Insurance, Benefits, & Consulting

"The Affordable Care Act: Past, Present and Future"

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As an employee benefits consultant for the last 36 years, I will try to take an objective look at the law, its intent, its function and its future. I hope my observations and predictions will be useful in the ongoing discussion of the ACA and its evolution. I offer these with the acknowledgement the law is far from finished or perfect, but has been passed and is currently the law of the land. At this point rather than pursuing the idea of repealing it, I suggest we work together to make it better.

There are many issues with how this law was presented and sold to the American public, and many views on where this law takes us. The passage of the law was a bruising political battle and the scars from it are shaping its progress and evolution. **The ACA is the most important piece of legislation in the healthcare industry since Medicare and Medicaid in 1965. So let's discuss the ACA in the context of healthcare infrastructure in the United States.**

History of the U.S. Healthcare System

Healthcare costs were not always this expensive. Before the development of medical insurance, patients were expected to pay all healthcare costs out of their own pockets. Think through that idea for a minute. During the 1920s, some hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations in the 1930s. Today most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency healthcare procedures, and also most prescription drugs, but this was not always the case. The rise of private insurance was accompanied by the gradual expansion of public insurance programs for those who could not acquire coverage through the open market.

In the 1930s, President Franklin Roosevelt's administration explored possibilities for creating a **national health insurance program** while it was designing the Social Security system. But it abandoned the project because the American Medical Association (AMA) fiercely opposed it, along with all forms of health insurance at that time. The AMA was concerned we were becoming too socialistic.

Employer-sponsored health insurance plans expanded dramatically as a direct result of wage controls imposed by the federal government during World War II. The labor market was very tight because of the increased demand for goods and decreased supply of workers during the war. Federally imposed wage and price controls prohibited manufacturers and other employers from raising wages enough to attract workers. When the War Labor Board declared that fringe benefits, such as sick leave and health insurance, did not count as wages for the purpose of wage controls, employers responded with significantly increased offers of fringe benefits – particularly healthcare coverage – to attract workers. This set the stage for the explosive growth of group benefit plans.

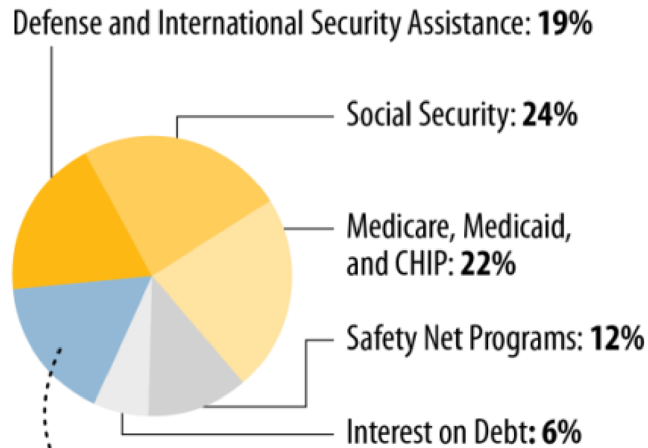
Between 1940 and 1960, the total number of people enrolled in health insurance plans grew seven-fold, from 20,662,000 to 142,334,000, and by 1958, 75% of Americans had some form of health coverage. According to the Kaiser Family Foundation 2013 Employer Health Benefits Survey (www.kff.org), 149 million non-elderly people are now covered by an employer sponsored group health plan. This is the majority of working adults in the U.S.

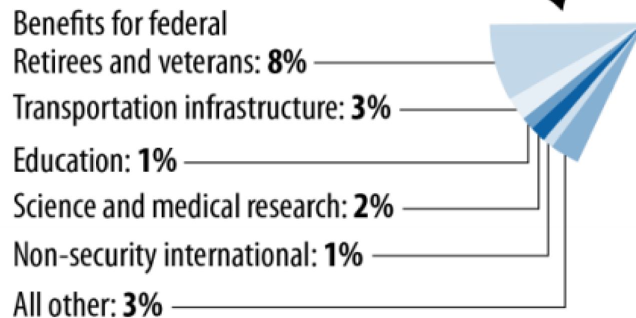
Medicare and Medicaid:

