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Obamacare in 2014: Clearing Up Some of the Major Questions

HOW MUCH DO YOU KNOW ABOUT THE NEW HEALTH CARE LAW? HERE ARE SOME DETAILS.

The Patient Protection and Affordable Care Act (PPACA), more commonly known as Obamacare, is more than 2,700 pages long, which means you probably haven't read much of it – and certainly don't know when and in what fashion certain provisions of the act will take effect, much less how they will impact you and your patients. Well, you'd better know, because key provisions of the act are scheduled to take effect in a few short months.

Enter Matt Minnella, director of insurance for the Association of New Jersey Chiropractors (ANJC). In this article, Matt clears up some of the pressing questions surrounding Obamacare, highlighting provisions taking effect in 2014 that are pertinent to you as both a doctor of chiropractic and a consumer of health insurance plans.

Health Insurance Exchanges

All states must have an operational health insurance exchange taking open enrollments by Oct. 1 2013, for plans that will begin coverage Jan. 1, 2014. Each state can run its own exchange, partner with the federal government or let the federal government run an exchange in the state. The exchanges will be online marketplaces where consumers can compare and purchase health insurance plans.

There are rules that govern what plans can be sold on the exchanges. Each state can choose the "benchmark" plan that is to be sold on its state exchange, regardless of whether the state or the federal government is operating the exchange.

The federal government has defined a set of essential health benefits (EHB) that must be included in all health insurance plans going forward. A state can choose a benchmark plan that exceeds the EHB requirements. If a state does not choose a benchmark plan, then the default will be the largest small-group plan in that state, determined by enrollment.

For example, my home state of New Jersey has chosen the Horizon HMO Access HSA Compatible plan as its benchmark plan. This plan includes coverage for "therapeutic manipulation" for up to 30 visits annually. We have seen certain carriers in N.J. allow spinal manipulation, but only if done by an MD, DO or other medical professional besides a chiropractor.

So, when first reading this, I feared that these plans could bar a chiropractor from performing the therapeutic manipulation. This fear is quelled somewhat by Sec. 2706 of PPACA, which states, "A group health plan . . . shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."

This excerpt may need to be pointed out to carriers in the future, but the language of the law should ensure chiropractors will be allowed to perform the therapeutic manipulation that is part of New Jersey's or any other state's benchmark plan. It is also important to note that the benchmark plans are not the *only* plans that will be sold on the state exchanges. It simply means that no plan can be sold on a state's exchange that includes *less* coverage than that state's benchmark plan.

Editor's note: Legislation introduced July 24, 2013, would repeal Section 2706 of the PPACA. H.R. 2817, the "Protect Patient Access to Quality Health Professionals Act of 2013," appears to be the result of intense lobbying by several medical organizations. Learn more in this issue's News in Brief section.

There will be one uniform aspect to all plans sold on the exchanges: All plans will be labeled as

either a bronze, silver, gold or platinum plan. The purpose of this is to make comparisons of the plans easier for consumers. Each level of plan equates to a different amount of costs covered by that plan. Bronze plans cover 60 percent, on average; silver 70 percent; gold 80 percent; and platinum 90 percent.

Plan deductibles cannot exceed $2,000 for an individual or $4,000 for a family. The out-of-pocket(OOP) maximum allowed for plans sold on the exchanges is not to be higher than the OOP limits on HSA plans. For 2013, the OOP limits are $6,250 for an individual and $12,500 for a family.

There will be subsidies to cover the premiums and out-of-pocket expenses based on the consumer's income relative to the federal poverty level (FPL). If someone earns less than 133 percent of the FPL, they would be directed to Medicaid. There is a sliding scale of subsidies on premiums for households making 133-400 percent of the FPL. For reference, the 2013 FPL is $11,490 for an individual and $23,550 for a family of four; 400 percent of the FPL for a family of four is $94,200.

Medicaid Expansion

Next year is when the expansion of Medicaid will take effect. Prior to this expansion, eligibility for Medicaid has varied greatly from state to state. Most commonly, Medicaid / CHIP has been offered to children, pregnant women and parents with very low incomes. Among these groups, eligibility was determined by the individual's income as a percentage of FPL. States' eligibility threshold varied from as low as 17 percent of FPL to as high as 215 percent. The Medicaid expansion will make a uniform eligibility level of 133 percent of the FPL.

States do not have to accept this expansion, as ruled by the U.S. Supreme Court. If they do, the federal government will cover 100 percent of the cost of the newly eligible participants for 2014-2016. The percentage covered will gradually decrease to 90 percent in 2020. The percentage is not defined beyond 2020.

If all 50 states accept the Medicaid expansion and all eligible citizens enroll, this would add 15 million participants to Medicaid nationwide. But there are concerns as to whether eligible individuals will enroll. A Kaiser Family Foundation survey found that two-thirds of uninsured and low-income Americans do not understand the health reform laws and how the laws will affect them.

Even if all those who are eligible do end up enrolling in Medicaid, would this be beneficial to the chiropractic profession? This would insure more individuals and, in theory, make them potential patients, right? Inclusion and reimbursement rates for chiropractic care under Medicaid vary from state to state. States that do reimburse chiropractic care under Medicaid generally do so at very low rates. For example, the current reimbursement for a chiropractic visit under Medicaid in New Jersey is $6. Adding new patients at this level of reimbursement is not likely to be of significant economic benefit to chiropractors.

