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HEALTH REFORM: 2014 AND BEYOND

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HEALTH REFORM: 2014 AND BEYOND

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I. OVERVIEW

A. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

1. On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act ("PPACA"), into law. The PPACA was later amended by the Health Care and Education Reconciliation Act of 2010 ("HCRA"). Many of the law's key requirements are effective beginning in 2014. The following summary explains these key health reform provisions relating to the establishment of state-run American Health Benefit Exchanges, and the law's most controversial requirement, the "individual mandate."

2. A group of cases challenging the constitutionality of the PPACA's individual mandate is currently pending before the United States Supreme Court. If the Court decides that these cases are properly before it at this time, it will determine whether the individual mandate is constitutional, and, based on that determination, whether the Act as a whole can survive without the mandate. Alternatively, the Court could determine that the issue of the individual mandate's constitutionality will not be properly before it until the mandate takes effect in 2014.

II. AMERICAN HEALTH BENEFIT EXCHANGES

A. EXCHANGE BASICS

1. The PPACA requires states to establish Exchanges that will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will increase competition in the health insurance marketplace, improve affordable health coverage choices, and give small businesses the same purchasing clout as large businesses. PPACA §§ 1301, 1302, and 1311.

2. To participate in an Exchange, insurers must offer a range of plans that meet certain minimum benefit requirements, including

ambulatory care, emergency care, hospitalization, prescription drugs, maternity and newborn care, mental health and substance abuse treatment, rehabilitative and habilitative care, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including oral and vision care). Exchange plans, referred to as qualified health plans ("QHPs"), will also be required to meet requirements relating to marketing, choice of providers, plan networks, and other features. PPACA §§ 1301 and 1302.

3. QHPs must be offered on the Exchanges which provide coverage at the following levels: bronze, silver, gold, and platinum. The actuarial value (percent expense paid by the insurer) of the expected essential health benefits costs each plan will cover will determine the QHP's status as follows: Bronze level- 60% of the full actuarial value of the benefit package; silver level – 70% of the full actuarial value of the benefit package; gold level – 80% of the full actuarial value of the benefit package; and platinum level – 90% of the full actuarial value of the benefit package. PPACA § 1302.

4. Exchanges will be established as independent state agencies or as non-profit entities, and will be overseen by the state. PPACA § 1301.

B. SMALL BUSINESS HEALTH OPTIONS PROGRAM ("SHOP") EXCHANGE

1. Beginning in 2014, small businesses with up to 100 employees will have access to SHOP Exchanges, which will expand their health coverage purchasing power. The Congressional Budget Offices estimates that these Exchanges will drive down premiums by up to four percent for small employers. PPACA § 1311.

2. Beginning in 2017, businesses with more than 100 employees will also be eligible to purchase coverage through the SHOP Exchanges. PPACA § 1312.

3. Multiemployer plans that conform to certain requirements applicable to QHPs will be eligible to be considered SHOP plans. In addition, insured multiemployer plans may also be considered aggregators of premium contributions and arrangers of coverage through the SHOPs for plan participants. This will allow insured multiemployer plans to maintain the group for purposes of providing benefits in addition to those offered on the Exchange (HRAs, WRAs, life insurance, etc.). The Departments of Labor, Health and Human Services, and Treasury have indicated that detailed guidance

regarding the interaction of multiemployer plans (both insured and self-insured) and the Exchanges will be issued in the future. FR. Doc. 2012-6125 Filed 3/12/12; Publication date 3/27/12.

C. CONSUMER OPERATED AND ORIENTED PLAN (CO-OP)

1. The PPACA requires the Exchanges to include consumer-run, CO-OP plans as an alternative to traditional, for-profit plans. The PPACA requires HHS to award start-up loans and solvency grants to eligible CO-OP applicants to enable each state to have at least one CO-OP. PPACA § 1322.

2. At least two-thirds of all insurance contracts issued by a CO-OP must be QHPs issued in the individual and small group markets. 76 Fed. Reg. 77392 (Dec. 13, 2011).

D. INTERSTATE HEALTH CARE CHOICE COMPACTS

1. Beginning in 2016, interstate health care choice compacts, which offer QHPs in all participating states, will become operational. This will allow insurers in the individual and small group markets to offer a QHP nationwide. These plans will only be subject to the state mandate laws of the state in which they are issued, but will be required to comply with all of the PPACA mandates for qualification as a QHP. PPACA § 1333.

III. THE INDIVIDUAL MANDATE

A. OVERVIEW

1. Beginning in 2014, all U.S. citizens and legal residents who can afford health coverage will be required to have such coverage in place. Those who do not have coverage will be required to pay a financial penalty for each year in which they do not have coverage. PPACA §1501; IRC § 5000A.

2. Exemptions from the financial penalty will be granted for financial hardships, certain religious groups, Native Americans, Alaska Natives, undocumented immigrants (who will also not be eligible to purchase coverage on a health insurance exchange), incarcerated individuals, those with incomes below the federal tax filing threshold (for 2011, the threshold for those under the age of 65 was $9,500 for single individuals and $19,000 for married couples), and individuals for whom the lowest cost silver option exceeds 8% of household income. PPACA § 1501; IRC § 5000A.

3. The financial penalty will be phased in from 2014 through 2016. Beginning in 2014, the penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1% of family income, whichever is greater. For 2015, the penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2% of family income, whichever is greater. For 2016 and beyond, the penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater. The penalty is pro-rated for the number of months without coverage, and there is no penalty for a single gap in coverage of less than 3 months in a year. After 2016, the penalty amounts will be subject to annual cost-of-living increases. PPACA § 1501; IRC § 5000A.

