Healthcare Reform: 2014 - A Key Implementation Year

Financial Advisory White Paper

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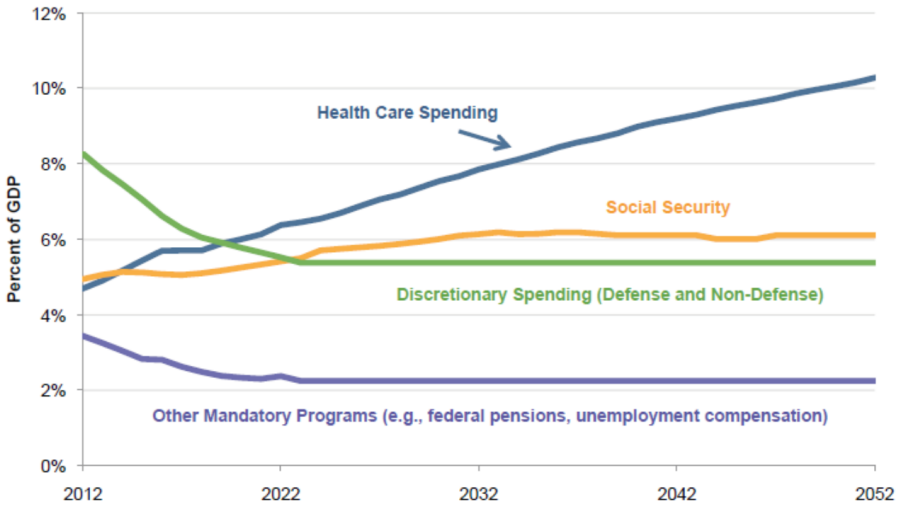
Over the past three decades, rising health care costs and the subsequent rise in health insurance premiums fueled an increase in the number of Americans without insurance to an estimated 50 million.

These uninsured individuals and uncontained healthcare expenses place considerable strain on the US economy. In 1960 the United States spent 5% of gross domestic product (GDP) on health care. In 2010, over $2.6 trillion was spent on health care, representing roughly 18% of GDP with spending projected to reach 21% by 2020. Simultaneously, other advanced nations provide health care services for significantly less (i.e. Germany 11.6% of GDP, United Kingdom 9.6% GDP, and Japan 9.5% GDP).

Ever-higher healthcare spending directly contributes to rising health insurance premiums, pressuring middle-class families at a time when wages have stagnated for decades. According to Commonwealth Fund analysis, health care premiums represented 18% of family income in 2009 and are expected to reach 24% by 2020. In addition, health care costs are becoming the primary driver of the nation's debt, as depicted in the chart below.

The increase in the cost of insurance also strains employers' ability to provide comprehensive healthcare benefits, leading to a shift toward less generous policies or dropped coverage. In this whitepaper, we review the history of health care reform, give an overview of the



Source: Congressional Budget Office's Alternative Fiscal Scenario (February 2013), additionally assuming that combat troops overseas decline to 45,000 by 2015 and that Hurricane Sandy funding is not allocated in future years; Bipartisan Policy Center extrapolations

current changes in health care, and, most importantly, clarify its impact on individuals.

The History of Health Care Reform

Due to the aforementioned negative secular trends in health care, attempts at reforming health care legislation are not new. President Bill Clinton introduced the Health Security Act which ran into major opposition from small businesses, insurers, and the Republican Congress. It became obvious that without constructive input from these key constituents, any attempt at reform was futile.

One of the most significant differences in the health care reform negotiations in place today is that employers and business groups, alarmed at the soaring cost of health care, took a seat at the health care reform negotiating table. Insurance companies, which helped defeat the Clinton plan, accepted the need for change and participated in the negotiations, while President Obama invited Members of Congress and leaders in the health care industry to the White House for an open discussion on health care reform options. As a result, The Patient Protection and Affordable Care Act (HR 3590) ("ACA") was born. One of the successes of the ACA is that the main political players agreed upon intentions of the healthcare reform.

