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Health-Care Reform

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The primary goals of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, the 2010 health-care reform legislation) are to ensure that all Americans and legal residents have access to a minimum level of affordable health care, and to help contain the burgeoning costs of our health-care delivery system. The health-care reform legislation invokes a shared responsibility between both state and federal governments, as well as employers and individuals, to contribute toward those ends.

In general, the legislation mandates that most individuals have minimum health insurance. While employers are not required to offer health insurance to their employees, those that choose not to offer coverage may face a penalty. The legislation creates new public programs and expands the Medicare and Medicaid programs to include more beneficiaries, while mandating that all health plans extend coverage to individuals, regardless of health status. Revenue provisions are also included, not only to help fund the cost of these programs, but to extend the viability of Medicare.

Insurance mandate

Beginning in 2014, most U.S. citizens and legal residents must have qualifying health insurance coverage. Those without coverage will face a penalty tax in 2014 of $95 per adult, $47.50 per child, or 1 percent of the family's income, whichever is greater, up to $285 per family. In 2015, the amounts are $325 per adult, $162.50 per child, or 2 percent of income, up to $975 per family. In 2016, the tax is $695 per adult, $347.50 per child, or 2.5 percent of income up to $2,085 per family. Thereafter, the penalty will increase annually based on cost-of-living adjustments. Exceptions to this requirement are available for individuals who qualify for a religious exemption, members of Indian tribes, undocumented immigrants, incarcerated individuals, individuals without coverage for a period of less than three months, those who cannot afford coverage, and those with income below the income-tax filing threshold for the year.

The creation of a temporary high-risk pool will provide subsidized premiums to individuals who have been unable to obtain coverage for at least six months due to pre-existing conditions. This program will expire on January 1, 2014, at which time plans are prohibited from excluding applicants due to pre-existing conditions.

Employers are generally not required to offer coverage, but those that don't may be subject to a penalty tax. Specifically, any employer with more than 50 employees that does not offer health insurance faces a potential monthly tax penalty of $166.67 per full-time employee (excluding the first 30 employees) for any month insurance is not offered. The fee applies if an employer has at least 1 full-time employee who enrolls in a state-sponsored health insurance exchange and who qualifies for a premium tax credit or cost-sharing reduction.

Similarly, even employers with more than 50 employees that do offer coverage will be assessed a fee if in a month the employer has at least 1 full-time employee who enrolls in an exchange and who qualifies for a premium tax credit or cost-sharing reduction, because (1) the plan's share of total cost is less than 60 percent, or (2) the employee's cost in the plan is considered unaffordable. The monthly fee is equal to the lesser of $250 ($3,000 per year) per full-time employee receiving a credit or reduction, up to the amount of penalty tax that would be due if the employer did not offer any coverage.

Employers with 200 or more employees must automatically enroll employees in health insurance plans offered by the employer. The employee may voluntarily opt out of the employer's plan.

Mandates affecting private health insurance

Individual and group insurance plans must meet new coverage requirements. The following provisions took effect in 2010:

• Policies may no longer exclude coverage for children based on pre-existing conditions.

• Dependent coverage must be extended to children up to age 26.

• Plans may not impose lifetime dollar limits on coverage benefits. (By 2014, plans will be prohibited from placing annual dollar limits on coverage, and plan waiting periods cannot exceed 90 days.)

• Plans are prohibited from rescinding coverage except in cases of fraud.

• Plans are required to provide coverage for certain preventive services and recommended immunizations as indicated by the Task Force on Clinical Preventive Services and the Director of the Centers for Disease Control and Prevention.

Effective in 2014, all new health insurance plans must offer, at a minimum, an essential health benefits package as defined by the Secretary of Health and Human Services, but including the following benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Habilitative and rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Existing individual and group plans need not meet this coverage mandate. Also, out-of-pocket costs for all plans in all markets cannot exceed the limits for health savings accounts, and deductibles for the small group market cannot be greater than $2,000 for an individual and $4,000 for a family, indexed by the percentage increase in average per capita premiums.

Public programs

Medicare

The health-care legislation has several provisions that affect the Medicare program. However, basic Medicare benefits remain unaffected.

Prior to enactment of the legislation, Medicare Part D drug program beneficiaries had to pay up to an additional $3,610, out-of-pocket, for medication after reaching an initial threshold, or donut hole, of $2,830 in total prescription drug costs (including Part D payments, beneficiary co-pays, and deductibles). But, in 2010, beneficiaries who fell in the donut hole received a $250 rebate, and, in 2011, they received a 50 percent discount on brand-name drugs. By 2020, a combination of federal subsidies and a reduction in co-payments will reduce the beneficiary coinsurance rate in the donut hole to 25 percent.

