VIRGINIA STATE BAR MEMBERS' INSURANCE CENTER

Health Care Reform – An Overview

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The two major bills signed by President Obama may represent the most significant change to our health system since Medicare was passed about 45 years ago.

The Patient & Affordable Care Act was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act was signed into law on March 30, 2010. The purpose of this article is to provide a high level summary highlighting certain provisions of the two acts. Without question this overview will not include all the provisions that could be highlighted. For example, Health Care Reform will offer new legal rights for employees to charge their employers with discrimination of health benefits. Nevertheless, the brevity of this article will hopefully assist in beginning to understand Health Care Reform. In the months ahead many thousands of pages of rules and regulations will provide specificity to the 2,900 pages which comprise this legislation.

While many of the provisions will not take place until 2014, some will become effective in 2010-2013. Under the new law, grandfathered plans (in place on March 23, 2010) will also be exempt from adopting some of these provisions until 2014. As of this date HHS has not issued clarification around the definition of grandfathering, so it is difficult to speculate on its exclusivity or inclusivity, i.e. a plan’s ability to maintain its grandfathered status if certain plan changes are made.

→ 2010

Starting six months after passage of this law, or at the start of your plan year following September 23, 2010:

- Plans may not implement annual or lifetime limits on coverage (all plans, with some limited grandfathering on non-essential benefits).
- Dependent adult children will be eligible for their parents’ health plan up to age 26 (all plans, with limited grandfathering).
- Insurers will not be allowed to rescind coverage except in cases of misrepresentation or fraud (all plans).
- Group health plans will be required to provide preventive coverage. Insurance companies will be prohibited from imposing any cost sharing requirements for preventive coverage (unless grandfathered).
- Waiting periods for pre-existing conditions for children under the age of 19 will not be permitted (all plans).
- Health insurance plans must have a coverage and claims appeal process (all plans).
- Fully insured plans may not provide discriminatory benefits in favor of higher wage earners (grandfathering allowed).
- Emergency services must be paid at in-network level regardless of provider (grandfathering allowed).
- Enrollees may designate any in-network provider as primary care provider (unless grandfathered).
- Coverage of certain preventive services and no cost sharing is allowed (grandfathering is allowed).

Within 90 days of the bill becoming law (June 23), people in Virginia without coverage for at least 6 months who have been denied coverage may purchase coverage through a temporary federally operated high-risk pool.

A 10% tax on indoor tanning services will be implemented.

For profit employers with 25 or fewer employees with average annual wages of less than $50,000 may be able to receive a partial tax credit for tax years 2010-2013 of up to 35% of the company's health premium costs if they meet certain qualifications. Non-profit employers can also qualify for a lesser amount. The amount of the tax credit declines as the number of employees exceeds 15 or average annual salaries exceed $25,000. Employers will be required to purchase coverage through an exchange in 2014-2015 to receive a tax credit (credit increases to 50% for profits and 35% not for profit) and then the credits are expected to expire.

A temporary reinsurance program will provide coverage to qualifying groups who provide early retiree coverage to those over age 55 to 65, but not eligible for Medicare. This program will reimburse employers 80% of early retirees' claims that are between $15,000 and $90,000. This program will end on the earlier of January 1, 2014 or when the program's $5 billion appropriation is exhausted.

A $250 rebate will be available to all Medicare Part D enrollees that enter the "donut hole."

Breast feeding stations will be required for employers with more than 50 employees.

The federal government will establish a process with states to require insurers to justify rate increases.

→ 2011

The excise tax on distributions from Health Savings Accounts for nonmedical or nonqualified purposes will increase from 10% to 20%.

The threshold to itemize unreimbursed medical expenses as a tax deduction increases from 7.5% to 10% of adjusted income.

Over-the-counter drugs without a prescription may no longer be reimbursed by a HSA, HRA or FSA unless prescribed by a physician.

Enrollees would potentially receive rebates from insurance companies if the amount spent on medical services is less than 85% of premium for large group plans and 80% for individual and small group plans.

Annual pharmaceutical industry fees will begin.

Employers must begin reporting the aggregate cost of employer-sponsored coverage on Form W-2.

Long term care coverage will be available through a national, voluntary federal program called Class Act. Employers opting to offer this coverage must auto-enroll employees and then allow an opt-out.

Payments by the federal government to Medicare Advantage plans are reduced.

→2012

An excise tax of 2.3% on the sale of any taxable medical device will be implemented.

All companies will have to issue 1099 tax forms not just to contract workers, but to any individual or corporation from which they buy more than $600 in goods or services in a tax year.

Flexible Spending Account limits reduced to $2500.

→ 2013

Individuals making $200,000 and joint filers making $250,000 will pay an increase of 0.9% in the Medicare tax (from 1.45% to 2.35%). Also a 3.8% tax on unearned income from high-income individuals will begin.

The tax deduction is eliminated for employers who maintain pharmacy plans and subsidize Part D.

→ 2014

All health plans must have "essential benefits" as defined by the federal government.

An annual insurer fee will be applied to all health insurance companies.

Health insurance plans may not require people to serve waiting periods for pre-existing conditions.

With few exceptions, everyone will be required to obtain health insurance or face financial penalties.

People may buy health insurance on state-administered exchanges. Exchanges will be administered by a government agency or non-profit organization and allow individuals and groups with up to 100 employees to purchase certain coverage.

Individual tax credits will be available to people with income above the Medicaid eligibility and below 400% of the federal poverty level ($88,000 – a family of four) if they purchase coverage through an exchange.

Employers with an average of at least 50 full-time equivalent employees will be subject to penalty if any full-time employee purchases health insurance through an exchange and their family income is below 400% of the federal poverty level.

Employers who offer health coverage will be required to provide a voucher to certain employees (if their contribution to the coverage they select exceeds a specified percentage of their family income provided it is below 400% of FPL) who do not participate in the employer's health plan. The voucher is to be used to purchase health insurance through the exchange.

All health insurance products in all markets will be guarantee issue and there will be no health status rating. However factors such as family size, geography and tobacco use will be allowed in setting rates. Premiums of older individuals may only be 3 times more than the cost of younger people's premiums. By comparison older people can pay 5-6 times more today (see later comment).

Employers will be prohibited from having a waiting period that exceeds 90 days before new full-time employees may enroll in their health plans.

Small employers (1-100) may offer health insurance with limited deductibles ($2,000 employee only; $4,000 family) and limited out-of-pocket maximums. It is unclear what implications this may have for larger employers.

States will be required to extend Medicaid coverage to all individuals under 65 who have income up to 133% of the federal poverty level.

Employers will be required to report to the IRS a variety of items pertaining to their health plan including: premiums, employer contributions, waiting periods, number of full-time employees covered, waiting periods and whether coverage meets minimum essential coverage.

→ 2018

An excise tax on high cost employer-provided coverage of 40% will be imposed on any plan above the threshold of $10,200 for single and $27,500 for families.

Perhaps the biggest impact Health Care Reform may have on the typical small firm in Virginia will be in 2014 when guarantee issue and community rating are required. Under this approach, firms and individuals may see wide fluctuations in premiums as younger people will pay more and will subsidize older people. Likewise, the healthy could see a considerable premium increase as they subsidize those with more serious medical risks.

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