www.ExactingEditor.com/ObamaCare-Shaffer-2016.pdf

ObamaCare — How It Works, Why It Doesn't

by June Shaffer (June@ArizonaLifelines.com)

JUNE SHAFFER has been in the health-insurance industry for 24 years. In 1996, she became the unofficial high-risk and hard-to-place specialist for Arizona. Various governmental groups and state agencies discovered that she'd make the extra effort to find coverage for people who could not get it on their own, and people who were uninsurable — or who simply thought they were. That "in" helped keep her busy until the onset of ObamaCare. Since then, she has helped consumers sort through the ever more confusing maze of what health "insurance" has become and what is available to them.

EDITOR's NOTE -- the great bulk of this document was created during the second half of 2016. **Updates made during December 2017 appear in purple and bolded type.** Reporters and media analysts should feel free to contact the author if they have questions.

ObamaCare — The Patient Protection & Affordable Care Act, later shortened to "ACA" — is neither a health care plan nor insurance; it is a mandate, signed into law on March 23, 2010, indicating — among numerous other aspects of its content — that everyone must buy insurance or pay a fine (with some exceptions, such as low income or hardship issues). This obviously meant that insurance companies could no longer pick and choose, or charge higher premiums for "impaired risk" (questionable health), and now had to accept all applicants.

The ACA is obviously much broader in its scope; however, these two elements are their most significant, as far as the impact to individuals and insurance carriers.

Those of us in the industry, as well as many consumers and medical providers, believe that the purpose of the ACA was not so much to make health coverage affordable as to pave the way to socialized healthcare, something that has been talked about for decades but with no success.

By making it nearly impossible for carriers (insurance companies that offer health coverage plans which accept and pay for the risk of medical issues) to continue to offer a number of competitive plans and rates, and consumers to be able to pick and choose (or not) — and afford — it has taken less than four years for this law to start to crumble.

The law also instructed carriers to provide ten "essential benefits" in all of their plans, including:

1. Outpatient care, such as you get without being admitted to a hospital
2. Trips to the emergency room
3. Treatment in the hospital for inpatient care
4. Maternity care before and after your baby is born
5. Mental health and substance use disorder services, including behavioral health treatment, counseling, and psychotherapy
6. Prescription drugs
7. Services and devices to help you recover if you are injured, or have a disability or chronic condition — such as physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, etc.
8. Lab tests
9. Preventive services including mammograms, colonoscopies, pap smears, prostate exams, health screenings, various preventive-level vaccines
10. Pediatric services, providing dental and vision care for children under age 19

The ACA is simply not designed for financial sustainability. After all, someone has to pay for all the medical conditions that before weren't covered… for the medications that are now seeing four-fold cost increases because the pharmaceutical companies know the carriers have to cover them… for all the now-"free" check-ups and physicals that in the past were covered only nominally.

Consumers heard "affordable health care" and "keep your doctor (or plan)" and "no one can be turned down." They did not hear how rates would have to be increased — first year increases fell in the 50% to 75% range — in order to make this happen. No one anticipated many providers not taking patients who had purchased their plans through the Marketplace.

Congress never made it clear to the American public that, ultimately, they would be paying for all this — one way or another. As for those subsidies that were promised to consumers whose income fell between 100 and 400% of the poverty level? The cost of those subsidies has far exceeded what was predicted when this law passed. Who will that financial burden fall on?

Has "the Marketplace" — www.HealthCare.gov — Helped?

The purpose of any marketplace is to allow entities to compete with each other in selling their products, providing customer service, and offer competitive prices. The Marketplace for healthcare started off well but no longer meets those criteria. We have a reduction of competition, higher prices, and products that often fail to meet the customer's needs. Easily two-thirds of those going to the Marketplace during 2017 have an option of only one or two carriers. In 2014, they had at least four and some states had as many as five or six.

- First — as a result of Obamacare, Medicaid expansion increased the amount of income one could have and qualify for public assistance (tax-supported aid) by as much as 38% in some states. This expansion was optional, though more than half the states complied. This in turn increased the number of people who have health care by thousands in most

states. Current statistics shows that nearly one-quarter of the population is covered through some form of Medicaid. Many individuals applying through the Marketplace are told they qualify for public assistance, and their information is then sent to their local Medicaid office, where they then get their coverage. However, these people are counted as those receiving coverage "through the Marketplace."

- Second — more than half of those going to the Marketplace had health coverage before they went — the difference is they would now have help to pay for it. Last year, over 80% of those selecting a plan through the Marketplace got some level of financial assistance. But while the subsidy did impact millions, for many, it simply changed how much they paid.

- Third — there are those who went to the Marketplace to browse and buy, who had insurance before and have it now, but who don't get a subsidy. They simply used the Marketplace as a one-stop shop, to look, buy and be done with the process. No real change in the number of insureds from this group.

Technically, the Marketplace — also known as "the government website" — is a shopping center for those getting subsidies. However, at almost any given time, there have been more plans available OFF the Marketplace than ON it. The Marketplace is simply where you have to go to be approved for a subsidy (if your income qualifies) and then, if you do, apply for your health plan at the same time.

Without the Marketplace, the majority of people who have coverage today, had it before. Without the ACA, they would still have it. While the law has in fact helped over 10 million people get insurance who did not have it before, without it, the rates for the tens of millions of those who already had coverage, would not have doubled and tripled. Notably, most consumers would not have required any subsidies at all!

With the implementation of the ACA, one unexpected consequence was the number of people who dropped coverage, citing cost as the primary reason. The subsidy didn't help them, their premium was still higher than their previous plan (which might gone away), and so they chose to self-insure.

This is a gamble, certainly, but statistics were in their favor: less than 15% of the insured public will even meet a deductible in any given year. However, the reality is that the unexpected — as more than half of all medical expenses are — could result in massive medical bills. Unpaid medical expenses can cost you your home, your savings…. even your future health. But — it's all about risk; that's why rates are what they are.

