The Calm Before the Storm: Preparing for Changes in the Health Insurance Marketplace

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I. Introduction

The American health insurance industry is changing in multiple and significant ways. Many of those changes were directly imposed by legislation. Others are being prompted by implementing regulations. Still others are the result of market forces which are, themselves, attributable to changes in health care delivery systems and the mechanisms through which Americans pay for health care that have yet to be implemented.

By upholding the constitutionality of the *Patient Protection and Affordable Care Act (PPACA)*, the Supreme Court virtually ensured that many of those changes will be lasting. However, what hung in the balance at the Supreme Court was not limited to the potential repeal of those changes which already had been implemented. Rather, it included several prospective changes that promise to change the health care system, health insurance industry, employer obligations and millions of American lives in significant ways.

Several of those changes are scheduled to become effective on January 1, 2014. The time to prepare therefore is running short.

II. The Individual Mandate

The "individual mandate" is a set of provisions which (with some exceptions) requires that all citizens obtain and maintain "minimum essential coverage" –a package of benefits within ten broad categories of health services -- by January 2014. Beginning in 2014, anyone who is not exempt will be required to make a "shared responsibility payment" as part of their federal income tax return if they do not have minimum essential coverage in place.

As outlined in Congressional testimony (and later explained in the Supreme Court's decision), Congress reasoned that the individual mandate was made necessary by a pair of significant limitations on insurers' ability to underwrite health insurance applications which also are scheduled to become effective in 2014. One – known as "guaranteed issue" -- prohibits health insurers from denying coverage to people for any reason, including their health status. The other – known as "community rating" -- prohibits health insurers from charging people more because of their health status and gender. Instead, premiums will be allowed to vary only on the basis of geographic area, age (by a 3 to 1 ratio), tobacco use (by a 1.5 to 1 ratio), and the number of family members.

The Supreme Court acknowledged that, without the individual mandate, those provisions raised a genuine risk of "adverse selection." As Chief Justice Roberts explained:

> "The guaranteed-issue and community-rating reforms do not . . . address the issue of healthy individuals who choose not to purchase insurance to cover potential health care needs. In fact, the reforms sharply exacerbate that problem, by providing an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage. The reforms also threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage. This will lead insurers to significantly increase premiums on everyone."

Roberts, C.J., pp. 16-17. The Congressional testimony had painted a far more desperate picture, suggesting that such a circumstance would cause the financial foundation supporting the health care system to fail, "in effect causing the entire health care regime to 'implode'." See, *Virginia v. Sebelius*, 728 F.Supp.2d 768 (E.D.Va. 2010).

Ultimately, the Supreme Court upheld the constitutionality of the individual mandate. In turn, many Americans simplistically believe that, beginning in 2014, they must either have health insurance coverage or be prepared to make a "shared responsibility payment" as part of their federal taxes. However, the individual mandate does *not* apply to everyone. To the contrary, *PPACA* exempts several classes of individuals from the individual mandate, including illegal aliens, members of recognized Indian tribes and certain religious sects, incarcerated people and anyone with a coverage gap of fewer than three months. It also provides for a hardship exemption.

At the same time, *PPACA* contains other provisions which effectively limit the impact of the individual mandate to high-income individuals.

For example, individuals who make less than 133 percent of the federal poverty level (FPL) are exempt from the individual mandate. *PPACA* instead addressed their need for health coverage by expanding *Medicaid* to include persons who make no more than 133 percent of the FPL. However, the Supreme Court's decision preserved the states' ability to choose whether to participate in that expansion of *Medicaid*. In those states which choose not to participate, individuals who make between 100 percent and 133 percent of the FPL may be left without coverage.

Individuals who make between 133 and 400 percent of the FPL will be eligible to obtain coverage through the health benefit exchanges that are scheduled to be created in 2014. They also will be eligible for premium subsidies which are designed to ensure that their cost of doing so does not exceed 9.5 percent of their income.

In 2011, the FPL for a family of four was $23,050. If that figure increases by just 4 percent per year, a family of four which makes 400 percent of the FPL will have an income of $112,176 in 2016. That family of four's cost of obtaining coverage through the health benefit

exchanges therefore will be capped at $10,657 per year. The rest will be paid by premium subsidies, but their alternative is to make a shared responsibility payment of just $2,085.

