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State Health Insurance Exchanges

We have elected to dedicate this Lingenfelter Letter to the topic of state health insurance exchanges and the corresponding premium tax credits.

The Affordable Care Act (ACA) introduces state health insurance exchanges and provides federal premium tax credits (for those purchasing health insurance through the exchange) in an effort to make private health insurance coverage more affordable, competitive, and easier to purchase for small businesses and individuals.

Small businesses with up to 50 employees, as well as individuals, can purchase health coverage on an exchange effective January 1, 2014 (with the open enrollment period beginning on October 1, 2013). Beginning in 2016, states may allow businesses with more than 50 employees (up to 100 employees) to purchase coverage on the exchange. In 2017, businesses with more than 100 employees may be allowed to purchase coverage on the exchange. Only U.S. citizens and legal immigrants are eligible to participate in an exchange. Individuals who are imprisoned are not eligible to purchase health coverage on one of the exchanges.

Health insurance plans to be offered on the exchange must include an essential set of health benefits and must provide comprehensive health care services. Annual out-of-pocket provisions may not exceed the out-of-pocket limitations placed on HSA Qualified Health Plans.

Plan options will be categorized as one of four “precious metal plans”:

1. Bronze Plan, which provides essential health benefits at a 60% actuarial cost equivalent level;
2. Silver Plan, which provides essential health benefits at a 70% actuarial cost equivalent level;
3. Gold Plan, which provides essential health benefits at a 80% actuarial cost equivalent level;
4. Platinum Plan, which provides essential health benefits at a 90% actuarial cost equivalent level.

A catastrophic plan will be available for those up to age 30 or to those who are exempt from the mandate to purchase coverage.

Premium Tax Credit

A premium tax credit will be available to individuals and families with incomes between 133% and 400% of the federal poverty level ($22,350 to $89,400 for a family of four in 2011). The amount of the premium tax credit is tied to the amount of the premium (as an example, older Americans, who face higher premiums, will receive a greater credit). However, the amount of the premium tax credit will be fixed on an age-adjusted benchmark plan, so individuals or families that choose to purchase coverage that is less expensive than the benchmark plan will pay less towards the cost of that coverage (the benchmark plan is the second lowest cost plan that would cover the individual or family at the silver plan level). The premium tax credit is not available to those who do not purchase coverage on an exchange, nor is the premium tax credit available to those whose income is greater than 400% of the federal poverty level.

The premium tax credit amount is equal to the difference between the premium for the benchmark plan and the taxpayer's expected contribution, determined by the income and age of the participant. The expected contribution is a specified percentage of the taxpayer's household income, with the percentage increasing as income increases (from 3% of income for individuals and families at 133% of the federal poverty level, to 9.5% of income for individuals and families at 400% of the federal poverty level). Note that individuals and families below 133% of the federal poverty level will be eligible to participate in their states' expanded Medicaid program.

The premium tax credit is fully refundable; meaning even individual or families who pay little or no federal income tax will receive the full benefit of the credit. The premium tax credit is advanced directly to the insurer on behalf of those families who cannot pay the full premium due to limited cash flow, which is expected to be the overwhelming majority of individuals and families participating in an exchange.

Starting in 2014, small employers participating in the Small Business Health Options (SHOP) program may be eligible for a tax credit of up to 50% of their premium payments. Employers qualify for this credit if they have 25 employees or less, pay employees an average wage of less than $50,000, offer coverage to all full time employees, and pay at least 50% of the premium.

Employees offered affordable, quality health insurance by their employer are not eligible for premium tax credits for coverage purchased through the exchange.

Where Do The States Stand?

On January 20, 2011, the U.S Department of Health and Human Services (HHS) announced funding opportunities for grants to help states implement health insurance exchanges. As of January, 2012, fifteen states have either enacted an exchange establishment law, or the governor has established one through an executive order. An additional 21 states have demonstrated interest in establishing an

exchange. At this time, 17 of these 21 states have received federal establishment grants (through a second round of funding, or Level 2) for state exchange development. Fifteen states have not pursued establishment of an exchange or have not made much progress in establishing one. For those states choosing to operate their own health insurance exchange, the exchange must be certified by HHS no later than January 1, 2013.

For states that choose not to operate their own health insurance exchange, businesses and individuals will be able to purchase a health plan from a multi-state or regional exchange established and run by a federal government agency, the states participating in the exchange, or a non-profit organization.

Why Is There Concern?

As the law is currently written, the penalty for an individual not having health insurance coverage is small. The annual penalty starts at $95 or up to 1 percent of income (whichever is greater) in 2014 and rises to $695 or 2.5% of income in 2016. Therefore, we expect that a large number of individuals will remain uninsured, as the penalty is substantially less expensive than purchasing insurance, and knowing coverage is available without pre-existing condition limitations or a pre-existing waiting period. Additionally, the means for collecting the penalty is limited (ACA explicitly states that there will be no criminal sanctions for failing to pay the penalty, nor can liens or levies be placed on an individual's property. Further, if an individual does not have a tax refund, the government will not have a mechanism to collect the penalty). This means that, unless the coverage is further subsidized by an expansion of the premium tax credit, we can expect that coverage on the exchanges will become increasingly expensive for many due to adverse selection.

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