Even with this growth, private insurance remained unaffordable or simply unavailable to many, including the poor, the unemployed, and the elderly. Before 1965, only half of all seniors had healthcare coverage, and they paid three times as much as younger adults, despite having lower incomes. **Consequently, interest persisted in creating public health insurance for those not covered by the private marketplace.**

The 1960 Kerr-Mills Act provided matching funds to states assisting patients with their medical bills. President Lyndon B. Johnson signed the Medicare and Medicaid programs into law in 1965, creating publicly run insurance for the elderly and the poor. Medicare was later expanded to cover people with disabilities, end stage renal disease and ALS. Medicare was predicted by the conservative right to bankrupt America much like the ACA has been predicted by the conservative right to bankrupt America. ***Most folks do not appreciate that healthcare costs have been increasingly shouldered by the tax base since 1965.***

Public programs now cover 31% of the population and are responsible for 44% of healthcare spending. Public insurance programs tend to cover more vulnerable people with greater healthcare needs. Both Presidents Nixon and Clinton explored the idea of a national health insurance plan unsuccessfully. **The idea that we need to offer tax support to Americans who cannot afford the cost of health insurance is not new. Fundamentally, this is the goal of the ACA. Let's set politics aside long enough to take a look at healthcare costs and financing in the U.S.**





Source: 2013 figures from Office of Management and Budget, FY 2015 Historical Tables.

Center on Budget and Policy Priorities | cbpp.org

U.S. Government Spending

In fiscal year 2013, the federal government spent $3.5 trillion, amounting to 21% of the nation's Gross Domestic Product, or the total value of goods and services that America produces in a year. Of that $3.5 trillion, nearly $2.8 trillion was financed by federal revenues. The remaining amount ($680 billion) was financed by borrowing. This deficit will ultimately be paid for by future taxpayers. As the graph here shows, three major areas of spending each make up more than three-fifths of the budget.

When I consider how we should spend our tax dollars, it helps me to consider where they go presently.

Defense and international security assistance: In 2013, 19% of the budget, or $643 billion, paid for defense and security-related international activities. The bulk of the spending in this category reflects the underlying costs of the Department of Defense. The total also includes the cost of supporting operations in Afghanistan and other related activities, described as Overseas Contingency Operations in the budget, funding for which totaled $93 billion in 2013.

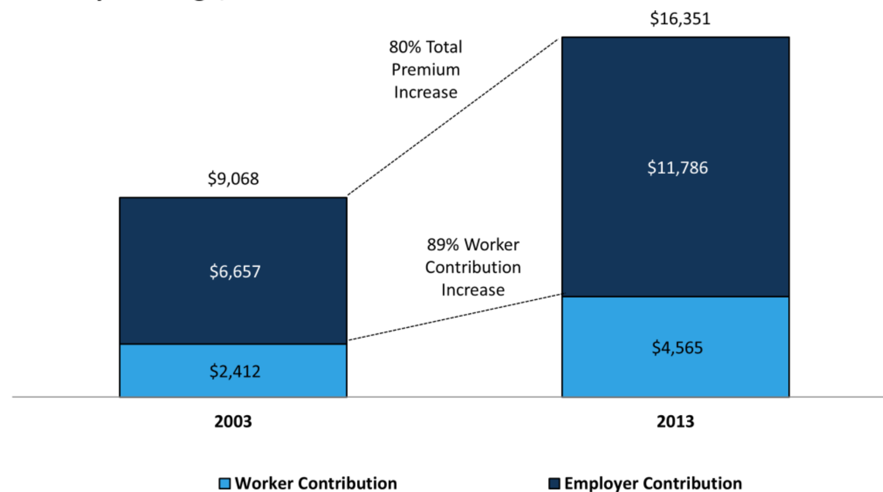
Social Security: Another 24% of the budget, or $814 billion, paid for Social Security, which provided monthly retirement benefits averaging $1,294 to 37.9 million retired workers in December 2013. Social Security also provided benefits to 2.9 million spouses and children of retired workers, 6.2 million surviving children and spouses of deceased workers, and 11 million disabled workers and their eligible dependents in December 2013.

Medicare, Medicaid, and CHIP: Three health insurance programs — Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) — together accounted for 22% of the budget in 2013, or $772 billion. Nearly two-thirds of this amount, or $498 billion, went to Medicare, which provides health coverage to around 54 million people who are over the age of 65 or have disabilities. The remainder of this category funds Medicaid and CHIP, which in a typical month provides healthcare or long-term care to about 70 million low-income children, parents, elderly people, and people with disabilities. Both Medicaid and CHIP require matching payments from the states.