Individuals who make more than 400 percent of the FPL will be subject to the individual mandate unless the cheapest plan available in a health benefit exchange costs more than 8 percent of their income. The Congressional Budget Office (CBO) has estimated that the cheapest plan available through a health benefit exchange (providing "bronze" level coverage) will cost a family between $12,000 and $15,000 per year. If the lower of those figures proves to be accurate, a family of four that makes no more than $150,000 in 2016 also would be exempt from the individual mandate.

As a practical matter, then, the individual mandate may apply only to individuals with substantial income. Logically, many of those individuals will already have health insurance through employer-sponsored group plans. For the rest, they will face a choice between paying something more than $12,000 per year for health insurance and making a shared responsibility payment of not more than $2,085. Whether (and to what degree) the individual mandate actually drives more Americans into the health insurance marketplace therefore is a debatable proposition.

III. The Employer Mandate

To make "minimum essential coverage" more available to working Americans, *PPACA* contains a set of provisions which sometimes has been referred to as the "employer mandate." Technically, those provisions do *not* require that employers offer health insurance coverage to their employees. Rather, they provide that large employers (with 50 or more full-time employees) will be assessed an annual fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer "minimum essential coverage."

Large employers who choose to offer coverage will be required to automatically enroll employees in the employer's lowest cost premium plan if the employee does not sign up for employer coverage or opt out of coverage. However, they will be required to pay an annual fee of $3,000 for each employee who has an annual income below 400 percent of the FPL and opts out of the employer's plan.

Many large employers therefore may currently be reviewing which alternative is most economical: offering minimum essential coverage to their employees or paying penalties for not doing so. Since the employer mandate applies only to large employers, some also are considering the possibility of limiting their workforce to fewer than 50 full-time employees.

Researchers have used various types of studies to predict the effect of *PPACA* on employer-sponsored health insurance. In August 2012, the Government Accounting Office (GAO) reported that microsimulation studies provided near term estimates ranging from a decrease of 2.5 percent to an increase of 2.7 percent in the number of individuals with employer-sponsored coverage. According to the GAO, some studies that used other analytic approaches predicted a net increase of 6 percent, while others predicted a net decrease of between 2 and 3 percent. The estimates provided by employer surveys uniformly projected a net decrease in the

number of individuals with employer-sponsored group coverage, with estimates ranging from 2 to 20 percent.

Ultimately, PPACA's true impact on the availability of employer-sponsored group coverage cannot be known until the employer mandate becomes effective in 2014. However, the baseline year for calculating an employer's obligations under *PPACA*'s employer mandate is 2013. The employer mandate's pending implementation therefore presents a time-sensitive opportunity to help large employers identify and evaluate their options.

IV. Health Benefit Exchanges

PPACA also created a new Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to Americans who lack coverage because of a pre-existing condition. As of April 30, 2012, twenty-three states and the District of Columbia had elected to have their PCIP program administered by the federal government, while the remaining twenty-seven states had chosen to run their own programs. By design, though, the PCIP program is temporary. Indeed, it is scheduled to terminate in 2014, when the health benefit exchanges will become effective. 42 C.F.R. § 152.45.

To that end, *PPACA* provides for funding to assist the states in establishing health benefit exchanges. It also directs the Department of Health and Human Services to establish an exchange (directly or through agreement with a not-for-profit entity) in any state that fails to establish its own. As of the date of the Supreme Court's decision, forty-nine states (i.e., all but Alaska) and the District of Columbia had applied for and received up to $1 million in Exchange Planning Grants. However, only thirty-two states and the District of Columbia had applied for and received Level 1 Establishment Grants, and just two states had applied for and received Level 2 Establishment Grants.

A number of the states that challenged *PPACA*'s constitutionality decided to wait for the Supreme Court's decision before spending time or money to create exchanges. Recognizing that circumstance, the federal government extended until February 15, 2013 the date by which each state was required to announce its intention to create a state-run health benefit exchange. Four days later, the Department of Health and Human Services announced that a total of 24 states (plus the District of Columbia) were on track to run exchanges, either on their own or in partnership with the federal government. The remaining 26 states have opted to rely solely on the federal government to establish and operate exchanges.