Subsidies helped the lower and much of the middle income sector. But, after the first year, premiums went up 20 to 30%; in the second year, they went up even more. 2017 will see more health premium increase in excess of 50% in order for carriers to continue to be able to pay their claims. Subsidies, on the other hand, have only increased a few percent at best.

For 2018, rates fluctuated from a negative increase to 15-25% in most states. But more carriers dropped out of offering individual major medical coverage during 2018. Subsidies remained essentially the same.

It was expected that most consumers would flock to the Marketplace to buy their coverage. In fact, an equal number still buy directly from the insurance companies since they know they are not going to qualify for a subsidy, and might find more plan options off the marketplace. For the same plan offered both on and off the marketplace, the rates do not change; only the application of the subsidy makes them "cheaper."

Grandfathered Plans

Consumers with grandfathered (or grandmothered) plans are hanging onto them, where they can. These are essentially plans that went into effect prior to 12/31/13. While their premiums increase every year, for most policy-holders they are still lower than what the current premiums would be if they applied for a new plan. Grand'ed plans do not include the "essential benefits" and still have lifetime limits, but their cost is more affordable. If the carrier offering those plans withdraws from the state, the grand'ed plans cease to exist.

The ObamaCare Beneficiaries

Three groups have been unquestionably helped:

- Those who could afford insurance but could not get it due to adverse medical history. Absolutely, one of the best parts of Obamacare — but the country most definitely did not require a law of this magnitude to make it happen.
- Those whose income was not really adequate to allow them to buy health coverage and have much left over for other necessities like rent, groceries, utilities, etc. Those subsidies definitely helped them — but not all of them. Many fall through the cracks (see further).
- Pregnant women who have no coverage. The new law covered maternity immediately. The down-side: maternity as a benefit is not a cheap one, and was included in the mandate as an "essential benefit," meaning everyone got it and paid for it. Same with pediatric dental. Making these benefits optional could have cut premiums, as most men and women over 50 don't need either of these "essential benefits," among others.

In many states, premium rates dropped for individuals after the mandate went into effect, as the subsidies provided aid to many whose incomes fell into specific ranges. This was a good thing — a good thing that couldn't last.

Exemptions

In some cases, a "hardship" exemption can be applied for which will exempt the individual

from (1) being required to buy health coverage and (2) paying the penalty. Scenarios that allow an individual to qualify for this exemption include:

- Filing bankruptcy within the last six months
- Recent death of an immediate family member
- Recent issues with domestic violence
- Homelessness
- Termination of utility services
- Eviction or home foreclosure within the last six months
- Substantial property damage as a result of natural or human-caused disasters
- Cancellation of your current health plan with the belief that marketplace plans are too costly
- Inability to pay medical expenses within the past 24 months, resulting in excessive debt
- An unexpected increase in your expenses due to taking care of sick, aging or disabled family members (many people definitely do not know this)
- An unspecified hardship in obtaining a qualified health plan (requiring documented proof and not always easy to prove)

Many people live on the financial edge. After the basics are paid, what's left doesn't make paying $600 or $700 per month feasible. Consumers often help support other family members, are paying off major debts, or trying to buy their kids clothes at Target rather than Goodwill. They can apply for an exemption not specified above, directly with the carrier, and possibly get a plan with a lower rate. Such plans are usually reserved for the under-30 age group, but exceptions can be made.

Employer-Provided Insurance

Employers aren't happy — and many small businessmen are taking it in the shorts.

Do you pay top dollar to get good people, and offer them health coverage but cut your profits so much that you may end up closing your doors? This happened to a substantial number of Mom-and-Pop businesses in the first year, as many small and medium-sized businesses reacted in a panic; over two million employer plans disappeared. They hadn't offered health insurance in the past but now that the price of it was burdening the employee, who might only be making $10-12 per hour, many good workers went looking for jobs that offered health coverage. This left their former employer having to train new help, hoping they already had coverage.

Employers are no longer able to help offset the cost of an employee's private policy without counting that offset as taxable income to the employee. To pay this offset to the employee, the employer had to raise the cost of their services or goods, etc.

Middle-sized employers were deliberating: cut employees' hours down to under 30 per week, and then not be required to offer health coverage, or keep employees at 40 hours but eliminate some jobs? This prospect kept both employers and employees up at night, as there were more

lay-offs, hours cut and positions eliminated. (On the flip-side, offering health coverage as a benefit became a major draw to attracting better employees, even at lower pay levels.)

It is estimated that, excluding those on Medicaid or who have opted to go without coverage at all, half of all Americans are covered under an employer plan.

Self-employed individuals now have to work more hours or charge more, to cover their increasing health insurance costs, and many spouses have gone back to work just to try to get health coverage.

Demise by Design?

Arizona is not the only state witnessing the systematic withdrawal of carriers, but did go from eight carriers in 2016 to four off-Exchange and one on-Exchange in one county, and just one on- and off-Exchange in the other 13 counties. However unintentional, from the standpoint of on-Exchange, this creates a monopoly in the counties these carriers serve.

We are not alone. Carriers nationwide are exiting the Marketplace at a disturbing pace, premiums are escalating to an unaffordable level, and the provider networks are shrinking.

Many individuals have medical conditions that can be addressed only by specialists who may not contract with the plans available to them in 2017 **or 2018 -- that individual's "choice" becomes no choice.** Consumers who can afford it have said they will continue to see their doctors and just pay cash, only to discover that a handful of physicians have indicated that they will no longer see cash-pay patients.

The panic button is understandably being hit. If they didn't (1) have to pay a premium for a plan they can't use or (2) didn't have to deal with the penalty, patients could likely afford to pay for the specialists and medications without coverage at all (excluding hospitalizations). But such an option doesn't exist and, at this time, the "exemptions" don't include "If your doctor doesn't take any of the currently-offered plans in your area." They should.

