THE AFFORDABLE CARE ACT: CHALLENGES AND OPPORTUNITIES FOR EMPLOYERS AND ADVISERS

Prepared for

INDEPENDENT INSURANCE AGENTS & BROKERS OF AMERICA, INC.

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EXECUTIVE SUMMARY

The Affordable Care Act has permanently altered the health insurance industry and is a topic of tremendous importance to agents and brokers in all areas of insurance and financial advising. For many brokers, there are substantial changes to the marketplace that necessitate considerations of changing business models, including adding consulting services and supplemental insurance products. Advisers must remain ahead of emerging trends, develop referral relationships with navigators, and seek out new business in areas of growth, namely an increase in self-funded plans, consumer-driven health plans and private exchanges. Meanwhile, advisers must be certain that they maintain accurate sources of information and maintain or expand their online presence and accessibility through mobile platforms.

The reform law has and will continue to impact insurance plans differently depending on the type of market the plan is considered. The individual and small group markets are those most directly affected by the Affordable Care Act. Most notably, individual and small group plans must now cover a series of ten essential health benefits, as well as severely limit cost-sharing and deductibles, and conform to the actuarial value of one of four metallic tiers. For plans in those markets, the era of determining premium rates based on medical underwriting is also over; all individual and small group plans must conform to community rating criteria, basing premiums on age, geographic location, family size and tobacco use. Large group plans are spared some of the more restrictive requirements, at least for a few years. However, large group plans are prohibited from denying coverage to an applicant on the basis of a pre-

existing condition, of requiring cost-sharing above established limits or imposing either lifetime or annual dollar limits on any essential health benefits that a policy covers.

For most employers, the Affordable Care Act requires little, but does impose requirements on larger employers that will have a financial impact on those business organizations that do not offer employees health benefits and trigger a series of decisions for nearly all employers about whether to adjust the means of providing health benefits. Advisers must prepare employer clients to avoid the imposition of an annual penalty of $2,000 per full-time employee and review health plans offered to avoid a $3,000 penalty if a full-time employee receives a tax credit for a plan through an exchange. For employers of all size, particularly those who self-fund their plans, advisers must be knowledgeable of forthcoming tax consequences and reporting requirements beyond the employer mandate, including a tax on benefit-rich plans, a Medicare surtax on high wage earners, and a transitional reinsurance fee. For smaller business, the law creates opportunities to purchase group coverage through a small business exchange and potentially to qualify for a tax credit to reduce the cost of that purchase. Statistically, a very small number of employers will be impacted by the tax penalties that can be assessed beginning between 2015 and 2016, and experience from a similar regulatory scheme in Massachusetts indicates that the rate of employer-sponsored insurance will remain stable or even increase in the coming years.

Millions of Americans will obtain health coverage as a result of the Affordable Care Act and millions more will benefit from the increased financial and health security that results from being protected against excessive out-of-pocket costs that lead to bankruptcy, from never being able to lose or be denied coverage, and from never having a dollar limit placed on coverage for expensive and chronic conditions. Nationwide change, however, is almost never positive for all and almost always entails risk and uncertainty. The Affordable Care Act has ushered in tremendous uncertainty for many, as well as financial strain and limited choices for others. Included among those impacted are financial professionals. Agents, brokers and financial advisers must proactively adapt to new requirements and regulations and a changing marketplace to ensure viability and success in a post-reform era.

INTRODUCTION

On March 23, 2010, the nature, availability and cost of health insurance in the United States was permanently altered with the enactment of the Patient Protection and Affordable Care Act (PPACA). That piece of legislation, coupled with the Health Care and Education Reconciliation Act, signed one week later as a legislative fix due to political changes since the passage of PPACA, became known as the Affordable Care Act (ACA). Reforms, including unprecedented new requirements on insurance plans and carriers, gradually went into effect between the spring of 2010 and early 2014. The most impactful reforms took effect January 1, 2014, effectively ending medical underwriting, creating a new individual market and, for the first time ever, requiring nearly all Americans to obtain a particular product. For agents and brokers in the health insurance industry, it has been a time of often competing outlooks, ranging from the hopeful to the uncertain to the downright fearful. This white paper discusses the Affordable Care Act and the post-reform world of health insurance, with particular focus on the impact on insurance agents and brokers in 2014 and beyond.

THE HEALTH INSURANCE MARKETPLACE POST-REFORM

For insurance agents and brokers who offer, sell and write health insurance policies, the passage of a law that requires nearly all Americans to purchase their product may seem like a windfall sent from Washington. However, for many agents and brokers the health care reform law has brought concern that this particular profession may go the way of a typewriter salesman after the first personal computer

was released, or any other industry on the verge of obsolescence. There is little reason to believe that insurance advisers[1] will face obsolescence in the coming years. The ACA primarily upends the individual market, so advisers who have dealt with the 10-15 million Americans who purchase health plans through the individual market are the most likely to see a change in clients or business opportunities. The reason for that is the existence of the Health Insurance Marketplace, also known as the Exchange, accessible through healthcare.gov. However, individuals selecting and purchasing health plans for themselves and their families still need guidance on which plan is the right choice for their health and financial needs. As of late last year, brokers who sell Qualified Health Plans (QHPs) are able to have applicants apply for the tax credits that subsidize the cost of premiums[2], meaning that many brokers will be able to sell a government subsidized product that millions of new potential customers are seeking.

For brokers who deal with large group clients, little is changing, with the exception of the level of confusion on the part of clients, which leads to an increased need for skilled and capable brokers. However, even for those who work with large group clients, uncertainty abounds. Many believe that the Affordable Care Act is the beginning of the unraveling of the relationship between employment and health insurance. Others believe that the federal requirement that large employers offer health

[1] For ease of language, I will generally refer to "insurance agents and brokers" collectively as "advisers" where a distinction is unnecessary or immaterial.
[2] Timothy Jost, "Implementing Health Reform: A Closer Look At Direct Enrollment By Insurers." Health Affairs Blog, November 20, 2013. Available at: http://healthaffairs.org/blog/2013/11/20/implementing-health-reform-a-closer-look-at-direct-enrollment-by-insurers/

benefits will lead to an increase, or at least to stability, in the number of employers who offer benefits and therefore require the services of a health benefits adviser.

Uncertainty breeds confusion. When it comes to the Affordable Care Act, it may seem as though nearly everyone is very confused. If clients and potential clients are confused, it is imperative that advisers become well-informed. Even for those clients who may purchase their plans through a state or federal exchange, there may be ample opportunities for advisers with expertise in health care reform to offer themselves as a fee-for-service consultant or to shift to a focus on supplemental insurance products.

Risks and Incentives of Health Care Consulting

Consulting should not be viewed as a replacement to the role of an agent or broker, but rather a supplement that allows the adviser to more fully serve the needs of a range of clients. Consultants provide expertise, guidance and solutions separate from the selling and writing of health insurance policies. Focusing on consulting, however, poses risks. First, the need for consultants will gradually diminish. In a matter of a few years, the changes implemented by the ACA, including the complex regulations and reporting requirements, will be well understood by most players in the field and the need to receive outside guidance on reform-specific issues will be substantially less. Secondly, it may not be clear to many clients why there is the need to begin with. They can easily obtain information, albeit cumbersome and potentially unreliable, online and either will turn to their broker for advice or not offer health benefits at all and have no real need for consulting. Thirdly, there is likely to be little opportunity for maintenance

of service in health care consulting. That is, even if a client sees the need for a consultant and pays for a service, that is not likely to turn into a continuous or repetitive relationship in the same way that an insurance broker or even an accountant or attorney will be able to repeatedly offer new services to the client. For example, if a client pays a consultant to design a strategy for avoiding tax penalties, that strategy will presumably remain fairly static and be a one-time sale to the customer, rather than the start of an ongoing and lucrative professional relationship.

There are, however, strong incentives to include consulting as a service available through an adviser. For group clients that will continue to offer health benefits, they will require both brokerage services to sell them a plan and consulting services to help them navigate the various reporting requirements, tax implications and new plan designs. As employers look to modify benefits to save money, they may require the services of a consultant to design a benefits package that fits their needs and budget, rather than someone to sell and write a plan for their organization. Organizations that do not offer benefits but will be required to in 2015 will need professional advice to navigate waters they have never before entered. Gaining an expertise in health care post-reform also opens doors to other clients for a financial adviser, including medical providers and governments. Many people are highly confused and very nervous about the implementation of this law, which means the sharing of knowledge can assuage many concerns, clarify facts and put potential clients both at ease and on a path to financial security.

