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Intelligent Money

Current thinking from Haven Financial Advisors

The Role of the New Health Insurance Exchanges

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Special Notes of Interest:

According to an analysis by the Rand Corporation, "in the absence of policy change, health care spending in Massachusetts is projected to nearly double to $123 billion in 2020, increasing 8 percent faster than the state's gross domestic product (GDP)."

The Euro has fallen more than 13% against the Dollar this thus far in the calendar year

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act. The bill is popularly known as "Health Care Reform". Many of its measures become effective over the course of several years. The follow on effects on the rest of the economy are far from clear at this point.

This newsletter will focus on the creation of new statewide health care exchanges mandated by the bill. A health care exchange is an organized health insurance market with a single enrollment portal. The intent of the exchanges is to aggregate the purchasing power of uninsured individuals and small businesses so that economies of scale make health insurance more affordable.

Health Insurance Exchanges

The Health Care bill provides federal funding for the establishment of American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. In 2017, states may open the exchanges to larger groups

Plans offered through the SHOP exchanges must adhere to several specifications by January 1st, 2014. For example, there are four tiers of benefit levels that must be offered in addition to a high deductible plan available to individuals aged 30 and under. Each succeeding tier must cover a progressively larger fraction of the expected costs of medical care for the individual.

The reform bill offers subsidies to lower wage earners seeking individual health insurance coverage. Basically, people who make three or four times the poverty level would get enough federal money so that they would not have to pay more than about 10 percent of their income for health insurance. For a family of four, the threshold for receiving a subsidy is an annual income of about $88,000 These subsidies will be available only to those buying individual policies within the exchange mechanism. Subsidies will also be available to those employees whose share of premiums in a group plan is deemed to be unaffordable.

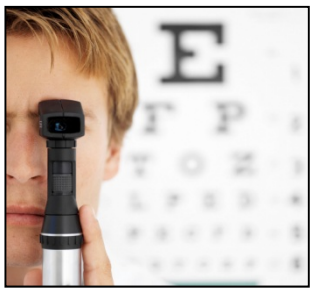
Policies offered both inside and outside the exchange mechanism must employ *modified community rating* to price risk by January 1st, 2014. That means that there will be limits to which insurers can vary rates based on the insured's age and health. Older consumers will pay no more than three times the rate of the youngest consumers. Tobacco users will pay no more than half again the rate of non users. Health premiums must also be gender neutral.

Insurers will be prohibited from withholding insurance to a prospective insured due to a preexisting condition as of January 1st 2014. Children will be guaranteed automatic acceptance with six months – no need to wait until 2014. Insurance policies may no longer be retroactively cancelled under the pretense that the insured failed to disclose a material condition. This process is now known as *rescission*.

Insurers can still offer policies outside the exchange mechanism. However, tax credits for lower income insureds will only be available to policies offered within the exchange. The restrictions imposed on risk pooling will also apply to policies offered outside the exchanges. Conversely, fines will be charged to individuals that fail to purchase health insurance.

The notion that insurers will be unable to refuse applicants due to a pre-existing condition sounds humane and pro consumer at first glance. However, this change in the law invites the young and the healthy to avoid the insurance market altogether until a chronic condition is diagnosed. The fines mandated for failure to own an insurance policy are far less than the fair value of a comprehensive policy. Moreover, the enforcement of the insurance mandate will be extremely difficult anyway. Failure to buy insurance will not be a crime- why not wait until there is something wrong with you.

Some provisions of the bill have already been enacted preemptively by the insurance industry as a whole. For example, the decision to end rescission, as the practice is known, was made during a afternoon conference call last month of



chief executives organized by their trade group, America's Health Insurance Plans,

There are also regulations regarding the marketing, customer service, and reporting of health policies offered under an exchange. Individual states must set up a web-based portal supported by a telephone operator that will allow consumers to effectively compare policies offered through the exchange. The federal government will provide funding for these exchanges over the next few years.

The Issues

At a high level, the insurance exchange mechanism has some appealing characteristics. Smaller employers and individuals are at a disadvantage in purchasing health insurance. Insurers must often resort to inefficient marketing methods to reach these scattered consumers. The exchange allows small buyers to aggregate their purchasing power and can provide insurers direct access to numerous customers without an army of individual insurance agents.

"A fundamental idea behind the exchange mechanism is to shift insurance competition away from attracting the best risks and towards price and quality of service."

A fundamental idea behind the exchange mechanism is to shift insurance competition away from attracting the best risks and towards price and quality of service. Incentives and penalties are put in place to encourage all to purchase a policy.

In fact, insurance exchanges are not new. They have been tried on numerous occasions at the state and employer level. There are some public employee benefit programs that have used the exchange successfully for years. The Federal Employees Health Benefits Program (FEHBP) and the California Public Employees' Retirement System (CALPERS) are two examples.

Variations of the exchange mechanism at the state level have produced discouraging results. California, Florida, and Texas all started exchanges. After initial success, usage dropped and the programs were discontinued. An exchange has been operating in Massachusetts since 2006 that is still open but the verdict is still out. Health insurance prices there have escalated dramatically there.

Despite the theoretical basis for insurance cost reduction, exchanges have not delivered lower prices to their consumers. And they, too, have fallen victim to adverse risk selection as insurers have sold most policies to healthier people outside the exchange.

Exchanges have not delivered cost reductions in the area of marketing either. Insurers have found that they need to retain a marketing presence within the pool of exchange consumers. Policy loyalty is more tenuous inside the exchange as consumers have easy access to a multitude of plans and can switch carriers at any open enrollment period.

Where exchanges have tried to limit the commissions of agents, who largely duplicate the functions of the exchange, agents have simply steered applicants elsewhere. This reform bill leaves a place for agents to participate. It is not yet clear, however, how well private agents will fare with a mechanism that provides a single enrollment portal and publically funded consumer support.

"Individuals making up to 133% of the Federal Poverty Level (FPL) will be eligible for Medicaid. In effect, Medicaid is absorbing those too poor to buy insurance in a health care exchange."

How Medicaid Expansion will Affect Texas

Another key element of the health care reform legislation is the expansion of Medicaid. Individuals making up to 133% of the Federal Poverty Level (FPL) will be eligible for Medicaid. In effect, Medicaid is absorbing those too poor to buy insurance in a health care exchange.

The impact will vary across states – depending on coverage already in place. Texas is particularly affected as childless adults are generally not covered here today. Children can receive Medicaid if their families are at 100 percent of the poverty level. The parents are ineligible if they make more than $4,824 a year, or 26 percent of the FPL. It is estimated that 2.1 million people will be added to Texas' Medicaid rolls. That is almost half the people that are expected to obtain insurance coverage in the state as a result of the health care bill.

The expansion of Medicaid rolls may be a daunting fiscal hurdle for Texas. The federal government will pick up every state's tab for Medicaid expansion through 2018. Thereafter each state's share of cost will phase in towards 10% in 2020. Texas will be subject proportionately and absolutely to a large increase in Medicaid liability.

Estimates of the impact on the state vary from $370 million to more than $2 billion annually once this steady state has been reached in 2020. There is a high degree of variability as yet since it is unclear how much the state will save in subsidies to care for a reduced number of uninsured.