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Special Alert: Health Reform

The Patient Protection and Affordable Care Act of 2010 was signed into law on March 23, 2010. The health reform legislation will make health insurance available and attainable for millions of United States citizens and legal residents who lack coverage.[1] It will also ensure that people who currently have health insurance do not lose their coverage if they get sick or have a pre-existing condition. Lifetime caps on coverage will end and children will be able to stay on their parents' policies until age 26. Some changes will be effective right away and others will be phased in over time, many in 2014. This brief overview is the first of several Butzel E-Alerts on the health reform legislation. It contains a summary of the key highlights of this sweeping legislation and suggests a few of the many consequences of health reform on key stakeholders. Due to the exceptional complexity of this legislation and its long phase in period, Butzel Long will provide detailed, industry specific information to its clients in the near future.

Individuals will be required to have qualifying health coverage or pay a tax penalty unless they are granted an exemption for reasons of financial hardship, religious objections, undocumented immigrant status or other reasons. Premium credits and cost sharing subsidies will be offered to eligible low income individuals and families who purchase health insurance. Individuals with chronic and pre-existing conditions may be expected to flood the new Exchanges, while the young, healthy or contrarian may be tempted to forgo coverage and pay or challenge the tax penalty. Individuals without workplace coverage will have to deal with the impact of insurance costs in their family budgets. Will individuals be able to afford the coverage they are required to buy?

Employers' obligations vary with the size of the employer's workforce. Large employers with more than 200 employees will be required to automatically enroll employees into health insurance plans offered by the employer, unless the employee opts out of coverage and are prohibited from imposing waiting periods in excess of 90 days. Large employers must continue to provide coverage or face a fine. Medium sized employers of 50 or more employees will be encouraged to provide their workforce with coverage or pay a penalty. Employers with less than 50 employees are encouraged to provide coverage but are exempt from the penalty. Small business tax credits will be available to induce employers with no more than 25 employees and average wages at certain levels to provide coverage until the Exchanges are up and running. Employers that offer health insurance coverage will be required to offer "free choice" vouchers to certain employees. Temporary reinsurance programs will be made available to employers who provide coverage for retirees over the age of 55 who are not eligible for Medicare. After 2012, Flexible Spending Account contributions will be capped at $2500 per year.

Health Care Providers will benefit from reduced bad debt and charity care loads as 32 million more people have health care coverage at some levels, although overall payment may decrease. Millions of new people seeking health care, and able to pay for it, will exacerbate the current shortage of health professionals, especially among primary care providers, even though their pay is to increase. This sea of change may usher in a new era whereby primary care is provided by nurse practitioners and physicians assistants, rather than physicians. Alternative types of providers will proliferate, such as federally qualified health centers, community and school based clinics. The delivery model will include medical homes with multi-disciplinary approach to preventative, primary and chronic condition care. Changes in payment methodology from a volume based system to a merit system that pays for quality and good outcomes creates uncertainty in the provider community.

Health Insurance Exchanges will be created and administered by a governmental agency or non-profit organization through which individuals who do not get coverage at work and small businesses of up to 100 employees can purchase essential health benefits from a variety of different plans (bronze, silver, gold, platinum and catastrophic) with different benefit tiers. The Exchanges will create a marketplace where individuals and small businesses can pool together to gain leverage to purchase quality, affordable care from insurance plans. Out of pocket limits are equal to Health Savings Account (HSA) limits, but are reduced for low income individuals. States may form regional exchanges or allow more than one Exchange to operate within a state if they serve different geographic regions. The ability to purchase insurance through the Exchanges is limited to United States citizens and legal residents. Since the Exchanges are new and do not currently exist, their regulations become effective in 2014 to give them time to be created and become operational.

