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Looks Like ObamaCare ...

The electorate has spoken, and it looks like President Obama's Patient Protection and Affordable Care Act (affectionately referred to as "ObamaCare") is here to stay. President Obama's signature legislation has been on the chopping block twice: once in the hallowed courtroom of the United States Supreme Court, and once in voting booths across the country. Both times, this divisive law has emerged essentially unscathed.

Up to now, we've seen the implementation of the relatively modest, generally positive, and for the most part, less controversial parts of the law. So far, most of the Affordable Care Act (ACA) changes have been viewed as positives for most Americans. We've seen coverage being extended to dependents up to age 26 (even if they are married or supporting themselves). We've seen insurance companies provide up-front coverage for many types of wellness care at 100%. We've seen the removal of certain benefit limitations and dollar caps, the elimination of preexisting condition limitations for children up to age 19, and the payment of rebates to policyholders if insurers failed to hit certain minimum loss ratios. In fact, with the exception of the medical loss ratio (MLR) rebates, none of the ObamaCare changes so far have been a big deal … until now.

Amongst a whole slew of smaller things slated to kick in on January 1, 2014, here are a few of the bigger ones: (1) insurance companies will no longer be able to exclude coverage for the preexisting conditions of any insured individual (not just children); (2) state insurance marketplaces known as "exchanges" are scheduled to begin operation; (3) the contentious individual and employer health insurance mandates will become effective; (4) tax credits and subsidies will kick in; (5) community premium rating for group insurance plans will replace health underwriting; and (6) in most states, Medicaid will be available to people with income up to 133% of the federal poverty level (currently $30,657 for a family of four). In the interest of space, I'll briefly touch on these important impending changes.

At first blush, the **elimination of preexisting conditions** sounds like a pretty good idea. It's hard to argue that a fellow American should be financially punished simply because he or she has the misfortune of having a preexisting medical condition. After all, we are a compassionate nation, right? If you dig deeper, however, you'll quickly see that eliminating preexisting condition limitations without mandating that everyone has coverage encourages someone to wait until they get sick before they enroll in, and pay for, health insurance coverage. This adverse selection can (and will) have serious financial consequences for the rest of the country, as it will raise premiums for those who are currently insured.

"Hold on," you say. *"I thought ObamaCare required everyone to carry insurance coverage. Won't that address the adverse selection nonsense you're spewing out?"* Well, yes and (more likely) no. While ObamaCare does require everyone to carry insurance coverage or pay a tax, the relatively toothless tax penalty of $95 per year most certainly won't be enough to overcome the anti-selection that occurs with immediate coverage for preexisting conditions. People are smart enough to do basic math, and if annual health insurance premiums are $5,000 for an employee and $14,000 for a family (which they are), many people will simply choose to go bare until the insurance need arises. This will undermine the most basic actuarial assumption of how insurance is supposed to work: pooling of unknown and random risk. Inevitably and invariably, this will raise premiums. Of course, rising premiums will cause more healthy people to drop coverage, which will further erode the health status of the pool, and the cyclical death spiral will continue to worsen.

On January 1, 2014, every state is supposed to have a **health insurance exchange** in operation. These exchanges are going to be marketplaces run by the state, the federal government, or both, where people can shop for and obtain health insurance coverage if they don't already have it through their work or a government program. It is important to note that you will need to purchase your insurance through one of these exchanges if you qualify for a refundable premium tax credit.

The **employer "play or pay" mandate** will also take effect in 2014. Generally speaking, this part of the law requires employers with 50 or more full-time equivalent employees (FTEs) to either "play" by offering a minimum level of health insurance, or

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to "pay" a financial penalty. If the employer decides not to "play," there are two types of penalties: (1) if the employer doesn't offer any coverage, there is a $2,000 per FTE penalty (with the first 30 FTEs being exempt from the penalty); and (2) if the employer offers "inferior" or "unaffordable" coverage, there is a penalty of $3,000 per FTE who receives a government subsidy (with the maximum penalty being no more than $2,000 times the number of FTEs). Many employers have already said they are going to pay rather than play because it will be far cheaper to pay the penalty than it will be to extend coverage to all FTEs.

Hand in glove with the employer mandate is the **individual mandate**. This part of the law says that unless a taxpayer is otherwise exempt, he or she will be assessed a penalty if the taxpayer doesn't carry "minimum essential coverage" through an individual policy, an employer-sponsored plan, or a government-sponsored plan (*e.g.*, Medicare, Medicaid, CHIP, TRICARE). The penalty is the greater of a percentage of income amount (1% in 2014, 2% in 2015, and 2.5% in 2016 and thereafter), or a flat dollar amount ($95 in 2014, $325 in 2015; $695 in 2016 and thereafter).

With the exception of certain taxpayers who are exempt, most taxpayers will have to carry insurance coverage unless they truly can't afford it (*see below*). In an effort to assist individuals and families who can't afford or who don't have minimum essential coverage, the ACA provides for **refundable premium tax credits** for low-income individuals (provided coverage is purchased through an eligible government exchange). Generally, these "low-income individuals" are defined as taxpayers with income between 100-400% of the federal poverty line (FP"). In other words, under the current FPL guidelines, a family of four with household income of $92,200 would qualify for a premium tax credit. In addition, individuals and families at or below 250% of the FPL may qualify for an additional **"cost-sharing reduction subsidy"** which will further help them pay for deductible and co-payment amounts.

So which taxpayers are exempt from the individual mandate? There are several categories: (1) religious conscience objectors under the ACA; (2) members of a "health care-sharing ministry" (*e.g.*, Medi-Share); (3) individuals who are not citizens, nationals, or lawfully present in the U.S.; (4) incarcerated individuals; (5) individuals who cannot afford coverage because it would cost more than 8% of their household income; (6) individuals whose household income does not exceed the threshold for filing a federal return; (7) members of certain Native American tribes; (8) individuals who have a gap in coverage no longer than three months; and (9) individuals who receive an exemption from the Secretary of Health and Human Services (HHS).

Starting in 2014, insurance companies in the individual and small group markets will have to **community rate** their policies (grandfathered plans are exempt). This means all small employer plans will have the same basic rates, which will essentially eliminate financial incentives for healthy lifestyles. There are a few minor exceptions to this community rating requirement which will allow for group-specific underwriting. These limited exceptions are: (1) coverage category (*e.g.*, individual versus family coverage); (2) geographical differences; (3) age (limited to three times the lowest rate); and (4) tobacco use (limited to 1.5 to one). Expect the rates of healthy groups to jump significantly, while the rates for the unhealthy groups will come down as allowable rate bands get squished together.

Finally, I'd like to briefly touch on **Medicaid expansion** under the Affordable Care Act. Currently, Medicaid requires states to cover certain limited categories of people (*e.g.*, impoverished families, pregnant women, children, the blind, the elderly, and the disabled). Initially, ObamaCare was supposed to have extended Medicaid coverage to 17 million more Americans; however, because the Supreme Court reined in this mandate, states are now free to decide for themselves whether they want to expand their Medicaid programs to adults with incomes of 133% of the FPL ($14,856) or below. The federal government has promised to pay 100% of the cost of the "newly eligible" Medicaid enrollees through 2016, and 90% thereafter. Needless to say, the cost of Medicaid expansion (regardless of who is ultimately footing the bill) will be astronomical.

As Always ...

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