Consultants may establish one of several means of charging for their services, and thus increasing their income potential. These include:

- Charging by the project: the consultant determines the expected number of hours that she will work on the project and then multiply that by the hourly rate
- Per diem rates: clients would pay the consultant a fee based on the number of days spent advising or preparing a package
- Performance-based fees: successful consultants will lower the health care costs for their clients. Consultants can then charge their clients a percentage of the savings obtained
- Long-term contracts: much like a retainer agreement, this is a popular option for consultants dealing with large group clients who will periodically have questions and issues that arise.

Particularly for advisers who are branching out into consulting for the first time, it is important to network with other professionals and form strategic alliances. A successful consultant will have relationships with area attorneys, accountants and other financial planners from whom and to whom clients will be referred while ensuring that all of the client's professional needs are satisfied. Consultants and those seeking to add consulting to their range of services should be careful to obtain current guidance from their state insurance, health or financials services department to ensure that they are in compliance with any applicable laws.

States Requiring Separate Consulting Licenses

The following states require a consulting license separate from the broker's producer license:

State	Licensing Information / Contact
Georgia	http://www.inscomm.state.ga.us/Agents/Forms-Counselors.aspx
Indiana	http://www.in.gov/idoi/2479.htm#7
Kentucky	http://insurance.ky.gov/static_info.aspx?static_id=61&MenuID=66&Div_id=2
Maine	http://www.maine.gov/pfr/insurance/producer/licforms.htm
Maryland	http://www.mdinsurance.state.md.us/sa/producer/insurance-advisor.html
Massachusetts	http://www.mass.gov/ocabr/docs/doi/producer/candidate-licensing-handbook.pdf
Montana	https://www.asisvcs.com/publications/pdf/122700.pdf
Nebraska	http://www.doi.nebraska.gov/license/apps/Individual%20Consultant.pdf
New Jersey	Consult State Insurance Department
New Mexico	http://www.osi.state.nm.us/agent-

	licensing/docs/individual-applications/insurance-consultation-application-250.pdf
New York	http://labor.ny.gov/stats/olcny/insurance-consultant-general.shtm
North Dakota	http://www.nd.gov/ndins/producers/otherlicenses/consultant/
Oklahoma	http://www.ok.gov/oid/Licensing_and_Education/Licensing_Forms.html
Oregon	http://licenseinfo.oregon.gov/index.cfm?fuseaction=license_seng&link_item_id=1523
Texas	http://www.tdi.texas.gov/licensing/agent/revaglityplhic.html
Utah	https://insurance.utah.gov/agent/producers/special.php#consultant
Vermont	http://www.dfr.vermont.gov/insurance/producer-licensing/consultant-license-info
Virginia:	http://www.scc.virginia.gov/boi/pro/files/consult.pdf

Major Trends in Employee Health Benefits

Successful advisers will endeavor to be a step ahead of their competition, which requires being prepared for emerging trends. Like any major piece of legislation or new

institutions, the ACA has led to and will continue to lead to countless unintended consequences. Nothing in the text of the law or its implementing regulations envisions or foreshadows these trends, but the changed nature of the health insurance market will lead to an increase in three major trends: (1) an increase in self-funded plans, including among smaller companies; (2) a continued rise in the popularity of consumer-driven health plans; and (3) an increase in private exchanges among very large employers.

Self-Funded Plans: Large employers already tend to fund their own health benefit plans, rather than purchasing group coverage through a carrier. Health insurance organizations are overwhelmingly planning for an increase in self-insurance as the post-reform era begins.[3] This will include medium-sized and small businesses. Self-insurance poses a greater financial risk for business organizations and requires greater administrative overhead on the part of the employer, but the exemption from certain ACA provisions may be enough to encourage self-insurance among a wider pool. Generally, self-funded plans are not stand-alone in nature; rather, they are paired with stop-loss insurance to cover the most catastrophic claims that would otherwise seriously threaten to bankrupt a company. The employer who self-insures is paying directly for claims and therefore assumes all risk. Thus, if an employee – or several – were to be diagnosed with cancer or another serious, expensive medical condition, the

[3] Kathryn Mayer, "PPACA spurs rising interest in self-funded plans." BenefitsPro, April 15, 2013. Available at: http://www.benefitspro.com/2013/04/15/ppaca-spurs-rising-interest-in-self-funded-plans

employer is responsible for covering those costs, which can be staggering. Stop-loss insurance, quite simply, prevents such a financial loss.

Increased self-funding is good news for advisers. Employers of any size – but particularly smaller employers – cannot administer benefits without the assistance of a broker. Sending employees onto the Exchange, on the other hand, can easily be done without a broker. There are numerous benefits to employers that self-insure and a health insurance adviser can explain these benefits. By self-funding a plan, the employer enjoys the flexibility to tailor health care benefits to meet employees' needs. There are also significant financial benefits: self-funded plans generally cost less than commercial insurance and give employers more control over health care expenditures[4]; employers pay for the cost of their employees' care and not a set amount to an insurer; they are generally exempt from state premium taxes; and when health care costs are reduced, the employer collects the savings, rather than the insurer.

Self-funded plans are exempt from any medical loss ratio requirements, can continue to medically underwrite, need not provide a package of essential health benefits nor guarantee issue or renewability. Those benefits may be enough to encourage smaller firms to consider self-funding – and employee benefit advisers should accordingly be prepared to capture that market.

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[4] Deborah Chollet, "Self-Insurance and Stop Loss for Small Employers." Mathematica Policy Research, 2012. available at
http://www.naic.org/documents/committees_b_erisa_120626_chollet_self_insurance.pdf;
See also, Self-Insurance Institute of America, Inc. "Self-Insured Group Health Plans," available at
http://www.siia.org/i4a/pages/Index.cfm?pageID=4546

Consumer-Driven Health Plans: Consumer-Driven Health Plans, including products now familiar to many such as Health Savings Accounts and Flexible Spending Accounts, have been surging in popularity for well over the past decade. As employers will continue to face rising premiums due to high cost of health care coupled with new, often costly requirements of the ACA, these consumer-driven health plans will be a favorite choice of both employers and employees looking to save money. As the "Cadillac tax" approaches on 2018, imposing a 40 percent surcharge on insurance plans with higher costs, many employers will likely shift benefits to the less-regulated and more tax advantaged CDHPs. CDHPs are favored by employees for the freedom to spend as they choose and the ability to control costs oneself and are noticeably less expensive: the average cost of family coverage through a CDHP is $1,500 less annually than coverage for a family through a preferred provider organization (PPO).[5]

Consumer-driven health plans are also likely to see an increased usage as a direct result of the ACA. The reform law creates the SIMPLE Cafeteria Plan (an acronym for "Savings Incentive Match Plan for Employees"), which allows smaller employers (those with an average of 100 or fewer employees in either of the previous two years) to establish an employer-sponsored plan through which employees may choose traditional health plans, consumer-driven plans, fringe benefits, cash or a combination thereof. In addition to the tax savings provided to both the employer and employee, the Simple Cafeteria Plan is exempt from IRS Nondiscrimination rules, meaning that

[5] Employer Health Benefits: 2013 Annual Survey. Kaiser Family Foundation & Health Research and Educational Trust. August 2013. p. 22. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf

employers may offer a more generous benefits package to highly compensated employees. As Simple Cafeteria Plans are designed to include products like HSAs and FSAs, the expansion of cafeteria plans to smaller employers will likely lead to an increase in consumer-driven health plans.

Private Exchanges: A 2013 study by the consulting firm Accenture estimated that one million people would enroll in health plans through private exchanges that year, but predicted that 40 million would enroll in 2018.[6] Private exchanges operate as online marketplaces (separate from those found through healthcare.gov) for a single large employer or a group of large employers that offer a range of health plans from different carriers, administered through a private facilitator. One such private entity is Aon Hewitt, which in 2014 has 600,000 lives covered through a private exchange that it operates for eighteen companies.[7] Aon Hewitt built the exchange from the ground up, starting only in April 2013.

