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MANAGING HEALTH TODAY

Serious News & Ideas for Healthcare Executives

featured facility:
Nyack Hospital *pgs. 10-11*

The AHA and Exchange Issue

Photo Galleries from our summer socials – Hudson River Cruise and Renegades Game

Issue highlights:

AHA Wage Index Proposal Pulled

Public vs. Private Exchanges

The Affordable Care Act – Opportunities and Challenges

Open Enrollment through the Health Exchanges Begins

featured article

Employee Benefit Plans:
How do Public and Private Exchanges Fit In?

Barry Schilmeister, FSA, Healthcare Practice Leader Mercer

"We'll Play."

That's the answer most employers—and, even more so, most health care organizations—have given to the "Play or Pay" question presented by the Affordable Care Act (ACA). Nationally, 93% of large employers—and 97% of large health care organizations—intend to keep offering health benefits to their employees, rather than end coverage and pay a Shared Responsibility penalty to the government on every full-time employee, sending many them to find coverage through Public Health Exchanges. If you are among those continuing to offer health benefits, can Public Exchanges still have a role in your benefits planning? What about Private Exchanges? How do they differ and can they be an option as you manage future benefits costs?

The ACA created Public Exchanges to expand access to affordable coverage to all Americans. Each state offers a Public Exchange, or relies on the federal government, in whole or in part, to offer one. Offering several plans from multiple carriers, and large premium subsidies based on household income, Public Exchanges act as a broad safety net of coverage for those who do not have adequate, affordable insurance through employment or other government programs.

Public Exchanges might not impact an employer's benefit planning or cost if that employer still offers health benefits to its full-time employees. But there are exceptions, including:

- If your program fails to meet ACA standards for value and affordability, employees may opt for Public Exchange coverage, which may mean a Shared Responsibility penalty charge to you, the employer.
- If your program covers substantially all FTEs, but not all FTEs, as defined by the ACA, you could see Shared Responsibility penalties if those without coverage opt for the exchange.
- Retirees not eligible for Medicare: Exchanges offer a new source of coverage for these retirees, notably those not yet eligible for Medicare, if you are covering them today under the active employee plan.

Private Insurance Exchanges serve a different need: to offer employers a program to better manage future costs while still offering valuable benefits. By deciding to continue to offer benefits, employers acknowledge the importance of these programs in retaining talent. Private Exchanges offer a new kind of benefit structure, one focused on value to employees and cost management to employers.

Private Exchanges offer, in one place, a menu of benefit plans, pre-screened and negotiated, tools to optimize employees' experience, and a platform designed to streamline administration, choice and funding.

How do Private Exchanges balance cost management with employee value? By:

- Promoting flexible choice: Employees see an array of benefit options and education tools. Employees can customize their benefits to fit their needs, with programs beyond medical that could include dental, vision, life, disability and an array of voluntary programs. Today, there is no "one size fits all" plan.
- Simplifying administration: The Exchange can take on many traditional HR roles—vendor management, design decisions—simplify compliance, and streamline plan administration while actually expanding choice and employers' funding options.
- Improving the customer experience: A wide choice of benefits to fit personal needs, delivered through a consumer-friendly platform with tools and information to help make benefit choices--building employee satisfaction, staff productivity and competitiveness.
- Facilitating defined contribution (DC): The Exchange offers employers a way to more easily retake control of medical cost increases. With DC, employer cost increases can better track with what the business can afford. With many employees over-insured for medical, the Exchange helps them "right size" their coverage, lowering top-line costs and making the employer's DC go further.

Offering a full palette of benefit choices on a single platform is, in fact, designed with long-term cost management in mind. Think of this in three stages:

- Stage 1: The Platform. Moving your welfare benefits to a single platform that is set up to facilitate benefit delivery and employee interaction can save administrative cost and free up current resources for other work. Vetted programs offer choice and, in many cases, lower costs through the power of collective purchasing.
- Stage 2: The Program. A one-stop benefit shop refocuses employees on Total Benefits—the value of the full slate of programs you sponsor—moving away from the piece-by-piece way that benefit programs are typically viewed. The idea is to better promote choice across programs, customizing that choice to personal needs and spending on programs in the most meaningful way.

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Spencer Bautista is Chief Strategy Officer of Cardon Outreach. In this capacity Spencer is responsible for strategic planning for Cardon Outreach. Spencer has deep knowledge and expertise in the areas of Medicaid, Medicare, Social Security Disability, and the Affordable Care Act, and the implications of these for Healthcare Providers, Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs), Government Agencies, and the like. Prior to his appointment as Chief Strategy Officer, he held positions as Chief Executive Officer, Vice President of Finance, Director of Finance and Director of Human Resources at Cardon.

For 34 years, Doug has served in various Senior Leadership roles for large financially distressed hospitals, multi hospital systems, physician practices, financial services firms, and for one of the largest national healthcare outsourcing companies. In his current role with Bon Secours Health System, Doug has responsibility for Patient Access, Patient Financial Services, the Charge Master, Health Information Management, Revenue Integrity, and Clinical Documentation Improvement for the three New York based hospitals.

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- Stage 3: The Pricing. In the Exchange, you still control what employees pay for each program and, so, what you subsidize. In many cases, you control the funding of your health care offerings—insured or self-funded. Through the pricing, you may still influence the choices people make. The Platform and the Program also support a "defined contribution" funding approach, where employer funding across potentially all benefits becomes a fixed amount of money that employees spend on putting together a Total Benefit Package best fitting their individual needs. "Defined Contribution" aims to give an employer more control over the money it will spend on benefits, per employee, year after year.

As the delivery of health care changes, so does the purchase of health care benefits. The Total Benefit value proposition between you and your employees must begin to be seen as extending past health care—the most visible and probably the most valued of all benefits—to include a full benefit palette of employer-sponsored benefits, subsidized and voluntary. Because, changes to health care purchasing is pushing us to look at design and spending in new ways, ways that require we re-look at how we spend the Total Benefit Dollar and how to leverage these new vehicles—Public and Private Exchanges.

.Barry is a Principal in Mercer's Health and Benefits business, and is Mercer's Healthcare Industry Solutions Leader. As an actuary and senior consultant at Mercer, Barry advises employers on the strategic planning, structure, and financing of their group benefit programs, focusing largely on health care clients. He is the New York spokesperson for Mercer's National Survey of Employer-Sponsored Health Plans.