If all of ACA stands

The Individual Mandate

What is the Individual Mandate, and why is it so important to the Affordable Care Act? It is the requirement that most Americans participate in the health insurance purchasing market. This was hoped to minimize the adverse impact that the other provisions of ACA would have on premiums.

Upholding the individual mandate as a tax rather than a penalty ACA now requires all individuals to purchase health insurance or pay a penalty for not enrolling by 2014.

Experts are still working on the effects of the ruling on the expansion of Medicaid which was limited by the ruling. There is some question whether

ACA can require an unfunded mandate of the states such as this. As written, ACA expands Medicaid eligibility to include individuals who earn $15,000/yr or less. It will not be necessary for a child to be on Medicaid for a parent to qualify at that time.

Refundable tax credits (similar to the Earned Income Tax Credit) will be available to individuals and families who are at 138% - 400% of the Federal Poverty Level. That means that a family of four or more can qualify for the refundable tax credit (subsidy) with household incomes of $88,000 or less. The amount of the subsidy can be as much as 100% of the premium for a basic medical plan for those at the low end of the income spectrum. The subsidy decreases as income rises. Individuals with incomes below 138% of FPL are exempted from the penalty for non-enrollment in health insurance.

Now that the individual mandate is upheld here are the penalties for not enrolling in insurance by 1-1-14:

2014…$95/adult/year……..	..$47.50/child/year	$285/family maximum
2015…$325/adult/year……	……$162.50/child/year	$975/family maximum
2016…$695/adult/year……	..$347.50/child/year	$2085/family maximum

Because the penalty is not much of a deterrent to going uninsured, the end result could be much higher premiums when those with health conditions begin to enroll without restrictions. ACA seems to allow for anytime open enrollment. That is, a sick person could enroll for insurance when he/she needs it. One option the Secretary of HHS would have at her disposal to counteract the anticipated higher premiums is to issue a ruling that enrollment will be restricted to specific periods of time, such as once a year and/or include late enrollment penalties for not enrolling during the initial eligibility period as determined by HHS.

To qualify for a subsidy an applicant must enroll through the Exchange that will be in operation by January 2014. An eligible applicant who enrolls for insurance directly with an insurance company will not be awarded a subsidy.

Many believe the Exchange may be too cumbersome to manage effectively, which leaves open the possibility for amending this provision of ACA.

Other issues now become clear.

ACA forbids gender bias on rates beginning January 1, 2014. Health plans at that time must use a "unisex" rate.

ACA forbids health status bias then as well. Insurance companies will not be allowed to charge more for a person with a pre-existing health condition than it would charge for a healthy person.

Age bias is tightened too in 2014. The current spread between the youngest adults and the oldest adults not eligible for Medicare will be tightened from a 7 – 1 spread to a 3 – 1 spread.

The age, gender, health biases are restricted on group plans too.

Who are the winners and losers:

Winners: People with pre-existing conditions; women

Losers: Young people, men, individuals without serious pre-existing health conditions

Maternity coverage will be mandated as an Essential health Benefit, as will mental health coverage. That is, mental health benefits must be treated as any other illness without benefit limits.

It is not hard to see from these mandates, that without the IM, health insurance costs are likely to soar, especially if no restriction is placed on "when a person may enroll." The likelihood of low cost insurance for young people continues to look pessimistic. Insurance carriers may raise the rates on older Americans modestly, but the young are likely to see large premium increases, maybe as much as 200% or more when the age bands are compressed to a 3 – 1 ratio.

On the other hand, premiums for those with pre-existing conditions may actually some ease a bit, especially when insureds with pre-existing conditions will no longer have to continue on high premium COBRA or other expensive "guaranteed issue" plans through the state or federal government. Of course, any speculation, the direction premiums will take, are premature at this point. Premiums are dependent on the level of enrollment and whether that enrollment enhances or diminishes "adverse selection", which is a phenomenon that increases risk to an insurance company when a preponderance of unhealthy people enroll versus the number of healthy people participating.

The federal government's "Pre-existing Condition Insurance Plan" will be terminated when the private market place plans begin accepting pre-existing conditions.

Additional benefit mandates that will continue to move forward include:

-Annual maximum benefits will be eliminated by 2014. All policies will have no annual or lifetime benefit maximums by then.

-Routine physical exams, including routine colonoscopies, will continue to be offered at no out of pocket cost to the patient.

-Contraception and sterilization will continue to be available without no out of pocket cost to the patient. (It is important to note this mandate was not spelled in the language of ACA. It is a function of the powers given to the Secretary of HHS by ACA.)

-Some health plans do not cover mental health benefits now. By 2014, they will have to cover both the medical and medication components.

-Maternity coverage will be considered an Essential health Benefit, and will be a mandated benefit on all health plans.

-Rescission of policies for inadvertent misrepresentation are not allowed and will continue to be banned under the remainder of ACA.

-Plans that have been grandfathered (excluded from certain mandates) will lose that status on January 1, 2014. All health plans must conform to all ACA mandates at that time.

-Streamlined claims appeals procedures will continue without the IM.

-Guaranteed Issue for children will remain. Until 2014, the current practice of private individual insurance plans not offering this coverage in the open market is likely to continue. That only leaves very limited options for insuring children without a parent or guardian on the policy.

-Allowing children to remain on parents' coverage to age 26 will continue even if the child is married, living independently outside the home, or is covered by his/her own insurance.

Taxes and government revenue enhancements will continue as well:

-Individuals with $200,000 adjusted gross income ($250,000 for joint filers) will pay .9% more in Medicare taxes.

-Additional taxes on medical equipment were included in ACA. The latest news looks like this probably will be repealed through legislative action.

-However, the 10% excise tax on sun tanning parlors will continue.

-Drug companies will pay a tax on brand name drugs dispensed. A sliding scale will determine the amount of tax.

-Elective medical procedures will also be taxed.

-Over-the-counter medications will no longer be eligible for HSA reimbursement without a written doctor's prescription.

All of these taxes except the additional Medicare tax are "pass through" taxes. That is, the additional costs could easily be passed through to the consumer.

The health insurance Exchange will become operational on January 1, 2014. The federal government will operate a default exchange if any states fail to set up their own exchanges. The Exchange will be another outlet through which individuals and small groups may purchase insurance. Individuals who may qualify for a subsidy MUST buy through the Exchange.

The Exchange will offer plans from multiple carriers. The shopper may shop for benefits and price. ACA does prescribe three levels of benefits to be sold in the Exchange (Gold, Silver, and Bronze). The subsidy will most likely be based on the premium attributable to the Bronze plan. The exact level of benefits in each category is still being worked out by HHS but, all must contain the required minimum level of Essential Health Benefits. As of now, EHBs do include, preventive care, maternity, doctor care,

hospital care, mental health, prescription drugs and may not impose any annual or lifetime maximum caps.

Because ACA defers to the Secretary of HHS for much interpretation of the various provisions of the law, there are likely to be new mandates issued in the weeks and months to come. Among the most pressing issues, now that the IM has been upheld, is establishing annual open enrollment periods and considering late enrollment penalties.

The Congress is likely to renew debate over some of the inefficiencies of what remains of ACA and of course, the November elections will also play an important role in the future direction of ACA.