HEALTH CARE REFORM:
HISTORICAL OVERVIEW

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UNDERSTANDING THE IMPACT OF HEALTH CARE REFORM ON EMPLOYERS

I. Health Care Reform: Historical Overview

A. Introduction

1. Reasons for Reform

a. The United States has the most expensive health care system in the world, and yet arguably is one of the most inefficient systems as far as getting care to those who need it. The Unites States is ranked in 38th place in the area of health care by the World Health Organization.

b. It is estimated that 70% of all deaths are caused by chronic diseases such as heart disease, diabetes, cancer, etc, many of which would have been preventable had quality care been provided, including early detection.

c. Health care costs have been rising in unprecedented rates, causing a tremendous burden on working families, and the projections for long term growth of the Nation as a whole. In 2003, for example, the costs of health care rose 7.7%, which was four times the national inflation rate.

d. It is estimated that health insurance costs are rising at a rate of approximately 11% per year. If costs continue to rise at the current rate, heath care expenditures will reach 20% of the GDP within the next decade. This will be the highest percentage in the developed world and twice as much per person than any other developed country.

i. Increased costs have forced employers to either cut out health care coverage entirely, or significantly

increase the cost sharing responsibility of employees.

ii. Employers have likewise been forced to cut back on other benefits, and employees have lost a significant portion of their spending power – all contributing to a weak economy.

iii. Employers that do attempt to keep pace with rising costs find themselves unable to compete with global markets, since the increased cost of health care naturally flows to the consumer.

e. Health insurance remains unobtainable to over 43 million citizens, many of whom have only minimal coverage. Further, it is estimated that half of all bankruptcies result from medical costs.

B. The Great Debate: Should Health Care be Nationalized or Otherwise Controlled by the Federal Government?

1. What Does Nationalized Health Care Mean?

a. In light of the soaring costs of health care, legislative attempts in the past have focused on transitioning the system to a nationalized system instead of the privatized system currently in effect where:

i. Pharmaceutical companies can advertise and compete for business with the public.

ii. Employers are free to determine whether they will offer health care coverage to their employees, and, if offered, are free to choose a plan from competitors.

iii. Individuals are free to purchase insurance on the open market if they so desire, and if they do not so desire, have no obligation to maintain health insurance.

b. Under a model nationalized system, medical care would be provided for all citizens, and the price of such care would be paid by the government. Further, health services provided would be regulated by the Federal Government.

2. Argument for a Nationalized Health Care System

a. By far the most controversial aspect of Health Care Reform is the extent to which the Federal Government will take control over and remove "free enterprise" from the health care sector.

b. Some of the arguments in favor of a nationalized system are as follows:

i. Lower Costs: Proponents argue that nationalized health insurance would reduce the costs of health care significantly, including the costs of health care products. This is an assumption drawn from the fact that other countries with nationalized health

care systems have lower costs for their health care products, including pharmaceuticals.

ii. Increased Portability: Workers would gain greater portability if assured that they will have insurance in all job markets, since individuals would not feel pressured to stay in jobs they dislike in order to keep employment which offers health care insurance for their family.

iii. Increased Innovation: It has been argued that the economy would benefit from greater innovation as individuals who have traditionally put off their aspirations of starting their own business for fear of losing health insurance would now be able to start these businesses. Traditionally, the market has reacted favorably to times when small business, created under innovative ideas, is flourishing and growing.

3. Argument Against a Nationalized Health Care System

a. There is an inherent fear in turning over any portion of our free trade enterprise to national control.

b. Opponents cite to problems of other nations that have incorporated nationalized health care:

i. National health care does not ensure equal access to health care. For example, New Zealand's coverage guidelines indicate that in care for end stage renal disease, persons over the age of 75 should generally not be considered when placement in renal facilities is difficult to obtain.

ii. There is some evidence that without free enterprise playing any part in the industry, the quality of care, and the quality of health care products, are reduced. While the United States is considered to have the most expensive health care in the world, the actual quality of care is considered optimal. The U.S. has lower mortality rates for cancer patients than many nations with socialized health care, due to new detection products, access to preventative medicine, and emphasis on early detection.

iii. Some of those nations with nationalized health care are now in fact re-introducing free-market alternatives back into their health care systems-including Germany, Sweden, and Australia.

C. Prior Attempts at Reform

1. As far back as the Great Depression, there have been attempts at reforming this country's health care system. In fact, National health insurance was part of the legislative discussion surrounding what later became the Social Security Act passed in 1935. Organized medicine opposed inclusion of the health care component in the Act. Further, at the time, the individuals working on the legislation determined that health insurance was a lower priority than the retirement benefit. Accordingly, health insurance was left out of the final bill.

2. Shortly after World War II, President Truman advocated the passage of a national program to ensure the right to medical care. Truman's plan wilted, however, in the face of staunch opposition by the American Medical Association ("AMA") which dubbed Truman's plan as "socialized medicine". As a result of the AMA's public campaign combined with anti-Communist sentiment resulting from the start of the Cold War, public support for a nationalized health care system was not sufficient to support passage.