The ACA is no longer working for the masses. It is estimated that nearly two-thirds of tax-payers across the nation have two or less carrier options on the Exchange, with many of the remaining consumers having only one carrier option. This obviously gives no choice to the public, and forces them to select a plan that may not contain their doctors, thus creating physical or financial hardship, even with a subsidy. By choosing not to buy coverage, they will be fined for something they had no choice about in the first place!

The public cannot reasonably handle 200+% increases over a four-year period — chances are their incomes aren't much higher than they were in 2014. Providers cannot continue to take less for their services as PPOs disappear (HMO contracts do not reimburse at the same level that PPOs do). Hospitals cannot continue to make money (or not lose as much) if the networks they belong to no longer participate with the carriers still offering coverage in their area.

Let's not put the blame on the carriers: while a number of them made some profit through their Marketplace plans in the first year, such "profit" dwindled in the second and — for many carriers — had disappeared by the third. Many carriers have taken losses in excess of $45 million per year in each state, and some over $100 million — with no hope of recouping them.

If insurance companies were making a profit, they wouldn't be exiting the Marketplace or, in too many cases, leaving the state. Through what is called a "Risk Corridor," the administration promised carriers that they would be reimbursed for losses sustained through Marketplace sales made during the first two years of Obamacare. **As of 2017,** less than 13% of those losses have been reimbursed and it is doubtful they will ever see the other 87%.

Time Flies

On March 23, 2010, after what felt like a record-shattering period of time to create a mandate whose size exceeded 2400 pages, the Affordable Care Act was signed into law. Thus was ObamaCare born, with an actual effective date of January 1, 2014. The name "Affordable Care Act" has countless times been referred to as a total contradiction in terms.

Carriers had almost four years to prepare — and it wasn't enough. Jobs disappeared as tens of thousands of underwriters — the gods of the insurance world — were no longer needed, broker commissions were cut by more than half (that was just in the first year), carriers now had to adhere to MLRs (Minimum Loss Ratios, which require that 80% of their income be committed to claims, instead of 70-75%), and some smaller insurance companies felt they couldn't handle the losses and closed their doors early on.

We all heard Obama promise everyone that they could keep their plan, keep their doctors — proof positive that those who penned this law had no real knowledge as to how insurance worked and how providers interacted with it. Yes, you could keep your plan — if the carrier didn't discontinue it, or leave altogether. You could keep your doctor — if the network he was contracted with was still contracted with the carrier. So far, much of this concept has totally disintegrated. Even carriers didn't see some of this coming four years ago.

Representatives of the insurance world — executives, underwriters, brokers — filed into Congressional gatherings at both the federal and state levels to discuss what they saw happening as a long-term result of this mandate. They weren't there just to plead their own case, but the position of the consumer and how he was going to be affected.

Many of those sitting in those sessions weren't really interested in hearing more: they had already made up their minds. They were tired of dealing with the topic, there weren't many questions, and some were too distracted by their laptops. Thousands of Americans wrote to their Congressman — we knew the majority of Republicans were against the mandate and that very few Democrats opposed it. Republicans are still opposing it as a growing number of constituents call, write angry letters and ask them to "fix it."

And it has to be fixed soon, before it totally spirals out of control.

National Healthcare (socialized healthcare/single-payer) VS Choice

If things continue as they are, the day is fast-approaching when the government announces to consumers: "Well, we gave you what you wanted" (by whose definition?), "You voted for it" (we did not), and "Apparently ObamaCare is not working" (apparently!), followed by "So we are going to replace the Affordable Care Act with national healthcare."

In the presence of sky-rocketing premiums and a dwindling number of carriers offering fewer plan options for individual coverage, national healthcare might not look so bad. It will sound like what many people bought into in 2008: hope and change — with no real knowledge of what that really might translate into until it was too late.

Consumers need to remember some of the benefits we had before the ACA: the biggest was choice. When you have only one or two carriers, who have to charge high rates in order to pay for all the claims they now must cover, you lose choice.

A few years ago, we had many choices. We could forego coverage without being fined — a policy considered illegitimate by many — and were not penalized for being healthy by paying the same rates as those with severe medical issues. We had dozens of plans and carriers to choose from. We had PPOs and HMOs, large networks and out of state coverage — benefits we have pretty much lost. Note: most employer plans still have these benefits.

You might ask, what would be missing under national healthcare?

(1) Choice. The consumer's medical care — which so far has been between them and their doctor — may end up being up to the healthcare system. Under the age of 65 it might not be so bad so long as you remain relatively healthy.

(2) Cost. Many cite Canada — but their system is not "free." Unless you buy into a private plan, you have one government-sponsored (single-payer) system. A family of four in a middle income bracket in 2013 paid an average of $13,000 per year for their healthcare through a combination of government revenue and taxes. Interestingly, their system does not include coverage for prescription drugs. In 2013, a family of four in the US paid an average of $7,500 (higher or lower depending on where they lived) and had a choice of many carriers and plans. US plans have always included drug coverage, though in recent years, brand-name might have a separate deductible.

(3) Timely Healthcare. People in countries with national healthcare experience a very slow delivery system. Many doctors are frequently not taking new patients; you can wait up to a week to see a doctor for a cold, while more serious needs can find you on a months-long wait list to see a specialist — often limited in countries with this type of system. With socialized healthcare's inherent waiting periods, a condition can easily worsen during that wait, as the patient moves beyond life-saving treatment. Canada's long wait times to see specialists, have non-emergency surgery, etc (average time in 2014 was 18 weeks) prompts those who can afford

the time and money, to travel to the US because they can receive care quickly. This isn't just Canada, but dozens of other countries, as well.

