Four Things Agents Need to Know About The *Affordable Care Act*

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Introduction

On June 28, 2012, the Supreme Court issued its decision in a trio of cases which challenged the constitutionality of certain provisions in the *Affordable Care Act*. Ultimately, a majority of the justices concluded that the Act's "individual mandate" was not authorized by the Commerce Clause. At the same time, though, a different majority of the justices concluded that the provision was within Congress' power to "lay and collect taxes." The *Affordable Care Act* therefore has survived its primary constitutional challenges.

Given its ambitious scope, the *Affordable Care Act* promises to have a profound impact on health insurers, employers and virtually every American citizen. However, because they occupy a unique place in the health insurance industry, insurance agents and financial advisors may be affected more by the *Affordable Care Act* than most other Americans. Indeed, they are consumers of health insurance. As employers, they often provide health coverage to their employees. As producers, their livelihood may depend on their ability to market health insurance to others. Their ability to succeed also may be affected by the creation of state-run health benefit exchanges and other changes in the health insurance marketplace.

To be sure, the public remains divided in its support for the *Affordable Care Act*, and the presidential election in November 2012 already has sparked further debate about whether to expand, contract or otherwise substantively change its terms. Regardless of how the political winds might change the *Affordable Care Act*'s course, though, an understanding of the basic changes for which the law calls is essential for every insurance agent and financial advisor.

1. The Individual Mandate is Riddled with Exceptions.

Congress reasoned that the individual mandate was necessary to counteract a pair of significant limitations on insurers' ability to underwrite health insurance applications which are scheduled to become effective in 2014. One – known as "guaranteed issue" – will prohibit health insurers from denying coverage to people for any reason, including their health status. The other – known as "community rating" – will prohibit 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 covered.

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). Most insurers therefore had anxiously awaited the Supreme Court's decision.

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 <u>*not*</u> apply to everyone. To the contrary, the *Affordable Care Act* 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, the *Affordable Care Act* contains other provisions which effectively limit the impact of the individual mandate to high-income individuals:

· <u>Individuals Who Make Less than 133% of the Federal Poverty Level</u>: These individuals are exempt from the individual mandate, so the *Affordable Care Act* addressed their need for health coverage by expanding Medicaid to include persons who make no more than 133% of the federal poverty level. 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% and 133% of the federal poverty level may be left without coverage.

· <u>Individuals Who Make Between 133% and 400% of the Federal Poverty Level</u>: These individuals 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% of their income.

In 2011, the federal poverty level for a family of four was $23,050. If that figure increases by just 4% per year, a family of four which makes 400% of the federal poverty level 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.

Although the numbers are different, families which earn less than 400% of the federal poverty level will face similar choices. Indeed, while subsidies will ensure that families do not use more than 9.5% of their income to pay for health coverage, the alternative always will be to make a shared responsibility payment of no more than 2.5% of their income (capped at $2,085).

· Individuals Who Make More than 400% of the Federal Poverty Level: These individuals will be subject to the individual mandate unless the cheapest plan available in a health benefit exchange costs more than 8% of their income. The Congressional Budget Office 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 will 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.

2. The Market for Employer-Sponsored Coverage May Shrink.

To make "minimum essential coverage" more available to working Americans, the *Affordable Care Act* 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."

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. Importantly, the baseline year for such calculations is 2013. The *Affordable Care Act*'s employer mandate therefore presents agents with a time-sensitive opportunity to remind their largest clients that the value of employer-sponsored coverage should not be measured on economic terms alone.

Large employers that 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 provide a voucher to employees with incomes below 400% of the poverty level if the employee's share of the premium cost is between 8% and 9.8% of the employee's income. They also will be required to pay an annual fee of $3,000 for each employee who has an annual income below 400% of the federal poverty level and opts out of the employer's plan. Large employers therefore can benefit from an agent's assistance in fashioning an employer-sponsored group plan which offers coverage that is both affordable and preferable to other options.

Tax credits already give small employers (with fewer than 25 full time employees) some incentive to offer employer-sponsored group coverage, and those credits are set to increase in 2014 (from as much as 35% to as much as 50%). However, both individuals and employers with fewer than 100 full time employees also will be eligible to purchase health insurance through the state-run health benefit exchanges which are scheduled to be created in 2014. In addition, the *Affordable Care Act* provides for subsidies that may make it more economical for low-income families to obtain coverage through the exchanges. Collectively, then, the *Affordable Care Act*'s provisions may actually cause the employer-sponsored coverage market to contract by prompting many Americans to obtain health coverage through the exchanges.

3. Agents Will Face New Competition in the Exchanges.

Ostensibly to give consumers greater choices in the health insurance marketplace, the *Affordable Care Act* provides for government-run "health benefit exchanges" from which individuals and small employers (with fewer than 100 employees) can purchase insurance. Plans in the exchanges will be required to offer benefits that meet a minimum set of standards. Insurers therefore will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required. They also will offer a catastrophic coverage plan.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the exchanges. Cost-sharing subsidies also will be available to people with incomes between 100-400% of the poverty level to limit their out-of-pocket spending.