Presently 22% of our federal budget goes toward covering 124,000,000 folks in the U.S. As a comparison, employer sponsored plans cover 149,000,000.

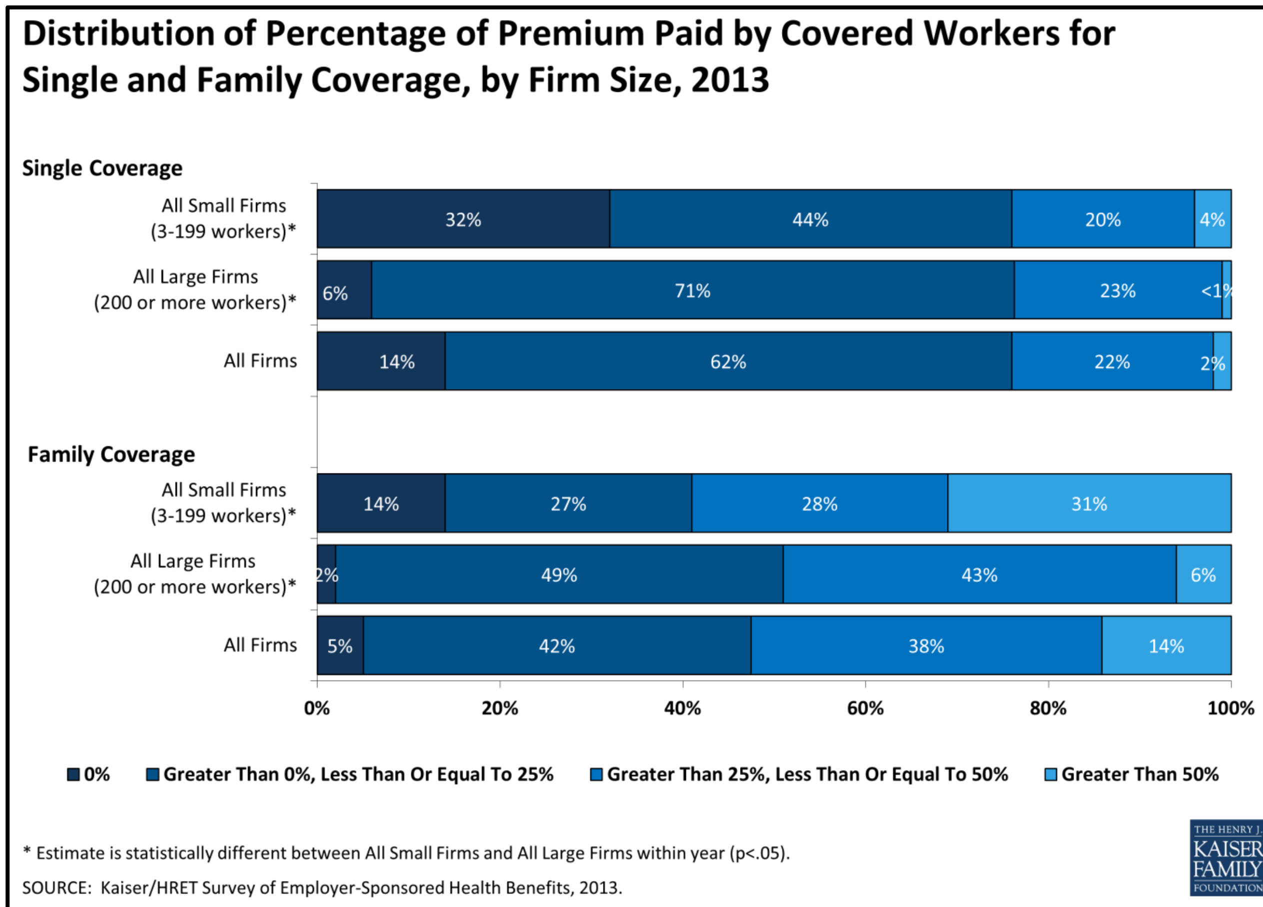
Employer Sponsored Insurance

The 2014 Annual Milliman Medical Index (www.milliman.com) reports the cost of care for an average family covered by an employer sponsored PPO is $23,215 per year. That amount is broken down as follows: $13,520 (58%) is paid by the employer and the employee pays $5,908 in payroll deductions and $3,787 in out of pocket costs. This represents a 5.4% growth rate over 2013. The chart below shows how this has grown over the last 10 years.