3. President Johnson, in 1965, with former President Truman by his side, realized perhaps the greatest success in connection with health care reform when both Medicare and Medicaid were incorporated into the Social Security Act.

4. In the early 1970's, Senator Ted Kennedy promoted his idea - - the Health Security Act - - throughout the country. The Health Security Act called for a single-payer plan, with no cost sharing from consumers, to be financed via payroll taxes.

A single payer plan would involve one entity acting as administrator (Federal Government) which would collect all fees and pay all costs. Currently, there are tens of thousands of health care organizations. President Nixon proposed his own version which preserved a role for insurance companies. A middle ground bill was produced with bi-partisan support for health reform. However, several competing proposals seemed to stall the legislative process. Further, Watergate loomed its shadow over any attempt at health care reform. Thus, the bill was never put forth for vote.

5. After the initial setback, Senator Kennedy continued attempts for a national health care system. However, in the face of a poor economy in the late 70's and the conservative environment of the 80's, those attempts failed to gain any traction until President Clinton took office.

6. President Clinton introduced the Health Security Act of 1993 during the early part of his administration. This Act, like the others that preceded it, called for universal coverage with requirements for employers to provide coverage, and was to be regulated by the government. A health care task force was created and chaired by First Lady Hillary Clinton. However, the reform legislation, as most remember, was met with staunch opposition by insurance groups and many businesses. The Act, portrayed as more complicated than the health care system it sought to reform, was a difficult sell even with the Democrats controlling the Senate and the House. In the end, the bill failed to generate enough votes.

D. Patient Protection and Affordable Care Act

1. President Obama's 2009 Health Care Proposal

a. Entitled the Health Care for America Plan.

b. Operates similarly to Medicaid for individuals who do not have any health insurance.

c. The Plan was expected to lower health care costs by allowing the government to bargain for lower prices and reduce inefficiencies in the system.

d. This Plan proposed that health care costs would be lowered and result in savings to families, equaling $2,600 in 2020 and up to $10,000 by 2030.

e. It was agreed that the decreased costs would have lowered unemployment, and would have reduced the deficit by 6% of the GDP by 2040.

f. A primary feature was that by expanding health care coverage, emergency visits by the uninsured would have been supposedly reduced to the point of saving $100 billion per year.

g. Government sponsored health care would have removed the burden of coverage from small businesses, potentially allowing them to be more competitive and attract more highly skilled workers.

2. House Health Care Reform Bill: Affordable Health Care for America Act

a. This bill was announced October 29, 2009, and passed by the House on November 7, 2009.

b. The estimated cost of the bill would be $894 billion over 10 years.

c. However, it was argued that the bill would reduce the deficit by $104 billion, and save $460 billion over 10 years by levying a surtax on high income earners.

d. Similar to Obama's 2009 Plan in that it would provide a government run health insurance program.

e. The bill would also offer direct subsidies to help the uninsured purchase insurance through exchanges.

3. Senate Reform Bill: Patient Protection and Affordable Care Act

a. The bill was announced on November 18, 2009 and passed by the Senate on December 24, 2009.

b. The Act proposed a cost of $871 billion over the next 10 years, with a reduction in the budget deficit by $132 billion over the next 10 years.

c. A major feature of this bill is that it would create an exchange to allow individuals and employers to shop for insurance plans.

d. The bill would fine companies that don't provide insurance, but provide a tax break for small businesses that can't afford health coverage.

e. Most citizens and legal residents would have to be covered, but premium and cost-sharing credits available based on income level.

f. Small business employers would also be able to purchase plans on the exchange.

g. Employers would have to pay penalties for employees who receive tax credits for health insurance.

h. The government would be able to impose regulations on health plans on the exchange, and on individuals and employers purchasing insurance on the exchange.

4. Obama's 2010 Health Care Reform Bill

a. Efforts to reconcile the House and Senate bills failed.

b. In February, President Obama introduced a new health care reform proposal, which essentially was built on the Senate Bill.

c. This bill proposed to regulate the health care industry under a seven-member Health Insurance Rate Authority that could deny or limit substantial premium increases (traditionally a power left to the states).

d. Like the Senate Bill, the President's bill would create an exchange that allowed families and small businesses to shop for insurance plans.

e. The bill would require most U.S. citizens and legal residents to have health insurance coverage.

f. Individuals purchasing their insurance on the exchange would receive cost-sharing credits, based on their income.

g. Employers would have to pay penalties if they employed individuals receiving tax credits from the Exchange.

h. This bill cut federal funding for abortion but cut back taxes on the high end health plans (dubbed the "Cadillac Plans").

i. The government would be able to impose regulations on health plans on the exchange, and on individuals and employers purchasing insurance on the exchange.

