HEALTH care

The Affordable Care Act at 5 YEARS

BY BRIAN MARKS, CEBS

The Affordable Care Act (ACA) has taken many turns since it was enacted on March 23, 2010. There have been multiple delays and clarifications since its passage. On its fifth birthday, here is an update of where the ACA stands in its implementation and key future milestones.

The ACA's impact has been immense. Its intent was to provide access to affordable health care coverage for all Americans, and public opinion has been divided since its passage. A recent Kaiser Health Tracking Poll found 43 percent of Americans have a favorable view of the ACA and 42 percent view it unfavorably. This division is likely a result of the law's varying effects on different individuals.

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

INDIVIDUAL MARKET

Since Jan. 1, 2014, all Americans are required to have minimum essential health insurance coverage or pay a tax. This tax has led to more complexity in our tax code and confusion among taxpayers. The tax for 2015 is the greater of $325 per person, or 2 percent of income, and the tax increases in subsequent years. All individual coverage is available on a guarantee-issue basis but must be purchased during the annual open enrollment period absent of a qualifying event. For 2016, the enrollment period will run from Nov. 1, 2015, through Jan. 31, 2016.

Individuals can purchase policies in the marketplace and receive a subsidy if their income is generally between 100 percent and 400 percent of the federal poverty level and they have no access to affordable minimum value coverage through an employer plan. These subsidies are only available to purchases made through the marketplaces. The Centers for Medicare & Medicaid Services (CMS) announced on March 31, 2015, that 10.2 million people have health insurance through federal/state marketplaces in 2015. Of these individuals, an estimated 85 percent will receive a federal subsidy for their coverage. CMS also stated that 7.5 million of these individuals live in states that utilize the Federally Facilitated Marketplace (FFM). FFMs operate in states like Virginia that chose not to establish their own marketplaces. At press time, the validity of the payment of a subsidy through the FFM is before the U.S. Supreme Court with the *King v. Burwell* case. The Court has heard arguments and was expected to deliver a decision in June. If the Court rules that these subsidies cannot be paid through FFMs, it will clearly have a major impact on the ACA.

Individuals who do not have access to employer plans and are not subsidy-eligible generally purchase plans in the private market (i.e. off of the marketplace) because many of the marketplace providers offer limited product selections or plans with a smaller provider network than traditional plans. However, most carriers' individual plans offer significantly fewer product choices, more intensive cost controls and more limited networks than their group programs. These factors, coupled with the tax-favored nature of group programs, appear to be driving some smaller groups that had traditionally had individual plans back to the group market. It's a trend I do not believe many people expected.

SMALL GROUP CHANGES EXPANDING TO 51–100 EMPLOYER GROUPS

A small group in Virginia has been defined as an employer with at least two but less than 50 full-time equivalent (FTE) employees. This definition will expand to 100 employees in 2016. There were significant underwriting changes to the 2–50 market in 2014 that led to major pricing disruptions:

>> No medical underwriting or risk adjustment

>> Age bands can be no larger than 3:1 from youngest to oldest

>> Tobacco users may receive a 50 percent surcharge

These changes had various effects on groups, depending upon their demographics and medical risks. Younger groups with less-than-average medical risks were negatively affected from a rating standpoint, while older and/or high-risk groups saw favorable results. Some groups with favorable risks negatively affected by these underwriting changes (many times with increases of 50 percent or more) pursued self-funding, which allows for medical underwriting. This led to lower rates than an employer with a favorable demographic and risk profile could obtain in the non-medically underwritten post-ACA market. Self-funding in this context is greatly simplified, as compared to large group self-funding.

Essentially, a group is funded at the "worst case" scenario, and then if its claim ▶

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TABLE 1. IRS FORMS REQUIRED FOR APPLICABLE LARGE EMPLOYERS' HEALTH CARE REPORTING

FORM	PURPOSE	USED TO DETERMINE IF ER OWES PENALTY	USED TO DETERMINE IF EE IS ELIGIBLE FOR SUBSIDY	WHO NEEDS TO FILE	INITIAL PERIOD FORM COVERS	DEADLINE (2016)
1094-C	ER reports summary information to IRS	X		Applicable large employer, generally 50+ FTEs	2015	Feb. 28 for paper; March 31 for electronic
1095-C	ER reports information about each individual employee covered	X	X	Applicable large employer, generally 50+ FTEs; if fully-insured, the carrier completes 1095-C Part III, employer does not need to complete	2015	Feb. 28 for paper; March 31 for electronic; 1095-C due to employees by Jan. 31
1094-B, C	ER reports information about employees enrolled in plan		X	ER offering self-insured health but is NOT an applicable large employer (generally less than 50 FTEs)	2015	Feb. 28 for paper; March 31 for electronic

FTE = Full-Time Equivalent per ACA
ER = Employer
EE = Employee

experience is favorable to projections, some of the gains are returned. Also, this approach leads to more traditional rate structures of employee, employee plus spouse, family, etc. The ACA mandated each employee receive a rate based upon their age with dependent/family rates as a compilation of each member's individual rates. These new age rating tiers are stated as one rate for those 20 and under in one-year bands from ages 21 to 64. Administering these age tiers is extremely problematic for employers that had been underwritten on community rates; the new age-rated approaches dramatically affected their employees. Some carriers offer the accommodation of conversion-to-rates as a billing option, while others do not.

