John Locke
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spotlight

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Redistribution of Health

Severe Side Effects of the Affordable Care Act's Health Insurance Exchanges

KEY FACTS: • **A health insurance exchange, commonly referred to in the media simply as an "exchange," is an online marketplace where individuals can shop for heavily regulated nongroup health plans offered by participating insurance companies.**

• **The federal health law's 3:1 community rating ratio provision means that a high-risk individual cannot be charged more than three times the amount of a low-risk individual's health insurance premium. This means young and healthy individuals will experience rate shocks.**

• **North Carolina's health insurance premium percentage increases rank 4th highest in the nation.**

• **The Affordable Care Act, as written, restricts the distribution of premium assistance subsidies, or tax-credits, to state-run exchanges.**

• **The Obama Administration claims that an individual earning an income between 100-400% of the Federal Poverty Level (FPL) will be eligible for premium assistance subsidies through the exchanges. However, in North Carolina, subsidies do not extend beyond 309% FPL for low-risk individuals under age 34.**

• **The 2014 federal budget sequester will scale back additional cost-sharing subsidies for eligible individuals earning below 250% FPL by 7.2% — equating to a deficit reduction of $286 million before FY 2014 ends.**

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Full implementation of the Patient Protection and Affordable Care Act, commonly known as Obamacare, relies largely on the states. Within the federal health law's 2,700-plus pages, one key provision is the implementation of health insurance exchanges. A health insurance exchange, commonly referred to in the media simply as an "exchange," is an online marketplace where individuals can shop for heavily regulated health plans offered by participating insurance companies.

Under the law, the original enrollment period for an individual to sign up for health insurance and pay the first month's premium runs from October 1, 2013 to March 31, 2014.[2] However, since the exchanges' enrollment launch, the federal exchange website, healthcare.gov, has suffered from an infestation of technological bugs[3] and accessibility problems. Due to healthcare.gov's glitches, the enrollment period to purchase health insurance has been unilaterally extended by the White House at the request of major individual market players.[4]

Clearly, healthcare.gov needs a major fix. But the bigger problem lies within the actual policy implications of the exchange provision itself – not the online tool that allows consumers to compare plans. The fine print is worth some examination.

Health Insurance Exchanges

The exchanges are one of the most important pillars of Obamacare, because they are the mechanism through which the Obama Administration aims to deliver its promise of making comprehensive health benefits available to individuals at affordable prices.

Federal law mandates that all individual health plans sold on and off the exchanges must include the following 10 essential health benefits:[5]

1. Ambulatory Patient Services
2. Emergency Room Services
3. Hospitalization
4. Mental Health and Substance Abuse Services
5. Preventative Care, Wellness Visits, and Chronic Condition Prevention
6. Rehabilitative and Habilitative Care
7. Laboratory Services
8. Prescription Drugs
9. Maternity and Newborn Care
10. Pediatric Services (Including Oral and Vision)

Meanwhile, Obamacare redistributes federal tax dollars in the form of subsidies, or tax-credits, to eligible consumers who purchase plans on the exchanges.

