar year.

Individual Mandates: All individuals are to have health insurance or face tax penalties.

Full-Time Employee: Works on the average 30 hours or more a week for employer

Marketplace/Exchange: Entity set up to allow the public to compare health care insurance options electronically, run by individual states, or the Federal government if a state refuses.

Coverage Options:

- Platinum: designed to pay 90 percent of covered claims costs.
- Gold: designed to pay 80 percent of covered claims costs.
- Silver: designed to pay 70 percent of covered claims costs.
- Bronze: designed to pay 60 percent of covered claims costs.

Individual Subsidies: Available to individuals with income up to 400 percent of Federal poverty level without access to affordable employer sponsored coverage. Individual applies for health insurance coverage through an Exchange/Marketplace and it will certify if individual is eligible for subsidy.

Affordable Employer Sponsored Coverage: Cost of employee only coverage to the employee can be no more than 9.5 percent of their income.

Penalties: There are employer penalties if the employer does not offer minimum essential coverage to all FTE employees and at least one employee receives a subsidy through an Exchange/Marketplace but this was suspended until 2015. There are employee penalties if they do not get health insurance ($95 per adult and $47.50 per child, up to $285 per family, or 1 percent of family income in 2014; $325 per adult, $162.50 per child up to $975 per family or 2 percent of family income in 2015; $696 per adult and $347.50 per child up to $2,085 per family or 2.5 percent of family income in 2016).

Minimum Essential Coverage (MEC): Coverage has to include 10 essential health benefits; ambulatory/outpatient, emergency, hospitalization, maternity and newborn care, mental health and substance use, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services including pediatric dental and vision care.

Minimum Value (MV): Employee plan must have actuarial value of at least 60 percent. https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-10463.pdf

References

All definitions and information above from Anthonie(TJ) Goedheer, Consultant, Employee Benefits, Diversified Insurance Services, 100 N. Corporate Drive, Suite 100, Brookfield, WI 53045 agoedheer@div-ins.com.

See Henry J. Kaiser Foundation website for a tool that calculates "affordability" based on employee's wages: www.kff.org/interactive/subsidy-calculator

Phyllis Mensh Brostoff, CISW, ACSW, CMC is the CEO and co-founder of Stowell Associates, providing geriatric care management and care managed home care services to the elderly, disabled adults and their families since 1983.

Phyllis is a founding member of the National Association of Professional Geriatric Care Managers and was the President of the National Board in 2009 and President of the Midwest Chapter Board 2006-2008.