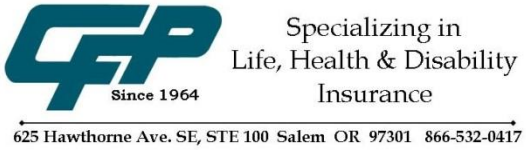
Health Care Reform
How the Individual Mandate Will Impact You

By Harold Christensen, Benefits Advisor, CFP, Inc.



The Individual Mandate is part of the Affordable Care Act (ACA) and requires all residents in the United States to have health insurance that meets "Minimum Essential Coverage" in 2014. With few exceptions, people who do not have compliant health insurance will be subject to a tax penalty.

Medicare, Medicaid, Tricare, and Tribal Coverage are a special type of coverage and considered to be "minimum essential coverage". Group coverage through an employer and individual plans as of their January 1st renewals will be considered compliant. LIMITED benefit plans such as a dental only, accident plan, or workers compensation are not compliant.

ACA regulations stipulate that individuals are responsible for tax penalties owed by spouses, children and other dependents. The penalty for not having health insurance in 2014 is $95 per adult and $47.50 per child or one percent of your taxable income — whichever is greater. Any penalties will be assessed on individual income tax returns but the ability of the IRS to collect the penalties is limited by law. The IRS cannot initiate civil or criminal penalties, seize bank accounts or garnish wages to collect penalties. Also, no interest accumulates for unpaid penalties. Under current law, the only practical way for the IRS to collect on penalties is to withhold tax refunds.

A crucial piece of Health Care Reform is the elimination of medical underwriting on all plans beginning January 1st 2014. This change makes coverage accessible to everyone. Now the uninsured, underinsured, those unable to afford or previously been denied coverage, will be able to purchase health care. Individuals earning less than 138% of the Federal Poverty Level may be awarded a 100% subsidy. The elimination of medical underwriting enables everyone to obtain coverage.

The new marketplace makes high risk plans such as OMIP (Oregon Medical Insurance Pool) and Portability obsolete. Both were a safety net for individuals unable to obtain coverage through medical underwriting. Anyone on these plans will need to obtain new coverage as their existing plans will terminate December 31st 2013.

Anyone covered by an Individual Plan will receive notice from their carrier advising of termination of the plan December 31st 2013. Individuals can either re-enroll with that carrier or move to another carrier for a plan that has Minimum Essential Coverage. As of January 1, 2014 individual medical plans will be ACA compliant. If you want your coverage to be active on January 1st 2014 you must submit your application to the carrier by December 15th.

Some carriers may automatically move a member from an existing Individual Plan to a new one of their choice with Minimum Essential Coverage. Other carriers will require the member to actively enroll on a new plan, forcing them to engage in the process. We advise people not to take what a carrier moves you to without making sure it covers the doctors and facilities you need. Although all individual plans

beginning in 2014 will have Minimum Essential Coverage, plans may differ significantly between carriers. Pay attention to specific coverage's such as Prescription Formularies, doctor and hospital networks, copays, and premium pricing. We encourage you to review your options carefully before applying.

Beginning in 2014 you will only be allowed to enroll on an Individual Plan during Open Enrollment, or if you have a Special Enrollment right. The initial Open Enrollment for 2014 Individual Medical Plans inside and outside the Exchange began October 1st. Due to the number of people needing to convert old plans or obtain new coverage, the initial Open Enrollment Period will be extended to March 31st, 2014. In subsequent years we expect Open Enrollment to match Medicare Open Enrollment – October 15th through December 7th.

If you choose to go through the Oregon Exchange, Cover Oregon, and want your plan to be in effect on January 1st 2014, you must apply by December 15th. Applications submitted between December 15th and December 31st will have an effective date of January 15th. In subsequent months, applications submitted by the 15th of the month will be effective the first day of the following month.