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2013.

Now let's see how size of your employer may affect your opportunity and cost to obtain benefits:



There are a couple of obvious conclusions I draw from the above information:

First, the cost of health insurance today is beyond the reach of most workers without a significant employer contribution.

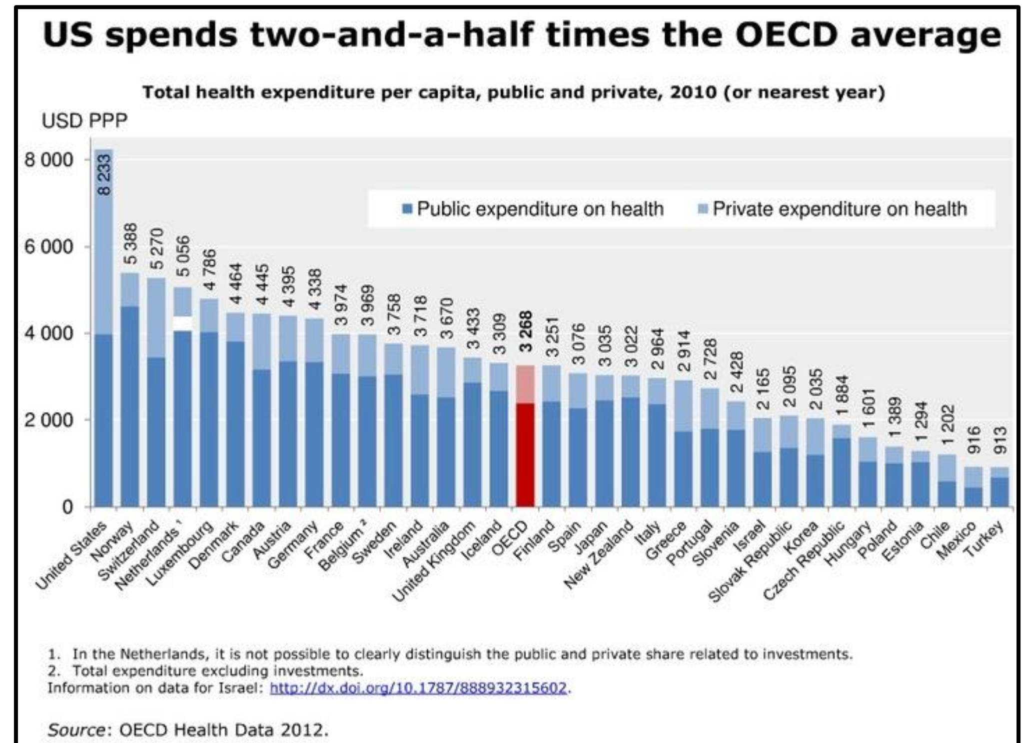
Second, the smaller the employer, the less likely the employer will offer a plan and make a significant contribution. Hence the need for tax support at certain levels of our economy.

U.S. Healthcare Costs

Take a look at this slide from the Office of Economic Cooperation and Development:

Average U.S. Income

In 2011 the median household income in the U.S. was $50,054 according to the U.S. Census Bureau. That works out to $4,171.16 per month on a gross basis. If the cost of a family's health coverage (not including out of pocket costs) is $1,362.58 per month, is it realistic to expect that family to pay 32% of its gross income per month for health insurance premiums? ***We have come to a place where healthcare costs are a disproportionately large part of our economy.***



Our Current U.S. System

In the 36 years I have worked with employers on benefit plans I have come to learn Americans have a unique perspective on healthcare in at least two regards:

1: We expect the latest and best technology to be available to everyone immediately.

2: We expect our health insurance to cover it … whether or not the technology, procedure or pill existed when we bought the policy.