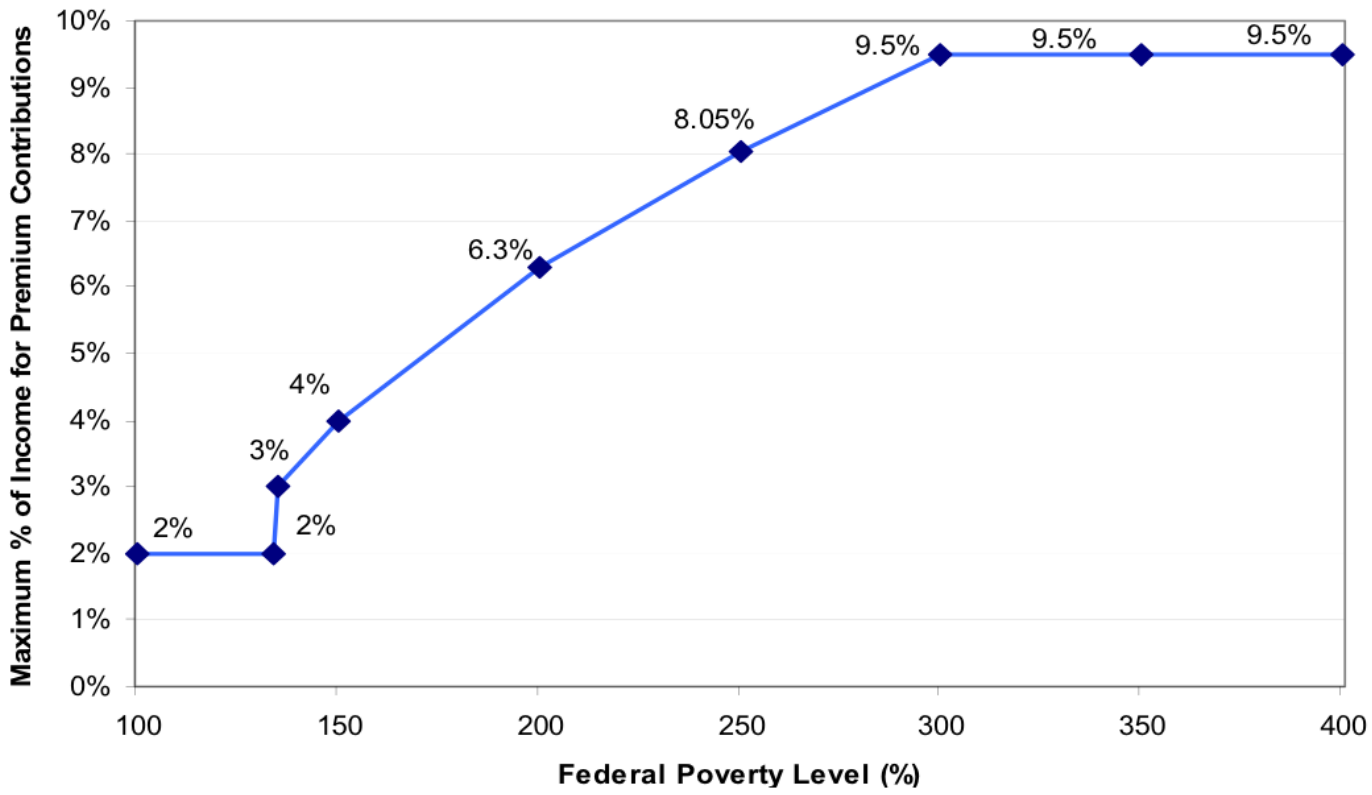
The Obama Administration incessantly advertises that such eligible consumers are those who earn an annual household income between 100-400% of the Federal Poverty Level (FPL).[6] This translates to:

- Individuals: $11,490-$45,960
- Couples: $15,510-$62,040
- Family of four: $23,550-$94,200

These subsidies purportedly offset much of the cost of health insurance premiums, but they do so at the expense of federal taxpayers and businesses. Reallocation is based on a sliding scale – the more an individual earns, the lower the granted subsidy.

Figure 2 shows a Congressional Research Service chart of examples following the formula.

Figure 1: Maximum Percentage of Income, as Measured by FPL, to go towards Premium Contributions[7]



Source: CRS analysis of ACA.

Unintended Consequences

Because Congress cannot force[8] a state to establish its own exchange, there are primarily two types of exchanges: state exchanges and federal exchanges.[9] Currently, North Carolina is one of 36 states[10] that have opted for the federal government to facilitate their exchanges. This decision by those states may greatly impact the success of the exchanges. This is because Obamacare's exchange provision contains a major loophole that may ultimately clot the flow of subsidies in the 36 states that have opted for federally facilitated exchanges.[11]

Consider the law's legislative history. The final Senate Bill could not have passed into law without concessions. One of the major concessions that passed was that only states that created their own state-run health insurance exchanges would receive federal subsidies. Meanwhile, a state that opted for a federally facilitated exchange would not receive federal subsidies to offset premium costs to eligible exchange consumers.[12]

This should mean that the 36 states that have opted for a federal fallback[13] will receive no federal subsidies, freeing individuals from the employer and individual mandates. In the law as written, federal subsidies go hand in hand with employer and individual penalties.[14] For example, under the employer mandate, if an employee cannot afford his employer's health plan *and qualifies for a premium assistance subsidy*, the employer is faced with the employer mandate tax. This tax pays for part of the federal subsidy distribution.

