

TAKING THE **PULSE** OF THE AFFORDABLE CARE ACT

For many reasons, health care access and affordability is becoming more difficult. There are new ways to make health insurance more affordable for some CPAs and their clients, but real issues plaguing the health care system continue to exist.





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The Affordable Care Act (ACA) has been the topic of much debate since it passed in 2010. Repeal attempts have been numerous — 70+ by most counts — and the political dialogue has been unending. Nonetheless, at the writing of this article in July 2018, the ACA for the average business or individual remains relatively unchanged. The fundamental goal of the ACA was to enhance the affordability of, and access to, health care. The method for this objective largely focused on the health insurance markets. Its implementation created winners and losers in the process. In my opinion, many of the ACA reform proposals we have seen recently, reform of health care reform, deal with new issues of affordability and access created by the ACA itself.

The intent of this overview is to make you aware of a few of the responses to what would be viewed by many as negative impacts of the ACA. Again, I agree there are two sides to every issue and there were clearly benefactors of the law. However, for this summary, I will focus on various activities and strategies that have been implemented to address some of the ACA's unintended consequences.

INSURANCE ACCESS FOR SOLE PRACTITIONERS

Virginia SB 672 expanded the definition of a small group in Virginia to include single member organizations, or those businesses run by a sole practitioner. This bill was a direct result of the large individual health insurance premium increases and limited carrier choices we saw in 2018. Large portions of Virginia have just one carrier choice, and rates in

2018 went up an average of 57 percent based upon carrier filings with the Virginia Bureau of Insurance. Charlottesville was hit particularly hard — according to a recent Kaiser Family Foundation study, it has the highest individual rates in the United States this year.

Individual insurance buyers on the marketplace receive subsidies to help pay their premiums (about 85 percent of individuals historically) and are not impacted by these high rates since the amount they pay is a fixed percentage of their income. However, many CPAs' and other small business owners' income levels are too high to receive subsidies and they paid those huge insurance premium increases in 2018. The intent of SB 672 is to provide some relief for this group, either via carrier choice, product selection and/or rates.

The criteria to be considered for these plans can be somewhat restrictive. The definition of a sole proprietor is an individual who derives a substantial portion of his or her income from a trade or business:

- operated by the individual as a sole proprietor;
- through which the individual has attempted to earn taxable income; and
- for which the individual has filed the appropriate U.S. Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year.

The law is clear that the organizations can only have one owner. That is, any jointly owned organizations will not qualify. If a solely owned business qualifies, they may receive significant advantages over ►

Know this...

- Despite the political dialogue, currently, the Affordable Care Act (ACA) as it affects the average business or individual remains relatively unchanged.
- A new Virginia law, effective July 1, allows sole practitioners to qualify as small businesses under the ACA and obtain health insurance available to small businesses in Virginia — potentially resulting in significant cost savings for sole CPA practitioners.
- The Tax Cuts and Jobs Act removed the individual tax penalty for individuals not having coverage beginning Jan. 1, 2019, which is currently being challenged in court by 20 states.

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the available alternatives in the individual market, absent a premium subsidy. I see the key advantages as follows:

Improved carrier choices

By allowing sole practitioners to qualify for insurance afforded to small groups, they will be able to take advantage of the insurance carriers available to small groups — notably that there are usually more options in a given market. In most portions of Virginia, there are at least three carriers available for small groups where there may be just one for individual plans.

Better plan choices

The individual market generally has limited plan options available in comparison to the group market. For example, Virginia's largest health insurer, Anthem, has 10 individual plans available this year, which is more than some of their competitors. Conversely, they have 55 small group plan options from which to choose. This is further compounded in that they have limited the individual plan options to a smaller area than their full service area. In addition, the individual plans from most carriers typically utilize a more limited network and institute the greatest cost control measures available, such as primary care physician referrals and more restrictive drug formularies. This is not to say these cost controls measures are not acceptable; however, the inability to pay more for flexibility is troublesome. Options are simply not available in many areas.

More competitive pricing

Due to many factors, individual plans are not priced as competitively as small group options. Based upon my personal experience, I have routinely seen individual prices 50 percent or more above comparable group plan options in many instances. In addition, the price increases in the individual plans have been much larger. For 2018, the average individual plan in Virginia increased

57 percent versus 7 percent for small group plans, according to Virginia Bureau of Insurance filings. The initial data for 2019 is similar, but not so dramatic — 19 percent and 8 percent, respectively. In short, currently the small group market has better and more stable pricing than the individual market options.

I anticipate this change to be well received by sole member organizations as a solid alternative to the ACA individual options available. My firm has already had many inquiries about this from sole practitioners who hope to benefit.

SELF-FUNDING FOR SMALL EMPLOYERS

The ACA underwriting changes created winners and losers within the small business community. The compression of age bands to three times from youngest to oldest (it had routinely been six

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or more) and the removal of medical underwriting essentially pulled all groups to the mean. Groups with older employees, or with more medical conditions, received rate reductions. Conversely, groups with younger employees, or with few medical conditions, saw large rate increases, sometimes in excess of 100 percent. So how can small businesses mitigate the impact of these changes? Many carriers implemented self-funding approaches to organizations with five or more employees as a response to these changes.