B. AFFORDABILITY ASSISTANCE

1. Premium Assistance Credits – Eligible individuals and families with incomes between 133-400% of the Federal Poverty Level ("FPL") (between $14,856 and $44,680 for an individual, and $23,050 and $92,200 for a family of four in 2012) will be eligible for refundable and advance premium credits to help with the cost of health coverage purchased through an Exchange. In order to be eligible to purchase coverage through an Exchange, an individual must either not have employment-based coverage available to them, or such coverage must be unaffordable to them. Individuals whose contribution to their employment-based coverage is greater than 8% of their modified adjusted gross income will be eligible to purchase coverage through an Exchange. PPACA § 1401; HCRA § 1001(A).

2. Cost-Sharing Subsidies – Cost-sharing subsidies will also be provided to eligible individuals and their families with incomes between 100-250% of FPL. These subsidies will reduce the amount of out-of-pocket expenses that individuals pay for coverage under an Exchange plan, therefore increasing the actuarial value of the coverage. Without a subsidy, the actuarial value of the silver level plan is 70% - this means that the plan will cover 70% of health care costs. For individuals between 100-150% of FPL the value of the coverage will be increased to 94% with the subsidy, for individuals between 150-200% of FPL the value of the coverage will be increased to 87%, and for individuals between 200-250% of FPL, the value of the coverage will be increased to 73%. PPACA § 1402; HCRA § 1001(B).

IV. MEDICAID EXPANSION

A. MEDICAID ELIGIBILITY

1. Beginning in 2014, Medicaid eligibility will be expanded to include all individuals under the age of 65 with modified adjusted gross incomes of up to 133% of the federal poverty level (currently $14,856 for a single individual and $30,656 for a family of four). PPACA § 2001.

B. ENHANCED SUPPORT FOR CHILDREN'S HEALTH INSURANCE PROGRAMS ("CHIP")

1. States are required to maintain income eligibility levels for CHIP through September 30, 2019. States will also receive a 23% increase to the federal CHIP match reimbursement rate. PPACA § 2101.

V. EMPLOYER RESPONSIBILTIIES

The law does not contain a requirement that employers provide health coverage. However, employers with 50 or more "full-time equivalent" employees who do not offer minimum essential health coverage will be assessed a fee of $2,000 for each employee (in excess of 30 employees) if any employee receives a premium credit through an Exchange. PPACA § 1513; IRC § 4980H.

Employers with 50 or more employees that do offer minimum essential health coverage, but have at least one employee who receives a premium credit through an exchange will be required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees). PPACA § 1513; IRC § 4980H.

The PPACA also requires large employers with more than 200 employees that offer coverage to automatically enroll employees into the lowest cost premium plan available if the employee does not sign up for employer coverage or does not affirmatively opt out of coverage. PPACA § 1511. However, the U.S. Departments of Labor, Health and Human Services, and the Treasury have indicated this requirement will not be effective until official guidance is issued after January 1, 2014. IRS Notice 2012-17 (IRB 2012-9), March 5, 2012.

Beginning in 2014, large employers will also be required to report to the Secretary of HHS whether they offer full-time employees (and their dependents) the right to enroll in minimum essential coverage under an eligible employer-sponsored plan, the applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of the total allowed costs of

benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage. PPACA § 1514.

VI. INCENTIVES FOR SMALL EMPLOYERS

A. SMALL BUSINESS TAX CREDITS

1. The PPACA adds a new Section 45R to the Internal Revenue Code, which provides a tax credit for eligible small employers that provide health insurance to their employees. For 2014 and 2015, eligible employers who purchase coverage through a SHOP Exchange can receive a tax credit of up to 50% of their premium contributions. To be eligible for this credit, employers must have 25 or fewer employees, pay employees an average annual wage of less than $50,000, offer all full-time employees coverage and pay at least 50% of the premium. PPACA § 1421.

VII. FINANCING HEALTH REFORM

A. ANNUAL FEES AND EXCISE TAXES

1. Beginning in 2012, annual fees will be imposed on the pharmaceutical manufacturing sector. Beginning in 2014, annual fees will also be imposed on the health insurance sector. These fees will be reduced for certain non-profit insurers and voluntary employees' beneficiary associations (VEBAs) not established by an employer.

2. Beginning January 1, 2018, a 40% excise tax (calculated on the amount above the threshold amount) will be levied on insurance companies and plan administrators for any health coverage plan that is above the threshold of $10,200 for individual coverage and $27,500 for family coverage. These threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions. The threshold amounts will also be increased in 2018 based on the growth of the Blue Cross Blue Shield Federal Employee Plan's standard option. The threshold amounts will be further increased by the Consumer Price Index for All Urban Consumers (CP-U) thereafter. PPACA § 9001; HCRA § 1401.

3. Beginning January 1, 2013, the hospital tax rate will be increased by 0.5% on any individual taxpayer making more than $200,000 ($250,000) for married couples filing jointly. PPACA § 9015.

4. Beginning January 1, 2013, the adjusted gross income threshold for claiming medical expenses as itemized deductions is increased from 7.5% to 10%. Individuals age 65 and over will continue to be eligible for the itemized deduction at 7.5% of gross income through 2016. PPACA § 9013.