Intentions of the ACA

The stated intentions of the health care reform legislation include:

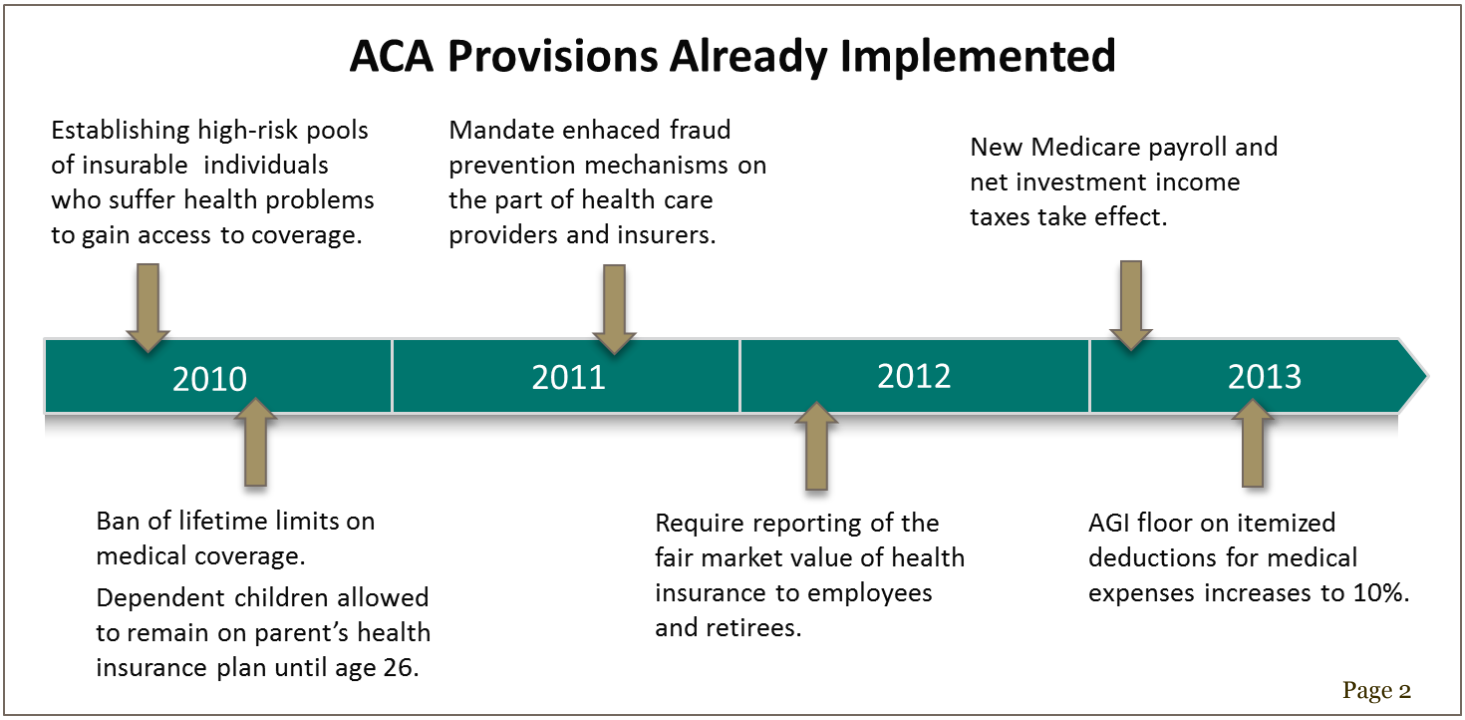
- Guaranteeing that 95% of Americans will have health insurance.
- Making health insurance affordable, including the largest middle class tax cuts for health care in history.
- Protecting consumers and reining in insurance company abuses.
- Holding insurance companies accountable through lower premiums and prevent coverage denial.
- Reduce the deficit by more than $100 billion over the next decade and by more than one trillion dollars over the following decade.

The Patient Protection and Affordable Care Act of 2010

The current health care reform is two new laws: the ACA, signed into law by President Obama on Tuesday, March 23, 2010; and the Health Care and Education Reconciliation Act of 2010 (HR 4872), passed by Congress on March 25, 2010, amending various provisions of the ACA and including several new provisions. The passage of these two new laws fundamentally alters health insurance distribution and regulation in the United States. Contrary to certain media outlets, the reform is not a government takeover of health care, as occurred in Canada or Great Britain, as the key parts of the current U.S. system (i.e. employer-provided insurance, Medicare for the elderly, and Medicaid for the poor) remain unchanged.