If we get national healthcare here, unless our tax structure changes drastically, consumers should be prepared for tax increases; there is no other way to pay for it. After all consumers have recently been through — higher premiums, losing plans and/or doctors they were told they could keep — how will this impact us? How will it impact our health?

(4) Objective Healthcare. In most countries with socialized healthcare, care for those over age 70 is triaged based on current health and remaining useful life expectancy versus cost of treatment, surgery etc. We would hate to think Grandma can't get that pacemaker, Uncle Bill won't receive that new hip or Aunt Sue won't be eligible for her kidney transplant…due to their advanced age. Coverage under age 65 isn't guaranteed, either, but is more equitable.

Young Non-Enrollees Disrupt Establishment Calculations

Part of the ACA's premise was that younger people would buy coverage — which few would likely ever use — which would then help to offset the claims of the older and predictably less-healthy group. It did not turn out that way: many young people, finding the premiums too high for their budget, went without. The penalty was minimal at younger ages and they were willing to chance it. This should have been predictable, as the idea of paying a penalty tomorrow is remote compared to what younger consumers want to use their dollars for today.

Co-ops

These were federally-funded "insurance" plans that existed in about 23 states, 17 of which have failed primarily because they were upside down. Their premiums came in lower, they were counting on the risk corridor (referenced earlier) for reimbursement of losses, and the perception is that these under-funded co-ops took on more than their "fair share" of high-risk individuals. Of course: premiums were super-low in many states, so more people enrolled.

The co-ops were the negotiated end to a public option; Congress would not allow a public option and so created these co-ops, which sounded good — till they ran out of money.

Options — Good, Bad and Otherwise

Health Ministries, Cost-Share, etc — these are not insurance, do not cover preexisting conditions, but will keep you from paying the penalty. The fine print will tell you there is no guarantee of any payment for any claims, so beware. And some claims — for instance, alcohol-caused — might not get paid at all. These plans can't do what insurance does; they are not intended to replace insurance — and even state that — but people buy them for that reason. We are seeing a surge in sales of these plans. Why? They attract consumers to avoid the high price tags of regular insurance, and possibly because these plans pay nice commissions. Personally, I see too much financial risk.

Short-term Medical plans — I like STMs. Not ACA-compliant, they won't keep you from paying the penalty **(which is still in force until January 1, 2019),** but — ! Until April 1, 2017, some of these temporary plans could go up to 11 months; after April 1, the maximum time per application **became** limited to 90 days, though an applicant **could** re-apply for additional coverage at the end of those 90 days. STMs are available in most states.

Many individuals in good health will take these plans, knowing they cover only for anything new in the way of illness or injury, up to $1million or more — but do not cover pre-existing conditions, mental health, existing medications, maternity or routine check-ups. In some cases, the combination of the penalty and the premium for an STM can be less than the cost of the cheapest major medical plan. And — you are not limited as to providers or coverage area — like you are with most of the newer major medical plans.

In 2015, nearly a quarter million people applied for STMs, with over half citing their reason for doing so as the cost of regular coverage. We see an increase in applications for STMs, especially in the final two to three months of the calendar year, if someone has no significant medical issues. Why at this time? Because the penalty does not apply to a single gap of two months or less **in a calendar year.**

If someone has an STM and it expires, this loss does not create a qualifying event for a regular plan. So having an STM that lasts all year — or at least till the end of the year — can be financially advantageous. They are worth considering. **Some** applications do ask more serious-type health questions and coverage will be denied if there are any "yes" answers (pregnancy is an automatic denial **with most short term carriers**). However, these are ideal if you are pretty healthy and lose coverage and/or cannot afford a regular plan, if you miss the open enrollment, or if you just don't want to pay the higher rates.

The hard copy version of this book referenced that Health & Human Services (HHS, who is literally in charge of everything) was pushing to limit these plans to a maximum of 90 days — and they succeeded. **This went into effect on April 1, 2017.** This, obviously, **was** to continue to force consumers to buy the higher-priced major medical plans. Consumers buying STMs do not add to the numbers supporting ObamaCare's "success" (i.e., did not go to the Marketplace). But I see it more to the mandate's financial benefit: the more STMs sold, the more penalties get paid. (Flip-side: the less premiums paid to the major carriers, the less funds available to pay claims.) Win-win-lose.

The Penalty

On December 20, 2017, the individual mandate requiring that you purchase major medical coverage or pay a penalty, was overturned, meaning – not right away but soon – no penalty. This change goes into effect January 1, 2019.

What this will mean is that if someone wants to not pay the higher premiums of regular major medical, they can buy a short term – or just go without – and face no penalty. However, there is no ability to buy a plan during the calendar year, same as exists now.

We do not know if there might be other caveats to the abolishment of the penalty but, as 2017 ends, its end can only be viewed as a very good thing. For those with medical concerns, leaving a major medical plan would not be good idea. Going without coverage is not good, either. If something new in the way of illness or injury occurs, you want some kind of protection. That is where the short term plans come in handy, BUT – they must be in effect before the new illness or injury manifests itself.

The current penalty is based on $695 or 2-1/2% of your Modified Adjusted Gross Income (MAGI), whichever is higher. The first $10,150 (single) of gross income does not count toward the MAGI; this is called a "filing threshold." For families that threshold is higher ($20,300).

The IRS will not levy a lien against your property or garner wages if you do not pay an assessed penalty, but they can take the penalty out of future tax refunds. If you don't make enough to file taxes…no penalty. No-brainer.

To determine a penalty, see end of chapter for website address to an excellent article on penalty determination.

Subsidies…and Medicaid

If someone's gross income is under a specific amount, they don't have to file taxes and are eligible for Medicaid. There is no penalty. The income requirements are different from state to state, based on cost of living. If their income is higher than the maximum allowed for Medicaid, then they normally qualify for a subsidy. The ACA was very good in this regard — and, the larger the family, the higher the subsidy. Over a certain income level, of course, there is no subsidy. This group pays more for their coverage and gets no assistance.

