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Deciphering the Healthcare Bill – Part 1: The Rules of the Game

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Part 1: The Rules of the Game

By Bridget McCrea

Ever since President Obama signed the Healthcare Reform Bill (officially titled the Patient Protection and Affordable Care Act) into law in March, businesses of all sizes and across all industries have been scratching their heads over the slew of new rules, regulations and requirements. Where in the past it was enough to provide a basic health care plan for employees – and, in some cases, it was OK to

avoid this step altogether – the detailed new law raises much concern over just what is required of American companies and their workers.

In Part 1 of a two-part series on this important topic, we'll look at the new law itself, show you what's changed and help you figure out exactly what it means for your firm. In Part 2 we'll give you some solid tips on how to deal with the changes and stay on the right side of the law without sacrificing too much time or money in the process.

Nuts and bolts

Although there is strong disagreement about many aspects of the final bill, few Americans would argue about the need for radical health care reform. Inadequate or nonexistent coverage, costs that were spiraling out of control and overpriced prescription drugs are just a few of the major issues that Americans and their employers grapple with on a daily basis.

Enter the health care bill – a sweeping multi-year package of reforms that promises to make coverage more accessible to all Americans while putting more of the financial responsibility on the backs of their employers. "Was reform needed? Yes it was," says Rob Wilson, president at Westmont, Ill.-based Employco USA, a human resources provider for small and midsized firms. "Health care prices were going up year after year at rates that were much higher than inflation."

Wilson blames insurance firms' own growing expenses and issues like litigation and malpractice lawsuits for boosting the average American's health care costs. Lawsuits with multi-million dollar jury awards, for example, are a "big expense for hospitals, doctors and insurance companies," Wilson explains. "Unfortunately, the reform act didn't change much of that." What the new bill did change is the way in which employers handle their workers' health insurance coverage. While the cost burden may shift more toward employers, the bill also requires more responsibility on individuals to take advantage of preventive care services like smoking cessation programs and annual health screenings. The bill also creates tax incentives for companies with fewer than 25 employees. Here's a primer on the key changes included in the bill:

- Employer Requirement: Penalties would be assessed on employers with 50 or more workers who fail to offer coverage to employees. The penalty would be assessed if even one employee receives a subsidy to purchase coverage through a health insurance exchange. Employers would also incur penalties if the coverage they offer is considered "unaffordable" to the employee or if the health plan has an actuarial value of less than 60 percent or pays less than 60 percent of covered health care expenses.
- Individual Requirement: The new law requires individuals to purchase health insurance coverage or pay a tax penalty beginning in 2014. The penalty, which is phased in, starts at $95 or 0.5% of income per individual in 2014 and increases to $750 or 2% of income in 2016. The penalties for families would be capped at $2,250. Religious and hardship exemptions are available.
- Excise Tax on High-Value Health Plans (also known as the "Cadillac" tax): Employers offering health plans that exceed a certain cost (the total employee and employer cost) would be subject to an excise tax on the amount above that value. For individual coverage, the threshold would be $8,500; for family coverage, the threshold would be $23,000. These thresholds would be indexed at the Consumer Price Index plus one percentage point. Certain high-risk provisions would have a higher cost threshold.
- Insurance Market Reforms: The new law requires insurance plans to provide coverage to any individual who requests insurance. It also includes a prohibition on pre-existing condition restrictions in the individual and small group health care market. Health insurance premiums would be allowed to vary based only on tobacco use, age, family composition and geographic location. Large employers that purchase coverage through a health care insurance exchange would be eligible for the above insurance protections. Both self-insured and fully insured plans are required to provide coverage for dependents up to age 26. Health plans are also prohibited from establishing annual and lifetime dollar limits on coverage.
- Wellness Programs: Employers can offer increased incentives or rewards to employees for participation in a wellness program or for meeting certain health status targets beginning in

2014. Rewards or premium reductions up to 30 percent of the cost of coverage are now permissible.

- Free Choice Vouchers: Employers offering coverage are required to provide "free choice vouchers" to qualified employees to purchase insurance through the exchanges. To be eligible for a voucher, an employee's contribution under the employer's plan would be between 8% and 9.8% of income, and the employee's income would be at or below 400% of the Federal Poverty Level.
- Flexible Spending Accounts (FSAs): Contributions to health FSAs would be capped at $2,500 beginning in 2011 and over-the-counter medicines would only qualify for reimbursement with a doctor's prescription.
- Medicare Hospital Insurance Tax: Beginning in 2013, an additional Medicare tax of 0.9% is imposed on individuals with income in excess of $250,000 for joint filers or $200,000 for single filers.

Wilson says that for 2011, manufacturers should focus on three key points that may impact their health care responsibilities and costs. The first involves dependents age 26 years and under who can now be covered under their parents' health care plans. In the past, children could remain on their parents' plans until age 18 or 19 if they did not go to college, and 23 or 24 if they were enrolled full-time in school. "With unemployment as high as it is, a lot of students are graduating from college and not working," says Wilson. "Now those young adults have to be covered until they're 26, with no exclusions unless they get their own jobs with their own health care plans." The law doesn't stipulate who is responsible for paying the adult dependent's coverage.

The second consideration involves new group health plans, which must cover preventive services with no co-pays, deductibles or co-insurance. In the past, for example, insurance firms might cover one physical examination a year for free or at a nominal cost, "but when it comes to preventive care, no one wanted to cover it," says Wilson. "Now, any of these services are covered. That's good for employers, who don't have to worry about co-pays or deductibles for care that will keep workers healthy."