The Implementation of the ACA

The drivers of health care costs are complex and multi-faceted. Just as no single driver is responsible for the high and rising health care costs, no single policy solution will be adequate to meet this challenge. The premise of



the ACA was to package health care cost containment options that, if implemented together, could reduce system-wide health care costs, slow cost growth, and improve the efficiency and quality of care in the United States. Such wide-sweeping reform would have stressed the existing infrastructure if implemented concurrently. Consequently, the ACA is being implemented in stages, with the more palatable changes taking effect first in order to garner public support. The timeline on the previous page outlines the provisions implemented in the past few years.

2014—A Key Implementation Year

Many of the more groundbreaking provisions affecting the greatest number of Americans take effect in 2014. These include the *individual shared responsibility* provision, which requires nearly all Americans be covered by a health plan that provides *minimum essential health benefits* by the end of open enrollment period on March 31, 2014, or pay a penalty. Essentially, everyone has to have a plan and every plan has to contain all of the *minimum essential health benefits*.

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Individual Shared Responsibility

This provision is, perhaps, the most controversial piece of the health reform legislation and the most critical for the ACA to work. If citizens do not have coverage, they can either qualify for an exemption or pay a penalty. The government enacted this provision to get healthy, often younger, people, who are reluctant to buy insurance, into the system to increase the pool of insured individuals. Ideally, these healthier individuals should help fund the higher cost of covering high-risk individuals currently lacking health insurance. This function is absolutely critical to the success of the ACA and is where many of the implementation hiccups have occurred. Examples of plans that satisfy the *individual shared responsibility* provision include*:

- Employer-sponsored coverage (including COBRA and retiree coverage)
- Coverage purchased in the individual market
- Medicare Part A and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration

**This list is not all inclusive.*

Minimum Essential Health Benefits

This provision requires every insurance policy to have the same minimum level of benefits, regardless of whether they are in an employer-sponsored insurance plan, an individual plan being sold on the open market, or by the new government-run marketplaces (HealthCare.gov or the state-run health exchanges). This aspect of the ACA essentially standardizes insurance policies. The *minimum essential health benefits* required are listed below:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity care and newborn care
- Mental health services and substance use disorder services
- Drug coverage
- Rehabilitative and habilitative services and devices
- Laboratory tests and services (i.e. X-Rays)
- Preventive and wellness services, as well as the management of chronic diseases
- Pediatric medical services (including both dental and vision)

Penalties for Individuals

In order to accomplish the formidable task of achieving 95% of the population with health insurance policies all containing the same standard benefits, the ACA had to incent behavior through penalties on individuals and corporate controls applied to insurance companies. If an individual fails to acquire insurance or does not qualify for an exemption, they must pay a penalty, assessed on their federal income tax return. Religious and financial exemptions exist, but all others are subject to a penalty for failing to obtain health

insurance coverage. The penalty will be phased in from 2014 through 2016 as follows:

The penalty will be the greater of:

- 2014 - $95 per adult, or up to 1% of household income above the IRS stated threshold
- 2015 - $325 per adult, or up to 2% of household income above the IRS stated threshold
- 2016 - $695 per adult, or up to 2.5% of household income above the IRS stated threshold

Individuals must provide sufficient health insurance documentation with their tax returns. Beginning in 2015, insurance providers will send the IRS a form confirming coverage by a plan providing the *minimum essential health benefits*.

The penalty is determined by the number of uninsured people per household and household income. For example, a family of four with household income of $250,000 will be assessed a penalty of $2,300 in 2014, scaling up to roughly $5,900 by 2016. However, the IRS is limited in its ability to collect the penalty. **There is currently no enforcement mechanism for collecting the penalty other than reducing a taxpayer's refund.** The ACA does not allow the IRS to file a Notice of Tax Lien for failure to pay the penalty. This means that the IRS cannot attach a lien to your wages, bank accounts, or personal assets.

Premium Fairness Required

Premium discrimination is prohibited for sex or health status but allowed for age and tobacco use. For example, an individual with high cholesterol or blood pressure cannot be assessed a higher premium, even though their risk to the insurer is higher.

Pre-Existing Conditions

Insurance can no longer be denied based on pre-existing conditions. Individuals diagnosed with cancer or any other condition cannot legally be denied health insurance.