The plan you select is not affected by the subsidy — any plan on the Marketplace is eligible to have the subsidy applied, if you qualify. Additionally, if your income falls between 100% and 250% of the poverty limit, and you choose a Silver-level plan, you become eligible for what is called Cost Sharing. Cost Sharing lowers that plan's deductible, out-of-pocket maximum exposure and co-pays.

There is a gray area surrounding Medicaid. Example: the minimum income at age 34 might be $16,800, to get a subsidy, and let's say the consumer earns $16,200… but the maximum income level in that state for Medicaid is $14,900. What does the client then do? He applies through the Marketplace and lets them send their information and recommendation to Medicaid. If he applies directly to Medicaid (in this scenario), he will be declined. The Marketplace transmittal to Medicaid trumps a direct application.

The Answer

There are many alternatives to ObamaCare. You might ask, "Why then didn't we take one of those routes back in 2010?" In a nutshell, you have to look at who designed it and what all the other implications of this law were. In all fairness, the creators of the ACA looked at

many options — but those people were not part of the health industry, were not suffering any medical care losses or high premium costs, and had little to do with insurance.

Until ObamaCare, 35 states had high-risk pools. While there were a few variations, this is generally where one carrier is deemed "the carrier of last resort" and they accept all the uninsurable, high-risk applicants (for a higher premium, of course), and receive subsidization through state funds (similar to Medicaid). These high-risk pools had little effect on the premiums paid by consumers buying coverage from the other carriers.

By late 2013, 17 states had begun the process of transitioning their state-operated pools to the federally-run Preexisting Condition Insurance Plan (PCIP, another part of the ACA), which created a high-risk pool in *all* states to transition "higher risk" consumers into ObamaCare. The PCIP officially went away in April 2014, though as late as 2014, 18 states still operated high-risk pools. As of 2016, 11 states still continue to, while the other seven stopped taking new applicants.

The feds could have instructed the states that had no high-risk pools to create one. To offset the pool's higher premiums, a subsidy could be offered to these individuals based on income — similar to ObamaCare, but without its far-reaching ramifications. And without affecting the carriers, their networks, the providers and the premiums. Problem solved. Too simple? Maybe it is, but the best solutions are often the simplest. It would have been a start.

Many people have something in their medical history, such as a heart attack three years ago or cancer five years ago, etc. — that made it difficult (if not impossible) to get insurance prior to ObamaCare, especially in states that had no options. Arizona had no high-risk pool but did have two health plans specifically for self-employed, regardless of health, with reasonable rates.

Point: Many individuals rarely posed a risk to the carriers, as their medical issues had been resolved, or required little more than medication and maintenance check-ups. Not all of the "uninsurable" applicants had major issues, but still found it difficult to get coverage based on history. ObamaCare eliminated that, but under the current system, the cost of any risk now affects <u>all</u> policy holders, regardless of <u>their</u> health.

So, yes, there are options — the best would be to take the best parts of the Affordable Care Act and eliminate the worst and try to meet in the middle.

- Don't penalize the unhealthy by denying them coverage (mandatory high-risk plans?),
- Don't penalize those who don't want coverage by fining them (it's their wallet),
- Don't penalize the healthy by charging them the same rates as those who have health issues,
- Don't force people to take and pay for benefits they couldn't possibly use, and
- Don't limit the enrollment period to three months — this creates undue stress on the part of the system and consumer, and mistakes are made.

Bring back competitive plans with more carriers, offer a range of premiums based on actual medical history, guarantee coverage to those who can't get it and subsidize their premiums….

In other words, something like…..what we used to have: Choice.

Following are three "white papers." The first covers short-term plans. The second talks about options for obtaining prescription medications that are lower than "normal" prices — including Canadian mail order. And the third goes into the details of considering a non-co-pay plan over one that has co-pays...

1. SHORT-TERM PLANS MADE EASY (and HOW TO DETERMINE THE TAX PENALTY)

Short-term plans have been around for several decades and definitely fill the bill when one is "in between" jobs, or has just graduated from college and isn't on a group plan, been dropped from a parent's plan or has suddenly recently lost regular coverage, and needs the security of knowing they are not "out there naked" in the event something unexpected happens. Even with no health issues, no one likes to be without that protection. It's even an option for those on ACA plans with no pre-existing health conditions who want to save money for one or two months prior to going onto a group plan or Medicare. There is no penalty for being without full-bore ACA coverage for two consecutive months or less in any calendar year. You could be without full-bore major medical coverage from November 1 till March 1 and -- under current guidelines -- have no penalty. **But you would still have to apply for regular coverage before the end of the open enrollment (December 15th, 2017, for 2018 enrollments).**

There are other reasons someone might take a short-term plan:

(1) Money is tight and they can't afford a full-bore major medical. Until April 1, 2017, short-term plans could continue up to 364 consecutive days; now, the limitation is 90 days per application period. The problem this creates is that if you have any medical concerns in the first period of coverage, that issue could become preexisting to the second term of coverage and might NOT be covered (depending on the carrier). Also, the loss of short term coverage does not create a "Qualifying Event," which would normally qualify one for regular major medical. Short term plans can be taken for periods of 30 to 90 days, for those who are looking just to fill a gap, between jobs, if they move, etc.

(2) A person is within a year of going on Medicare and can cut their premiums by 25 to 50% by getting off a major medical. So long as they have no significant preexisting conditions, this can be a monetary life-saver to a 64-year-old. There would be no coverage for routine check-ups but for the savings, they can usually pay for their own check-ups.