While the Affordable Care Act neither directly creates nor explicitly envisions private exchanges, their growth is yet another unintended consequence of the changing health insurance market. In addition to the changing marketplace, a handful of reforms stemming from the ACA make private exchanges more attractive. The Affordable Care

[6] "Are You Ready? Private Health Insurance Exchanges Are Looming." Report by Accenture, 2013. Available at: http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Are-You-Ready-Private-Health-Insurance-Exchanges-Are-Looming.pdf

[7] Aon press release, "Multiple U.S. Organizations, Including Walgreens, Will Offer Employees More Choice and Control Over their Health Benefits Through the Nation's Largest Multi-Carrier, Private Health Exchange." September 18, 2013. Available at: http://ir.aon.com/phoenix.zhtml?c=105697&p=irol-newsArticle&id=1855857

Act standardizes health insurance as a product, allows for comparison-shopping, and opens the pool of potential enrollees by millions. With plans rated using the metallic system of platinum through bronze, coupled with the availability of easy-to-read summaries of benefits and coverage (SBC), consumers are better able to compare plans. The prohibition on exclusions based on pre-existing conditions now in effect means that consumers no longer have uncertainty as to whether they can actually enroll in a plan if they choose to apply for one through an exchange, private or otherwise.

Not all private exchanges are created equal, and advisers should look for certain features of a successful private exchange. Included among those are the facilitation of payment. A private exchange must offer an efficient, user-friendly means of purchasing health coverage, whether it is employer-subsidized coverage or a plan on the individual market. A successful private exchange will integrate features such as online payments through credit or debit cards or automatic bank transfers that allow for both the employer and employee to pay on time with ease. Private exchanges can also lead the way in making defined contribution accounts for health benefits an increasingly attractive option for employers. A private exchange with a simplified and integrated payment system can effectively take nearly all involvement, oversight and responsibility for health benefits out of the hands of employers and place that with consumers and advisers.

Variety is critical for private exchanges to do well. A strong exchange requires a wide range of major medical plans, usually an inventory of at least 10-20 plans ranging from plans with high out-of-pocket costs to plans with no out-of-pocket costs.

As discussed later in this white paper, the availability of supplemental or ancillary benefit products is increasingly important post-reform and these products should play a key role in any private exchange. This will allow a consumer shopping on a private exchange to choose a low-cost health plan alongside supplemental benefits to create a more robust benefit package without as high of a price.

Decision support tools should be a part of any private exchange – and brokers should be accessible, as well. Consumers should be able to compare plans and their benefits, services and costs side-by-side, along with technology that makes recommendations based on the consumer's needs and the ability to connect with a knowledgeable broker.

Despite the technical issues when healthcare.gov was launched, the concept of being able to compare plans online and shop around for the best value is highly appealing to both consumers and employers and private exchanges can fulfill that concept while keeping control and flexibility in the hands of the employer – and keeping brokers in business. Private exchanges present a tremendous growth opportunity for brokers. Brokers play the key role in educating employers about private exchanges, in selling the supplemental benefit products not available on the public exchange, and helping consumers navigate a wider range of health plans than most are accustomed. They are a viable product for the next generation of consumers and skilled brokers and benefit consultants will likely profit from having a large number of prospective clients and customers to whom they can sell a variety of insurance products.

Promoting and Selling Accountable Care Organizations

Among the primary goals of the Affordable Care Act is to reduce the overall growth of health spending, particularly relative to inflation. One of the vehicles available to achieve this goal is the concept of Accountable Care Organizations (ACOs). The framework for establishing ACOs was envisioned by the ACA, with final regulations issued in October 2011 and the ACOs have been in place since early 2012. An ACO is a collaborative group of medical providers, including primary care physicians, specialists, hospitals, pharmacies and other care professionals (such as social workers and nurses) who coordinate the care they provide to Medicare patients (as well as, now, non-Medicare patients), primarily those with chronic conditions with the incentivized aim of lowering costs by reducing duplicative services, hospital readmissions and medical errors. While Medicare, and in turn most private carriers, have long operated under a fee-for-service model, the ACO model aims to financially reward the provision of better quality care, rather than merely quantity of services.

The paramount incentive for those operating an ACO is the ability to profit from the cost savings achieved. The Centers for Medicare and Medicaid Services (CMS) established two payment models for ACOs: the one-sided model, in which the organization participates in shared savings for the first two years, then, beginning in the third year of operation, assume shared losses in addition to the shared savings; and the two-sided model, in which ACOs participate in both shared savings and losses for all three years. The one-sided model poses less immediate risk, but ACOs have a

maximum sharing rate of 50 percent in the one-sided model and a higher maximum sharing rate of 60 percent in the two-sided model, provided that the ACO achieves the two percent minimum shared savings rate threshold.

Accountable Care Organizations present a tremendous opportunity for insurance carriers and health plans to monetize a successful, popular and profitable concept – and for brokers to encourage enrollment in them. Thus far, few plans have created benefit packages centered around specific ACOs, which would give particular plans a strong competitive advantage.

Initiating or Expanding Supplemental Insurance Product Sales

Supplemental health insurance or ancillary benefits – the products that consumers purchase in addition to traditional health insurance have been among the fastest growing segments of the employee benefits industry, not in the least because of the effects of the Affordable Care Act. This trend has been seen before, both in the United States and abroad. After the passage of Medicare in 1965, supplemental products (today known collectively as Medigap) came into high demand and are now one of the most purchased insurance products in the country. Similarly, after Japan nationalized its health insurance system, supplemental benefits soared in popularity. For many, the ACA will lead to narrower provider networks, higher premiums (or lower premiums with higher out-of-pocket costs), and, for some, a loss of benefits that include dental or vision coverage. Particularly for consumers choosing lower-tiered

plans with high cost-sharing provisions, supplemental coverage to fill gaps could be tremendously appealing to millions of potential customers.

Popular types of supplemental (ancillary or voluntary) benefits include hospital indemnity insurance, accidental death and dismemberment, disability insurance, as well as standard dental and vision plans. Rates for these types of coverage have been relatively stable, particularly when compared to the soaring prices of major medical plans, giving both the adviser and the consumer greater planning confidence.

While supplemental benefit products may prove to be lucrative business for advisers, ethical and fiduciary duties arise – as well as an increased need for knowledgeable guidance – to thoroughly explain that supplemental benefits will not close all gaps created by high-deductible plans. A supplemental plan designed to aid with unexpected costs associated with cancer treatment, for example, will do nothing for a consumer who suffers a heart attack or frequently gets ear infections.

Maintaining Current and Accurate Sources of Information

Among the greatest challenges for advisers over the next several years will not be knowing all the right answers to questions related to reform, but rather knowing where to go to obtain accurate information to answer those questions. Misleading, apocryphal and outright false information, including purported news stories, abound when it comes to the Affordable Care Act.

Professionals should distinguish between a need for information and a desire for analysis. Both are tremendously useful, but their value varies depending on the

situation. The need for information refers to the need to provide definitive answers – most often to clients – on which someone can reasonably rely to perform their duties or comply with the law. Analysis, on the other hand, is an interpretation or examination of a situation. Analysis could be scholarly and data driven, the type that would appear in an academic journal, or more based on opinion and anecdotal evidence, the type that would appear in opinion columns.

In serving clients, advisers will most often need information rather than analysis. The most comprehensive and authoritative source of information regarding the implementation and requirements of the Affordable Care Act is the Federal Register. Published daily by the federal government, the Federal Register is the official journal of the government and includes proposed and final rules and regulations. The three agencies primarily responsible for implementing the Affordable Care Act are the Department of Health and Human Services (which includes the Centers for Medicare and Medicaid Services), the Internal Revenue Service and the Department of Labor. All three have and will continue to issue regulations relevant to various provisions of the ACA. Advisers can stay updated as to newly proposed and final rules by subscribing to relevant listservs from each agency and should familiarize themselves with www.regulations.gov, where digital copies of the Federal Register are available and easily searchable. Additionally, the Center for Consumer Information and Insurance Oversight has created a website as a resource for agents and brokers: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html

Advisers, like all professionals, should be highly discerning when evaluating any news or information they receive, particularly if they are going to pass along that news or any information to clients. An adviser may see a report on television or a post on social media that they believe is important and newsworthy, as it may be. However, a quick Google search to verify the veracity of the story may be enough to save the adviser from professional embarrassment. Above all, advisers should consider the sources of information and employ their judgment and critical thinking skills to determine whether claims made in a news story or piece of analysis are an accurate reflection of reality.

