Are You Ready for Healthcare Reform?

By Edward E. Bonifant and Brian Green, CPA, CAE

On Mar. 10, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). Since then, some of the aspects of the bill have come into focus, while, at the same time, we have witnessed continued debate, political posturing, a Supreme Court ruling and more. Throughout, however, the systematic implementation pressed on. Most of the implementation that has taken place so far has almost entirely focused on business- and employer-sponsored healthcare plans. With more than three years now under our belts, what has generally been regarded as the "meat" of the Affordable Care Act (ACA) takes place in 2014, with the Individual and Employer Mandates set to go into effect on January 1.

The ACA defines employer size by "Small" (less than 50 employees) and "Large" (more than 50 employees), and the rules and applications of the law are distinctly different for each.

For the most part, small employers will be served by state- or federal-based healthcare exchanges and, in most instances, by either a public or private variety. Small employers will also avoid the penalties that are most associated with the large employer plans. This doesn't mean, though, that these small employer plans won't be impacted by higher premium costs. A requirement of the ACA says that small group pricing must soon adhere to adjusted community rating (ACR) for 2014: a way of pricing insurance not based on a policyholder's health status, but may be based upon other factors, such as age and geographic location. This could impact small group pricing to a great degree for those plans renewing January 2014 and thereafter. Much of the recent discussion surrounding employers in this market segment is about their intent to stay under 50 employees; however, the full-time equivalent (FTE) calculator includes part-time employees in the final count and could push that otherwise small employer over the threshold.

Large employers, as defined, have the choice to either "pay" or "play." "Pay" simply means that the employer chooses to opt out of providing health coverage to employees and chooses to pay a penalty instead. The penalty is assessed to help defray costs

associated with the exchanges and is generally $2,000 per full-time employee per year. It is important to note that any penalties assessed in the large employer market are not deductible as business expense, whereas health insurance premiums are generally deductible. To "play," the employer chooses to provide health coverage to employees and avoid the possibility of penalties; once again, the employer must provide coverage that is "affordable" and that provides "minimum essential coverage." There are calculators available that can estimate possible penalty scenarios and help an employer structure programs accordingly. Surprisingly, President Obama recently announced a suspension of the employer mandate for one year. As a result, large employers will not be required to report or comply with the employer mandate for 2014.

Several taxes and fees, however, take effect in 2014 and will have a resulting impact on premium costs over a broad range of employer-provided healthcare plans. They include:

- Patient-Centered Outcome Research Institute fee (PCORI).
- Transitional reinsurance fee.
- The insurer fee.
- Risk adjustment fee.

The Impact on Commercial Real Estate

Similar to all types of businesses, commercial real estate companies typically use health insurance to attract and keep qualified employees. The ACA will affect the commercial real estate industry the same as it does all other industries.

If you have not done so already, it is highly recommended that a full review of your health benefit programs be completed to determine the impacts on your business. Employers must measure the cost implications of maintaining the current level of health benefits while complying with ACA mandates. Many factors must be considered when making this determination. They include:

- Whether your current policy offering meets the required minimum levels of coverage.
- Whether there will be an increased number of employees eligible for coverage.
- The likelihood of increase premiums.
- The cost of compliance with non-discrimination requirements in the PPACA.
- The cost of increased employee communications concerning coverage options, as well as increased reporting on W-2s.
- A possible excise tax on high-cost plans (2018 provision).

Also, as an industry that is served by a variety of different product and service providers, expect that the expenses for operating properties will increase as the full effects of reform are felt. For instance, it is fairly typical for a contract to provide services to include provisions for passing along additional expenses related to changes in laws or regulations. As service providers assess their own health benefits programs for the impact of ACA, it is possible there will be additional cost to comply with ACA. If your current contract with a service provider contains the provision mentioned here, you can expect any additional cost to be passed along.

Health Insurance Exchanges

The Affordable Care Act (ACA) provides for health insurance exchanges to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. For the purposes of healthcare exchanges, small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. However, states may limit employers' participation in the exchanges to businesses with up to 50 employees until 2016. Large employers with more than 100 employees are to be allowed into the exchanges in 2017.

States have three options with respect to their exchanges. They can:

1. Establish and run a state-based exchange;
2. Have Health and Human Services (HHS) establish a federally facilitated exchange (FFE) for their residents; or
3. Partner with HHS so that some FFE functions can be performed by the state.

Originally, the healthcare reform legislation provided that workers who qualified for an affordability exemption to the coverage mandate, but did not qualify for tax credits, could use their employer contribution to join an exchange plan. This requirement was known as the "free choice voucher" provision. However, the federal appropriations bill signed by President Obama on Apr. 15, 2011, eliminated the free choice voucher provision from healthcare reform.

On Mar. 11, 2013, HHS proposed a transition policy for small business health option (SHOP) exchanges to delay implementation of the employee choice model as a requirement for all SHOPs until 2015 plan years. For plan years beginning on or after Jan. 1, 2014, and before Jan. 1, 2015:

- State SHOPs would not have to allow employers to offer their employees a choice of qualified health plans (QHPs) at a single level of coverage.
- FF-SHOPs would not allow qualified employers to offer their

Next Steps

Start the conversation with your product and service providers now for two reasons. First, make sure they are aware of the requirements and are taking the necessary steps now to prepare for meeting the milestones associated with ACA. Lack of planning by a provider could be disruptive to the operations of their business and affect the service they provide to you. Second, make sure you are aware of any anticipated additional cost that may be passed along related to increased health benefit programs.

Discussion and debate will continue throughout the next year or more, as final implementation takes place and employers, legislators and various industry groups weigh in with their thoughts and concerns. Stay tuned, as it's bound to be interesting.

About the Authors: Edward E. Bonifant is executive vice president with Howard W. Phillips & Company (**www.hwphillips.com**) in Washington, D.C., one of the largest privately owned independent insurance agencies in the Mid-Atlantic Region. Bonifant leads the company's employee benefits division and has participated on the advisory boards of several national and regional health insurance companies and administrators. Brian Green is CFO and vice president of Finance, Administration, IT & Research with BOMA International. He has been involved in the procurement of benefit products for nearly 20 years and has participated in a local coalition surrounding the creation of the D.C. Exchange.