Private Insurance will be subject to a number of wide ranging reforms designed to protect the consumer. Some are effective immediately and others become effective in 2014. Insurers will be required to spend at least 80% of premiums on actual health care services. New insurance market rules will prohibit insurers from rescinding coverage except for fraud and will prohibit lifetime and annual limits on coverage. Pre-existing condition exclusions are limited for children within 6 months of enactment and by 2014 for adults. A national high risk pool is established on a temporary basis to deal with pre-existing condition liabilities and coverage for high risk individuals. Benefit coverage is extended to adult children up to age 26. Waiting periods for coverage are limited. Health plans are required to issue report cards on the proportion of premium dollars spent on clinical, quality and other services and provide rebates in certain circumstances. Penalties are imposed for unjustified premium increases. Consumer protection is enhanced. States are permitted to form health care choice compacts to facilitate the purchase of individual insurance across state lines. To oversee the implementation of health reform initiatives in the private insurance industry, a new federal Health Insurance Reform Implementation Fund will be established within the Department of Health and Human Services.

Expansion of Medicare, Medicaid and CHIP will occur: In addition, there will be numerous changes to Medicare operations many of which are geared to reduce or slow the growth of the Medicare spending. One such change is the creation of Accountable Care Organizations (ACOs) which will be addressed in more detail in the next release of this alert. Medicare's size and purchasing power will continue to drive payment policy. Medicaid will be expanded to cover all individuals under age 65 at certain income levels. States will receive additional federal funding to finance coverage for the newly eligible. Primary care providers will be paid more to provide care for Medicaid beneficiaries. States are required to maintain current income eligibility levels and

extend funding for the Children's Health Insurance Program (CHIP). Children eligible for CHIP who are unable to enroll due to enrollment caps will be eligible for tax credits in the Exchanges. Seniors covered by Medicare will enjoy free preventative care. The Medicare "doughnut hole" for prescription drug coverage is gradually filled for seniors facing high drug costs and covered seniors will receive a 50% discount on certain drugs while in the doughnut hole. The subsidies that go to private insurers that offer seniors coverage through Medicare Advantage Plans will be phased out over the next 1 ½ years, with the likely result that covered seniors may experience benefit cuts or increased out of pocket premiums.

Tax Changes Related to Health Insurance or Financing Health Reform are complex, extensive and have unique effective dates. A new penalty will be levied on individuals who opt out of health insurance coverage. The payroll tax rate for Medicare will increase for high income taxpayers defined as those with wages over $200,000 for individual taxpayers and $250,000 for married couples filing jointly. An additional 3.8% surtax will be imposed on unearned income for high income taxpayers. Reduction to deductable medical expenses for individual taxpayers will be enforced by increasing the AGI limit from 7.5% to 10%. There will be increased requirements for corporations making estimated tax payments. Contributions to HSAs will be limited and over the counter drugs will no longer be reimbursed from HSAs on a tax free basis. Distributions from a HSA that are not used for qualified medical expenses will be subject to an increased tax. Insurers of "Cadillac" employer sponsored health plans, $27,500 for a family or $10,200 for individual coverage will pay a 40% excise tax, subject to special adjustments for various categories. New pay to play fees will be imposed on the sectors of the health industry, including pharmaceutical, medical device manufacturers and insurance providers, with different rates for-profit and non-profit insurers, VEBAs not established by an employer, and other insurers. Income tax deductions for compensation paid to health insurance executives is limited. Indoor tanning services are taxed at 10%. The common law developed economic substance doctrine to be codified with increased penalties on positions challenged by the IRS. Unprocessed fuels are excluded from the definition of cellulosic biofuels for purposes of obtaining tax credits. Besides the additional revenue raisers many taxpayers will be required to disclose additional information to the IRS.

Legal challenges to the legislation have already begun. In our next Alert we will provide a more detailed analysis of the legislation, some recommendations regarding strategic actions and planning as well as an update of the legal challenges in addition to a reflection on challenges to prior legislation involving Medicare. While some provisions are effective immediately, the 2014 effective date for much of this legislation will give all constituents some time to understand and implement changes, keeping in mind that some important changes to private insurance may occur immediately or in the near future.

If you have any questions about the above, please contact your Butzel Long attorney, or any member of our Health Reform Team as indicated below.

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[1] H.R. 3590, the Patient Protection and Affordable Care Act. Lawmakers are debating H.R. 4872, the Health Care and Education Reconciliation Act of 2010, a reconciliation bill that would amend H.R. 3590. The House passed H.R. 4872 on March 21, 2010 and the Senate must take up the measure.