A free enterprise system cannot easily accommodate this expectation. I know of no publically funded system which can completely support this expectation. The lags in services are due to the time required to restructure benefits in a governmental process. *So a free enterprise system which can respond to consumer demand more nimbly is actually a better solution than a true government-run healthcare system for our country.*

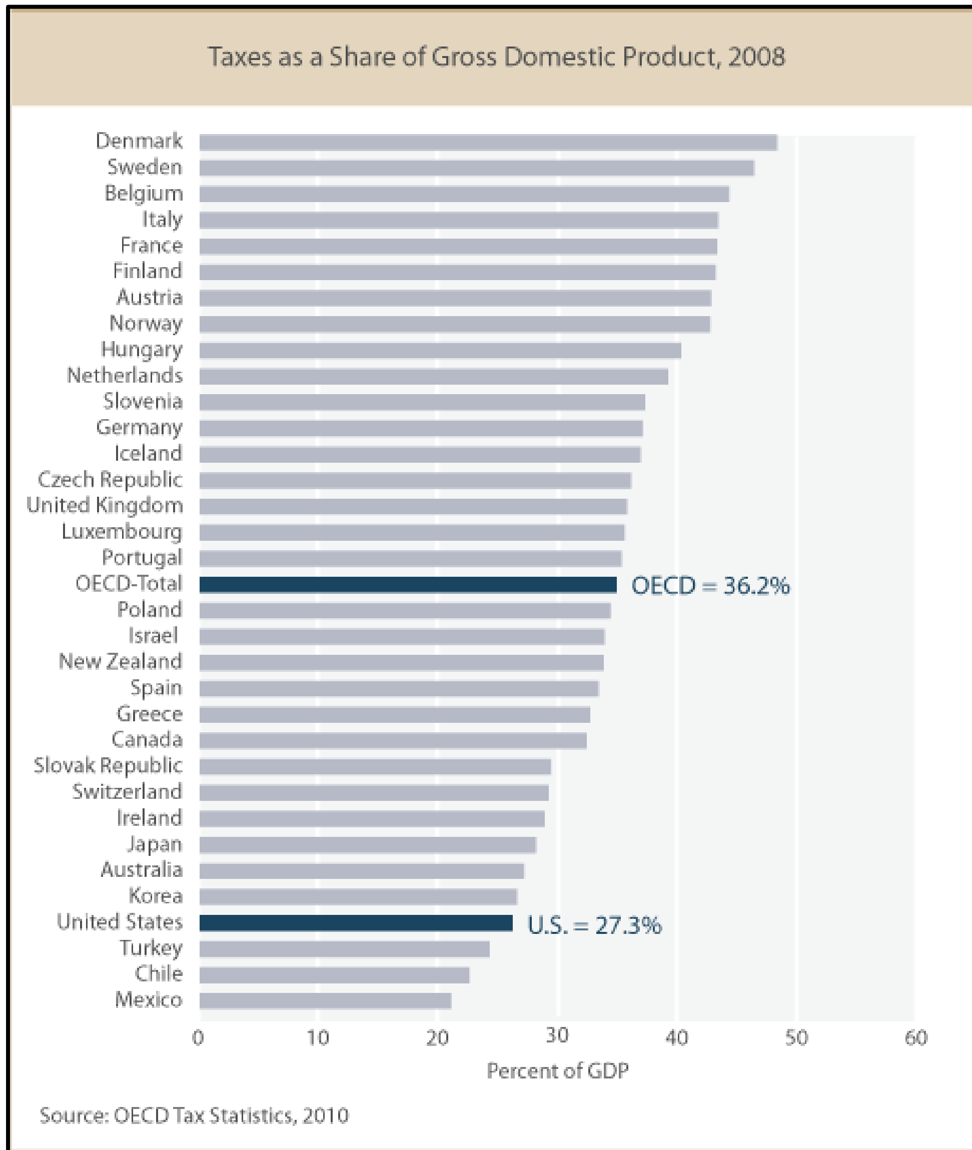
A majority of working adults get health insurance through their employer. Were this not so, presumably the employee would need and receive a higher wage to offset the cost of health insurance. Employers who offer coverage as part of compensation avoid F.I.C.A taxes on these monies and are able to offer a menu of benefits purchased in a convenient group platform from which employees can choose. Employers have resources available to answer questions and help them enroll in the correct plan. *I predict this service will remain a desirable benefit for employers to offer.*

The notion that the American public wishes to navigate the waters of a health insurance purchase like they would buy a book from Amazon is incorrect. Insurance purchasing is a dreadful task for most folks. I have always said insurance and taxes are two things most folks want handled for them by a professional who can help them to make the correct decisions. I don't believe this preference will change much in the future.