Expanding Online Presence

Insurance brokers need to have an active internet presence and be engaged in selling policies through web-based platforms. The Affordable Care Act surely accelerates this imperative, but it is far from the driving force behind it. The launch of healthcare.gov and the online Health Insurance Marketplace ushered in a new era in which anyone can browse, compare and purchase individual (and eventually, group) health plans. Additionally, trained professionals at call centers can answer questions and in-person navigators are available through various non-profits, pharmacies and other organizations. So it may seem as though there is no role left for the insurance broker. However, particularly for small business clients, the role of the broker is to do more than process a transaction; it is that of an adviser, partner and often a benefits manager in place of an HR executive. Even for individuals who do shop for plans

through the Health Insurance Marketplace, a broker could be a very valuable partner. Navigators may be able to handle easier cases, but many insurance considerations are more complicated and require expertise beyond that of a navigator. A broker who partners with navigators will likely find an ally who procures many leads. Brokers themselves should complete the training courses required for the Federally Facilitated Marketplace or the exchange in their state.

Healthcare.gov is not the only game in town – even for consumers seeking subsidized health insurance. Brokers can sell subsidized plans directly and online brokerage sites (namely, ehealthinsurance.com) allow brokers to sell plans, including the subsidized ACA plans, online.

Consumers – both individuals and business owners – are searching for and comparing health policies on the internet and brokers must have a robust presence, including investments in search engine optimization (SEO) techniques, to attract prospective clients.

COMPARATIVE IMPACTS FOR THE INDIVIDUAL, SMALL GROUP AND LARGE GROUP MARKETS

The individual and small group markets are affected by the Affordable Care Act far more directly than the large group market and self-funded plans offered by large employers. The Exchanges aim to primarily upend the individual market and attract those who were previously uninsured, but the experience of late 2013 made it clear that new requirements – namely to cover a package of essential health benefits – have resulted in unintended consequences for individual plans not sold on the exchange; small group plans could experience similar disruptions soon.

Impact of Health Insurance Exchanges

The launch of the Health Insurance Marketplace (the Exchanges) has the potential to fundamentally transform how millions of Americans obtain health insurance, as well as the relationship between employment and insurance. Employers may decide to send employees to the Exchange for subsidized coverage. Many large employers are already shifting part-time employees onto the Exchange while continuing to offer benefits to full-time employees (those who work in excess of 30 hours per week). The employer mandate will limit the number of employers who choose to no longer offer health benefits; additionally, employers offer health benefits for reasons having nothing to do with the cost or any legal requirement. Health insurance is a pre-tax means of compensating employees and a part of compensation that most Americans have come to expect. Employers also have a vested interest in the health of their employees. There will continue to be overwhelming demand by employees for coverage sponsored by their employer. Indeed, the experience in

Massachusetts indicates that demand may actually increase in the coming years, as discussed later.

There was substantial news coverage in late 2013 of people who had been covered by an individual policy who were receiving notices that their existing plan would be cancelled and replaced with an ACA-compliant plan. Starting around October 2014, millions of Americans who receive coverage through their employer in the small group market will likely also begin receiving what appear to be cancellation notices, as their plans must be replaced. Many small group policies renewed before December 31, 2013 to avoid the requirements that caused millions of individual policies to be cancelled.[8] Those plans will expire at the end of 2014, making October – the start of the next open enrollment period – a prime time for cancellation notices.

The health insurance exchange has primarily impacted the individual market. Those who had previously relied upon an individual plan and those who had been previously uninsured are the target consumers for the individual exchange. Among the more than five million people (as of March 17, 2014) who have enrolled in qualified health plans through the exchanges, very few previously had group insurance.

Of particular note about the qualified health plans available for purchase through the individual exchange is that the market is currently shopping on price,

[8] Scott Gottlieb, "Thousands Of Small Businesses Will Also Start Losing Their Current Health Policies Under Obamacare. Here's Why." *Forbes*, November 6, 2013. Available at: http://www.forbes.com/sites/scottgottlieb/2013/11/06/thousands-of-small-businesses-will-also-start-losing-their-current-health-policies-under-obamacare-heres-why/; see also, Ariana Cha, "Second wave of health-insurance disruption affects small businesses." *The Washington Post*, January 11, 2014. Available at: http://www.washingtonpost.com/national/health-science/second-wave-of-health-insurance-disruption-affects-small-businesses/2014/01/11/dc2f7404-6ffe-11e3-a523-fe73f0ff6b8d_story.html

meaning that consumers are looking at the cost of premiums far more than they are considering deductibles, out-of-pocket limits, or other specifics of a particular plan. This indicates which types of plans are likely to be the most popular, but also highlights the critical role that advisers can and must play in counseling consumers about exchange purchases. Many consumers who believe they have purchased a plan that meets their financial needs may find themselves surprised to be experiencing hardship when they must continue paying out of pocket to meet a high deductible or when a particular course of treatment is not fully covered. A well-trained adviser can discuss financial and medical needs with a particular consumer and assist in choosing a plan that will avoid financial surprises.

The Small Business Health Options Program (SHOP) Exchange

The ACA creates a program designed to increase the number of small employers (fewer than 100 employees, unless the state sets a lower threshold) who can afford to offer health insurance to their employees. The Small Business Health Options Program (SHOP) is intended to be an online exchange, much like the individual exchange accessible through healthcare.gov that would allow small business owners to browse and compare plans available for their employees and easily purchase plans. The SHOP exchange, while well-intentioned, is likely to fail. The plans will not be available on the web for the 36 states that use the federal exchange until late 2014. Many of the plans that are available, including in those states with an active small business exchange site, have been more expensive than those available on the individual exchange – and the

premiums are not subsidized. Interest among small businesses in states that are operating their own exchanges has been disappointing.[9]

While the SHOP Exchange is well-intentioned idea, it is likely to fail, for three primary reasons:

1) It's an empty exchange.

The SHOP Exchange in most states – the 36 that are run by the federal government – has only one plan. That's not exactly the textbook definition of competition. In the states that are operating their own exchanges, a lot of insurers have opted out of the small business exchange. With lackluster enrollment figures, more carriers are not likely to get on the SHOP bandwagon in the coming years.

2) The premiums remain out of reach for many employers.

If small business owners expect to log into the SHOP website when its functioning and find premiums they can afford, they are likely going to be disappointed. While many of the plans available through the SHOP exchange offer lower premiums than what is available on the outside market, the costs still exceed what most employers are willing to pay.[10] Other, more robust plans offered on the SHOP exchange have been more expensive than those available to small businesses off the exchange and even more expensive than comparable individual policies available,

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[9] Patrick Clark, "Why Small Business Owners Are Staying Away From Obamacare Exchanges." *Bloomberg Businessweek,* January 17, 2014. Available at: http://www.businessweek.com/articles/2014-01-17/why-small-business-owners-are-staying-away-from-obamacare-exchanges

[10] A 2013 study survey of small employers found that most -56% - could not afford monthly premiums of $200, well below the lowest-cost plans available on state SHOP exchanges. See Jon R. Gabel, Heidi hitmore, Jeremy Pickreign, Jennifer l. Satorius and Sam Stromberg, "Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchange and Self-Insurance." *Health Affairs*, 32:11, November 2013.

even before taking into account the subsidies available to most customers. And that's the big drawback of the small business exchange – there are no subsidies. A modest tax credit is available for two years to certain small employers, but it's too complicated to obtain and its incentives too small.

3) It doesn't eliminate the administrative burden.

Most small businesses lack the human resources staff that larger companies have to ensure successful benefits administration. This creates an opportunity for brokers, however, to serve the needs of small business clients who are eager to offer health benefits.

In short, employee benefit companies and advisers who deal with small business clients should not particularly fear competition from the SHOP exchange.

Impact of Reform on Individual and Small Group Policies

The ACA mandates new requirements for individual and small group plans – many of which have impacted premiums and other costs – of which all advisers should be well aware. The law aims to transform the small-group market so that price and quality – enhanced by competition and transparency – trump the now-prohibited medical underwriting as the driver of premium rates. The most significant is the requirement that individual and small group policies now cover a package of essential health benefits. Any plan sold in these markets must cover services considered to fall within the following ten categories:

- ambulatory patient services;

- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

The essential health benefits package also includes limits on cost-sharing. Small group plan deductibles are limited to $2,000 for individuals and $4,000 for families. As with large group policies, out-of-pocket expense, including deductibles, co-payments and co-insurance cannot exceed $6,350 for self-only coverage and $12,700 for family coverage. (These limits will be adjusted for inflation.) Together with the prohibition on annual and lifetime dollar limits on essential benefits, that also affects all market groups, these consumer protections contained in the ACA will substantial reduce bankruptcies and personal debt that has arisen as a result of a large medical bills.