Premium Increases

Insurers must disclose how they spend policy holder premiums, using a ratio showing the percentage used to cover medical care versus executive salaries and administrative costs. Insurance providers will have to allocate at least 85% of group plan premiums and 80% of individual policy premiums to medical care. Under the ACA, the Secretary of Health and Human Services will annually review "unreasonable" increases in health insurance premiums.

The Four Basic Plans

Obviously, the ACA defines what kind of insurance plan can be sold in the United States. The four basic qualified health plans that take effect in 2014 are distinguished from one another by their "actuarial value." Actuarial value refers to the average amount of insurance expenses paid for by the plan. The higher the actuarial value of a plan, the lower the out-of-pocket costs for the individual. The table below shows the different plans and the associated health care cost coverage under each plan.

Plan Type	Healthcare Cost Covered
Bronze	**60%**
Silver	**70%**
Gold	**80%**
Platinum	**90%**

In the market place, an insurer will charge progressively higher premiums among the four basic plans, with Bronze Plans having the lowest premiums and Platinum plans having the highest. Individual insurance companies are not required to offer all four plans, but must offer the Silver and the Gold plans.

The ACA allows for a *Catastrophic Plan* as a catch-all for individuals not covered by the four basic plans. This plan allows individuals under the age of 30, as well as individuals exempt from the mandate due to a hardship, to purchase catastrophic coverage when they can demonstrate problems affording a Bronze Plan. The hardship exemption was recently expanded for 2014 to include individuals who had their private health care plans canceled because their plan did not meet the *minimum essential health benefits* requirement. This plan is only available through an exchange and tax subsidies cannot be used to reduce its premiums.

Health Care Exchanges

One of the primary features of the ACA is the creation of health insurance exchanges. An exchange is an electronic insurance marketplace with the goal of helping individuals and small businesses access affordable, quality health insurance.

States have authority to create two exchanges: an American Health Benefits Exchange for individuals and a Small Business Health Options (SHOP) Exchange for businesses. Should a state opt not to establish a health insurance exchange, one will be offered to residents of the state by the federal government.

Consumers can shop for coverage on or off the exchange, but subsidies are available only through the exchange. Subsidies will be limited to people who meet specific income requirements. In addition, individuals with access to insurance through their employers, but who decide to purchase insurance on the exchange instead, are eligible for subsidies only if their employer's plan does not cover at least 60% of estimated medical expenses, or if it would cost the worker more than 9.5% of household income.

Healthcare exchanges also help people determine eligibility for federal subsidies or Medicaid. Under the ACA, everyone with income below 133% of the federal poverty level (FPL) will be eligible for Medicaid, increasing the number of individuals qualified for Medicaid. For the first three years, federal taxpayers will pick up the full cost of the expansion. This 100% funding rate will phase down to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020.

The Supreme Court ruling gave state lawmakers the ability to opt out of expanding their state Medicaid programs. To date, twenty-one states have opted out of the expansion as they are worried that, given federal budget pressures, Washington will not be able to continue to cover 90% of the costs after 2020, leaving them with the inability to roll back programs or pay the bill. It is estimated that about two-thirds of the newly insured will be served from the expanded Medicaid programs, while the remaining one-third will be covered through the exchanges. The cost of this could be substantial and is unknown.

Impact on the Individuals

The ACA's goal is to provide health care coverage to over 35 million uninsured Americans over the next few years through healthcare exchanges, employers, and Medicaid expansion. However, coverage comes at a substantial cost that must be funded through tax law changes, increased insurance premiums, and covered benefits.

New Medicare Payroll Taxes

Beginning January 1, 2013, high-income households began paying more into Medicare as a result of the new health care reform law. The Medicare payroll tax was increased by an additional 0.9% on earned income for individuals making more than $200,000, and joint filers making more than $250,000. The additional tax only applies to income above the threshold amount. For example, if your filing status is Single and you have earned income of $220,000, you will pay 1.45% Medicare tax on the first $200,000 of earned income and 2.35% (1.45% + 0.9%) on the additional $20,000 of earned income.

