Health Care Reform Takes Effect:

What Choices Do Businesses and Individuals Have?

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On January 1, 2014, four years after the date of enactment, President Obama's landmark health care reform law is scheduled to take effect. By that date, businesses and individuals must make a series of choices about their health insurance coverage.

Many Americans believe erroneously that health care reform – also known as "Obamacare" and more formally as the "Affordable Care Act" (ACA) – includes a new, government-run health plan. (Washington Post November 30, 2011). In fact, rather than establish a new plan, the health care reform law seeks to ensure that virtually every American has *health insurance*. Whether the law ultimately is viewed as a success will depend crucially on how well it ensures that Americans have health insurance coverage.

This paper presents an overview of the parts of the ACA affecting businesses and individuals. The law is complex, and readers should consult with a qualified attorney or financial advisor to determine how the law applies in their particular circumstances.

The Elements of the Health Care Reform Law

Although the massive health care reform law is complex, at bottom it contains five major initiatives that, taken together, seek to ensure that Americans have health insurance:

- **Employer mandate.** Employers must provide to their employees health insurance that meets certain minimum essential coverage requirements, or pay a penalty for failing to do so. Employers are required to provide coverage only for the worker, not for members of his or her family. The employer must bear the bulk of the cost of providing the insurance, although a worker can be required to contribute an amount up to 9.5% of the worker's income. In July 2013, the Administration deferred the enforcement of the employer mandate, announcing that the IRS will not fine employers for failing to provide insurance before January 2015.
- **Individual mandate.** Beginning January 1, 2014, every American must have health insurance that meets the minimum essential coverage requirements. Someone who does not receive insurance through an employer or under Medicare or Medicaid must purchase insurance, or pay a penalty for failing to do so.
- **Pre-existing conditions.** The law prohibits insurance companies from denying coverage or charging higher premiums based on the state of the applicant's health (pre-existing conditions).
- **Exchanges.** The law requires each state to set up an "exchange" or "marketplace," an Internet portal where people seeking insurance can get information about coverage options and fees. If a state fails to establish an exchange, the federal government will do so for the state. The exchanges are to be up and running by October 1, 2013.
- **Subsidies.** Families with income between approximately $24,000 and $94,000 may receive a federal subsidy when they purchase insurance on an exchange. Workers eligible for employer-provided insurance coverage are not eligible to receive a subsidy.

  Under the law as written, families with income under approximately $24,000 were to receive insurance at no cost under Medicaid. This provision of free insurance represented a significant expansion of existing Medicaid coverage, and the law required the states to pay a portion of the Medicaid expansion cost. The Supreme Court, however, held that the federal government cannot constitutionally require the states to contribute to this expansion of Medicaid. Thus, each state now has a choice whether to expand Medicaid for its residents. Many states (typically those with Democratic governors) have decided to expand Medicaid and provide the additional free insurance. But many other states (typically those with Republican governors) have chosen not to do so. Low-income families living in states that do not expand Medicaid will have health insurance only if they access it through an employer or purchase it on an exchange. Perversely, as the law is written, families with income under $24,000 are not eligible to receive subsidies when purchasing insurance on an exchange, because the law assumed they would receive insurance for free. Thus, very few low-income families living in states that do not expand Medicaid are likely to have insurance coverage.

Complying With the Insurance Mandates

Whether the mandates work to ensure that Americans have health insurance will depend on the extent to which employers and individuals comply. An employer can avoid the mandate in three ways:

- Businesses with fewer than fifty employees are not subject to a penalty for failing to provide insurance to their employees. There is some concern that small businesses might choose to remain under fifty employees to avoid the mandate. Some special rules apply here:
  - Businesses substantially owned by a single person or entity are aggregated to determine whether the group as a whole has fewer than fifty employees. Thus, splitting a single business into two businesses under the same owner will not avoid the fifty employee limitation.
  - Part-time employees are aggregated to produce the number of "full-time equivalent" employees. For instance, two employees working half-time will be treated as a single full-time employee in determining whether the business has fewer than fifty employees.
- Businesses are not required to provide insurance to part-time workers, defined as employees who work fewer than thirty hours per week. (Note that part-time workers are aggregated for purposes of determining whether a business has fifty employees, but, even if a business thus goes over the fifty employee threshold, the business is *not* required to provide insurance to those part-time employees.) Some businesses already have indicated they will hold part-time workers to fewer than thirty hours to avoid the mandate.
- Some businesses that cannot take advantage of the above exceptions might choose to pay the penalty rather than provide insurance to their employees. Employers might be less concerned about offering insurance now that their employees cannot be rejected for individual coverage. The penalty on an employer for failing to provide insurance – which won't begin until 2015 in any event – is only $2,000 annually per employee, much less expensive than paying for employee coverage. An employer could share these savings with employees by providing additional bonuses, which an employee could use to purchase insurance on an exchange.

To the extent an individual does not receive insurance from his employer (or under Medicare or Medicaid), he or she is required to purchase insurance under the individual mandate. But young and healthy workers might choose to pay the penalty rather than purchase insurance. The maximum penalty is $2,085 per family or 2.5% of taxable income, whichever is greater. Moreover, the IRS, which is charged with collecting the penalty, can do so only by a reducing a tax refund otherwise due. Thus, the penalty cannot be collected from people who pay no income tax (or who do not overpay their tax through estimated payments)

Effects of the Law

In the final analysis, how well does the ACA ensure that Americans have health insurance? Following the above analysis, it is reasonable to expect that a significant number of members of the following groups will not have insurance coverage:

- Employees who choose not to make the required contribution to purchase employer-provided insurance (either because they are young and healthy or because they cannot afford to do so).
- Family members of a worker who does not receive family coverage from his employer and does not purchase family coverage.
- Families with income below about $24,000 in a state that does not expand Medicaid.
- Families who are exempt from the penalty because insurance would cost more than 8% of their income.
- Undocumented workers.
- Healthy people who choose to pay the penalty rather than purchase insurance.

The latest nonpartisan government studies estimate that the ACA will shrink the number of uninsureds by about half, from 60 million to 30 million. (Congressional Budget Office, July 2012). This reduction will come at a cost to both the government and to affluent Americans. A portion of the cost is funded by a new 3.8% tax on investment income

received by families with adjusted gross income above $250,000. The remaining cost must be recouped through spending cuts – the law seeks to implement cuts in Medicare reimbursement amounts – additional taxes, or new government borrowing.

There is a subsidiary issue that arises from the low penalty amounts. If employers chose not to provide employee coverage and healthy people decline to purchase insurance on their own, then the people who purchase insurance are those more likely to be sick. (See Consultant Says Employer Mandate Delay Could Mean Sicker Enrollees in Exchanges, Bloomberg BNA, July 3, 2013). That is an untenable situation for insurance companies, who could be forced to raise rates significantly or exit the business altogether.

What Should Businesses and Individuals Do?

Businesses must decide whether to provide employee insurance coverage in 2014, and, if so, whether also to provide family coverage. They also should consider whether to scale back (or not increase) number of employees or hours for part time employees before the employer mandate becomes enforceable in 2015.

Individuals who are not eligible to receive coverage from employers or under Medicare or Medicaid must decide by January 1, 2014, whether to purchase coverage on the exchanges (perhaps with benefit of a subsidy) or allow the IRS to reduce tax refunds they would otherwise receive by the amount of the penalty for failing to do so.

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