(3) A person gets a new job but has a waiting period before their employer's plan kicks in and they have no significant health issues — short term is ideal for this

(4) A person is offered COBRA but is sure they will have options to get on other coverage in a few months through marriage or a job; the short-term will be about 45-65% cheaper than would be COBRA. Again, no coverage for preexisting conditions, mental health, maternity, or routine checkups.

Currently, only one carrier that offers short term plans will currently take someone who is pregnant or has a pregnant dependent. Nothing related to the pregnancy would be covered, but that one carrier does not ask about pregnancy and would cover anything new in the way of illness or injury, not related to maternity. Otherwise, most STM carriers generally will not take someone who is pregnant or has a pregnant dependent (defined as someone for whom the applicant is financially responsible, even if the dependent is not applying for coverage).

There are numerous plans in the short-term family, with deductibles ranging from $500 to $10,000. Processing is easy and payment can be made monthly or — for additional savings — all at once (with some carriers). There is at least one carrier who asks no health questions at all — but again, pre-existing conditions are not covered. Period. And the rates are not much higher than those plans asking questions - in some zip codes and age range, actually lower.

Short-term plans often use medical networks for first dollar repricing. If there is no discounting network, then payment of claims is based on UCR (Usual, Customary and Reasonable) - so going to the Mayo Clinic would never be a good idea on a short-term plan!

Some people hip-hop through the system on short-term plans, never applying for a regular plan because they don't know from month to month where their job will take them, or where they will even be working, etc. This is dangerous -- what if something major happens while they are on an STM of truly short duration? They could be out of luck when the short-term plan goes away (unless it expires at the end of the year or offers what is called "continuous coverage" -- as more short term plans are). At this time, several short term plans will consider something that occurs in the first period of coverage, to *not* be preexisting going into the second (or third or fourth) period of coverage so long as the coverage periods are consecutive with no gaps. The

deductible, however, starts all over again with each period of coverage.

Always read the fine print when applying for a short term major medical plan. If someone is diagnosed with invasive cancer or has a heart attack while on a short-term plan, the plan will cover him or her only till the last day of the plan's coverage -- or beyond, if they renew immediately? Also, school sports and what are considered to be hazardous sports (read: anything that would make your mother nervous) are often not covered on the STMs.

Short-term plans *will* follow an applicant from state to sate if they move, but coverage does not extend outside the US. Most carriers allow unlimited re-applications for additional coverage; some may limit to a maximum of three application periods before requiring a break. Several have a discounted rate for pre-payment.

While most STMs offer 80/20 coinsurance, some 70/30 and our guarantee issue product covers 100% after the deductible. Some ask about height and weight, but tobacco usage is rarely a consideration. If someone is paying by credit card, then the application can be faxed to the carrier; some allow for online application.

Since STMs very blatantly do not cover conditions who symptoms were present, diagnosed or not, prior to the effect date of the plan, it is advisable that a consumer not tell a doctor they even *have* this kind of insurance if they are going for something related to a condition that was diagnosed or treated before the start of their plan. This is not because they are trying to get something covered but because most doctors will send in a claim just to see what they can get, even if they are told it is not covered. Some carriers have cancelled short-term policies due to doctors doing this. Why? Because to them, it means that the patient, who knows that the plan does not cover preexisting conditions, may be trying to "pull a fast one" on them.

Basically, if you are aware of something (or have symptoms, even if you have not been to the doctor yet), *before* you buy a short-term plan, it will not be covered.

STMs are a great instrument for those in-between situations, and most pay out up to one million dollars in a worst-case scenario. Since short-term plans can take 5-10 days to process, even though your effective date will be the date you request (so long as it is not a date prior to when they receive the application) please allow that time. If the carrier gets your application on the 20th, for instance, before 3pm, your effective date can be the next day or any date thereafter.

With regard to taking a plan for the long haul, only you, the consumer, can determine if the combination of the short-term plan premium and the penalty will be worth not taking a plan under the Affordable Health Care Act -- ObamaCare.

Here's the link to an easy-to-understand website that can help you understand how to determine a penalty:

https://www.verywell.com/calculating-an-individual-health-insurance-tax-penalty-1738924?utm_source=emailshare&utm_medium=social&utm_campaign=shareurlbuttons

2. PRESCRIPTION HINTS AND HELPS

"WHERE CAN I GET THE BEST PRICES ON PRESCRIPTION DRUGS?"

First of all, whether you are 25, 45 or over 65, prescription costs can be a bear. Some carriers won't cover certain drugs, some drugs haven't been in wide spread use long enough to be approved by various plans, some are excluded due to sheer cost…but there *is* help!

There are many avenues to saving money if you don't have a health plan that covers your particular medication needs — or if you don't have a plan at all.

First….. doctor's samples. Almost every prescription that a doctor can write has been given to him in sample form, by pharmaceutical reps. Generally, a doctor should be able to give you a two week to two month supply of samples. Some doctors have kept patients going indefinitely on samples. But — it depends on the medication.

Second….. ask if the prescription comes in a generic form. It is surprising how many doctors just write out the prescription for the brand name, even when there is a generic. The savings here is tremendous.

Third….. if you take a medication that is in a breakable tablet form, ask your doctor to write it for double your usual strength with the instructions to break it in half. The price difference between 20 and 40mgs of a drug is often less than 20%. Sometimes, there is no difference at all.

Fourth….. shop around! Many of the stores have those wonderful $4 generics. For the most part, the least expensive retail stores I have seen for brand name are Costco and Sam's Club — you do not need to be a member to use their pharmacy. Go to their websites and you can check out any of your prescriptions — you may be surprised by some of those rates. They will usually give you quotes over the phone, too.