New Medicare Tax on Net Investment Income

Beginning January 1, 2013, a new 3.8% Medicare tax will be applied to the lesser of "Net Investment Income" ("NII") or the excess of the individual's modified Adjusted Gross Income ("AGI") over $200,000 ($250,000 for joint filers). This additional tax is designed to increase the services of Medicare to comply with the new essential health benefits required to be covered under the ACA. NII is defined as investment income from, but not limited to: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, and passive business investments. Distributions from retirement accounts (i.e. IRAs, Roths, 401ks, etc.), pensions, and tax-exempt interest are not included as NII. For example, if you are married, filing jointly and have $400,000 of AGI ($240,000 in wages and $160,000 of investment income), you will pay an additional tax of $5,700. This is due to having $150,000 of AGI above the $250,000 threshold, which is less than $160,000 in NII. It is important to understand the additional 3.8% tax also applies to all non-grantor trusts (i.e. irrevocable trusts, credit shelter trusts, marital trusts, bypass trusts, etc.). The additional 3.8% will be in addition to the trust tax rates.

Itemized Medical Deductions

Taxpayers under 65 will see the AGI floor on itemized deductions for medical expenses rise to 10%, beginning in 2013. Taxpayers aged 65 and over will be exempt from the cutback through 2016.

Individual Shared Responsibility Provision

Each individual must be covered by a plan by March 31, 2014 that provides *minimum essential health benefits,* qualify for an exemption, or they must pay a penalty.

Canceled Plans

Over the past several months, there has been significant press coverage about individuals who have had their private health care plans canceled by insurance companies as a result of the ACA. There has also been much confusion regarding the reason why these plans were canceled. The ACA is designed to provide a higher level of care for all individuals. The core of this higher level of care is the requirement that all current and future insurance plans provide

essential health benefits. Individual private plans that did not meet the essential health benefits requirements, were canceled by insurers, to be replaced with plans that will meet these requirements. If a plan was canceled, the individual may purchase a new health care plan from the health care exchange or directly from an issuer. In 2013, a client received a cancelation notice from their private insurer stating that their high deductible plan did not qualify under the new *minimum essential health benefits* requirement. They were offered an alternative plan with more comprehensive coverage, which also came at a higher premium cost.

Medicare

The ACA does not require individuals on Medicare to replace their coverage. Medicare is not part of the health care exchanges; therefore, you still have the same benefits and security with Medicare. To comply with the new *minimum essential health benefits* requirement under the ACA, Medicare now covers more preventative services, without charging the Part B coinsurance and deductible. These preventative services include yearly "wellness" visits, mammograms, colonoscopies, etc. These preventative services are designed to encourage individuals to be more proactive with their health care visits and catch medical problems earlier, when there is a higher probability of treatment. There is also a discount of 50% on Part D brand-name prescription drugs when an individual is in the "donut hole." When insured under Medicare Part D, prescription drugs are covered 100% up to the $310 deductible. After reaching the deductible, individuals pay 25% of drug costs on the next $2,490 and 100% of drugs cost up to $4,550, after which Medicare Part D pays 95% of drugs costs over this limit. This gap in prescription drug coverage is commonly referred to as the "donut hole." The new discount will be a huge savings to individuals who take brand-name medications that are often very expensive. The discount is automatic and will be applied at your local pharmacy. The "donut hole" will be closed by 2020.

The Employer Mandate

The health care reform laws will have varying outcomes for employers and businesses depending on size. The employer mandate scheduled to go into effect January 1, 2014 is delayed until January 1, 2015 due to strong pressure from the business community. This legislation will also impact individuals and we will continue to keep you informed throughout the year as those changes unfold because we expect there will be changes in many employer-sponsored healthcare offerings.

As you can see, the ACA is a complex piece of legislation that will fundamentally alter health care in the United States both now, and for years to come. There will be lasting implications requiring continuous research and planning for individuals as the aftermath of implementation has yet to be quantified. At Rinehart Wealth Management, our job is to help guide you so that you can make better, more-informed decisions. Please contact us with any questions and let us know how we can help.

Rinehart Wealth Management

Rinehart Wealth Management is an experienced boutique Registered Investment Advisory firm dedicated to independent comprehensive wealth management for our clients. Founded in 1985 by Mary Rinehart, the firm from its inception has had a singular focus: to provide highly customized investment management and financial planning solutions to clients.

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