All individual and small group plans must meet one of four metal tiers (bronze, silver, gold and platinum) of actuarial values ranging from 60 percent to 90 percent of the total allowed cost of benefits.

Waiting periods are now limited. For plan years starting on or after January 1, 2014, the IRS prohibits waiting periods longer than 90 calendar days for employees who become eligible for coverage.

Medical underwriting has also been eliminated for these markets. Prior health status and gender cannot be taken into consideration with determining premiums. Instead, a modified community rating must be used in the individual and small group markets. Premiums may be adjusted based on age, with a rating band limited to 3:1, such that the premium for the oldest individual enrolled cannot exceed three times the premium for the youngest individual; based on tobacco use, with a rating band limited to 1.5:1; and according to geographic location. In short, the nature of what was previously available in the individual and small group insurance markets is fundamentally distinct from what can be sold in 2014. Premiums may be more expensive and networks narrower, but purchasers of these plans should also be aware of additional coverage and consumer protections that are mandated by federal law in the policies they purchase.

Impact of Reform on Large Group Plans

For advisers who work with large group clients, the years 2014 to 2017 will bring changes to the nature of both the product and the process. The Affordable Care Act primarily targets the individual and small group markets, with the express policy goal of leaving employer-based plans largely unchanged, save for certain patient protections.

Included among those patient protections are controls designed to halt the large number of bankruptcies declared annually because of high medical bills. The ACA now prohibits placing any limits on coverage claimed – whether annually or over the course of a lifetime – for any non-grandfathered plan, including large group policies. These limits apply to any of the ten essential health benefits, which while not presently required to be covered by large group plans, any benefits within these categories cannot have monetary limits.

Large group plans, like all insurance plans, are not permitted to deny applicants on the basis of prior medical status or a pre-existing condition. Advisers writing large group policies will still be able to underwrite, in marked contrast to individual and small group plans, which now prohibit medical underwriting. However, advisers should be aware that, beginning in 2017, if states permit large group plans to be sold on their exchange, then medical underwriting for plans both on and off the exchange, will be similarly prohibited. Eliminating medical underwriting makes the application process far simpler but also restricts the ability of insurers to adjust premium rates and therefore changes the nature of prospecting and selling for advisers.

Large group insurance changed notably as both lifetime limits and annual limits on coverage falling within any of the ten essential health benefit categories are now prohibited. All non-grandfathered health plans also must now limit out-of-pocket expenses to a federally-mandated level. For 2014, out-of-pocket expenses, including deductibles, co-payments and co-insurance cannot exceed $6,350 for self-only coverage and $12,700 for family coverage. Small group plans have lower limits on deductibles,

but that does not impact the large group market. What large group plans have seen recently, however, is that plans that previously had lower deductibles than the mandated limits have increased deductibles to the ACA-compliant limits in order to restrain premium increases.

Large group plans, like plans in other markets, are experiencing changing risk pools; however, the contrast is less noticeable, as large group plans were less likely to deny coverage on the basis of prior health status than individual and small group plans.

Large group clients also incur new reporting requirements, including:

- Reporting the amount of coverage on employees' forms W-2.

All employers who issue more than 250 Forms W-2 and also offer health benefits are required to list the full amount of coverage enjoyed by the employee on their Form W-2. This number is to be placed in Box 12 of the form using code DD. The amount reported should be the sum of the employer contribution and the employee contribution. The W-2 reporting requirement is for informational purposes only and does not impact the tax treatment of health benefits.

- Reporting offers of minimum essential coverage to the IRS.

Regardless of whether the employer offers acceptable coverage or pays the penalty, any qualifying large employer must file a report with the Internal Revenue Service. The IRS will release two forms for use by applicable large employers (ALE) to satisfy their reporting requirements under the employer mandate. These will be forms 1094-C and 1095-C. The former will be a transmittal, while the latter will be an employee statement.

Any ALE must file a report with the IRS on the health coverage offered to any employee who was a full-time employee for at least one month during the preceding calendar year. Additionally, the employer must deliver a report to each employee mentioned. The report to the IRS, Form 1094-C, will contain, at a minimum:

- The name, date and employer identification number (EIN)
- The name and telephone number of the employer contact person
- The calendar year for which the report is being filed
- A certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an employer-sponsored plan
- The number of full-time employees for each much during the calendar year
- The name, address and taxpayer identification number of each full-time employee during the calendar year and the months, if any, during which that employee (and any dependents) were covered under any such health benefit plans.
- For each full-time employee, the employee's share of the lowest cost self-only monthly premium offered

To each full-time employee, every ALE must provide a Form 1095-C, which will contain

- The name, address and EIN of the ALE
- The information about that employee that was transmitted to the IRS

- The employee's share of the lowest cost self-only monthly premium offered

- Notice of Exchange

Upon hiring a new employee, all employers subject to the Fair Labor Standards Act must issue a written notice to the newly hired employee informing her of the option to enroll in a qualified health plan through the Health Insurance Marketplace at healthcare.gov. The notice is for informational purposes only and has no impact on the employer-sponsored coverage or any penalties under the employer mandate. Failure to issue this notice will not result in any tax consequences or civil penalties. Employers must make this report to newly hired employees within 14 days from the date of hire.

Experience in Massachusetts

The strongest predictor of future performance is past performance and while the reforms ushered in by the Affordable Care Act have no nationwide precedence, they are very closely modeled on reforms enacted in Massachusetts in 2006. One of the foremost experts on health care reform - MIT Professor Jonathan Gruber – whose research I rely on extensively, helped draft the Massachusetts law and predicted at the time that employers would stop offering coverage for employees. After all, the law created Commonwealth Connector, a public exchange and offered more generous subsidies, plus the penalty for employers who did not offer coverage in the Bay State was nominal - $295 per employee. Data now shows that Massachusetts employers did not stop offering health benefits; rather, more started offering. Between 2005 and 2012,

employer-based insurance declined nationwide by 5.7 percentage points, but increased a full percentage point in Massachusetts.[11] That included small employers, as only 45 percent of small employers offered employee health insurance prior to the law's passage, compared with 59 percent five years later.

[11] "The Massachusetts Experience: Employer-sponsored health insurance post reform." Report by PricewaterhouseCoopers LLP, 2013. p. 2. Available at: http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-massachusetts-health-reform.pdf

CHALLENGES AND OPPORTUNITIES CREATED BY THE ACA

This section should be prefaced with the expression of the notion that all challenges can be opportunities for the right individual or institution. Whether the Affordable Care Act is good or bad as a matter of public policy (as though those are the only two possible classifications) is now beyond the point of a being a useful discussion. For advisers and the clients they serve, it is very much reality, and so even changes ushered in that present obstacles will be reimagined by an entrepreneurial industry as opportunities for growth.

The Medical Loss Ratio

The Affordable Care Act creates a federal benchmark for insurers that dictates the percentage of premium revenue that the insurer can spend on certain activities. For individual and small group insurers, the medical loss ratio (MLR) is set as 80/20 and for large group insurers it is 85/15. This requires that 80 (or 85) percent of all revenue derived from premiums be spent either paying claims or on activities that are considered to improve the quality of health care. Insurers are required to submit annual reports to the Department of Health and Human Services detailing all revenue received and itemizing how it was spent. Any spending below the 80 (or 85) percent threshold triggers a mandated rebate to all policyholders, proportionate to the amount by which the ratio was not achieved. For employer-based plans, that means that the employer is most likely to receive the rebate, rather than the actual employees enrolled in the plans. While the MLR provision aims to encourage less spending on overhead

expenses and more on paying incurred claims, the regulations allow for spending on "health care quality improvement activities" to be counted towards the medical spending portion. Whether premium revenue is being used for activities that improve health care quality is somewhat complicated and vague. HHS regulations set forth four essential requirements an activity must satisfy in order to be considered quality improvement activities:

1. It must be designed to improve health quality
2. It must be designed to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements
3. It must be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; and
4. It must be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

Prior to the ACA, most states had MLR regulations that applied to the individual and small group markets, but not the large group market. Additionally, the MLR requirements varied significantly from state to state. In 2009, prior to passage of the

ACA, the largest health insurers had medical loss ratios ranging from 68 percent to 88 percent in the individual market; 78 percent to 84 percent in the small-group market; and 83 percent to 88 percent in the large-group market.[12]

Over time, the Affordable Care Act's MLR provision is likely to have the greatest impact – and potentially a highly detrimental one – on the individual market, and perhaps the small group market. The MLR of a particular plan is impacted by three factors: the membership of the plan (how old, how sick); the size of the plan (how many lives covered); and the price of the plan. Large group plans have more favorable membership, much larger size and have greater leverage in pricing power than the individual and small group markets. Thus, it is markedly easier for large group plans to achieve their MLR. Since the passage of the ACA, this has led major insurers to withdraw from the individual market in several states.[13]

In anticipation of the potential threats to the individual market, states are permitted to seek waivers from HHS to modify the MLR requirements for the individual market in their state. A handful of states received waivers for 2011-2013 in order to adjust to the new requirements, but waivers have not been granted in two years.

