Webinar Title Q&A – the following questions were asked during the two webinar sessions in July 2017

Q: The current calculation used for affordability is 3 fold. We currently use 9.5% of lowest paid employee when setting premiums. What did you say the calculation would be per the proposed bill?

A: The current bill does not affect the affordability calculation per se, but it removes penalties for failing to offer insurance, making the calculation moot.

Q: What is the future of Association plans in the proposed legislation?

A: The current Senate version of the bill establishes small business health plans (SBHP) that could be used in this context. The House version of the bill does not include a provision for association plans.

Q: Are there any indicators pointing toward reductions in out-of-pocket or deductible levels?

A: Neither bill directly reduces the out-of-pocket or deductible levels in health plans, but there may be more flexibility given to the states to offer plans with other limits if the legislation passes.

Q: When they are estimating that 23 or 22 million will be uninsured by 2026, what does this really represent? Are they saying that people are going to voluntarily not take coverage because they aren't required? Is that because it won't be affordable? That they'll be forced out of coverage?

A: Most of the reports indicate that the bulk of the predicted uninsured would come from the decreased funding of Medicaid and end of the Medicaid expansion. A much smaller number would drop coverage due to premium costs, and some might drop coverage rather than take coverage that is less comprehensive. This number is above current projections of roughly 15 million uninsured, meaning that with passage the estimated total number of uninsured would be 37 or 38 million people.

Q: I'm researching group shares (like Medi-Share), which share medical costs across an aligned group. Would these programs be impacted by any of the new legislation?

A: Neither the House or the Senate bill in current form address this.

Q: Has there been any discussion about continued use of the required metal tier benefit system using the actuarial value calculator?

A: In the House version of the bill, plans offered after December 31, 2019, would no longer need to comply with the actuarial requirement. The current Senate version of the bill does not address this.

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Q: If HRAs & HSAs reduce the effect of the deductible, isn't this the same effect targeted by the Cadillac Tax?

A: Not really. The Cadillac tax is an excise tax of 40% that is charged to employer, insurance carriers and TPAs when the value of certain benefits exceeds a threshold limit. The Cadillac tax may be an incentive for employers to scale back health related benefits and tax advantaged account offerings, whereas HRAs and HSAs are tools used to offset the cost of care and offer a tax benefit to both employers and employees.

Q: It feels like our country is being drawn in the direction of single payer with the continued disagreements in healthcare on both sides. What is EBCs position on this? If this current Republican effort completely fails, what do you think are the odds of a single payer or "Medicare for all" option getting serious traction?

A: Employee Benefits Corporation does not take a position on this issue, rather our role as a third party administrator of consumer directed health care is to educate our clients and broker partners regarding the impact of legislation on employer-provided and consumer directed benefits. We do know that with the current political landscape and a Republican controlled Congress, single-payer is unlikely to gain serious traction in the near term.

Q: With the recent decision on Church plans and ERISA, are you still recommending they get a Wrap?

A: This decision to adopt a Wrap plan for non-ERISA employers should be made with legal counsel. Adoption of a Wrap plan may subject an employer to ERISA that may otherwise be exempt.

Q: Would the State Pools be able to raise rates or deny benefits for those with medical conditions even if no gap in coverage?

A: Only the House AHCA would allow rates to be raised if a person had a gap in coverage, but the proposal only speaks to what insurers could charge, not state high-risk pools. Under both bills high-risk pools could be created in states in order to help offset the cost of providing coverage for high-cost conditions. There is additional federally funding to help states stabilize the market, including through the use of high-risk pools. However, the details of those high-risk pools would be left to the states.

Q: Senate would be age and income based for subsidy. Are there charts out there that break that subsidy out for ages and incomes?

A: The current version of the Senate bill can be found here: http://www.ecfc.org/files/ecfc-news/BetterCareJuly13.2017_.pdf and the section by section analysis can be found here: http://www.ecfc.org/files/ecfc-news/BCRA_Section_by_Section_Summary_7.13_.17_.pdf

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