Due to the limited Open Enrollment Period for Individual Plans, if you do NOT enroll on time you may not be able to obtain coverage until January 1st 2015. Once Open Enrollment closes the only way to obtain individual medical coverage will be through a qualifying event such as loss of coverage or moving from an area where coverage was not transferable.

A common question we hear is "*Can I get free insurance through the exchange?*" The answer is – possibly, but it's complicated. To qualify for any subsidy or cost sharing you must purchase coverage through an Exchange. The application for Oregon's subsidized coverage is about 20 pages long. They take an in-depth look at the number of people living in the home and the collective household income. Generally, an individual may be eligible for a subsidy if they:

- Have a household income between 100 percent and 400 percent of federal poverty level
- Are not eligible for Medicare or Tricare
- Are not eligible for Employer Sponsored Coverage.

An individual that qualifies for and receives a subsidy should report income changes throughout the year. If your income increases mid-year it could make you ineligible for subsidies. Subsidies received would then need to be repaid when doing year-end taxes. If free coverage is available, you would need to qualify for the Oregon Health Plan (OHP) and earn under 138% of the Federal Poverty Level.

If you or your spouse work and are eligible for an employer group plan that allows dependent coverage, it may invalidate your ability to obtain a subsidy. Follow this guideline:

If an employer plan allows dependent coverage, and the employee pays less than 9.5% of their household income for self-only coverage, a spouse and children would not be eligible for a subsidy through the Exchange.

For those not eligible or interested in a subsidy, you can still purchase a plan through the Exchange, Cover Oregon. However you will find more options available by going direct to carriers outside the Exchange. If a carrier offers an identical plan both inside and outside the Exchange the price will be the same.

Individual Medical Plans made direct with a carrier will require the inclusion of a pediatric dental plan regardless of the enrollee's age. Pediatric Dental coverage can only be used by children up to age 19 yet is one of the "Essential Health Benefits" required by Health Care Reform. Carriers realize adding

pediatric dental to every medical plan unnecessarily inflates cost. To satisfy the law, carriers are now adding "free" pediatric dental coverage to adult medical policies if they have no children enrolling. Carriers offer if for free because no benefit is available for adults. A certificate is issued by the carrier to fulfill the Federal requirement for coverage and the medical plan is now compliant without increasing cost. Anyone applying for an Individual Medical Plan with children needs to make sure pediatric dental coverage is included.

Clarifying Health Care Reform Terminology:

Over the past three year's rules, phrases and their interpretation have become blurred. Here are a few common terms and definitions.

Minimum Value: A health plan is deemed to meet 'minimum value' requirements if the plan will cover at least 60% of expected costs. As of January 1st all individual plans sold will meet minimum value. All group plans, at their renewal on or after January 1st, 2014, will meet minimum value.

Minimum essential coverage: This refers to the coverage needed to avoid the Individual Mandate penalty. Group, Individual, Medicare and Tricare plans are considered to meet minimum essential coverage. Coverage does not have to include essential benefits to be minimum essential coverage.

Essential Health Benefits: The Patient Protection and Affordability Care Act (PPACA) determined that certain benefits MUST be covered in 2014. In addition, each state has the option to add additional benefits they feel are essential. Essential Health Benefits include coverage such as ambulance, hospitalization, emergency services, prescriptions, as well as pediatric dental and pediatric vision. Effective January 1st, all Individual plans will include essential health benefits. All Small group plans, as of their renewal on or after January 1st, 2014, will include all essential health benefits. Large employer plans (group with over 50 employees) are exempt from having to provide Essential Health Benefits. Individuals are not required to have Essential Health Benefits to comply with the Individual Mandate; but they must have Minimum Essential Coverage.

Our office is here to help you navigate the complex world of Health Care Reform. If you have questions, we have a number of resources to help you answer questions you may have. If you have questions about this article, or health reform, or any other benefits related questions, feel free to call us here at CFP (866-532-0417) or by email at benefitshelp@cfpinc.net. CFP has been working with OCAPA for several years and appreciates the opportunity to help with your benefits planning.