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Health care reform essentials

Ten things CPAs should know about the Affordable Care Act.

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The Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, created the most significant government health care program since the Medicare and Medicaid legislation in the 1960s. The law's complexity is compounded by the intricacies and interdependencies of health insurance and the health care delivery system that the legislation and related regulations have struggled to address.

CPAs have a significant role to play in helping businesses make the best health insurance decisions in an environment that has changed significantly as a result of the new laws. Here are 10 things CPAs need to know to steer businesses in the right direction:

1. Insurance Markets: Individual, Small Group, Large Group, and Self-Insured

The PPACA's underwriting provisions primarily affect the individual and small group insurance markets and have a smaller effect on the large group and self-insured markets, so it is important to understand which is which. Although its use is not required, the small group market exchange known as SHOP (Small Business Health Options Program) presently is available to employers with 50 or fewer employees, but it will be available to those with 100 or fewer employees in 2016. That redefinition of the small group market exchange is a critical event for affected employers because costs tend to be higher and benefits lower in the small group market than in the individually underwritten policies more available to the large group market.

Individual policies are a higher risk for insurers because they are managed one at a time. They are subject to different deductible and out-of-pocket limits under the PPACA. One thing CPAs should keep an eye on is that, if the pattern of "bad risk" in exchange-sold individual insurance policies continues, states may decide to exercise their option under the PPACA to "merge" the individual and small group risk pools into a single risk pool. This would lead to another dramatic premium increase for small employers. Massachusetts did this after its 2006 health care reform law went into effect.

The self-insured market is where many employers may want to be, and it warrants an analysis, especially if you have a "good risk" profile—such as young, healthy employees in a low-risk industry.

2. The Precious Metals of Health Insurance

The PPACA mandates certain coverage levels for the individual and small group markets that fall into four metal tiers, which are not based on the quality of care, but rather on the plan's actuarial value (AV), which is the amount that a plan pays toward medical expenses and the premium and out-of-pocket costs covered by the customer.

These metal levels are platinum (90% AV), gold (80% AV), silver (70% AV), and bronze (60% AV). All plans offered in these markets by carriers must fall within these parameters and cannot vary by more than ±2% from any AV (e.g., a gold plan could have an AV between 78% and 82%). This will cause plan offerings in the individual and small employer markets to clump around these AVs, which will lead to changes to plan options when renewals are made throughout 2014. In addition, these metal values are important to the large group market in 2015 for employers with 100 or more employees and in 2016 for employers with 50 or more employees, since an employer must offer a plan that meets a minimum value level (bronze) or potentially pay a penalty.

Among individuals selecting Health Insurance Marketplace plans, the silver plans overwhelmingly have been the most popular. Sixty-five percent of individuals selecting a Health Insurance Marketplace plan through April 19 chose silver plans, according to Department of Health & Human Services data. Bronze (20%), gold (9%), platinum (5%), and catastrophic (2%, available only to individuals) were considerably less popular. *Note:* The figures do not add up to 100% because of rounding.

3. Pricing and Benefits

All forms of insurance involve the actuarial measurement of the insurer's risk and cost of payout against the underlying coverage in the policy, and health insurance is certainly no exception. Certain covered benefits are mandated by the PPACA in the individual and small group markets, but this is not so in the large group and self-insured markets.

How those mandated benefits price out, however, can vary dramatically by state (each state defines its own benchmark plan); what hospital and physicians are available under the policies; the level of co-pays, deductibles, and maximum out-of-pocket expense; the prescription drug formulary; and a host of other factors making health insurance one of the most complex insurance products sold. The PPACA's new requirements have led to more complexity and greater costs with the addition of these benefits.

4. Government-Sponsored Exchanges

Basically, there is no reason to buy health insurance from the exchange unless you are looking for one of the PPACA's subsidies or credits or believe you are better qualified to evaluate it than an insurance agent. An exchange is a useful place to understand what is available in the small group market, but the same policies available on the exchanges must also be available in the "regular" small group market (but not the other way around), so you can research your options to determine whether subsidies and credits are available and before deciding whether you are comfortable choosing a policy without additional input.