Meanwhile, an individual residing in a state with a federal exchange will be exempt from the individual tax if his premium exceeds 8% of his annual household income. An estimated 400,000 low and middle-income North Carolina residents who would have been subject to the individual mandate under a state exchange, should be exempt.[15]

However, not surprisingly, in May 2012, the IRS unilaterally amended[16] regulations accompanying the already enacted health care legislation so that subsidies would be allocated in state ***and*** federal exchanges.

This issue has sparked multiple lawsuits that are currently pending at the federal district court level. One critical lawsuit, *Halbig et. Al. v. Sebelius*,[17] was filed by Sam Kazman, general counsel of the Competitive Enterprise Institute, in May 2012. All the plaintiffs are individuals and employers residing in states with federal exchanges. Judge Paul Friedman of the D.C. federal district court denied the government's motion to dismiss the suit and plans to issue a ruling by February 15, 2014.[18]

The exchange subsidies are the beating heart of Obamacare. If these critical lawsuits are successful, then two-thirds of states will not be granted these subsidies, making health plans on the exchanges unaffordable for many

Figure 2: Illustrative Examples of Required Premium Contributions and Monthly Credit Amounts, if Premium Credits were Available in 2013, by Coverage Tier[19]
For the 48 contiguous states and the District of Columbia

Coverage Tier	Income Level (based on FPL)	Federal Poverty Level (FPL)	Maximum Premium Contribution as a % of Income	Age of youngest adult[a]	Monthly Premium[b]	Required Monthly Contribution from Enrollee(s)	Monthly Credit Amount
Self-Only	$17,235	150%	4.0%	20	$183	$57	$126
	$17,235	150%	4.0%	60	$782	$57	$725
	$40,215	350%	9.5%	20	$183	$183[c]	$0
	$40,215	350%	9.5%	60	$782	$318	$464
Family of Three[d]	$29,295	150%	4.0%	20	$549	$98	$451
	$29,295	150%	4.0%	60	$1,747	$98	$1,649
	$68,355	350%	9.5%	20	$549	$541	$8
	$68,355	350%	9.5%	60	$1,747	$541	$1,206

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; and "National Health Care Calculator," U.C. Berkeley Labor Center, http://laborcenter.berkeley.edu/healthpolicy/calculator/.

Notes: Under ACA, premium credits will not be available until 2014; the data in this table are for illustrative purposes only. The monthly premium and contribution estimates reflect 2013 dollars. With respect to the poverty guidelines, different income levels apply in Alaska and Hawaii (see "Annual Update of the HHS Poverty Guidelines" referenced under Source). The poverty guidelines are updated annually for inflation.

a. Premiums for exchange plans will be age-adjusted to allow for a maximum 3:1 variation based on age for adults. Exchange premiums also will be allowed to vary based on tobacco use (1.5:1 variation), family size, and geography. For additional information about these rating restrictions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

b. The actual premiums for exchange plans are not known at this time. The premium estimates are based on the Congressional Budget Office's national estimates for silver-tier plans, as incorporated in the National Health Care Calculator. Given these are national estimates, they do not reflect variation due to geographic cost differences; differences which are allowed to be incorporated into premiums for exchange plans.

c. The required premium contribution for an individual whose income is $40,215 in 2013 would be $318 per month, which is 9.5% of $40,215 divided by 12. However, the monthly premium for a 20-year-old is lower ($183), so that person would pay the lower amount for exchange coverage.

d. Premiums for exchange plans are allowed to vary based on family size. In this table, the hypothetical family comprises two adults and one child under age 21.

citizens. Pushback against this monumental pillar of the law will lead to a serious reconsideration of the very viability of Obamacare.

