A Brief Review of “Health Care Reform:” the Patient Protection and Affordable Care Act of 2010 (“PPACA”)
(slang: “P-PAC”)

As of September 7, 2010

I) Overview

The law seeks to achieve near-universal coverage in three ways:

1) requiring insurers to provide coverage to anyone who wants it;
2) making it feasible for insurers to offer such coverage (especially for people with existing medical conditions) by requiring everyone to obtain insurance, thus broadening the risk pool;
3) making sure that people can afford the insurance they will be required to have by providing subsidies (if needed).

The key will be state-based insurance “exchanges” which begin in 2014, whereby people without employer-based insurance will be able to shop for health plans that meet coverage standards set out in the law. It is estimated that by 2018, 24 million people will be buying their insurance through exchanges, 19 million of which will receive at least some assistance from the federal government in the form of either premium “credits” or subsidies.

Availability of insurance through exchanges is aimed at people who cannot obtain or afford coverage through their workplace. Either the employer does not offer it, the coverage is too expensive for the worker to purchase, or they are unemployed or self-employed.

The exchanges will require insurance companies to offer certain standard levels of “essential health benefits” (to be defined by the U.S. Department of Health and Human Services). Benefit coverage will vary through what are typically referred to as “metallic” levels: bronze (covering 60% of the cost of the “essential health benefits”), silver (70%), gold (80%) and platinum (90%).

Since most of this assistance will not begin until 2014, the government has provided $5B in funding for the immediate (June 2010) creation of a nationwide “high risk pool” for those with existing medical problems and who have been uninsured for at least 6 months.

II) Employer Considerations

For the most part, there will be minimal impact in the near future on the majority of Americans with employer-based health insurance. Changes effective September 2010 include allowing adult children to age 26 to remain on parents’ coverage and the cessation of limitations on lifetime benefits.
“Grandfathering”

Plans in existence when the law was signed are not immediately required to comply with all of the new regulations, though there are myriad exceptions.

Over time all employer-based plans will be prohibited from using annual benefit limitations but initially will not be required to have all of the “essential health benefits” included in plans to be sold through exchanges.

However, since PPACA does not use the term “plan” in the same context that ERISA does, and while it is not totally clear yet as to what would cause an employer-sponsored plan to lose its grandfathered status, most believe that since employers change benefits “plans” eventually, it is just a matter of time before most employer-based plans lose their grandfathered status and will need to conform to the full set of new rules.

In fact, the National Business Group on Health recently reported that 85-90% of its surveyed members expect to lose their grandfathered status by 2011.

**Employer Coverage Provisions**

Beginning in 2010, employers with as many as 25 employees and average wages of up to $50K will be able to obtain tax credits to help defray the cost of coverage. To qualify, the employer must pay at least 50% of premiums, and the size of the credit will vary based on the number of workers and their average annual pay.

Beginning in 2014, businesses with up to 100 employees will be able to buy coverage through exchanges under the assumption that small groups collectively will gain the buying power of larger entities.

Once an employer is in an exchange, it can stay even if it grows beyond 100 employees. Employers will be able to choose which “metallic” level they wish to offer and employees can choose from among various plans at that level. Thus, the employer will essentially determine how much they will contribute to employee premiums.

Starting in 2017, states will have the option of opening exchanges to employers with more than 100 employees, at which point employers will have to decide how deeply involved they want to be in the delivery of health benefits.

It’s been said that if large companies direct their employees to exchanges, this shift could dismantle the long-standing employer-based model.
Penalties For Employers

Employers (with 50 or more employees) are not required to provide coverage, but if they don’t they are likely to incur a penalty. A penalty is triggered if any employee receives a government subsidy to buy insurance through an exchange with specific rules as to what qualifies an employee for subsidies. Briefly, the penalties range from $2K-$3K per full-time employee (usually exempting the first 30 employees in the count).

Employers offering marginally affordable coverage will be required to give qualifying employees “vouchers” to help buy coverage in the exchange. If the employee uses the voucher and also qualifies for government subsidies, the employer would not incur a penalty.

“Cadillac Plans” Tax Penalty

Only a tiny fraction of employer-sponsored plans currently exceed the thresholds for this tax ($10.2K for individuals and $27.5K for families). However, beginning in 2018 a 40% “excise tax” will be imposed on such plans, which is certain to be passed on to the employer/consumer. The idea behind the tax is to make people with very generous insurance coverage more sensitive to medical costs, though presumably resulting in lower-benefit plans but with correspondingly lower premiums.

“Pay Or Play”

With employer premiums in 2009 averaging over $4K for individuals and almost $10K for families, some question whether employers will decide to exit the market and just pay the penalty, i.e., “pay rather than play.” It has been postulated that larger companies will increasingly encourage their employees to utilize the exchanges, thus over time dissipating the expectation for employers to provide insurance. Also, the Congressional Budget Office has stated that lower health care benefits costs for employers will translate to higher employee wages, resulting in higher tax revenues to help pay for the new law. Most experts believe this to be a highly optimistic assumption.