Once established, the SHOP exchanges created by the PPACA for small businesses are supposed to enable small group market employers to buy coverage online directly from health insurers rather than going through an agent. Currently, only paper applications are being accepted, and online functionality is expected in November.

If Massachusetts is to serve as a harbinger, in the years since its 2006 reform, virtually all small group market policies are being sold outside of its exchange. The key reason a small employer would select this method of purchasing is that this is the only way for a business to receive the Sec. 45R small employers' health insurance premium tax credit.

5. Private Exchanges

Given health insurance's ever-increasing costs, some employers are opting for a defined-contribution approach to the delivery of employee benefits. This trend is much like the movement to Sec. 401(k) plans in the retirement arena over the past several decades. An employer essentially allocates a set amount to the purchase of employee benefits, and then the employee selects a plan from what is typically a much broader choice of options. In most instances, six to eight health plans are offered in addition to other benefits such as dental, life, long-term disability, etc. This approach is gaining popularity due to the predictable expenditures for employers and broader choice for their employees.

6. Individual and Small Group Underwriting Changes

The PPACA mandated certain underwriting criteria to the 50-and-under employee and individual markets in 2014. The key changes were no medical underwriting (i.e., risk adjustments) and age band differentials of no more than 3-to-1 from the youngest to the oldest. The pre-PPACA market allowed broad adjustments for risk, and age band variances could exceed six times or more depending on the insureds' location. The impact of these changes has been a movement to mean (or average) for rates, due to a compression in the age bands and the removal of risk adjustment.

This has clearly created winners and losers in this market segment. Older and/or high-risk groups are experiencing rate reductions, and younger and/or low-risk groups are experiencing large rate increases. For example, one practitioner related the story of a client in this segment with a favorable risk profile and slightly-younger-than-average-age workforce who saw a 113% increase this year.

CPAs need to be aware of the changes to assist clients and organizations in expecting and managing these changes. In situations where the PPACA is providing rating benefits, the new underwriting should be implemented as soon as possible. Conversely, strategies should be implemented to avoid or delay the changes where the impact is negative.

7. Self-Funded Plans

In situations where younger and/or low-risk groups are adversely affected by the small group underwriting changes mandated by the PPACA, self-funding may be an option. Self-funded groups are allowed to risk-adjust and use more traditional age band structures. Groups with the appropriate profile

may mitigate the PPACA-driven increases. Many carriers are allowing self-funding for groups as small as 10 employees.

Small group self-funding is a much more simplified “off the shelf” solution than in the larger group market. Essentially, the risk is assessed, and then a maximum liability rate is calculated. The group pays rates based on this maximum liability and then shares in the savings if group members meet certain claim-level criteria (loss ratio targets). For example, if a group had a claim target of $50,000 and only incurred claims of $30,000, this would amount to a savings of $20,000. However, these savings are likely to be reduced because these arrangements typically have provisions whereby 25% to 50% of these savings are split with the carrier.

In these arrangements, the group will not pay more than the calculated maximum exposure. This approach has been made more attractive because of the large impact underwriting has had on the younger and/or best risks when compared with the mean or carrier base rates.

Prior to the PPACA, insurance carriers in many parts of the United States would adjust premiums up several times for the worst risks and provide discounted rates of 25% or more for the best risks. In addition, they applied fairly broad age bands of six or more times from the youngest to oldest members. As lower-cost groups return to the PPACA’s more normative community rates, the increases can be large.

In short, this can be a solid strategy to avoid the 50%-plus increases some employers will experience at a group’s renewal in 2014.

