HEALTH care

A brave new (health care) world

The Patient Protection and Affordable Care Act affects individuals and small and large groups in Virginia.

BY BRIAN MARKS, MBA, CEBS

When the Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010, many businesses and those in my industry had a lot of trepidation. Many felt that it would never survive to implementation. The first major challenge centered on the bill's constitutionality, which opponents felt would be its demise. But in June 2012, the U.S. Supreme Court ruled that the PPACA would stand. Opponents held out hope for the election in November, but with the re-election of President Obama and Democratic control of the Senate, it became clear that the PPACA is here to stay.

At the end of the day, the PPACA is the law of the land — with its roughly 2,000 original pages multiplied many times over with clarification upon clarification. I think everyone would agree, whatever his or her original stance on the PPACA, that this law is far-reaching and complex.

The PPACA's impact has been immense. Its plan is to provide all Americans with access to affordable health care coverage. Sweeping reforms of the insurance industry deliver affordable care in some situations and greater expense in others. In short, the direct impact of the PPACA is quite situational.

The PPACA has altered the various segments of the health insurance market in different ways. The effects are similar among segments and unique to some. I will attempt to cover the major impacts it has had, and will have, on each segment. This is a high-level summary of the key changes, and there are certain concepts and impacts which clearly go well beyond the scope of this article.

INDIVIDUAL MARKET IMPACT

Effective Jan. 1, 2014, all Americans will be required to have health insurance or pay a tax. This tax is the greater of $95 per adult/$47.50 per child or 1 percent of the taxpayer's gross income in 2014. This tax increases in subsequent years. In addition, there is no medical underwriting, all coverage is guaranteed issue (i.e., no denial) and pre-existing conditions are fully covered. Individual underwriting has changed significantly with the PPACA. Key changes are:

- No medical underwriting or risk adjustment
- Age-band ratios can be no larger than 3:1 from the youngest to oldest
- Tobacco users may receive a 50 percent surcharge

These underwriting changes favor the elderly and those with medical conditions. We have seen major cost impacts to the young and/or healthy and better rates for those who are older and/or have higher medical risks. Essentially, the rates have normalized to the mean.

There is little that an individual who is younger and/or has lower medical risks can do to avoid these increases at some time in 2014, unless he or she is in a grandfathered plan. A grandfathered plan is one that was issued prior to March 23, 2010, when the PPACA was signed into law. To be grandfathered, a plan could not have been altered significantly since this date (e.g., certain increases in deductible). If the plan is grandfathered, the aforementioned underwriting changes will not apply. If you are insured in the individual market, your carrier can tell you if your plan meets these criteria. If an individual has a low medical risk and/or is younger age, he or she may wish to maintain this plan as long as practicably possible. Otherwise, there will be significant rate changes due to the PPACA.

If a member in the individual marketplace is older or has medical conditions, he or she may be aided by these same PPACA underwriting changes. If the demographics or medical risks warrant it, an individual may wish to move to the new underwriting as soon as possible in 2014 to enjoy the lower rates that are available under the PPACA. The advantage or disadvantage of the PPACA underwriting changes is situational.

Beyond the underwriting changes, individual plans are offered in both the private market and through public marketplaces. Virginia is a part of the Federally Facilitated Marketplaces (FFM), which are vehicles where individuals can shop for qualified plans. If an individual is between 100 and 400 percent of the federal poverty level and does not have access to an affordable and/or minimum benefit level plan, they may be eligible for federal subsidy. These subsidies are based upon the second lowest "silver level" health care plan available in the Marketplace. The subsidies provide a maximum payment level for a non-tobacco user, which ranges from 2 to 9.5 percent of ▶

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income. These subsidies are only available to purchases made through the Marketplaces. To learn more about subsidy eligibility, check out the subsidy calculator developed by the Kaiser Family Foundation at http://kff.org/interactive/subsidy-calculator/.

If an individual chooses to not purchase through the FFM in Virginia, he or she can purchase directly from the insurers who are offering individual policies. An individual may wish to obtain coverage outside of the Marketplace for a broader product selection. Many of the carriers in the Marketplace are offering limited product selections or plans with a smaller provider network than they traditionally would. My experience has been that in Virginia the only people utilizing the FFM are those who will likely receive subsidy.

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HEALTH CARE INDUSTRY SYMPOSIUM

Want to know more about health care reform and its effect on the accounting world? Join us on May 19, 2014, at the Williamsburg Lodge for the 3rd Annual Health Care Industry Symposium. Find out about the state of the health care industry in Virginia and connect with nationally recognized experts in the health care accounting field. Visit www.vscpa.com/HCIS for more information or to enroll.