“Exiting” the system doesn’t really become an issue until 2014 when the individual mandate, “essential health benefits” standards and exchanges begin. Employers will need to decide if the upsides of exiting (avoiding some or all administrative and reporting responsibilities, potential short-term cost savings, etc.) outweigh the disadvantages (no/limited access to health status data, the difficulty of gauging productivity effectively and assessing hidden costs of poor health, etc.).

Incentives For Employers

The new law is very aggressive in terms of promoting “rewards” (including financial) to employees based on “satisfaction of a standard related to a health status factor.” This could mean anything from getting a flu shot to completing a health risk assessment to receiving prenatal care or virtually anything deemed important to employee health.
In 2014, the amounts allowed for rewarding healthy behavior will rise from 20% to 30% (of a combination of the employee and employer contributions to the health care premium dollars), and potentially to 50% if jointly allowed by the Secretaries of Health, Labor and Treasury.

Employers are required to make special accommodations for people with “extenuating medical circumstances” and incentives cannot be a “subterfuge for discriminating based on a health status factor.” It remains to be seen how regulators will determine whether incentives reward people for healthy behaviors or punish them for bad genes.

**Other Employer Considerations**

$5B has been set aside to give employers a financial incentive to cover retirees age 55-64 now. Employers can obtain reimbursement for certain expenses they incur in caring for early retirees and family members, which must be used to reduce premiums, copays, etc.

There is one catch: the offer is good only as long as the $5B lasts.

Also beginning in 2014, employers are prohibited from requiring new hires to wait more than 90 days before receiving health benefits, and must automatically enroll workers to make sure they are not left out of coverage.

**The Future For Employers**

Expert consensus is that since PPACA does little to control costs, they will continue to rise. Some point to Massachusetts where despite near-universal coverage, health care costs have continued to rise. The law’s mandates (adding “adult” children, taxes on insurers and suppliers, lower reimbursements to providers, prohibitions on pre-existing condition limitations and lifetime maximums, etc.) all put upward pressure on rates.

In addition, increased utilization will increase costs. A 2010 study by Mercer predicts a further 4-6% increase in cost over current trend as a result of the new law.

**III) Insurers, Providers, Individuals (Briefly)**

Insurers become subject to 3 major new rules in September 2010:
1) Sharp restrictions on “rescission” (revoking coverage after a claim is filed);
2) Inability to deny coverage to children with pre-existing conditions;
3) Inability to impose lifetime limits on benefits paid.
In addition, beginning January 2011, insurers are required to spend a minimum of 80%-85% of income from premiums on medical care; less than that and they will be required to send rebates to customers.

Individuals will be required to have insurance coverage beginning in 2014 or face financial penalties, which increase by 2016 to a maximum of $695 or 2.5% of income for an individual, and 2.5% of income for a family.

Encouragement is given to the development of “Accountable Care Organizations,” networks of providers who agree to be responsible for the overall care of patients for the long term and in which providers are paid a set fee rather than fee-for-service, very similar to capitation-model HMOs of the 1990s.

Also, member-owned, nonprofit, co-op insurance plans, which could team up with accountable care organizations are also being encouraged. (Two such co-ops currently exist—one in Seattle and one in Minneapolis).

**IV) Opinions/Issues/Comments From The “Experts”**

159 new committees, bureaus, agencies, etc. are created as a result of PPACA.

Official estimates are that the new law will cost $938B over the next decade with a little more than half going to tax credits and other subsidies for small business and individuals through exchanges. The remainder will go to assist more people to obtain coverage through Medicaid and other programs for the poor and elderly.

Funding for the law will come from other provisions that either reduce spending on existing government programs or impose new taxes and penalties on individuals and businesses (the latter including $27B from pharmaceutical companies, $60B from insurers, and a to-be-determined amount from excise taxes on medical devices, all certain to be passed on to consumers and employers). These are projected to generate over $1T (trillion) over the next decade.

Some think the relatively small penalties (for individuals and businesses) which portend a potential problem of younger, healthier people not “buying in,” the prospect of loose enforcement (partially due to the “toxic” political environment and likelihood of lax enforcement in some states), and the absence of addressing rising health care costs combine to leave premium rises unchecked, compliance uncertain and spotty, and thus imperils the whole effort.

If the intent of the law fails, some envision the emergence of a two-tier market in which regulated public plans serve as a safety net and private plans function as supplemental coverage, the latter perhaps sponsored by collectives rather than employers.

In any case, the next several years are sure to be transformational for American health care insurance coverage.
Resources

2) MacGillis, Alec, Ibid., pp.85-92
3) Hilzenrath, David S., Ibid., pp.153-161
5) Montgomery, Lori, Ibid., pp.169-178
6) MacGillis, Alec, Ibid., pp.99-105
7) Hilzenrath, David S., Ibid., pp.153-161
9) Hilzenrath, David S., Ibid., pp.145-152
10) Hilzenrath, David S., Ibid., pp.157-158
12) Frye, Gerald W., Ibid.
15) MacGillis, Alec, Ibid., pp. 191-194
16) MacGillis, Alec, Ibid., pp.93-98
17) MacGillis, Alec, Ibid., pp.85-92
18) Brown, David, Ibid., pp.135-143
20) Montgomery, Lori, Ibid., pp. 169-178
21) MacGillis, Alec, Ibid., pp.85-92