More Unintended Consequences

Nancy Pelosi once said that Congress had to pass the Patient Protection and Affordable Care Act "so that you can find out what is in it."

We certainly are. Even more unintended consequences continue to surface under the exchange provision, notably that fewer people will qualify for subsidized health insurance plans than the Obama Administration once promised.

According to a recent study by the National Center for Public Policy, in two-thirds of the states, subsidies do not extend beyond the 300% FPL level for individuals between the ages of 18-34, the so-called "young invincibles" population.[20] In fact, subsidies greatly diminish for individuals of this age group earning over $25,000 a year. In North Carolina, subsidies do not extend past 309% FPL ($35,504) for a 34-year old.[21,22]

This is another reason why Obamacare causes chest pain. For the exchanges to maintain a balanced risk-pool among all age groups and health conditions, the "invincibles" group must sign up for plans on the exchanges. The reason for this is community rating.[23] This concept under the federal health law mandates that a high-risk individual cannot be charged more than three times the amount of a low-risk individual's premium.

Enforcing the 3:1 community rating ratio is key to delivering on the Obama Administration's promise that high-risk individuals and individuals with pre-existing conditions will be offered affordable health plans. But for this outcome to occur, low-risk individuals must pay higher premiums to subsidize the health care costs of the high-risk population. The old and sick will benefit at the expense of the young and healthy if "invincibles" are not only willing to purchase expensive coverage but also able to afford these plans.

The Obama Administration's goal is for 7 million consumers nationwide to purchase health insurance policies through the exchanges by March 2014. In order to make the numbers work, they need over 2.7 million, or 40% of this population, to be young and healthy.[24] Otherwise, the exchanges will be flooded with older, higher-risk individuals paying higher premiums than anticipated. If this occurs, the insurance marketplaces will collapse.

Along with failure to deliver the promised distribution of premium assistance subsidies to eligible exchange consumers, another unintended consequence looms in the shadows of Obamacare that the administration has yet to address. Individuals earning below 250% of FPL ($28,000 for an individual) who purchase exchange plans are supposed to receive additional cost-sharing subsidies that limit out-of-pocket health care expenses. However, the 2014 federal budget sequester will scale back these subsidies by 7.2% -- equating to a deficit reduction of $286 million before FY 2014 ends.[25]

Though cost-sharing subsidies will be sequestered, premium assistance tax-credits will remain untouched. Within the Budget Control Act, the Gramm-Rudman-Hollings Act of 1985 exempts refundable tax-credits from any federal sequestration.[26] Chris Jacobs, Senior Policy Analyst at the Heritage Foundation, explains potential individual impacts of the cost-sharing subsidy cuts in *The Wall Street Journal*:

> Individuals who have managed to enroll in subsidized health insurance will find they've been misled about their copays and deductibles. Families who currently think their plan will charge a $20 copayment for doctor visits may instead face a $25 charge when the sequester kicks in. Individuals who now believe they face maximum out-of-pocket costs of $2,000 may end up paying hundreds more.[27]

The federal health law states that under the cost-sharing subsidy provision (section 1402), insurance companies must increase the actuarial value of coverage they provide to qualified consumers. In return, the cost-sharing discount

will be funneled back to the insurance company. But the 7.2% sequester cut means insurance companies will not receive the full subsidy amount.

The cost-sharing sequester will affect either eligible consumers, insurance companies, or both. At this time it is not clear how this issue will be resolved.

North Carolina's Exchange

Just two insurance companies, Coventry Health Care of the Carolinas and Blue Cross and Blue Shield of North Carolina, have signed up to participate in North Carolina's federally-facilitated exchange. Blue Cross and Blue Shield controls 85% of the individual market and is the only insurer offering plans in all 100 counties of the state. Coventry Health Care, meanwhile, offers plans in just 39 counties.[28,29]