For brokers, the Medical Loss Ratio provision – and concern over not meeting the prescribed ratio – presents a challenge under the ACA, as well as significant potential

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[12] Staff Report for the Chairman, "Implementing Health Insurance Reform: New medical loss ratio information for policymakers and consumers." U.S. Senate Committee on Commerce, Science, and Transportation. April 15, 2010. p. 3. Available at: http://www.pnhp.org/sites/default/files/docs/2010/MLR-Report.pdf

[13] Grace-Marie Turner, Testimony before the U.S. House Committee on Small Business, December 15, 2011. Available at: http://www.galen.org/assets/Turner_MLR_Testimony.pdf

for future legislative changes. (The provision has been in effect since 2011, so brokers have been making adjustments, if any, for a few years.) The Department of Health and Human Services has issued a final regulation that does not include commissions paid to brokers as part of health care quality improvement activities, and therefore commissions are part of the 15 or 20 percent that must also include administrative costs, marketing, compensation and profits.

Industry-aligned lobbying groups, including the Independent Insurance Association of Agents and Brokers, Inc., have argued strongly against the MLR provision for this reason and others. Opponents have argued that because insurance markets vary dramatically from state to state there will be little incentive to enter the market in a new state and increased incentive for existing carriers to stop providing coverage in areas where they will not be able to achieve the prescribed ratio. The provision may also encourage monopolization of the health insurance industry, as smaller insurers who have less favorable risk pools may be forced to pay out more for claims while receiving less in premium revenue. The MLR may also force some insurers to increase premiums in order to avoid layoffs.

As previously stated, if the MLR requirements are not met by a particular plan, the insurer is required to rebate the amount of premium revenue received in excess of the MLR threshold directly to the plan sponsor. The plan sponsor then must determine the percentage each plan participant paid towards the total cost of coverage in order to proportionately distribute the rebate funds. The funds can be directly distributed as a

cash payment, applied to future participant contributions as a premium reduction, or applied to the cost of benefit enhancements.

New Federal Taxes and Fees

Health insurance carriers and plan sponsors face a series of new taxes and fees under the Affordable Care Act.

(1) Patient-Centered Outcomes Research Institute Fee

Plan sponsors and carriers are required to pay a fee to fund the Patient-Centered Outcomes Research Institute (PCORI), which was authorized by Congress to help consumers make informed health decisions through evidence-based research. Both grandfathered and non-grandfathered health plans pay this fee, which is paid by the insurance carrier for fully-funded plans and by the employer for self-funded plans. The fee is paid by filing an excise tax return form 720 and currently amounts to $2 per covered life. This fee will be phased out after September 30, 2019.

(2) Annual Health Insurance Industry Fee

Only health insurance issuers are responsible for this fee, which largely funds the premium subsidies for those who purchase plans through the Exchange. The fee takes effect beginning in 2014; the total amount to be collected in the first year is $8 billion, rising to $14.3 billion in 2018. The individual amount to be paid by the insurer will be determined using that insurer's market share.

(3) Transitional Reinsurance Program Assessment Fee

The transitional reinsurance program aims to stabilize the market at insurance carriers transition to providing coverage through the exchange and without the benefit of medical underwriting for the years 2014 through 2016. Both insurance carriers and self-funded plan sponsors, including grandfathered and non-grandfathered plans, are responsible for this fee, which is estimated at $63 per individual enrolled under a plan or policy in 2014.

(4) Risk Adjustment Fee

Non-grandfathered, fully-insured plans in the individual and small group markets must pay a fee that transfers payments from issuers with lower-risk populations to those with higher-risk populations. This is a permanent fee that began in 2014.

(5) Cadillac Tax

Beginning in 2018, a forty-percent excise tax will be assessed on health plans that exceed an established annual cost ($10,200 for individual coverage and $27,500 for family coverage, adjusted for inflation). Insurers and plan sponsors are responsible for paying the excise tax that has been termed the "Cadillac Tax" because it targets benefit-rich plans, often paid almost entirely by employers and with very low or no deductibles, that have been viewed by some as "Cadillac" health plans.

Small Business Health Care Tax Credit

In addition to tax consequences, the ACA creates a tax opportunity that could be highly advantageous for the right small business if an adviser has the foresight to

encourage the necessary steps. Employers with fewer than 25 full-time equivalent employees and average annual wages below $50,000 who purchase coverage for all full-time employees through the SHOP Exchange may be eligible for a tax credit of up to 50 percent of the cost of premiums. The credit is available only for two years and is only available to organizations that purchase plans through the SHOP Exchange, which is not currently functioning as a website and is offering high premiums. Additionally, the credit is available on a sliding scale, meaning that the full credit of 50 percent is only available to those employers with 10 or fewer employees and average annual wages below $25,000. Relatively few employers have taken advantage of the smaller tax credit that was available from 2010-2014 and the same is expected to be true with the tax credit going forward, as the credit is small, complicated, available to a finite class of employers and limited to two years.

Better Informed Clients

The Affordable Care Act aims to make the health insurance industry more transparent and its products easier to understand for consumers. This creates a challenge for advisers, as clients and potential clients will likely feel more empowered to compare plans and make choices on their own, but also an opportunity to sell a quality product on its legitimate merits to a better informed consumer. The confluence of legal reforms with technological advancements means that plan participants have the ability to exercise greater control over their health care choices, even once enrolled, to

maximize savings, and feel a greater connection and sense of loyalty to both their insurance provider and the broker who serves them.

Consumers now have access to a standardized Summary of Benefits and Coverage for any plans available in the United States. Plans now have metallic tiered ratings to make comparisons simpler. Consumers can quickly compare their plan to any plan available on the Exchange. Enrollees can take advantage of more robust internal appeals and external review programs and regulations – and advisers will be a critical liaison in any appeals and review.

SERVING EMPLOYER CLIENTS

The Affordable Care Act has the least impact on employers who currently health benefits to their employees. The reform law aims to reinforce the relationship between employment and health insurance. A recent survey of business economists, conducted between late December 2013 and January 2014 revealed that only one in five of the responding economists believed the health care reforms was hurting business.[14] Three-quarters of respondents believed the law was having no impact, while five percent believe it is helping.

Employer clients will face a variety of changes, including aforementioned tax consequences and reporting requirements, but none has garnered as much criticism or generated as much concern as the Employer Shared Responsibility Provision, also known as the Play or Pay Tax or the Employer Mandate. Statistically, very few employers will be impacted by the Employer Shared Responsibility provision. Once implemented, only a very small percentage of employers – about 3.7 percent – are even large enough to be subject to the employer mandate.[15] That 3.7 percent of employers, however, is large enough to encompass nearly 63 million employees. However, 98 percent of qualifying large employers already offer health benefits.[16] Thus, those truly

[14] John Schoen, "Don't fret about the stock market selloff: economists."CNBC, January 27, 2014. Available at: http://www.nbcnews.com/business/dont-fret-about-stock-market-selloff-economists-2D11999172
[15] Sean Lowry and Jane Gravelle, "The Affordable Care Act and Small Business: Economic Issues." Congressional Research Service, August 15, 2013. Available at: https://www.fas.org/sgp/crs/misc/R43181.pdf
[16] Maggie Fox, "Delay in health insurance law won't affect many, experts say." NBC News, July 3, 2013. Available at: http://www.nbcnews.com/health/delay-health-insurance-law-wont-affect-many-experts-say-6C10527171

facing changes because of the employer mandate comprise 0.00074 percent of employers in the United States.