The *Affordable Care Act* acknowledges that agents and brokers can play an important role in helping individuals and employers consider the plans offered by an exchange, enroll in that plan, and apply for premium tax credits and cost-sharing reductions. See, 42 U.S.C. §18032(e). However, each exchange will establish its own rule about the precise role that agents and brokers can play. At the same time, the *Affordable Care Act* calls for the creation of a new participant in the exchange marketplace: the navigator.

Under the *Affordable Care Act*, navigators will have five duties: (1) to conduct public education activities to raise awareness of the availability of qualified health plans; (2) to distribute fair and impartial information about enrollment in qualified health plans and the availability of premium tax credits and cost-sharing reductions; (3) to facilitate enrollment in qualified health plans; (4) to refer enrollees with a

grievance, complaint or question about their health plan, coverage or coverage determination to a consumer assistance office or ombudsman; and (5) to provide information in a culturally and linguistically appropriate manner to the population being served by the exchange. Although the Secretary of Health and Human Services has not yet announced the precise standards with which a navigator must comply to participate in the exchanges, the implementing regulations specifically provide that a navigator cannot receive payment from insurers. 45 C.F.R. 155.210(d). Instead, navigators will be compensated only through grants which are funded by each exchange.

Again, agents and brokers may be navigators. They also may be able to participate in the exchanges as agents or brokers. However, they cannot do both. Either way, the plans available through the exchanges will be priced in a way which enables the exchange to compensate navigators. Agents and brokers therefore will face a competitive disadvantage if their compensation (in the form of commissions) is passed on to consumers as an additional cost of obtaining coverage through an exchange.

4. <u>Medical Loss Ratios May Change How Agents are Compensated.</u>

Even while waiting for the Supreme Court's decision, health insurers were taking steps to comply with the "medical loss ratio" requirements in the *Affordable Care Act*. In essence, the implementing regulations require that health insurers publicly report on how premium dollars are spent. They also establish standard percentages of each premium dollar which must be spent on health claims and/or quality improvement expenses: for insurers in the individual and small group market, the minimum is 80%; for insurers in the large group market, the minimum is 85%. If the applicable ratio is exceeded, the excess expense must be rebated to insureds. Indeed, any rebates payable for 2011 under the *Affordable Care Act's* medical loss ratio provisions must be paid by August 1, 2012.

There are numerous expenses that insurers must pay out of the 15-20% of premium dollars that remain after claims and allowable expenses. Importantly, those expenses include both commissions paid to agents and brokers and the insurer's profit. The *Affordable Care Act* therefore creates an undeniable tension between an insurer's desire to be profitable and its obligation to compensate agents and brokers.

Some insurers may remain willing to count the commissions paid to its sales force as part of the 15-20% of premium dollars from which it also must pay for its overhead, underwriting expenses, fraud prevention/detection, employee salaries, and compliance costs. Others may conclude that the remaining portion of premium dollars leaves too little profit. If so, they may begin asking employers and individuals to pay for their agents' and brokers' commissions, separate and apart from the premiums they pay for health insurance coverage.

If that comes to pass, some employers and individuals may look to the exchanges as a more cost-effective alternative. Others may begin negotiating with insurers – or with agents and brokers – about the commissions to be paid for traditional health insurance products. In either case, the terms on which agents and brokers are compensated for their role in the health insurance marketplace may significantly change.

Conclusion

The *Affordable Care Act* promises to change the health insurance industry in numerous ways. Many of its most popular changes (e.g., dependent coverage to age 26; no lifetime dollar limits; restricted annual dollar limits; small business tax credits) already are in effect, and many of its most politically charged changes (e.g., individual mandate; employer mandate) have yet to be implemented. From a practical perspective, though, many of the changes for which it calls will have a substantial impact on insurance agents and financial advisors.

As the American public prepares for those changes, insurance agents and financial advisors should recognize that they are uniquely qualified to help individuals and employers understand their obligations, evaluate their options, and develop a sensible plan for obtaining health insurance coverage on affordable terms. By acting now, they will both demonstrate their value to customers and better secure their place as an essential player in the health insurance marketplace.

About the Author

Rob Pohls is President and General Counsel of *The Law Department, Inc.*, a California law firm that was created in 2009 for the specific purpose of assisting insurance agents and financial advisors. A veteran trial attorney with almost 25 years' experience in litigating life, health, disability and long term care insurance disputes, Rob has earned a national reputation for his distinctive ability to achieve favorable outcomes in cases that involve challenging facts and/or novel legal questions. However, he is equally adept at helping clients recognize legal problems before they arise, identify their options, and develop winning strategies for using the law to both manage risk and gain a competitive business advantage. As General Counsel of *The Law Department, Inc.*, Rob uses those same skills to advise, counsel and represent insurance agents and financial advisors in connection with virtually any legal problem that can arise in connection with their businesses. For more information, visit the firm's website (www.thelawdepartment.com) or send Rob an e-mail at: rpohls@thelawdepartment.com.