8. Working Around the Play-or-Pay Penalty

The Sec. 4980H play-or-pay penalty or employer mandate is in effect for employers with at least 100 employees in 2015 and those with at least 50 employees in 2016. This PPACA mandate requires employers to offer a minimum value coverage level of bronze (60% AV) at an affordable level, generally no more than 9.5% of W-2 wages, or pay a penalty. Employers are required to offer benefits to any employee who works 30 or more hours a week on average. The penalty for not offering coverage is $2,000 per full-time employee (those working 30 or more hours per week) minus the first 80 employees for employers with 100 or more full-time employees including full-time-equivalent employees (FTEs) in 2015 and 30 in subsequent years for those organizations with at least 50 full-time employees including FTEs. If minimum value coverage is offered but it is deemed not affordable, the employer will be penalized $3,000 for any employee who purchases a plan on the Health Insurance Marketplace and receives a subsidy.

This has led many employers to carefully manage their part-time workers to ensure that those to whom they do not intend to provide benefits work less than 30 hours. In addition, many employers having trouble satisfying the affordability criteria may drive their benefits to the lowest possible levels allowed by the PPACA.

9. Employer Reporting

Employers will be affected by the PPACA reporting requirements in Secs. 6055 and 6056. Sec. 6055 is intended to assist the IRS in enforcing the individual mandate. It requires providers of minimum essential coverage and providers of coverage through an employer's group health plan to report information to the IRS about the type of coverage, the individuals covered, and their periods of coverage. It also requires that related statements be furnished to the individuals covered. Sec. 6056 is intended to assist the IRS with enforcement of the employer mandate. It requires applicable large employers to report to the IRS information about the coverage they offer to their full-time employees and requires them to furnish related statements to employees.

The filing requirements for both Secs. 6055 and 6056 begin with the 2015 calendar year (although employers may voluntarily report for 2014). Reports are due by Feb. 28 of the following year or March 31 if filed electronically. Employees are required to be notified by Jan. 31. These reporting requirements may lead to significant data collection issues for many organizations that currently do not capture this information. The time to begin preparing is now since the data file structures will need to be ready for reporting based on 2015 data.

10. Limited Network Plans

These plans caught the (negative) attention of the media as insurers looked to develop plans for the exchanges that met affordability and coverage requirements, and, as a result, many people found they could not keep their doctor. Limited network plans should not be overlooked by employers as one option, however, and this advice applies regardless of employer size. As was observed above in the discussion of setting insurance premiums, the insurer's cost of providing coverage drives the premiums. The competitive structure of health care markets is likely to result in hospitals, physicians, and other health care providers in the same geographic area getting paid very different rates for their services.

For example, an employer may be 20 miles from a major city that has a number of teaching hospitals. These hospitals get paid very high rates for providing much the same care that a local community hospital provides. Depending on how the health insurer sets premiums, employers are likely paying a share of the higher cost of the teaching hospitals even though their employees receive care locally. A limited network plan that excludes the teaching hospitals for care available locally, or one that charges a higher co-pay or deductible for being treated at the teaching hospital, can be a premium-saving alternative.

SUMMARY

The PPACA presents a series of challenges and opportunities, some of which are apparent and many of which have yet to be seen. CPAs can assist their clients or employer by staying on top of developments in this area and serving as the first contact in coordinating the team of advisers necessary to get the best result.

As the suggestions above indicate, numerous strategies are available to businesses as they try to make the best health insurance choices for themselves and their employees in this new regulatory environment. Choosing the right plan requires the knowledge to make the right choice.

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AICPA RESOURCES

JofA articles

- "Claiming the Small Employer Health Insurance Tax Credit (/issues/2014/feb/20138629.html)," Feb. 2014, page 48
- "Planning for 'Play or Pay': New Employer Health Care Rules (/issues/2013/jun/20137339.html)," June 2013, page 58

Conference

Healthcare Industry Conference, Nov. 6–7, Las Vegas

For more information or to make a purchase, go to cpa2biz.com (http://cpa2biz.com) or call the Institute at 888-777-7077.

Websites

- Health Care Reform Resources Center (http://tinyurl.com/na25lsv)
- PCPS Health Care Reform Toolkit (http://tinyurl.com/oa63rk6)