The Employer Mandate

Beginning in 2015, all organizations employing more than fifty "full-time equivalent" employees will be required to either offer a minimum level of health benefits to full-time employees or pay a tax penalty. The ACA originally called for this provision to take effect January 1, 2014, when many other sweeping provisions of the law took effect. However, the Treasury Department announced on July 2, 2013, that the Administration will refrain from enforcing this provision for an additional year, waiting until January 1, 2015. In February 2014, another delay was announced: the mandate will go into effect in 2015 only for those with more than 100 full-time equivalent employers and the following year for those between 50-99 full-time equivalent employees. Additionally, the requirement to cover substantially all full-time employees will be relaxed to a requirement to cover at least seventy percent of full-time employees for 2015, the year during which the mandate only applies to those with 100 or more full-time equivalent employees.

Only large employers are required to comply with the employer mandate. A large employer is defined as an organization that averaged fifty or more full-time equivalent employees in the preceding calendar year. Determining whether an organization is a qualifying large employer, however, is slightly more complex than merely tallying the number of employees currently on payroll.

The threshold inquiry in determining whether an organization is a large employer is how many of its employees count as full-time employees for the purposes of the ACA. The Act considers a full-time employee one who works an average of 30 hours per week. The regulations use the term hours of service to refer to work hours so that even if an employee is technically not conducting any sort of labor, but is being paid or otherwise "on the clock," this time will be considered part of his workweek. For example, if an employer pays for travel time or a lunch break, these may not be considered time spent working, but for the purposes of the law, they are considered hours of service and count towards the 30-hour threshold. The 30-hour threshold is designed to disrupt the fewest number of employment relationships. If the threshold were the traditional 40-hour week, then employers seeking to avoid offering health benefits could merely reduce existing full-time employees' hours to just below 40 per week.

Beyond full-time employees, the law takes into consideration "full-time equivalent" employees, which encompasses part-time workers. The hours of part-time employees are considered in the aggregate, using a formula to calculate the number of "full-time equivalents." Part-time employees must be totaled and then converted into full-time-equivalents by finding the total hours of service all part-time employees worked in a given month and dividing that amount by 120. The resulting amount is the number of full-time equivalent employees for a business organization. If this number plus the number of full time (over 30 hours of service) employees equals or exceeds 50, the business is a qualifying large employer. (The inclusion of part-time employees is

only for qualification purposes; not covering part-time employees will neither trigger nor increase the tax penalty.)

For any given organization, if the number of full-time employees and full-time equivalents totals 50 or more, they are a qualifying large organization and may be subject to a tax penalty.

There are two types of penalties that can be imposed on employers who fail to offer adequate coverage, both requiring two elements to be satisfied in order for the penalty to be assessed. One is the penalty under Section 4980H(a), the "subsection (a) penalty" or "no coverage tax" and the other is the penalty under Section 4980H(b), the "subsection (b) penalty" or "unaffordable plan tax." The subsection (a) penalty will be assessed against an employer if both elements of a two-part test are satisfied:

(1) The employer fails to offer substantially all full-time employees and their dependents the opportunity to enroll in an "eligible employer-sponsored plan" that provides "minimum essential coverage" and

(2) At least one full-time employee is certified to the employer as having received a subsidy for a qualifying health plan through an Exchange.

Thus, if a large employer offers plans that provide "minimum essential coverage" to substantially all full time employees, it will not face this particular tax penalty. The meaning of "substantially all" will be interpreted as 95 percent under a margin of error rule. If an employer offers health insurance to 95 percent of its full-time employees (or all but five employees, whichever is greater), then the employer will be deemed as having satisfied its obligation.

If a business is a qualifying large employer, does not offer minimum essential coverage to substantially all of its full-time employees and receives a certification from an exchange that an employee has purchased a plan with a subsidy, then it will be subject to paying a penalty assessed by the Internal Revenue Service. The tax will be determined on a monthly basis for each month that the employer qualifies as a large employer and does not offer health coverage. The penalty is calculated by multiplying the number of full-time employees, less a 30 person reduction, by the applicable payment amount.

When the penalty was to begin in 2014, the applicable payment amount was $166.67 per month, the equivalent of $2,000 per year. The payment amount will then be adjusted annually for inflation. Any penalty payment, whether subsection (a) or (b) is not tax deductible for federal income tax purposes, unlike the cost of health insurance coverage.

Merely offering health insurance that offers minimum essential coverage does not mean that a large employer will be exempt from a tax penalty under the ACA. The insurance plan offered must also have a minimum value and be "affordable." That is, an employer cannot escape liability for a penalty by offering every full-time employee a plan that they could not possibly afford. The regulations impose two tests to determine if an employer's offered plan will make employees eligible for a tax credit or premium subsidy and thus trigger a tax penalty under subsection (b).

1. <u>The Minimum Value Test.</u> The plan must cover at least 60 percent of the total allowed costs of benefits.

2. The Affordability Test. The premium for the lowest-cost employee-only plan must not exceed 9.5 percent of the employee's household income.

If an employer offers a health insurance plan to its employees and either of these tests is failed *and* an employee purchases a plan through an exchange *and* receives a premium tax credit, then the employer is subject to a subsection (b) tax penalty. The most likely scenario for employers to be alert for is a failure of the affordability test. The Congressional Budget Office estimated in 2011 that about 1 million Americans annually will receive a premium tax credit to purchase an exchange plan because their employer-based plan failed the affordability test.[17] The number of plans that will fail the minimum value test is expected to be small. The IRS is permitting a "safe harbor" provision that would allow employers to determine affordability by using only the employee's W-2 earnings. If the individual premium for the employer's lowest cost employee-only plan does not exceed 9.5 percent of W-2 earnings, the plan will be considered affordable.

Unlike the subsection (a) penalty, the subsection (b) penalty is assessed per employee receiving premium tax credits, rather than per each full time employee. There is no 30-person reduction rule for subsection (b). The monthly penalty tax under subsection (b) is $250 ($3,000 per year). Thus, an employer who has three employees receiving premium tax credits because the offered plans are unaffordable would owe $250 x 3 employees per month, or $750 per month.

[17] Testimony of the Director of the Congressional Budget Office before the Subcommittee on Health, U.S. House Committee on Energy and Commerce. March 30, 2011. Available at: https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf

Strategies Related to the Employer Mandate

There are several ways of mitigating or avoiding the impact of the employer mandate that business owners can take advantage of beginning in 2015 or 2016. Among the most popular to emerge once this provision is implemented may be a "play differently" approach. Namely, employers will plan and budget for the $2,000 per full-time employee annual penalty, while providing employees with a defined contribution account that will supplement their pre-tax income while allowing employees to purchase health coverage through the public Health Insurance Marketplace. This strategy may offer employers substantial savings from the amounts they currently spend for employee health benefits, while ensuring that employees still enjoy health coverage, saving the employee money and remaining in compliance with the law. Additionally, be mindful of the fact that while paying a tax penalty can be very expensive, the penalty remains far less expensive than the cost of providing employee health benefits. Therefore, for some employers, choosing to simply "pay" rather than "play" may make the most economic sense, even if it is not necessarily the best policy for employee retention.

For employers that offer coverage, it is critical that they monitor the affordability of their plans to ensure that no full-time employee will be eligible for a tax credit to purchase coverage through an exchange. Offering employers can also decline to offer coverage to a select number of full-time employees, while avoiding any penalty, so long as they offer coverage to at least 95% of full-time employees (70% for applicable employers in 2015). Employers will need to constantly monitor the hours that

employees, especially part-time and variable hour employees, work during a given month. They must also ensure that no full-time employee is expected to pay in excess of 9.5 percent of gross wages to for the lowest-cost health plan available. These are all ongoing monitoring and record-keeping necessities for which the adviser should clearly delineate responsibility at the outset. Any adviser working with employer clients on strategies related to employee health benefits should have a written contract or other agreement that establishes which party is responsibility for the monitoring, tracking and calculating activities with implications for Affordable Care Act requirements.