SMALL GROUP IMPACT

A small group in Virginia is defined as an employer with at least two but less than 50 full-time equivalent (FTE) employees. There have been significant changes in the underwriting of this market as well. The key changes are:

- No medical underwriting or risk adjustment
- Age-band ratios can be no larger than 3:1 from the youngest to oldest
- Tobacco users may receive a 50 percent surcharge

Much like the individual market, these changes have led to varying effects on groups, depending upon their demographics and medical risks. Younger groups with less-than-average medical risks are being negatively affected from a rating standpoint, while older and/or high-risk groups are affected more favorably.

Groups with favorable risks may wish to pursue a strategy of self-funding, which will still allow for medical underwriting in 2014. This could lead to lower rates than we will see in the broader community-rated market. Self-funding in this context is greatly simplified, as compared to large group self-funding, with the carriers offering a turn-key approach. Essentially, a group is funded at the "worst case" scenario, and then if their claim experience is favorable to projections, some of the gains are returned. In addition, this approach also leads to more traditional rate structures of employee, employee plus spouse, family, etc. Under the PPACA, each employee receives a rate based upon their age with dependent/family rates being a compilation of each member's individual rates. These new age rating tiers are stated in one-year bands from ages 20 to 64. This is much more complicated to manage than the current rate tier structure to which we are now accustomed.

Conversely, groups with poor medical risks or older ages may seek to re-enroll under the post PPACA underwriting to take advantage of better pricing due to no medical underwriting and age band compression. The new community rates should be quite advantageous in certain situations. Groups will need to weigh the advantages and disadvantages of changing their renewal dates. Any employee amounts accumulated toward deductibles and out-of-pocket maximums will be reset. However, if the savings are large enough, this could be warranted.

LARGE GROUP IMPACT

Large groups are those with more than 50 FTEs in 2014, but the large group employee number requirement will change to 100+ in 2016. Right now, the overall effect on these groups is minimal. Employers are not required to provide coverage or face a penalty until January 2015, which is a delay from the original 2014 timeline. This is commonly referred to as the "play or pay" penalty. The penalty is $2,000 per employee minus the first 30 employees if there is no coverage offered, or if the coverage offered does not meet the minimum benefit level of bronze-level coverage. Bronze coverage is considered to be 60 percent actuarial value (i.e., 60 percent of medical costs are paid by the plan). Most of the employers I speak with are surprised at the relatively low level of coverage under the requirement. For example, a $5,000 high deductible health plan (HDHP) that pays 100 percent after the deductible generally meets this criterion.

For coverage requirements and penalties, the PPACA defines an employee as an individual working at least 30 hours a week on average. Determining whether an employee is benefit-eligible can be complex. The PPACA has many variables to measuring employees' work hours, which go well beyond scope of this article. The actual calculation requires a full analysis by a competent employee benefit consultant.

When it comes to "pay or play," the more difficult measure is affordability. If a 50+ employer offers a plan that is at the aforementioned minimum benefit level, it must also be affordable to avoid any possibility of penalty. The affordability penalty's safe harbor is based upon an employee's premium cost of the lowest level plan offered not exceeding 9.5 percent of the employee's Box 1 W-2 wages. If the expense exceeds this limit, forcing an employee to seek coverage from the Marketplace and receive a subsidy, the employer could receive a $3,000 per employee penalty for any employee in this situation.

Employers in this segment have several things to do to prepare for 2015:

1. Determine if you are a large employer (i.e., have more than 50 FTEs)
2. Determine if you will offer coverage. If so:
   a. Does your plan meet the minimum-value requirement?
   b. Is your plan affordable?
3. If you decide not to offer a plan, you must calculate your penalty.

Your employee benefit consultant should be able to assist with these decisions. The determinations of employer size, FTE calculations, minimum-benefit levels and affordability can be complex. This is an instance where it is not wise to "go it alone."

SUMMARY

The impact of the PPACA has broad and varying effects on employers and individuals. One's perception of whether the PPACA's mandated changes are positive or negative is situational. My opinion is the PPACA is here to stay in one form or another. The landscape and the law will surely change as time moves forward, and the degree of this change will likely be the result of public opinion and the country's fiscal limitations. Nonetheless, as individuals and business people, we need to move forward with the situation as we know it to be today, not how we how we hope it will be tomorrow.

Fully analyze your situation and maximize your positioning. In any case, there are activities you can undertake to manage your situation this year and in the future. Never has there been a time when is it so important that you seek help from qualified employee benefit advisors. The complexity that has now become a part of the health insurance purchasing decision warrants more analysis and better advice than ever before. To ensure you are positioned well now and prepared for the future, you and or your organization will need to seek answers and options. ■

Don't take the "ostrich" approach

According to legend, an ostrich will shove its head in the sand when confronted with something unpleasant. I think you'll agree - probably not the best approach.

Are you ready for health care reform changes?

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