Health Care Reform - The Big Picture

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The dust is beginning to settle around the Patient Protection and Affordable Care Act (PPACA), which squeaked through Congress and was signed by President Obama on March 23. But the work that needs to be done by employers is just beginning.

Many of the provisions apply only to health care providers and governmental health programs, but others are intended to reform the health insurance market. These new provisions apply not only to insurers, but also to employer-sponsored group health plans.

The reforms are designed to change health insurance coverage practices, create health insurance exchange markets, require individuals to have health insurance and introduce incentives to encourage employers to offer group health benefits – and penalties for employers that don't.

What follows is a general overview. Also included in this issue of the *HR Focus* are articles that discuss in detail some of these new requirements, plus a timeline for changes.

Immediate Reforms

Although many of the most significant changes won't occur until 2014, some reforms involving employer-sponsored health plans will take effect in plan years that begin as soon as September 23, 2010. The reforms will require amendments to summary plan descriptions and other plan documents.

The changes include:

- Elimination of certain restrictions on coverage. Notably, exclusions for pre-existing conditions are being phased out, first for those under age 19, and then for everyone by 2014
- Elimination of life-time coverage limits and a phase-out of annual limits for essential benefits by 2014
- Extended coverage for children until age 26
- Uniform benefit descriptions that should allow employees to more easily compare coverage options

- New reporting requirements, both for individuals and the federal government, on health care quality and wellness initiatives

- Insured health plans will now be subject to nondiscrimination testing requirements, similar to those that apply to self-insured plans

Not all of these changes will impact every plan. Plans that existed on March 23, 2010 – the day the act became a law – will not have to immediately comply with all of the requirements. For more information on the required changes and whether they apply to grandfathered plans, please see the to-do list that appears on pages 6-8 You may also be interested in the article on page 5 that describes the grandfathering provisions.

In addition to reforming existing rules, the law also establishes new programs to encourage more employers to provide benefits. They state:

- Employers with fewer than 25 full-time equivalent employees who earn, on average, less than $50,000 are eligible for a tax credit of up to 35% of group health insurance premiums; the credit increases to up to 50% in 2014, tax credits for nonprofit employers are lower, (see article on page 4) and

- Employers who cover early retirees under a group health plan will be eligible on a temporary basis for re-imbursement of up to $60,000 of claims for each participant, starting June 2010

Individual mandates

One of the most significant changes prohibits insurers from denying coverage to individuals with pre-existing conditions. Insurers have relied on pre-existing condition clauses, particularly in the individual market, as a way to discourage individuals from waiting to buy insurance until they are ill.

To prevent this from happening, the law requires most Americans to have health insurance. This is intended to ensure that the risks and costs are spread among a large population, resulting in affordable individual premiums. Those who fail to maintain health insurance will pay a penalty, which phases in between 2014 and 2016.

Because health insurance is still expected to be expensive, the law also provides assistance in the form of refundable tax credits and reduced cost-sharing requirements. This assistance will be available to households that fall between 100% and 400% of the federal poverty level. Medicaid is also being expanded for households below 133% of the federal poverty level. Through these mechanisms, the goal is to insure an additional 35 million Americans.

Health Plan Exchanges

To make it easier for individuals to purchase coverage, the law requires states to begin operating health insurance "exchanges" by 2014. The exchanges will offer insurance plans to individuals, families and employers with 100 or fewer employees.

These plans will have to provide essential benefits and meet certain deductible and out-of-pocket limits. Individuals will be able to purchase different levels of coverage: bronze (60% coverage), silver (70% coverage), gold (80% coverage) and platinum (90% coverage).

Because individuals under the age of 30 have less need for comprehensive health insurance, these "young invincibles" will be permitted to purchase catastrophic-only coverage through the exchange. The catastrophic coverage also will be available for those over age 30 who are exempt from the individual mandate because they fall below certain income levels.

Play or Pay

Most Americans obtain their health insurance through their employers. The new law does not seek to replace this coverage. In fact, individuals will not be eligible for tax credits or reduced cost-sharing if they are eligible for coverage under their employers' health plans. Moreover, the law will penalize employers with more than 50 full-time equivalent employees who do not offer any health insurance or who do not offer affordable health insurance.

Those who do not offer any plan at all can expect to pay $2,000 per full-time employee (though there is no penalty for the first 30 full-time employees). Employers who do not offer affordable coverage (defined as coverage in which the employee contribution is less than 9.5% of household income and the plan pays at least 60% of costs) can expect to pay $3,000 for every employee who obtains coverage through the exchange and qualifies for tax credits and/or reduced cost-sharing.

Obviously, the penalties for failing to provide coverage are less than the costs of providing it. Congress is betting that employers will continue to provide health insurance benefits in order to attract and retain workers. Massachusetts has been running a similar program for four years and has not seen a massive drop in employer-sponsored health plans. Recent statistics indicate that 97% of Massachusetts residents are now insured. Congress is hoping for similar results nationally.

New Taxes

In order to raise the necessary dollars to fund these new programs, the law also includes some revenue-raising provisions:

- Payroll taxes are increasing for those who earn more than $200,000 ($250,000 for couples) a year

- Beginning in 2011, over-the-counter drugs can no longer be purchased on a pre-tax basis through health FSAs, HRAs or HSAs (unless prescribed by a doctor)

- Employers who are getting a subsidy under the Medicare Part D program for providing prescription drug coverage to retirees will find that the subsidy payments are no longer tax-free

- Beginning in 2018, employers who offer "Cadillac" health plans will have to start paying a 40% tax on the plan to the extent that its value is greater than threshold values (which will be indexed to inflation beginning in 2020)

Questions

If you have questions about the new law, or need help amending your plans and other documents, please contact any member of Warner Norcross & Judd's Employee Benefits group.