Impact of the Employer Mandate

The practical consequences of the employer mandate, coupled with other reforms, remain speculative. However, a handful of companies have publicly announced plans to make changes in anticipation of the mandate going into effect. These changes include laying off full-time employees, reducing hours for part-time employees, converting full-time employees to part-time employees, dropping employer-sponsored health insurance, or increasing the employee's share of insurance premiums. Prior to implementation, it is not possible to draw a definitive conclusion as to whether changes announced as stemming from ACA regulations are actually caused by the regulations or merely correlated to the timing. What is certain, is that the overwhelming majority of employers will be unaffected by the employer mandate.

This is not to say that the employer mandate and the ACA as a whole will not lead any employers to reduce workforces or cut hours. The way the employer mandate

is structured creates a perverse incentive for some employers to rely more on part-time workers or minimum-wage workers, even when they are full-time employees. A good starting point for predicting the impact of the mandate is to look at those industries with employees who work hours near the 30-hour/week threshold. The industries with the highest percentage of employees working slightly over 30 hours are restaurants, nursing homes, hotels, health care, retail stores, education and building services.[18] Researchers at the Labor Center at the University of California, Berkley made this determination based on data from the Current Population Survey. The Center's report analyzed those vulnerable industries and took into account the average income levels in each industry. Based on their analysis, restaurant workers are the most likely to see hours reduced as a result of the employer mandate.[19]

The Center for Economic and Policy Research released a study in July 2013 that analyzed whether the employer mandate would actually cost jobs. The study concluded that, based on available data, it is implausible that the employer mandate would be solely responsible for job losses.[20] As for workers seeing hours reduced, the same study found that the number of Americans working just below the 30 hours/week threshold, measured as 26-29 hours per week, actually decreased between 2012 and 2013 (the year before the mandate's requirements were originally to be effective),

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[18] "Data Brief: Which workers are most at risk of reduced work hours under the Affordable Care Act?" University of California, Berkeley, Labor Center. p. 1. Available at: http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf

[19] *Ibid*.

[20] Helene Jorgensen and Dean Baker, The Affordable Care Act: A Hidden Jobs Killer?, Center for Economic and Policy Research, July 2013. http://www.cepr.net/documents/publications/aca-job-killer-2013-07.pdf

indicating that employers were not suddenly shifting full-time workers to just below 30 hours per week in order to avoid consequences from the new law.

Even though crucial portions of the Affordable Care Act, including the employer mandate, have yet to be implemented, there is a close model that has been in effect for seven years that can provide some insight into what may happen. Massachusetts passed health care reform in 2006, including an individual mandate to purchase health insurance and a requirement that businesses with eleven or more employees provide health insurance (obviously a substantially lower threshold than the federal ACA). In 2005, the year before the reforms became law, 70 percent of Massachusetts employers offered health insurance. By 2011, after the law had been in effect for five years, 76 percent of employers did so.[21] Hawaii provides a model that offers additional insight into the impact of an employer mandate on part-time workers. In Hawaii, employers are required to cover anyone who works more than 20 hours per week. A 2011 study found that the number of workers in Hawaii who worked less than the 20 hour threshold increased 1.4 percent as a result of the law.[22] That figure is consistent with the Labor Center's estimate that 2.3 million workers, or 1.8 percent of the national

[21] Jonathan Gruber, "The Impacts of the Affordable Care Act: How Reasonable are the Projections?" National Tax Journal, September 2011

[22] Buchmueller TA, DiNardo J, and Valletta RG. The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii. American Economic Journal: Economic Policy. Volume 3, Issue 4, Pages 25-41, 2011

workforce, is at risk of having hours reduced as a result of the ACA's employer mandate.[23]

Another possible consequence is that employers that currently offer health insurance to full-time workers will end that practice. Despite the tax penalty that large employers would incur, the comparatively lower cost of the penalty coupled with the availability of individual plans may incentivize ending employer-sponsored health benefits. If employees are able to purchase coverage through marketplace at substantially lower rates, an employer would know that its employees will not be without access to coverage and instead of having to pay premiums around $15,000 per employee, they would simply pay a $2,000 annual tax penalty per employee. There is sharply conflicting evidence on whether large employers will eliminate or reduce health benefits for employees. A February 2011 survey, less than a year after passage of the ACA, by McKinsey & Company found that after the employer mandate goes into effect, 28 percent of large employers will definitely or probably stop offering employer-based plans to employees.[24] However, a survey released in August 2012 by Towers Watson survey of 512 very large employers found that no employers were "very likely" to end

[23] "Data Brief: Which workers are most at risk of reduced work hours under the Affordable Care Act?" University of California, Berkeley, Labor Center. p. 2. Available at: http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf

[24] Shubham Singhal, Jeris Stueland, and Drew Ungermann, "How US health care reform will affect employee benefits." McKinsey & Company, June 2011. Available at: http://www.mckinsey.com/insights/health_systems_and_services/how_us_health_care_reform_will_affect_employee_benefits

their employer-based benefits, with three percent of respondents saying they were "somewhat likely" to do so.[25]

Empowering Employer Clients

As important as it is for advisers to be well-versed in new rules, reporting and requirements created by the ACA, it is similarly important for advisers to empower employers. Advisers should prepare checklists, calendars, worksheets or software that allows employers to efficiently and effectively manage any responsibilities they have acquired since reform in the administration of health benefits. A key part of the relationship between adviser and client will be to conduct necessary fact-finding. While this concept is nothing new for the industry, the types of questions that need to be asked and the nature of the fact-finding is unique per the new risks, considerations and opportunities. Advisers will need to be particularly diligent in ensuring that they conduct thorough and periodic fact-finding into the number of full-time employees controlled by an organization, as well as the hours that part-time employees are working.

Advisers will need to diligently monitor new reporting and filing requirements and ensure that any deadlines are met on behalf of clients. This will require establishing a calendar at the outset of an adviser-client relationship that indicates important dates for action and reporting. Checklists will also be important as most

[25] Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, 2012. Available at: http://www.healthreformgps.org/wp-content/uploads/Towers-Watson-NBGH-2012.pdf

clients will never have had to complete most of the tasks required of them in the past. This is not to say that the checklists will necessarily be long or arduous – many, if not most, clients will have little new to do. Self-funded plan sponsors and large employers will likely have the most to do in the wake of the ACA reforms.

Simply because the employer mandate or other provisions of the ACA may not directly affect a particular business client does not mean that advisers do not need to work closely with those small business clients on any changes that should be considered to their employee benefit programs. As previously discussed, employers offer health benefits for a variety of reasons that stretch well beyond simply compensating workers or complying with the law. The indirect consequences of reform are numerous. Advisers should discuss possible strategies, weigh the risks and incentives and fully educate their clients on the changing nature of health benefits and how that can or should impact decisions that will affect the business's future growth and profitability.

CONCLUSION

The lasting effect of the Affordable Care Act and the reforms it ushers in will likely not be evident for many years. What is certain, however, is that the next few years will be a time of significant change for the health insurance industry and, like any major period of transition, require the market and the people in it to aggressively and proactively adapt.

Many positive changes are occurring. Millions of middle class Americans will benefit from lower premiums and the financial security that comes from being protected against exorbitant hospital bills that previously were the leading cause of bankruptcy.[26] Beyond that, millions who, for years, were unable to purchase health coverage due to a pre-existing medical condition will finally be able to obtain coverage. Entrepreneurs and anyone looking to take a risk and start their own business or venture out on their own will be freed from the "job lock" that kept many people in their existing jobs simply for the access to health benefits.

Yet with the good comes the bad. Many will pay higher premiums or find themselves in a plan with a higher deductible or more limited provider network as a result of the requirements of the ACA. Many businesses that consider themselves small, but qualify as large employers under the law, will face difficult choices and increased costs. Health insurance agents and brokers may find themselves with lower commissions or even facing redundancy and fewer clients.

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[26] Dan Mangan, "Medical Bills Are the Biggest Cause of US Bankruptcies: Study." CNBC, June 25, 2013. Available at: http://www.cnbc.com/id/100840148

The positive and negative impacts of health care reform aside, it is undoubtedly a period of sweeping change. Change can be difficult, but all industries inevitably face changes to their environment and must either adapt or fade away. The experience of states that have implemented similar reforms, coupled with expert analysis, offers a strong indication that advisers will adapt to the new market and new regulations. Indeed, with millions of new prospective customers, agents and brokers have an opportunity to thrive.