Fifth….. I have never heard a horror story about prescriptions filled in Mexico but, since those factories are simply independently contracted and Canada's are owned and operated by many of the manufacturer's themselves, I would *tend* to trust Canada more…

Sixth….. Canadian mail order. For some reason, some folks think this isn't around anymore. The only ones complaining about Canadian mail order are all the "middle men" involved in the distribution of prescription drugs who won't get their "cut" if you buy your prescription outside the US. By the time a medication leaves the factory and gets to your drug store, it goes through about *six* distribution points, each with their own fee tacked on. Try www.candrugstore.com — a very easy-to-use site. They are open Saturdays, and on the west coast. Their number is **866-444-6376**.

And they do not and never have ordered from China, due to quality-control issues.

Also, note that the patent on brand-name drugs is only good *in* the US. Many of the same companies who manufacture prescription drugs in the US make them in other countries also — in their own facilities. And the cost, ordering through Canada, is anywhere from 35% to 75% less the cost of the brand-name equivalent.

Seventh….. if you are low-income or simply have some really costly meds, contact the manufacturer directly and ask if they participate in a prescription-assistance program. Many do, and none advertise this. All it takes is for you and your doctor to fill out a form and send it in. Many drugs costing in the $75 to $300 range are dispensed at little or no charge by the manufacturers.

Eighth….. Arizona Life Lines offers a free RX discount card that works on generics quite well and offers 5-15% off brand-name. This does not replace any other card you might have but can provide discounts for those with no prescription drug coverage at all. See our contact information at www.ArizonaLifeLines.com.

Bear in mind, too, that many brand-name drugs, and some generics, are manufactured in China, regardless of where you are buying them. There have been some *recalls* of prescription drugs manufactured in China that contain heparin. The Internet is a valuable tool is keeping up with this type of information. More than half the prescriptions filled in pharmacies are manufactured outside the United States; your box may say "Distributed by…." or "Packaged by…." but won't say "Manufactured in…."

These tips are for everyone, not just the over-65, unemployed or disabled….*everyone.*

This next and final segment is not your typical "How to Buy Insurance" article…

3. IT'S ALL ABOUT THE NUMBERS

For 24 years I have helped people navigate the insurance waters, and I have learned that much of what my clients want isn't the most important part of their plan, and some of what they don't consider, really *is*.

Most want to be sure that their doctor is in-network (even if they only see him once a year), or their medication is covered (even though it costs less than $10 on its own), or that they won't pay much for a doctor appointment… but these often *aren't* the most important things to look for in a health plan.

First — and I am a numbers-cruncher — insurance is about the *math*. You've heard the phrase "penny-wise and pound-foolish"? Many consumers are unintentionally but exactly that way about their health insurance.

I was barely into my second year of insurance when I had a 55-year-old client who went to the doctor once a year for a physical and rarely at any other time. He absolutely wanted the lowest deductible available. I know most agents would have jumped at this — after all, lower deductible = higher premium = better commission.

To me, after nearly 20 years in the corporate world, this didn't make any sense. The $500 deductible then was $290 per month while the $1,000 deductible was only $230 — a savings of $720 if he would be responsible for an extra $500 per year — IF he even used the insurance — and the $*1,500* deductible was only $177 per month — a savings of $1,380 per year if he would be responsible for that extra $1,000 per year.

I told him, "It's not worth paying an extra $1,380 per year to protect $1,000." (And if *you* think it is, then I bet you also think if you put 75 cents into a slot machine and get 50 cents back, you've won). He had to think about it, as he had never had a deductible higher than $500. He would up with the $1,500 — and I can tell you that in the following years till he went on Medicare he never came close to meeting the deductible.

The point is: Don't pay more in <u>premium</u> per year than the amount you are going to <u>protect</u> (i.e., the deductible). My plan has a $5,500 deductible, I pay everything under the deductible, and it costs $2,800 per year *less* than the $3,500 deductible — so why would I want to spend $2.800 *more* in order to protect $2,000? And a co-pay plan would have cost still more.

If you only go to the doctor two or three times a year — don't buy a co-pay plan. Get a plan where everything comes under the deductible and save the difference. Chances are — if you do go to the doctor — the visit will be discounted and the premium savings will more than offset the cost of those visits. Face it, if you're going to meet a deductible, you're going to meet it no matter *what* the premium is, so why put money in the insurer's pocket when you can keep it in yours — at least, until you have to use it? *If you even have to use it.*

Remember: On all plans going into effect after March 2010, wellness exams have no out-of-pocket. And — if you have a plan where you pay everything out of your own pocket — most other services are going to be discounted 30 to 35% by the carrier anyway and you will only pay the difference.

I go to the doctor for a bad cold every other year, my visit is $170-180 and the carrier discounts it down to the pre-negotiated rate of $115-120 and that's what I pay. Why would I want a co-pay plan that costs me at least $50-100 *per month more* when I only occasionally use co-pay benefits? And even if I went once every other month, would it still be worth the extra $600 to 1,200 per year for a plan that requires I pay $30 to 40 per doctor visit, anyway? What would I really be saving?

If you have children or a lot of medical issues, that can be a different story. In that case, I would look at the premiums versus the out-of-pocket maximum. Someone somewhere said "If you can't afford the high deductible, you certainly can't afford the high premium." *Great food for thought.*

If a plan with a $20 co-pay for primary care doctors and a $1,000 deductible costs more than $1,200 per year than the plan with the $2,000 deductible and $30 office co-pay — buy the second plan. Are you really likely to see the doctor 12 times a year?

If you have several children, it may be better to get the co-pay plan. Many of my clients with children do not take co-pay plans, they basically take responsibility for the little expenses, pay less for their premium, and know the carrier will (1) count those little expenses toward the out-of-ocket maximum (which plans never did in the past), and (2) cover for the big stuff. Some people call that "self-insuring" — but it's only the first few thousand they are self-insuring, and they still get the benefits of carrier's discounts on all their services as well as free routine wellness care. True self-insuring means you have no insurance.