Also, beginning in 2011, the time period during which Part D and Medicare Advantage beneficiaries can make changes to their coverage is extended and runs from October 15 to December 7. This extension is intended to provide more time for beneficiaries to consider their options while ensuring that all changes are properly incorporated into the plan for the following year.

However, for some beneficiaries, their contribution toward the cost of the Part D program is changed. Part D premiums will increase for individuals with annual incomes greater than $85,000, and couples with incomes exceeding $170,000, as the federal subsidy offsetting some of the cost of Medicare Part D premiums is reduced.

Currently, full-benefit dual eligible beneficiaries (individuals eligible for both Medicaid and Medicare) receiving long-term care services at home or in a community-based setting are subject to Part D drug co-payments while similar beneficiaries receiving institutional care, such as in a nursing home facility, do not owe any co-payments. Beginning in 2012, the health-care reform legislation removes this imbalance by eliminating co-payments for individuals receiving services at home or in a community setting.

Some traditional Medicare benefits are also improved. For example, prior to enactment of the legislation, traditional Medicare paid 80 percent of the cost of a one-time physical for new enrollees within the first 12 months of enrollment. But beginning in 2011, Medicare covers the entire cost of an annual wellness exam; preventive care tests such as screenings for high blood pressure, diabetes, and certain forms of cancer; a personalized prevention assessment; and a plan to address a beneficiary's particular risk factors.

While basic benefits aren't curtailed, there are some cuts in government subsidies to some Medicare programs beginning in 2011. Medicare Advantage plans (Medicare benefits provided through private insurers) are subsidized by the federal government based on a formula determined by county. Generally, the government pays more to subsidize Medicare Advantage plans than traditional Medicare. The health-care legislation brings payments for Medicare Advantage plans closer to the average costs for comparable benefits paid for Medicare benefits. These cuts could reduce or eliminate some of the extra benefits Medicare Advantage plans may offer, such as dental or vision care, and some insurers may choose to increase premiums. However, Medicare Advantage plans that receive high quality ratings are eligible for bonus payments. In any case, Medicare Advantage plans cannot reduce primary Medicare benefits, nor can they impose deductibles and co-payments that are greater than what is allowed under the traditional Medicare program for comparable benefits.

The legislation also seeks to control the growth of Medicare spending. The Independent Payment Advisory Board is created to recommend alternatives to achieve spending reductions without modifying benefits, eligibility, premiums, or taxes. Payments for providers will be based on performance and efficient delivery of services. The new Center for Medicare and Medicaid Innovation is charged with the development, testing, and recommendation of innovative payment and delivery systems to improve the quality of care while reducing the cost care.

Medicaid

Medicaid eligibility is expanded under the health-care reform legislation. Individuals and families with incomes at or below 133 percent of the federal poverty level qualify for Medicaid, and individuals and families with income levels between 133 percent and 400 percent of federal poverty level are eligible to receive subsidies to offset the cost of health-care coverage. Equally important for some, eligibility is based on modified adjusted gross income with no asset or resource test.

For seniors and other disabled individuals receiving long-term care under Medicaid, states have the option of extending full Medicaid benefits to individuals receiving home and community-based services, and the Community First Choice Option, established in 2011, allowed states to provide benefits for community-based care to Medicaid-eligible individuals who otherwise require an institutional level of care, such as in a nursing home. Also, spousal impoverishment provisions apply to situations of Medicaid beneficiaries receiving care at home or in the community, allowing their spouses to preserve certain resources and income for their support.

Health insurance exchanges

Beginning in 2014, American Health Benefit Exchanges and Small Business Health Options Programs (SHOPs) will be established in each state to serve as a conduit through which individuals, families, and small businesses can shop for health insurance. U.S. citizens and legal residents are eligible to purchase insurance through an exchange. However, those who are incarcerated or eligible for affordable employer coverage will generally not be allowed to participate.

Each exchange must offer a uniform benefits package with at least four levels of coverage, making for easier comparison of plan options. The benefits offered must be comparable to those offered by a typical employer plan, as defined by the Health and Human Services Secretary. Using this benefit package as a basis, each level of coverage is based on a percentage of the full benefits package. For example, the Silver plan pays 70 percent of the cost of benefits covered by the plan. The levels of coverage are:

- Bronze--60 percent of full plan benefits

- Silver--70 percent of full plan benefits
- Gold--80 percent of full plan benefits
- Platinum--90 percent of full plan benefits

States may also offer a catastrophic plan available only to individuals under age 30 and those who are exempt from the requirement to purchase coverage because the premium cost would exceed 8 percent of their income.

SHOP insurance is available for purchase by employers (including the self-employed) with less than 100 employees. States have the option of allowing businesses with more than 100 employees to participate in the SHOP Exchange beginning in 2017.

