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Health Care Reform: A Brave New World?

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), enacting comprehensive health care reform legislation. On March 30, 2010, President Obama then signed the Health Care and Education Reconciliation Act (HCERA), amending certain provisions of PPACA (in this e-alert, PPACA and HCERA will be referred to together as the Act). The Act is lengthy, complex and will likely have a sweeping effect on the provision of health care to individuals in this country. Further understanding of the Act will require regulatory guidance and possibly additional legislation in the months and years to come. The purpose of this e-alert is to provide an overview of how the Act is intended to change the landscape of health care coverage in the United States.

Prior to the Act, health coverage has been provided to approximately 28% of the U.S. population through government programs: Medicare, Medicaid, Children's Health Insurance Program (CHIP), or the military services (CHAMPVA or TRICARE). About 5% of the population has been covered through individual insurance policies, and about 52% have been covered through employer-based group health plans. This has left about 15% of the population—an estimated 45 to 50 million people—uninsured.

The Act seeks to change this landscape, primarily to extend coverage to an estimated 30 million of the currently uninsured. The various initiatives to accomplish this goal include new coverage mandates, insurance reforms, individual "pay or play" requirements, a health coverage exchange marketplace, large employer "pay or play" requirements, individual and small employer subsidies, and reforms of Medicare, Medicaid and CHIP. The financing for this herculean task is partially built into these initiatives, but also partly covered by adding other new taxes. Effective dates range from immediate to 2020. Each of these points is briefly discussed below.

New Coverage Mandates

In promoting health care reform, President Obama's continuing mantra has been: "If you like your health care plan, you can keep your health care plan." The Act starts out by exempting "grandfathered" group health plans—those in effect on the date of enactment— from the new coverage requirements. However, the scope of the "grandfathering" rule is already being whittled away. HCERA amended PPACA by subjecting grandfathered plans to some of the new coverage

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mandates.

There is a special grandfathering rule for collectively bargained plans. However, it is very unclear which plans are considered "collectively bargained," and how the effective date applies. It is also unclear how an employer's contributions to a multiemployer health plan are taken into account for the "Play or Pay" requirements described later in this e-alert. Further guidance is expected on these issues.

2010/2011

The following changes are effective for the first plan year beginning on or after the date that is six months after enactment (September 23, 2010), unless otherwise noted. Those that apply to grandfathered plans, as well as non-grandfathered plans, are marked by "GF":

- GF - No lifetime limits or annual limits on essential health benefits. (Grandfathered plans may apply "restricted annual limits" on essential health benefits until plan years beginning on or after January 1, 2014)
- GF - Dependent child coverage to age 26. (Grandfathered plans need not extend coverage to adult children who are eligible for other employer-sponsored health coverage until plan years beginning on or after January 1, 2014)
- GF - No preexisting condition exclusions for children under age 19
- GF - No rescission of coverage in absence of fraud or intentional misrepresentation
- GF - Uniform summary of benefits and coverage explanations required (regulatory guidelines to be published by March 23, 2011, distribution date no later than March 23, 2012)
- GF - No reimbursement of over-the-counter drugs from an FSA, HRA or HSA without a prescription
- Coverage of preventive care without cost-sharing
- No preauthorization or referral for ob-gyn or pediatrician
- No preauthorization or out-of-network increased cost sharing for emergency

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- Internal and external appeals process that satisfies various requirements required
- Nondiscrimination requirements that currently apply to self-funded plans apply to insured plans

After 2011

The following changes are effective for the first plan year beginning on or after January 1, 2014 unless otherwise noted:

- GF - No waiting periods of more than 90 days to begin coverage
- GF - No preexisting condition exclusions
- Wellness incentive increases from 20% to 30%, with agency discretion to increase to 50% (It is not clear whether grandfathered plans can enjoy this new benefit or not)
- No discrimination against providers acting within scope of license
- Cost-sharing cannot exceed high deductible health plan limits
- Coverage for individuals in approved clinical trials

Insurance Reform

Insurers in both the individual and small group markets must comply with the coverage mandates outlined above, subject to the grandfathering rules. Effective with the first plan year beginning on or after January 1, 2014, several additional insurance reforms will apply to non-grandfathered plans. These reforms include guaranteed availability and renewability, fair premiums (rate band limitations), and minimum loss ratios, among others.