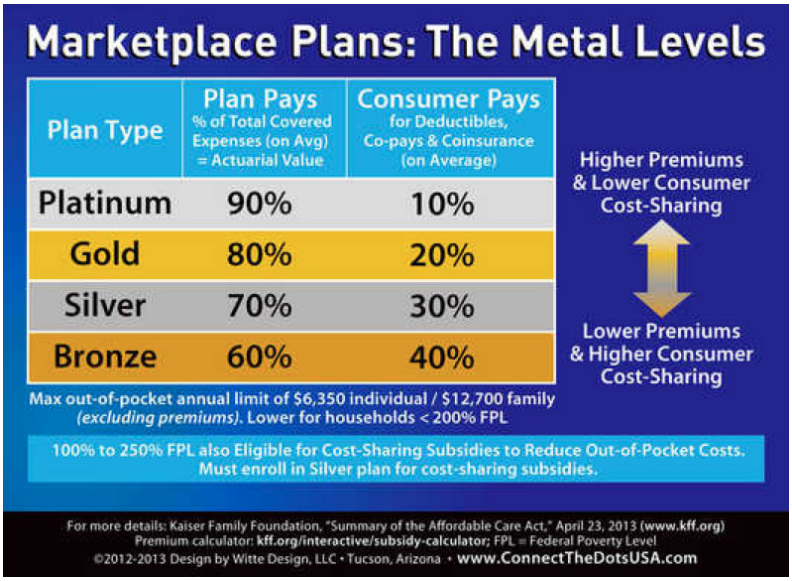
Within the first month of open enrollment, only 1,662 North Carolinians were able to complete the enrollment process through the state's federal health insurance exchange.[30] While some of these individuals have paid their first month's premium, others have selected a plan but still have yet to pay.

Through mid-November 2013, 43% of Blue Cross and Blue Shield's 375,000 individual policyholders had been told that they would not be allowed to renew their existing health plans. Almost 160,000 Blue Cross and Blue Shield consumers have received health insurance cancellation letters in the mail, along with 13,000 Coventry Health Care consumers.[31,32] These plans were canceled initially because they did not qualify as grandfathered plans.[33] As stated in the law, any individual policyholder who has switched plans since the law's passage on March 23, 2010 will have to purchase a bloated health plan that meets Obamacare requirements.

However, President Obama announced on November 14 that individual market policyholders may now renew their non-grandfathered plans for one more year at the discretion of state insurance commissioners. Shortly after the announcement, North Carolina's insurance commissioner, Wayne Goodwin, urged insurance companies to extend renewal of these "substandard plans" for affected customers. Blue Cross and Blue shield has moved forward with the policy renewal extension.[34]

Rate Shock[35,36]

Blue Cross and Blue Shield and Coventry Health Care offer a total of 51 qualified health plans on North Carolina's federal exchange. Premiums will vary, as there are 16 different rating areas in the state, and not all 31 qualified health plans are offered in every rating area. Premiums will also vary based on age, tobacco usage, and number of dependents on an individual plan.



The exchanges offer catastrophic plans along with four "metallic" levels that offer the least to most generous coverage: bronze, silver, gold, and platinum. Bronze plans cover 60% of benefits, meaning consumers will be responsible for higher out-of-pocket expenses. Meanwhile, platinum plans are the most expensive plans but cover 90% of benefits.[37]

The chart left displays the four metallic layers of coverage and their associated costs.[38]

According to the Manhattan Institute, percentage increases for North Carolina health insurance premiums in the individual market rank 4th highest nationwide.[39,40]

This data was calculated by comparing pre-Affordable Care Act (ACA) premiums to post-ACA premiums sold within each state. The Manhattan Institute averaged the five cheapest health plans sold in every county of the state for individuals at three ages: 27, 40, and 64. To create a more sound comparison, the pre-ACA average rates included extra charges for pre-existing conditions. These average rates were then compared to the five least-expensive bronze plans on the exchanges in each county.

The graphs below compare pre-Obamacare rates to post-Obamacare rates for male and female individual policyholders.[41]

Recommendations

Absurd rate increases may suggest that the federal government's health care takeover is near collapse, but the war is far from over. Rather than doubling down on our nation's already costly health care system with more government regulations, free-market principles should be embraced. Health insurance can be made more affordable by providing patients with a choice of plans that include benefits and services specifically tailored to their individual needs. Reduced health care costs can also be achieved by increasing price transparency, de-regulating the insurance market, and repealing Certificate of Need for hospital systems.