Premium assistance and cost sharing

Individuals

Rebates may be available to those insured through either group or individual health plans from their insurance providers. Beginning in 2011, insurers that spend less than a specified percentage of premiums each year on reimbursements for clinical services to enrollees and activities that improve health-care quality, are required to provide a rebate to each enrollee on a pro rata basis.

Effective in 2014, provisions in the health-care legislation expand Medicaid to individuals and families with incomes at or below 133 percent of the federal poverty level. Individuals and families with incomes between 100 percent and 400 percent of the federal poverty level who buy insurance through state exchanges will be eligible for premium subsidies in the form of tax credits and cost-sharing subsidies (which reduce the out-of-pocket cost of services like co-pays and deductibles). Subsidies generally are not available to individuals eligible for insurance under an employer-provided health plan unless the employee cost is greater than 9.5 percent of income, or the plan covers less than 60 percent of the cost of covered benefits.

Employers

The health-care legislation provides a tax credit to small businesses that offer health insurance coverage to their employees. The credit is available in two phases. For the years 2010 through 2013, the maximum credit is 35 percent of the employer's premium cost. For tax years 2014 and later, the maximum credit increases to 50 percent.

To be eligible for the tax credit:

- An employer must have fewer than 25 full-time employees for the tax year. Generally, this is determined by dividing the total hours worked by all employees during the year by 2,080.
- Average annual wages must be less than $50,000 (to calculate, total wages paid during the tax year are divided by the number of full-time employees, and rounded down to the nearest $1,000), and
- The employer must contribute at least 50 percent of the premium cost of a qualifying health plan offered to employees.

Special rules apply to seasonal employees and to tax-exempt employers. Also, sole proprietors, partners, 2 percent shareholders of an S corporation, and 5 percent owners of an employer generally are not considered employees for purposes of the credit. In addition, family members of ineligible employees are not included as employees.

The maximum credit is available to qualifying employers with 10 or fewer full-time employees with average annual wages not exceeding $25,000. The credit is phased out for employers with between 10 and 25 full-time employees, and for employers who have full-time employees with average annual wages between $25,000 and $50,000.

Beginning in 2014, the maximum credit increases to 50 percent; however, qualifying arrangements are restricted to health insurance purchased by the employer through state-run health exchanges. The credit can be claimed by the employer for only two years.

Tax provisions

There are many tax and revenue-generating provisions within the health-care legislation. Some of those tax-related changes include:

- Effective 2013, the itemized deduction threshold for medical expenses increases from 7.5 percent to 10 percent of adjusted gross income. The threshold increase does not apply to taxpayers age 65 and older for the years 2013 through 2016.
- Annual contributions to health flexible spending accounts that are part of cafeteria plans are limited to $2,500, beginning in 2013.
- The deduction for employers receiving a Medicare Part D drug subsidy for their retirees is eliminated as of January 1, 2013.
- Starting in 2013, the Medicare Part A payroll tax increases by 0.9 percent for individuals with wages exceeding $200,000 and for married couples filing jointly with over $250,000 in wages (the additional tax applies to self-employed individuals as well). An added Medicare tax of 3.8 percent is applied to unearned income (e.g., interest, dividends, royalties, rent, and gain from the sale of property) for individuals with adjusted gross income over $200,000 ($250,000 for married couples filing joint returns).

Long-term care

Health-care reform legislation has added new provisions to existing long-term care delivery systems, including Medicaid. For instance, starting in 2011, the Community First Choice Option is available for states to add to their Medicaid programs. This option provides benefits to Medicaid-eligible individuals for community-based care instead of placement in a nursing home.

In addition, the State Balancing Incentive Program, established in 2011 and running through October, 2015, provides increased federal funds to qualifying states that offer Medicaid benefits to disabled individuals seeking long-term care services at home, or in the community, instead of in a nursing home. In order to be eligible, a state must spend less than 50 percent of its total Medicaid expenditures for at-home or community-based long-term care services and support. The state must also agree to use the additional federal funds to provide new or expanded non-institutionally-based long-term care services.

The Independence at Home demonstration program, available in 2012, will be a test program that provides Medicare beneficiaries with chronic conditions the opportunity to receive primary care services at home. That is intended to reduce costs associated with emergency room visits and hospital readmissions, and generally improve the efficiency of care.

In the past, consumers had very little information available to help them compare nursing homes. The health-care legislation addresses the need for more transparency regarding nursing facilities. For example, nursing homes are required to disclose their owners, operators, and financers. The government will also collect and report information about how well a particular nursing home is staffed, including the hours of nursing care residents receive, staff turnover rates, and how much facilities spend on wages and benefits.

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