Although the exchanges are scheduled to become operational when calendar year 2014 begins, substantial questions remain about many states' ability to meet that deadline. It also is unclear whether those exchanges can truly be functional on January 1, 2014, whether they will be adequately prepared to handle a substantial number of new enrollments, and (in the long term) whether they can do so in a fiscally sound manner that serves *PPACA*'s goal of making health care *affordable*. Nevertheless, open enrollment for all exchanges is scheduled to begin in October 2013. For that reason, the Department of Health and Human Services (and numerous states) already are preparing to make concerted efforts at promoting their exchanges and attracting enrollees.

V. The Expansion of *Medicaid*

To make coverage available to Americans who have neither private nor employer-sponsored health insurance coverage and who do not have the means to obtain coverage through the exchanges, *PPACA* also calls for an expansion of *Medicaid* to include all individuals under age 65 with incomes up to 133 percent of the FPL. Initially, the federal government will fully fund the cost of covering those who become newly eligible for *Medicaid*. Beginning in 2017, though, the states which administer coverage to those newly eligible participants will be required to fund some portion of the associated costs.

The CBO has projected that, by 2015, those provisions in *PPACA* will increase *Medicaid* enrollment by 24 million people. CMS separately estimated that the expansion of *Medicaid* will impose between $20 and $42 billion in additional costs on the states by 2020 -- even after counting the federal financing. The Supreme Court's holding that individual states could elect not to participate in *PPACA*'s expansion of *Medicaid* without jeopardizing their funding for their existing *Medicaid* programs therefore has become a lightning rod for both opponents and supporters of *PPACA*.

According to an analysis by the New England Journal of Medicine, at least 13 states have indicated they will not participate in *PPACA*'s expansion of *Medicaid*. Given that 26 states participated in the related constitutional challenge, still more states may elect to forego participation before the expansion goes into effect. Either way, there will be large portions of low-income adults in some states that are ineligible for any publicly subsidized health insurance (i.e., *Medicaid*) and unable to afford coverage through other means.

VI. Conclusion

In a best case scenario, the individual mandate will prompt more Americans to purchase health insurance before they need it. In turn, health insurers will be able to use premiums collected from a new set of healthier individuals to offset the costs of providing guaranteed coverage and greater benefits to more people. The employer mandate will make coverage more available to working Americans, the health benefit exchanges will reach those who do not have employer-sponsored coverage, and the *Medicaid* expansion will ensure that consumers with lesser means have some mechanism to pay for the health care they need. At the same time, *PPACA*'s insurance reforms will make coverage more affordable, while – over time -- its modifications of the health care delivery system both improve patient outcomes and substantially decrease the costs of health care.

In a worst case scenario, the individual mandate proves to be ineffective, making the threat of adverse selection more real for insurers. The employer-sponsored group market for health insurance contracts, the health benefit exchanges are unable to function in a fiscally sound manner, and many states elect not to make *PPACA*'s expansion of *Medicaid* available to some of their most impoverished citizens. In addition, the substantial costs associated with *PPACA*'s modifications of the health care delivery system make the costs of health care higher, perhaps

even prompting systemic changes which jeopardize all Americans' access to the health care they need.

In all likelihood, the reality will fall somewhere in the middle. For now, though, there are substantial changes taking place in both the health insurance and health care industries. Thus far, Americans have experienced only some of the most consumer-friendly changes mandated by *PPACA*. However, new tax obligations, new marketplace choices and new relationships with health care providers are on the horizon. Whether they ultimately benefit consumers – or serve as a rallying cry for still further changes – can only be known with more time.

About the Author:

Rob Pohls is the Founder and Principal of *Pohls & Associates*, a California law firm that represents life, health and disability insurance companies in bad faith, ERISA and other complex forms of litigation. Rob is an active Member of DRI's Life, Health & Disability Committee and a DRI Spokesperson on Health Care Reform. He also is a Member of the Association of Life Insurance Counsel, a Member of the International Claim Association, a Member of the Northern California Life Insurance Association, and a former Chair of the ABA's Health & Disability Insurance Law Committee.