Self-funding in the small employer market is based on the same concepts utilized for larger employers, just somewhat simplified. Self-funding allows a carrier to underwrite medical risk, which is not allowed for small group fully insured plans, and eliminates some of the ACA taxes — most notably the Health Insurer Tax, which adds several percent to a fully insured premium.

By removing a group from the underwriting methodology of the ACA, organizations with younger and/or healthier employee populations can benefit from lower rates. These arrangements are typically fully funded for smaller employers, with a maximum liability exposure built into the funding arrangement. If structured properly, the overall risk of claim exposure can be mitigated. However, these plans need to be evaluated with competent advisory assistance to ensure an organization is properly protected.

Self-funding can also open the possibility of a return of premium for an employer. Most carriers that offer self-funding will return a portion of the estimated claim fund if the group's experience is favorable. The percentage of savings returned can vary among carriers, and even within options of a carrier. This approach can also benefit employers that wish to be more engaged in cost control and wellness initiatives. Again, small employer self-funding is not a solution for every employer. However, it can offer solid advantages to some employers over the ACA options available.

LEGAL CHALLENGE WILD CARD

The Tax Cut and Jobs Act removed the individual tax penalty for individuals not having coverage beginning Jan. 1, 2019, prompting a lawsuit from 20 state attorneys general (*Texas v. United States*). This legal action challenges the ACA as being unconstitutional without the tax in place. In its 2012 decision, the U.S. Supreme Court was deemed the tax penalty to be the key reason the ACA had not violated the Commerce Clause. The U.S. Department of Justice (DOJ) currently has elected not to defend the individual mandate and components of the ACA it sees as interrelated (pre-existing conditions and community rating). The DOJ believes that without the tax, those elements will be unconstitutional in January

2019. However, the DOJ also stated that removing the penalty would not affect many other components of the law, such as subsidies, marketplaces and Medicaid expansion.

The reintroduction of these risk management components, if it occurs, would throw the ACA and the insurance markets into turmoil in the short term. As of this writing, the real overall impact is indeterminable. The removal of the pre-existing condition language and the rating methodology of the ACA make it near impossible for carriers to effectively price the possible risks going forward in our current ACA world. What remains unclear is the impact of responses to this situation by any governmental branch. One thing is certain, however: The ACA will remain in turmoil for the foreseeable future with little hope of any concrete resolution to its operation.

REAL ISSUES

The ACA was an attempt to aid in the affordability and accessibility of health care in America. I personally believe the fundamental flaw in its approach is that attempted to do so by reforming health insurance, not health care. That is akin to altering the terms of a mortgage with no regard to the value of the underlying home. The real issue is health care system costs, of which the health insurers are only one component of the equation. What we truly see with the ACA today is the underlying issue of unaffordability of health care in our society. I believe we have approached medical care as an unlimited resource and have applied few market forces to its control for many decades.

Health care in America is immense at roughly 18 percent of Gross Domestic Product — and it is increasing rapidly. The net effect is that health care spending continues to crowd out other needs and resources. When asked, I often say explaining health care cost is simple — it is the number of units of care multiplied by the cost of those units. That is, it is no different than any other economic good. The question of how you control the total costs is much more difficult, however, in the emotional realm of health care, where quality and outcomes is incredibly subjective. In my opinion, the ACA has done little to address the real issue of costs, only how we finance it all.

I believe we will not come close to a solution on health care in America without an injection of market forces. We simply have no free market competition in the space. Also, due to a multitude of factors, there is a lack of good information, or incentive, to make cost-effective health care decisions. There is poor, sometimes nonexistent, transparency in health care pricing. I believe we will never impact health care expenditures until we effectively incentivize individuals to access care in the most cost-effective setting. I do believe this is possible if we effectively design ►

benefit plans to encourage people to access care from the most cost-effective providers of medical services. Of course, this is much easier said than done. Our system can be fragmented, and it is difficult to determine who or what is the best solution for your health care needs. Most of us evaluate a car purchase with much more effort than a medical procedure. That makes sense when you consider there is better information available on automotive options — and when you factor in that you pay the full cost of the car yourself, while most of us only directly pay a small portion of our health care.

WHAT NEXT?

In the long term, I do hope we will see some connection between cost and quality in our system. Regardless of how it happens, it does need to occur. I believe the government can assist by implementing policies that encourage and reward competition. The ACA has limited the incentive for solutions by removing the ability of those in my industry to have tools to innovate and

deliver cost-effective solutions. Concepts like the medical loss ratio requirements have made it difficult for smaller carriers to survive. Limits on plan designs have made it much more difficult to innovate.

What remains clear is we need to work as an industry to reduce medical costs overall. This can be done by encouraging efficiency from consumers, care providers and insurance companies. I am confident the ultimate solution will be found in competition in a free market, not with more regulations that put real solutions further out of reach. Stay tuned. ■

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