You may have heard that Obamacare is raising the reimbursements under the Medicaid program to entice more health care providers to participate. The fact is that Obamacare raises reimbursements only for family care, internal medicine and pediatric doctors. The rates are raised to Medicare levels for these services and this is only temporary – expiring in 2015. There is no raise to Medicaid reimbursement for any other medical professionals at this time.

Individual Coverage Mandate

Jan. 1, 2014 is the date when all U.S. citizens (barring a very small group of exceptions) are required to have at least minimum essential health insurance coverage. Individuals who do not

obtain such coverage will be subject to a tax penalty. This rule is pivotal to many of the other provisions of Obamacare.

The many demands imposed on health insurance carriers in terms of broader coverage are supposed to be made up for financially by the influx of new insurance consumers due to the individual mandate. There are reasons to believe this will not work out as planned.

The penalty for an individual who does not obtain coverage is the greater of either $95 or 1 percent of their income for that year. By 2016, the dollar amount rises to $695, the percentage of income to 2.5 percent, and is adjusted upward based on inflation going forward.

The national average health insurance premium on the individual market for single coverage was $2,580 in 2010. The state with the highest average premium was Massachusetts at $5,244, while the lowest was Alabama at $1,632. Based on either the dollar amount penalty or the percentage of the national per-capita income ($27,915) or median household income ($52,762), it is still significantly less expensive for uninsured individuals to stay uninsured.

Regardless of income, the penalty for not carrying health insurance will under no circumstances exceed the national average cost of a bronze (lowest)-level health insurance plan certified to be sold through the state health exchanges. That exact dollar amount cannot be determined until the plans and prices are in effect on the exchanges throughout the nation. Also, the IRS has been restricted in its means to obtain this tax penalty. No criminal penalties, liens or property seizures are allowed for failure to pay the individual mandate tax penalty.

It seems the main process the IRS will use to collect the penalty is to offset the offending individual's income tax return. The low cost of the penalty relative to the cost of insurance and the weak enforcement options have led many to believe that Obamacare will not inspire nearly as many Americans to obtain coverage as the law's authors suggested and intended.

No Annual or Lifetime Limits on Coverage

Under Obamacare, carriers will not be permitted to impose any dollar-value annual or lifetime limits on what the law deems to be essential health benefits. This provision has been in the process of being phased in for a number of years but will take full effect and apply to all health insurance policies as of Jan. 1 2014. This could certainly be seen as a positive for both consumers and providers. Carriers are no longer allowed to apply an arbitrary cap to a patient's treatment that otherwise could have cut off care before they reached maximum therapeutic improvement.

However, there are potential negative, unintended consequences to this rule. First, not allowing a carrier to build in a maximum payout on a particular service will apply upward pressure on its actuarial calculations. This is one of many reasons why there is a belief that Obamacare will actually lead to higher insurance premiums.

Second, this could affect utilization review procedures. Right now, there are a few large carriers / plans in New Jersey that do not impose utilization management of any kind. Instead, they simply allow the insured a pre-set number of chiropractic visits under their plan. If the carriers are not allowed to follow this protocol going forward, they would essentially be forced to perform some form of utilization management, since they cannot impose an annual or lifetime cap. It seems likely that if a carrier had to direct a department or vendor to review care, treatment could be cut off earlier than the previous annual allowance would have.

Guaranteed Availability of Insurance

There are two main components here. First, health insurers will no longer be able to deny coverage to anyone based on a pre-existing condition. Second, there are very specific reasons why carriers can charge different amounts for coverage. Carriers can only charge an individual higher premium based on age, geographic area, tobacco use and family composition.

Carriers can only charge up to three times more for premiums based on a consumer's age. Carriers can only charge up to 1.5 times more based on tobacco use. They can charge more based on region, and the family composition rule leaves the states to decide who in a household can be included on a family plan and at what cost.

It is believed that this rule will lower premiums for older Americans and women. Older insurance consumers are usually charged more because they require more care. Women are usually charged more because they also statistically require more medical expenditures. This is usually attributed to the medical costs of childbirth.

While it can certainly be seen as a positive for society to mandate that care be offered to those with pre-existing conditions and to not discriminate financially against women or older consumers, these changes will add significant cost to carriers. This cost will be passed on to someone. That someone will likely be younger to middle-aged males. Several independent analyses expect premiums for certain demographics to increase by over 100 percent from 2013 to 2014 because of these changes in regulations.

Premiums

Starting in 2014, the PPACA will insist on broader coverage included in each health insurance plan (essential health benefits). It will not allow carriers to bar or charge more to consumers who have pre-existing conditions. It will restrict the level at which smokers and older consumer can be charged for health insurance relative to younger or non-smoking consumers. It will not allow annual or lifetime maximums to be placed on essential health benefits.

These factors will require greater payouts by carriers and hence necessitate more premium dollars. The theory of Obamacare is that these additional costs will be made up for by the newly insured. This is not necessarily the case. First, many of the new insureds under the law will be covered by Medicaid, which will not contribute anything to the premiums carriers take in. Second, many are skeptical that uninsured Americans will acquire coverage despite the mandate and penalty, as mentioned earlier.

In short, premiums will likely go down for older consumers, those with pre-existing conditions will be able to obtain coverage, and families making 400 percent or less of the federal poverty line will receive subsidies to purchase coverage and pay out-of-pocket expenses. However, those in the middle – both by age and economic class – will see significant increases in their medical expenses beginning in 2014.

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