Even with all the criticism of our national healthcare system, there is still much we like about how it works. It may be that we are just stubborn or resistant to change, or it may be that it works for a majority of us. Our national healthcare system in the United States is still very expensive, and was recently ranked dead last in a Commonwealth Fund comparison of 11 industrialized nations while comparing healthcare systems (www.commonwealthfund.org). Yet a recent Gallup poll showed over 66% of Americans are satisfied with our system. It is as though we live in a bubble.

My conclusion is this: The system works very well for *non-elderly working adults* who can afford it, but it works relatively poorly for those who cannot.

I do believe our system works pretty well for the elderly and indigent (Medicare and Medicaid). So what to do about those of us it doesn't work for? *In America, when something can't be solved by the free enterprise system, we tend to look at a government, or tax-supported solution.* So let's take a realistic look at taxes:



<u>The Numbers: How Do U.S. Taxes Compare Internationally?</u>

U.S. taxes are low relative to those in other developed countries. The chart to the left compares taxes as a share of our Gross Domestic Product. In 2008, U.S. taxes at all levels of government claimed 27.3% of GDP, compared with an average of 36.2% of GDP for the 33 member countries of the Organization for Economic Co-operation and Development (OECD).

According to a Tax Foundation analysis (www.taxfoundation.org) the average federal tax rate for all taxpayers rose to 11.8% in 2010. Filers in the bottom 50% of income paid an average of 2.4%. Filers in the top 1% of income paid an average of 23.4%. The full report is very enlightening but too much for this topic. Whether you are an advocate of the current system, a revision to a flat tax, as use tax, an increased sales tax, a VAT tax or an employer tax – the discussion of what to do as a people with our tax dollars will always continue.

The Core Function of the ACA

Setting aside the "Employer Mandate" (Section 4980H) of the ACA for a minute (we will come back to this), *the basic idea of the ACA was to provide a sliding scale of tax subsidy depending on where a family falls on the Federal Poverty Level or FPL, which measures income and family size.* Here is a chart from Health and Human Services (https://hhs.org) that shows us what the FPL looks like.

2013 Federal Poverty Guidelines for 48 Contiguous States and D.C.

Federal Poverty Guidelines Used to Calculate Premiums, Cost-Assistance and Taxes in 2013 - 2014:

Household Size	100%	133%	138%	150%	200%	300%	400%
1	$11,490	$15,282	$15,856	$17,235	$22,980	$34,470	$45,960
2	15,510	20,628	$21,404	23,265	31,020	46,530	62,040
3	19,530	25,975	$26,951	29,295	39,060	58,590	78,120
4	23,550	31,322	$32,499	35,325	47,100	70,650	94,200
5	27,570	36,668	$38,047	41,355	55,140	82,710	110,280
6	31,590	42,015	$43,594	47,385	63,180	94,770	126,360
7	35,610	47,361	$49,142	53,415	71,220	106,830	142,440
8	39,630	52,708	$54,689	59,445	79,260	118,890	158,520
For each additional person, add:	$4,020	$5,347	$5,548	$6,030	$8,040	$12,060	$16,080

The ACA is designed to limit annual expenses for healthcare to a percentage of income depending on where you fall on the FPL. It does this in two ways: an Advance Premium Tax Credit – commonly referred to as a "premium subsidy" – and Cost Sharing Reductions, which are additional dollars paid to your insurer to reduce your out of pocket costs such as deductibles and co-insurances. The chart below illustrates how these two tax benefits work to limit healthcare costs for those folks who are below 400% of the Federal Poverty Level.

Table 3. Maximum Monthly Premium Contributions for Tax Credit Recipients Enrolled in the Second-Lowest Cost Silver Plan, 2014

Based on 2013 HHS Poverty Guidelines for the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Maximum Premium Contribution based on a Percent of Income ("Applicable Percentages")	Maximum Monthly Premium Contributions for Tax Credit Recipients, by Family Size			
		1 person	2 persons	3 persons	4 persons
100%	2.0%	$20	$27	$34	$40
132.9%	2.0%	$26	$35	$44	$53
133%	3.0%	$39	$53	$66	$79
150%	4.0%	$58	$79	$99	$119
200%	6.3%	$122	$164	$206	$248
250%	8.05%	$194	$261	$329	$396
300%	9.5%	$274	$369	$465	$560
350%	9.5%	$319	$431	$542	$654
400%	9.5%	$365	$492	$619	$747

Source: CRS computations based on "Annual Update of the HHS Poverty Guidelines," 78 *Federal Register* 5182, January 24, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-01-24/pdf/2013-01422.pdf.