5. The Patient Protection and Affordable Care Act, P.L. 111-148 ("PPACA", "Health Care Reform" or the "Act")

a. Despite indications that passage seemed remote, if not impossible, on March 21, 2010, the House of Representatives passed the health care reform package (PPACA) initially passed by the Senate in December 2009.

b. The PPACA, signed into law on March 23, 2010, purports to overhaul the entire health care system within the United States, making it the most expansive health care reform statute in the history of the nation.

c. The PPACA was further supplemented and amended by the Health Care and Education Reconciliation Act, P.L 111-152 (March 30, 2010) ("HCERA").[1]

d. The responsibility for enforcement and the development of future guidance and standards rests with the Department of Health and Human Services ("HHS" or the "Secretary") and the Department of Labor ("DOL").

e. Substantial authority also rests with the Internal Revenue Service ("IRS"), which is responsible for assessing taxes and penalties for non-compliance and which will implement new reporting and disclosure requirements.

[1] For the purposes of this memo the terms "PPACA" or the "Act" are used, but where applicable, incorporate by reference the amendments made by the HCERA. Because the provisions of HCERA have been absorbed by and mirror the equivalent provisions of the PPACA, in most instances only the PPACA citations will be utilized. The term "Health Care Reform" used throughout shall also apply to HCERA.

f. The Act creates a health care system that is partially publicly financed but privately delivered.

i. Health care coverage may be obtained through an employer-provided plan if it otherwise meets the universal coverage requirement.

ii. Lower-income individuals, as well as some middle-class individuals, will receive a tax credit (or a health coverage voucher) to allow them to pay for health insurance coverage purchased from one of the new "American Health Benefits Exchanges" to be set up by each state.

iii. Private health insurance coverage will still be available to those who choose it – i.e. the PPACA does not mandate that individuals purchase their insurance through a state-run Health Benefits Exchange, or that Employers only offer insurance through the Exchange.

g. The Act expands and improves the Medicare program and proposes a system of universal health care coverage to "Qualified Individuals," including all legal U.S. residents and all residents living in U.S. territories.

h. "Qualified Individuals" is used to describe those persons eligible to enroll in a qualified health plan in the individual market. [PPACA

§1312(e)(f)(1)(A)]. Incarcerated persons are not qualified individuals. [PPACA §1312(f)(1)(B)].

6. Shared Responsibility Under the PPACA

a. Universal coverage is to be accomplished, in part, via the use of mandates placed upon individuals (to obtain coverage) and also upon employers (to offer coverage). These provisions of the PPACA are referred to as the "Shared Responsibility Requirements."

b. Individual Mandate – All individuals must maintain health insurance coverage that meets minimum criteria (described below) or must incur a penalty that will be calculated on a monthly basis based on a pre-established formula [PPACA §1501, 10106].

i. Individuals covered by a qualified health plan through an exchange will receive tax credits to help pay for insurance premiums.

ii. Health plans that meet the minimum criteria above include Medicare Part A, Medicaid, CHIP, TRICARE, VA, eligible employer-sponsored coverage, individual health plans, grandfathered health plans, and such other coverage as designated by HHS.

c. Employer Mandate – Employers electing not to offer coverage that meets the minimum criteria will be subject to an additional tax that will help finance the health care coverage for their employees [PPACA §1513].

i. Applies to employers with at least 50 full-time employees.[2]

ii. An exemption applies for small employers.[3]

iii. When calculating the number of full-time employees, the employer must include "full-time equivalents." Full-time equivalents are determined by dividing the sum of hours worked by part-time employees over the course of a month by 120.

iv. The penalty is generally the lesser of $3,000 for each full-time employee receiving assistance for credits to purchase coverage on the exchange or $2,000 for each full-time employee after subtracting the first 30.[4]

7. Stated Purposes of the Health Care Reform

a. The primary goal of the legislation is to ensure that all Americans have access to the highest quality and most cost-effective health care services, regardless of their employment, income, or health care status.

[2] A full-time employee is defined as an employee who works an average of 30 or more hours a week.
[3] Small employers are defined as those with less than 50 employees. Small employers are eligible to receive tax credits to assist them in providing coverage to their employees.
[4] Additional rules apply to an employer that offers coverage considered insufficient [PPACA §1401].

i. It is anticipated that the PPACA will result in coverage to more than 94% of Americans.

ii. Coverage will be extended to an additional 32 million Americans who currently do not have health care coverage.

b. The PPACA includes "dual use" programs intended to produce independently desirable results along with increased revenue through cost savings. For instance, the Act adopted improvements to crack down on waste and fraud in the Medicare and Medicaid system.

c. Coverage will be available via employer-provided health plans, private insurance programs, and state-run exchanges. The hope is that increased competition will lower health care costs.

8. Qualified Benefit Plans

a. For purposes of the Shared Responsibility Requirements, individuals must be enrolled in, or employers must provide coverage for, "Qualified Benefit Plans" that meet minimum standards.

b. Only Qualified Plans will be available on the Exchange.

c. Qualified Plans are plans that include the essential benefits package required of plans sold in the Exchanges and must comply with limitations and on annual cost-sharing for plans sold on the Exchange [PPACA §§1302(a) and (c)].

d. Private health insurers may continue to offer coverage outside of the Exchange, so long as the above requirements are met [PPACA §1312(d)].