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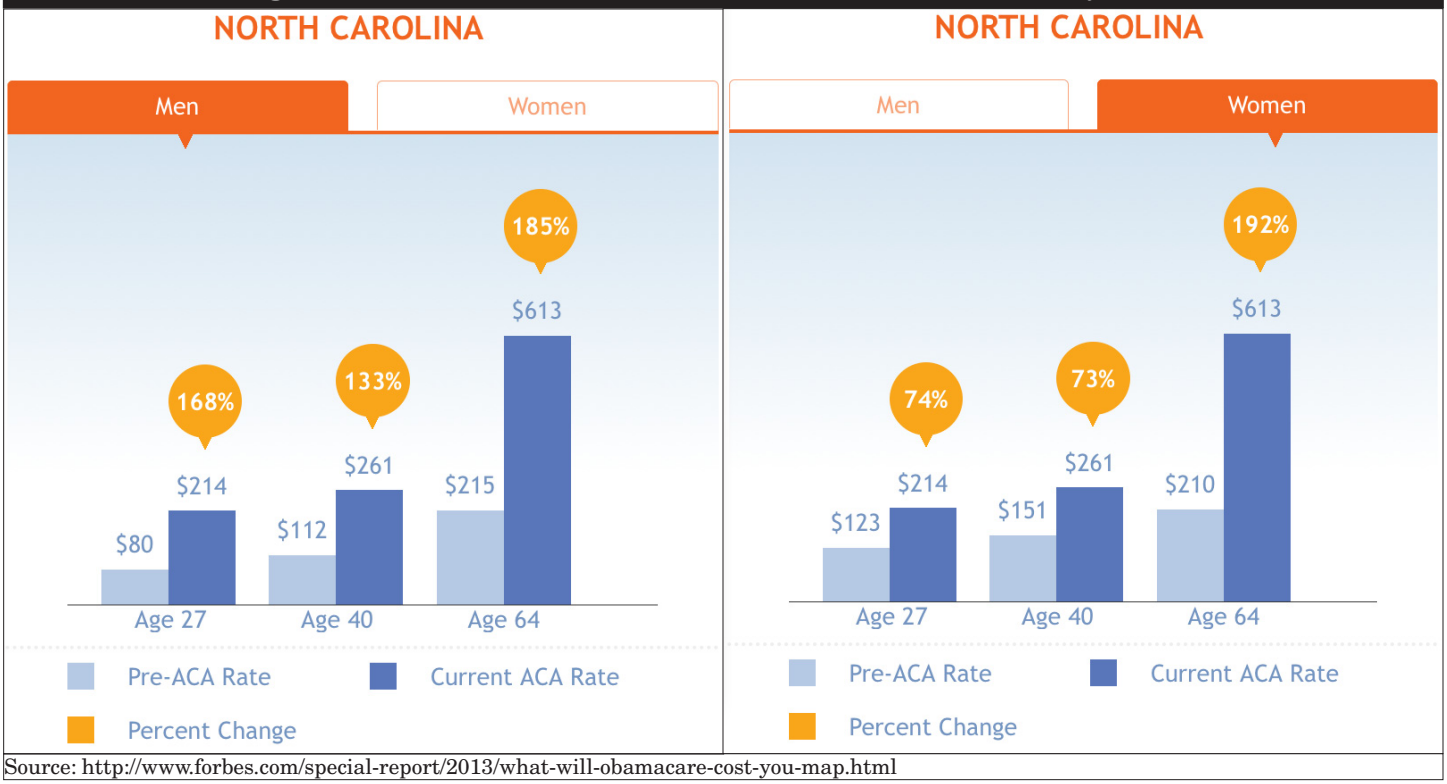
Figure 3: Pre- and Post-Obamacare Rates for Individual Policyholders



Source: http://www.forbes.com/special-report/2013/what-will-obamacare-cost-you-map.html

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