The final point of concern for businesses is the fact that there will no longer be lifetime limits on health insurance coverage. "Typically you would purchase a health plan and get two limits: one for in-network, and one for out-of-network care," says Wilson. "Most plans were capped at $1 million, $2 million and $5 million. Now, thanks to the reform bill, there are no longer limits on those health care policies."

The good and the bad

As you can see, some of the changes introduced by the health care reform bill will result in positive changes for companies and workers. Insurance providers, for example, can no longer cancel a policy if the insured person is sick. In the past, different states had their own laws regarding this issue.

"Clearly, this bill is going to have a major impact on business," says William Ruse, adjunct faculty member at the University of Findlay in Findlay, Ohio, and a former health care CEO. "In some cases, the impact will be favorable and in others it will be unfavorable, depending on the current level of coverage that the employer provides."

Manufacturers will want to look closely at the issue of grandfathering when assessing their responsibilities, says Ruse, and should keep a close eye on any plans that aren't grandfathered. Any insurance policy that was purchased and active before the bill was signed into law will have what is called "grandfather status." Plans can lose their grandfather status if they change certain benefits. Some benefits in grandfathered plans will be required to change in order to conform to new requirements in the bill.

The tax credit being offered to companies with 25 or fewer full-time employees with less than $50,000 in average wages is also worth a second look, according to Ruse. That credit is 35%, and

goes up to 50% in 2014. “That credit is significant,” says Ruse, “and based on premiums that the company pays out for health care.”

While the bill has its positive aspects, there are several areas of concern for companies. In the second part of this article, we’ll help you navigate those changes and come up with a plan of action for dealing with them. “By planning ahead,” says Ruse, “companies will avoid getting sidelined every year as the new changes go into effect.”

Bridget McCrea is a freelance writer who covers manufacturing, industry and technology. She is a winner of the Florida Magazine Association’s Gold Award for best trade/technical feature statewide.

Sidebar: New Year, New Changes

With many of the changes associated with the health care reform bill not going into effect until 2014, there are only a few areas that companies need to be concerned about right now. It never hurts to think ahead, of course, and to be prepared for the modifications that are coming down the pike.

Rob Wilson, president at Employco USA, breaks down the key changes impacting group health plans in 2010 and 2011. The 2010 changes are all currently in effect. In the second part of this article we’ll look at the changes going into effect 2012-2014.

2010

- Tax credits for businesses: Businesses with fewer than 25 employees and average wages of less than $50,000 could qualify for a tax credit of up to 35 percent of the cost of their premiums.
- Government oversight of insurance premiums: if an insurer spends too much on administrative expenses, a rebate is required to be paid.
- Mandated extended eligibility for dependent children: An employee will be allowed to keep his/her children enrolled in health coverage until age 26, unless the dependent is eligible for coverage through his or her own employment. Group health plans cannot exclude pre-existing medical conditions from coverage for a child under age 19.
- Group health plans must cover preventive services and such coverage must be without co-pays, deductibles or co-insurance.
- Group health plans will be barred from imposing lifetime caps on coverage. Restrictions will also be placed on annual limits on coverage. Insurers can no longer cancel insurance retroactively for things other than outright fraud.
- Small businesses with less than 25 employees and average wages of less than $50,000 will qualify for a tax credit of up to 35% of the cost of the health care premiums for workers.
- Health plans will be forbidden from setting lifetime limits on policies.
- Health plans will not be able to cancel policies because an insured individual got sick.
- Seniors will receive $250 to fill the Medicare Part D prescription drug coverage gap, also known as the “doughnut hole.”
- High-risk insurance pools will be established for uninsured people with pre-existing conditions.
- A 10% tax will be imposed on tanning salon customers.
- • A temporary re-insurance program will be created to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55 to 64.
- • A new independent appeals process will be established to ensure that consumers can appeal decisions by their health insurance plan.
- New health plans will be prohibited from establishing eligibility rules for health care coverage that have the effect of discriminating in favor of higher-wage employees.
- Increased funding for community health centers.
- Increased investment in training programs that will raise the number of primary care physicians, nurses and public health professionals.
- Aid to states to establish health insurance consumer assistance offices to help consumers file complaints and appeals.

2011

- Creation of a standardized definition of Qualified Medical Expenses for HSA, FSA and HRA.
- Increased tax (to 20%) on non-qualified medical expenses.
- Limiting reimbursement to only prescribed drugs through HSAs, MSAs, FSAs and HRAs.
- Large group plans that spend less than 85% of premium revenue and small group plans that spend less than 80% of premium revenue on clinical services must provide a rebate to enrollees.
- A $4.8 billion fee to be assessed on the pharmaceutical manufacturing industry.
- Small employers that establish wellness programs would be eligible for grants for up to five years.
- Employers must disclose the value of the benefit provided for each employee's coverage on W2s.
- States may cover parents and childless adults on Medicaid up to 133% (of the federal poverty level).
- A national, voluntary long-term care insurance program will be created and will be financed by voluntary payroll deductions.
- Health plans in the individual and small group markets will be required to spend 80% of premium dollars on medical services, while plans in the large group market will be required to spend 85%. Failure to meet the thresholds will result in rebates to policyholders.
- A 50% discount will become available on brand-name drugs for Medicare beneficiaries who hit the "doughnut hole."
- Co-payments and deductibles for preventive services provided under Medicare will be eliminated.
- A fee will be imposed on manufacturers and importers of branded drugs.

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