Conversely, groups with poor medical risks or older ages were favorably impacted by the ACA changes. The punitive nature of individual underwriting no longer exists for medical conditions, and older members have pulled to the mean. Clients with high rates relative to the market pre-ACA enjoyed significant rate reductions in the 2–50 market in 2014.

All of these aforementioned small group changes that affected the 2–50 employer in 2014 will affect the 51–100 employer in 2016. Underwriting changes will create the same effects of winners and losers in this market segment. Therefore, employers will use the same strategies of eager acceptance or delay and/or avoidance. If these employers so choose and implement the appropriate strategies, they can delay ACA-mandated changes until Oct. 1, 2017, due to transition relief regulations in Virginia. 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 justified. It is wise to seek the counsel of qualified employee benefit professionals to ensure you fully understand all effects.

100+ GROUP IMPACT

The employer mandate has been in effect since Jan. 1, 2015, for employers with more than 100 FTE employees — commonly referred to as the "play or pay" penalty. The penalty is $2,000 per employee minus the first 80 employees (reverts to 30 employees in 2016) if there is no coverage offered, or if the coverage offered does not meet the minimum benefit level of bronze coverage. Bronze coverage is considered to be 60 percent actuarial value (i.e. 60 percent of medical costs are paid by the plan).

For coverage requirements and penalties, the ACA defines an employee as an individual

working at least 30 hours a week on average. Determining if an employee is benefit-eligible can be complex. Employees who work variable hours should be monitored closely. If their working hours exceed 30 during an established measurement period, they must be offered benefits to avoid the penalty.

If an employer offers a plan that is at the aforementioned minimum benefit level, it must also be affordable to avoid any possibility of a second penalty. The affordability penalty's safe harbor is based upon an employee's premium cost of the lowest level plan offered — not to exceed 9.5 percent of the employee's wages. If the expense exceeds this limit, the employee seeks coverage from the health insurance marketplace and the employee receives a subsidy, the employer could pay a $3,000 penalty for each employee in this situation. For most employers, this provision will affect them at their first renewal in 2015.

These employers should be monitoring variable hour workers, minimum value and affordability provisions to ensure they are in compliance. There are many variables to measuring these criteria that go well beyond this article. The actual calculation usually requires a full analysis by a competent employee benefit consultant.

EXPANSION OF THE EMPLOYER MANDATE

Transition relief delayed the implementation of the employer mandate until 2016 for most 50+ employers. (There is certain criteria employers are required to meet to obtain this relief. If you are unsure if you qualify, please contact your employee benefit advisor.) With transition relief, the employer mandate expands to employers with more than 50 FTE employees in 2016. These employers will be required to ensure all full-time employees (30+ hours a week) are offered coverage, that this coverage is at the bronze level and that it is affordable. If they do not, they will be open to the same penalties the 100+ employer faced in 2015. Now is the time to address these provisions to make sure you will be in compliance.

EMPLOYER REPORTING

Sections 6055 and 6056 of the ACA require all applicable large employers (ALE) to report information to the U.S. Internal Revenue Service (IRS) on Forms 1094 and 1095 relating to their health plans beginning in 2015. An ALE is any employer with more than 50 FTE employees. These reports are not due until early 2016, but will report upon 2015 information. The report will determine if employers are offering minimum value and affordable coverage. In addition, this information will be used to determine an employee's eligibility for subsidy. Table 1 explains the purpose, responsible party and filing deadlines of these forms.

CADILLAC TAX

In 2018, plans that offer benefits with that cost more than $10,200 for individual coverage or $27,500 for family coverage will be required to pay a 40 percent excise tax on premiums above this amount. There has been much debate on this issue, as it is not related to benefit richness but is cost driven (e.g. a poor risk or older group could have high rates and a plan with modest benefit levels). Nonetheless, it is a current provision of the ACA and employers need to be aware of its potential impact as they strategize and plan for 2018. It may be helpful to run projections now to determine the likelihood of this tax affecting plans. Early planning may eliminate drastic benefit changes later.

DISCRIMINATION TESTING

The ACA expanded discrimination testing to fully insured plans, but this portion was delayed in late 2010 and has yet to be enforced. The provision essentially disallows contribution structures, which favor highly compensated employees. Until its delay, discrimination testing was creating significant issues for employers who had different levels of contributions for employee classes. The penalty for non-compliance was $100 per day for each affected individual. I expect this provision to return in the future, at which point affected employers may need to adjust their contribution approaches to become compliant.

SUMMARY

The ACA has had a large impact on businesses and individuals over the last five years. While there are many details that go beyond the limits of this article, please reach out to me if you have specific questions relating to your organization.

When it comes to the ACA, my advice is to fully analyze your situation and then maximize your positioning. There are activities you can undertake to manage your situation now and in the future. Never has there been a time where 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 your organization will need to seek answers and options. ■

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