Notes: For 2014, the income levels used to calculate premium credit eligibility and amounts are based on 2013 HHS poverty guidelines. If individuals enroll in more expensive plans than the second-lowest cost silver plan in their respective areas, they would be responsible for the additional premium amounts. If the required premium contribution exceeds the actual premium amount, individuals would pay the entire premium for exchange coverage. The premium amounts have been rounded up to the nearest dollar amount.

How the ACA Fits into U.S. Healthcare Infrastructure

So what we have evolving is really a four-tiered system of healthcare in the United States:

> The first tier is ***entirely tax supported*** plans for the indigent through Medicaid. The covered person pays nothing or very little for health services.
>
> The second tier is Medicare which is ***primarily*** paid for with tax dollars and supplemented by privately paid policies such as Medicare Supplements.
>
> The third tier is ***scaled tax subsidy*** for individual private policies offered in an Exchange environment through the Federal or State run Exchanges or Marketplaces. Unlike Medicaid, in every situation there remains part of the cost which must be paid by the ACA eligible person.
>
> The fourth tier is commercial group or individual policies provided through employers or paid for by individuals ***unsupported by the tax base other than the deductibility of the premium for businesses*****.**

As you can see our system already supports the poorest with tax dollars on a graduated scale. I see the ACA as another necessary step in the scale as support for those among us who cannot afford the cost of healthcare.

I'm sure by now you realize I don't intend to address all the provisions of the ACA. We are not finished modifying this law and while much is up for discussion, the most onerous piece of the law for businesses is the "Employer Mandate." As I mentioned previously, I wanted to get back to this provision of the ACA:

The Employer Mandate

I suppose the reason this provision became part of the ACA was primarily due to not being able to pass a law which placed the entire burden of cost solely on the tax base. Since so many of us currently had coverage through our employers, it seemed a fit to require businesses of a certain size to shoulder some of the cost burden. However, **the initial estimates from the Obama administration on how to pay for the cost of the tax subsidies relied on projections of as much at $140 billion dollars in employer penalties** … seemingly as though American business operates in a vacuum and would just acquiesce to an additional tax burden.

American businesses are very adept at developing solutions to avoid taxes – such as reducing hours, hiring different workers, or eliminating plans entirely to maximize profitability and sustainability. I attended the First National Exchange Conference in Chicago in 2010 and as usual for me, sat in the front row both days and asked every single speaker the same question: "Will the penalties work?" They all said "No." For anyone who has run a business, this wasn't rocket science.

We attended the AHIP National Exchange Conference in D.C. this past March where Cass Sunstein, one of the primary authors of the ACA began his presentation by confessing they should have included more people with business experience in the development of the law. After so many struggles dealing with aspects of the law which make no business sense, that was refreshing to hear.

The Flaw in the Law

At present, Section 4980H of the ACA requires an employer to offer a plan with minimum essential coverage of at least 60% actuarial value to all fulltime employees at no more than *9.5% of W-2 for single coverage only.* The intent of the law when it was first written was to require employers to provide that same coverage for *families* at no more than *9.5% of Adjusted Gross Income*, or face a tax penalty of either $2,000 or $3,000 per employee. **This evolution from A.G.I. to W-2 and single to family is why the Employer Mandate provision of the ACA just doesn't work.**

Our work with employers and focus groups shows that less than 10% of any group population would accept a bronze level plan at 9.5% of W-2. The cost of a 60% actuarial value or bronze plan is too expensive and the coverage is too lean. So for an employer to comply by offering a qualifying plan is always less expensive than paying penalties**. Employers will not be paying penalties as projected.**

Also the mandate excludes the dependents from obtaining tax subsidies through the exchanges if they are eligible under the employer group plan. Former President Bill Clinton referred to this in a 2012 speech as "The Family Glitch." **The law simply does not do what it intended; it does not cover families at no more than 9.5% of A.G.I.**