If you know you are likely to meet your deductible, try this: Multiply the premium by 12 and add in the out-of-pocket maximum for each plan you are considering — and buy the one with the lowest overall cost. If you aren't sure you will hit the deductible but think you might, go for the next to the lowest out-of-pocket maximum.

Here's a quote from one of the 2016 plans:

> Family: Parents ages 40 and 42, three children between ages 7 and 15...
> Co-pay plan — $1,000 deductible, premium $1,404 = $16,848 per year
> $4,000 deductible, premium $1,130 = $13,560 per year
> $6,000 deductible, premium $944 = $11,328 per year

Is this family likely to go to the doctor so many times that it's worth an extra $5,520 per year in premium? Wouldn't they be better off keeping it in their own pocket and then paying for doctor visits when they have them? Granted, the deductible for hospital is lower — but the out-of-pocket is still between $5,500 and $6,500 per year, and if anyone is likely to be hospitalized, chances are good they'll meet this out-of-pocket maximum with that hospitalization.

With the $1,000 deductible, the family is paying $3,288 to protect $3,000 (the difference between the $1,000 and $4,000 deductibles).

There are other factors: the lower the deductible, the lower the co-pays (as a rule). So someone might really *want* to pay only $30 when they go to the doctor rather than $40 or $50 and that may be worth an extra $70-100 per month to them. Co-pays are often lower on prescriptions, too — though often, plans have a separate deductible on brand-name drugs. If someone's medications are in the hundreds every month, then the higher cost of a co-pay plan could be justified.

If we asked our car insurance to pay for flat tires and tune-ups, the premiums would be astronomical. Health insurance is not a lot different: cover the small stuff, insure for the big stuff. Think about how much you give the insurance carrier for your premium, for a plan that is basically really meant for the *"what if….?"* scenario, and ask where you would rather put the money — in their pocket or yours?

One client told me she saw a doctor two to three times a month, went in for infusion therapy every eight weeks, and took medications totaling over $800 per month. She wanted a $1,500 deductible plan with 80/20 coinsurance, with a $650 premium. I suggested she take a middle-of-the-road deductible ($3,000) on a non-co-pay plan, for about $400 per month, get the deductible out of the way, and then only pay 10% for anything after that till she hit her out-of-pocket maximum of $5,000, which she was going to do no matter what kind of plan she had, and the premium she saved over the closest comparable deductible *co-pay* plan, was *over $3,000* for the year. She was going to hit that out-of-pocket maximum anyway, so….*in her pocket — or someone else's?*

I had a young family in their early 30s with two children, struggling with the premium. They couldn't qualify for a subsidy but wanted a plan with co-pays. After 10 minutes of quizzing, I discovered that the children only went to the doctors for wellness exams (all of which have no out-of-pocket costs these days, with any carrier), and maybe one cold a year. They could get a $1,500 deductible with no co-pay benefits for a good *$300 per month* less than a plan with the same deductible but with co-pay benefits. Mathematically, you can see where this went.

Insurance was never designed to cover 100% of everything, but to provide adequate protection for the services that can bankrupt you, that can stretch your budget so thin that making the mortgage payment starts competing with paying for insurance. Again: "If you can't afford a high deductible, you certainly can't afford a high premium."

Here's another funny statistic: you have a one in 20 chance of meeting a deductible in any given year. You have a 20 out of 20 chance of paying that premium every month — whether you use the insurance or not.

Start looking at insurance with an eye to the scales: what are you spending to protect

how much? How often do you go to the doctor? Can you afford the little stuff if you can save an extra $100 or so per month on your premium? Could you put some of that difference aside so that if you have that expensive MRI or ER visit, you would have something in reserve to cover the cost?

Note: H.S.A.-compatible plans are great, and you do not *have* to set up a Health Savings Account in order to have an H.S.A.-*compatible* plan (that is always optional), and if you do, you can never lose what you put into it.… but putting aside an extra $100-200 per month into that account, *tax-free,* isn't a bad idea at all. Many people buy those plans just to have another avenue to shelter some of their income — as much as $6500 per year depending on family size.

An H.S.A. account is actually a medical IRA. Most co-pay plans are not H.S.A.-compatible, as H.S.A.-compatible plans are usually plans whereby everything comes under the deductible. If a plan is H.S.A.-compatible, it will tell you that in its name. And, H.S.A.-compatible plans do not need to be *high* deductibles — deductibles can start at $1,000 and go up to $7,150. Only if the plan you buy has the phrase "H.S.A." or *Health Savings Account* in its name, does it qualify you to open a health savings account.

So next year, or next time you have to review your insurance, remember: one way or another, all health plans will cover the same services, so after all is said and done, it's all about the numbers. Money in, money out — and who can keep the most in their pocket at year's end.

SOURCES and RESOURCES

Short-Term Plans Targeted by HHS:

http://khn.org/news/hhs-announces-plans-to-curtail-consumers-use-of-short-term-insurance-policies/

Backing Up the Numbers:

http://obamacarefacts.com/sign-ups/obamacare-enrollment-numbers/

How to Determine a Penalty:

www.verywell.com/calculating-an-individual-health-insurance-tax-penalty-1738924?utm_source=emailshare&utm_medium=social&utm_campaign=shareurlbuttons

Information about Canada's Healthcare:

http://www.the globeandmail.com

http://healthblog,ncpa.org/free-canadian-health-care-costs

Information about Benefits:

https://www.healthcare.gov

http://www.hhs.gov/healthcare/about-the-law/index.html

Information about High-Risk Pools:

www.healthinsurance.about.com www.verywell.com/high-risk-pools

www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx

More general sources for this web document include
The Arizona Republic, The Economist, and The Wall Street Journal

---

URL for this document (uploaded January 25, 2018):
www.ExactingEditor.com/ObamaCare-Shaffer-2016.pdf

E-mail the author — June@ArizonaLifeLines.com