Individual "Pay or Play" Requirements

At the core of the Act is the requirement that, beginning in 2014, all individuals are required to have health coverage for themselves and their children under age 18. The coverage must cover "essential benefits," and participation in any

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"grandfathered" health plan will satisfy the requirement. Those who fail to comply with this mandate will have to pay a penalty tax. Several lawsuits have been filed to challenge the constitutionality of this aspect of the law.

Individual and Small Employer Subsidies

Beginning in 2014, lower income individuals (generally, those with household income between 133% and 400% of the federal poverty line) will receive tax credits to assist with the purchase of health coverage. Employees who are eligible for employer coverage are not eligible for tax credits unless the employer plan pays less than 60% of total plan costs or the employee's contribution exceeds 9.5% of household income.

Immediately, small employers with 25 or fewer FTEs and average wages of less than $50,000 can qualify for tax credits that offset tax liabilities, if the employer offers health coverage and pays at least 50% of the cost. For 2010 through 2013, the tax credit is 35%; in 2014, it increases to 50%.

Large Employer "Pay or Play" Requirements

Beginning in 2014, if an employer with an average of 50 or more full-time employees (FTEs) on business days in the prior calendar year (a large employer) does not offer health coverage for FTEs and dependents, and if at least one FTE receives a coverage subsidy, then the employer must pay a penalty. The penalty is calculated by month, equaling 1/12 x $2,000 x (total FTEs - 30). An FTE is one who works at least 30 hours per week. For employees working less than 30 hours per week, an employer must combine the aggregate hours and divide by 120 to arrive at an FTE equivalent for part-time employees for the month.

Also beginning in 2014, if a large employer offers coverage that doesn't pay at least 60% of costs or employee contributions exceed 9.5% of income, the penalty is the lesser of $2000 per FTE (excluding the first 30 FTEs), or $3,000 per FTE receiving a coverage subsidy. The employer can reduce the penalty by offering a voucher.

Employers of fewer than 50 FTEs are not required to provide health coverage, and pay no penalties.

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Health Coverage Exchange Marketplace

To facilitate the purchase of health coverage by individuals, the Act provides funds for each state to establish an Exchange, which is similar in concept to the "Connector" program established in Massachusetts in 2006.

- Beginning in 2014, individuals and certain small employers may purchase health insurance through an Exchange
- Beginning in 2014, employers that offer health coverage must generally offer "free choice vouchers" to lower-income employees for the purchase of coverage through an Exchange, if the employee's contribution to the employer health plan is between 8% and 9.8% of the employee's household income, and the employee does not enroll in the employer group health plan. The free choice voucher must equal the contribution that the employer would have made to its own group health plan
- Beginning in 2017, states may allow employers of any size to offer employees coverage through the Exchange
- Employers will be required to provide written notice to employees that the Exchange exists, that they may be eligible for a subsidy under the Exchange, and that if they purchase a policy through the Exchange, they will lose the employer's contribution to any health benefits offered by the employer. Notice must be provided by March 1, 2013 or upon subsequent hire

Medicare, Medicaid and CHIP Reform

Medicaid will expand eligibility for coverage, and CHIP will maintain eligibility levels; both will receive additional federal financing. Medicare will provide a $250 rebate in 2010 to individuals who reach the "donut hole" for the Medicare prescription drug program, and will close the "donut hole" between 2010 and 2020. Employers that receive Medicare Part D retiree drug subsidies, however, will lose their tax deduction for those subsidies in 2013. Both Medicare and Medicaid will reduce disproportionate share hospital payments, and Medicare will reduce payments to the Medicare Advantage program.

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Other Financing

The Act is projected to cost $940 billion over the next ten years. How will the cost be covered? A few highlights:

- Effective for taxable years beginning after December 31, 2010, health FSAs, HRAs and HSAs cannot reimburse over-the-counter medicine or drugs (other than insulin) without a prescription
- Effective for taxable years beginning after December 31, 2012, annual salary reduction contributions to health FSAs offered under cafeteria plans are capped at $2,500
- 40% nondeductible excise tax on high-cost health plans starting in 2018
- New 3.8% Medicare tax assessment on investment income of high income individuals (AGI over $200,000 individual; $250,000 joint)
- Additional 0.9% Medicare tax assessment on wages in excess of $200,000 (individual), $250,000 (joint)
- New taxes on drug manufacturers, medical device manufacturers and health insurers (but not self-funded plans or third-party administrators)

If you have questions about the Act, please contact your Reinhart employee benefits attorney.

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