The law was intended to go into effect in January 2014 and was postponed until 2015 or 2016 depending on employer size. A May 2014 article by the Urban Institute (https://urban.org) strongly suggests that distortion in the labor markets would be minimal if we did away with the Employer Mandate but that the real issue is simply this:

The political ramifications of losing between $46 billion and $140 billion in projected employer penalties (depending on which source you follow), which were sold as a way to pay for the ACA, are embarrassing. I predict that even if the mandate held, the penalties would be a fractional percentage of the estimate given the ingenuity of American businesses. *The estimate was fatally flawed at the outset and should not be the reason anyone clings to a provision which does not work to solve the problem of unaffordable healthcare.*

What to Do Moving Forward

We need to recognize that not everyone in the U.S. has affordable access to healthcare. I believe that much like Medicare and Medicaid have become an obligation of the tax base, ACA qualification on the basis of the FPL has become an obligation of the tax base. There has been no viable free market solution offered to really solve the problem of the cost of healthcare in the U.S. I believe our healthcare infrastructure should provide quality healthcare for all U.S. citizens whether they can afford it personally or not. We do need to identify how we should pay for this evolution and that part is very subjective. Let's get past the idea that someone else should pay for this and consider the following:

We could establish a flat national healthcare tax, applicable to all income earners as a percentage of earnings. Have the percentage actually pay for our tax supported healthcare costs without borrowing or repositioning our national debt. Let's pay it each year and protect it for this purpose alone. Let's not allow it to become a burden for our children and let's not allow these funds to be robbed or borrowed from to pay for any other programs.

We could instead add an ACA component to the current FICA tax rate with both an employee and employer matching percentage. This will get some kickback as those who are not subsidized will see this as unfair. But it is not really different than how we fund Medicaid, so I suggest we consider one of these two ideas very carefully. I recognize this is a tall order but we can and must do this.

The ACA Effect on the Employer Sponsored Market

I predict the Employer Mandate will never become a part of the ACA and its removal from the ACA will not significantly change our current system of healthcare offered as a piece of compensation. I predict American employers will make decisions on whether or not to offer benefits as part of compensation based on their best business practices and the effect those have on establishing a healthy work environment and developing employee engagement. I believe our free enterprise system will continue to steer the course of the healthcare infrastructure evolution.

Summary

Pretend your path crosses with a woman at the grocery store or standing with her child in a bus line. You exchange pleasantries and then it comes up in your conversation that she doesn't have the insurance or the money to get her child the surgery he needs to live. How would you respond?

In America no one says, "Too bad for you, Sister. You didn't work hard enough or make the right decisions." (If that is your thought I suggest you read Charles Dickens' classic, "A Christmas Carol," the story of Ebenezer Scrooge, or watch the movie with George C. Scott … tonic for the soul!) Thankfully, in our country we believe we should all have the best healthcare. We just need to figure out how we pay for it. Let's set aside the politics and work together to solve this problem.

Chris W. Durkin

RHU - REBC - President

After entering the insurance business in 1978, Chris founded The Fringe Benefit Company in February 1983. FBC has enjoyed a sustained period of significant growth from its beginning to one of the largest insurance and benefit consulting firms in the state of Arizona. Chris currently serves as president and CEO of FBC Insurance Benefits & Consulting.

Chris received his designation as a Registered Health Underwriter in 1994, and in 1995 he earned his Registered Employee Benefits Consultant designation from the American College. Chris also has his PPACA certification from the America College, a division of the Wharton Business School.

Chris is a national speaker on the Affordable Care Act and its impact on business owners and their employees. He has authored a series of articles on the evolution of healthcare and the subsequent change in business practices. He is very involved in explaining the migration of healthcare insurance responsibilities away from corporate America and onto the tax base.

Chris has twice been president of the Blue Cross Blue Shield broker advisory council and remains involved in helping vendors recognize the needs of employers both large and small. He confesses to being somewhat of an insurance geek.

Chris graduated from Arizona State University with a degree in English literature. He loves reading, golfing, bird hunting, and fly fishing. Chris and his wife, Shawn, have been married more than 36 years. They have been actively involved in Young Life ministry for more than 25 years and serve on the Young Life Africa committee. Chris and his family attend Highlands Church in Scottsdale. Both he and Shawn are very proud of their four sons, Ryan, Aaron, Garrett and Brett.