The Patient Protection and Affordable Care Act - 'ObamaCare' Abridged

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When the Patient Protection and Affordable Care Act (the 'Act') was being debated in Congress, more than one member confessed that he had not even attempted to read it. Until last summer when the Supreme Court ultimately upheld the Act, many others of us put off picking up a copy. Now that it appears likely to take effect, you may want to have at least a passing knowledge of what is in the law and how, generally, it may impact your clients. Here is a 'Reader's Digest' version of what has taken affect and what is in the offing this year and next.

Provisions you may have already noted:

Small Business Tax Credit [1]
For employers with fewer than 25 FTE's paying an average of no more than $50,000 per year, the Act set up a 4-year window for receiving a tax credit, up to 35% of the cost of providing health insurance to employees, subject to various restrictions. The goal of the Act is to maximize the number of individuals covered by insurance; and this credit is intended to entice small employers to provide coverage even when they are not required to do so. An employer with 10 employees who are paid an average of $25,000 per year, the credit is at the maximum; for more employees and/or higher earnings, the credit is phased out proportionately. (In 2014, the credit will increase to as much as 50%, but will be limited to a 2-year window.)

Nursing Mothers Protection [2]
Nursing mothers have a right to reasonable unpaid breaks in a private place other than a bathroom.

'High Risk' Insurance Pool [3]
Until the new comprehensive program is implemented for everyone, new insurance programs, assisted with federal funding, were established in Ohio under which anyone could obtain coverage, regardless of preexisting conditions, without a waiting period, and with out of pocket expenses capped. [Employers are prohibited from trying to shunt employees off their plans and onto the State plan.] -- This is supposed to sunset in 2014 when the Mandates take effect.

Children's Pre-Existing Conditions [4]
Employer group plans cannot exclude coverage of preexisting conditions -- for children.

No Rescinding Coverage [5]
Plans cannot rescind coverage retroactively once the individual is recognized as covered (other than for fraud).

No Lifetime Limits [6]

No Annual Limits [7]
Annual Limits on what a policy will pay have been re-set according to this schedule:

9/23/10-9/22/2011	$ 750,000
9/23/11-9/22/2012	$1,250,000
9/23/12-9/22/2013	$2,000,000

Thereafter, no annual limits are permitted.

However, inasmuch as there are many significant employers who offer very minimal insurance plans and who threatened to drop them completely, the Administration authorized itself [8] to grant 'waivers' from the schedule. They approved 1,578 employers, with 3.4 million covered employees [9].

Extended Children's Coverage [10]
Coverage must be offered to children under 26, regardless of income, marital status, or lack of status as an IRS-recognized dependent.

No Flexible Spending on OTC Drugs[11]
Since Flexible Spending plans use pretax earnings to purchase medical services, the government benefits by reducing the number of things which can be purchased with those plans - they eliminated over the counter drugs from the approved list, unless a doctor has actually prescribed their use.

Grandfather Status
One of the original premises of the federal law was that people who were happy with their coverage didn't need to change it. On that basis, there were additional changes that were mandated, but not on pre-existing ('grandfathered') plans. So long as those plans in existence on March 23, 2010, remained substantially the same, they didn't need to add these provisions.

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However, Grandfather status can be lost by taking any of the following steps[12]:

1 The elimination of all or substantially all benefits to diagnose or treat a particular condition;

2 Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (e.g. an individual's coinsurance);

3 Any increase in a fixed-amount cost-sharing requirement other than a copayment (e.g., deductible or out-of-pocket limit), if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds medical inflation plus 15%;

4 Any increase in a fixed-amount copayment, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of: (A) An amount equal to $5 increased by medical inflation (that is, $5 times medical inflation, plus $5), or (B) medical inflation plus 15%;

5 Any decrease in employer contribution rates toward the cost of coverage by more than 5% below the contribution rate for the coverage period that includes March 23, 2010;

6 Imposing an annual limit on the dollar value of benefits if the plan didn't have one on March 23, 2010.

In any event, newly issued plans which are not Grandfathered are now expected to include these provisions:

Preventive Care[13]

Preventive care, immunizations, and screening must be covered by insurance, without co-pay, co-insurance, or deductibles.

Preventive care for women includes contraceptives. Regulations attempting to deal with the application of those requirements to certain 'religious employers' were issued in August, 2011[14]. It is reported that, at this point, there are some 42 separate lawsuits pending[15] across the country in which this aspect of the preventive care requirements is being challenged.

Appeal Rights[16]

There is a new national standard for how internal insurance appeals need to operate. The insurer must provide the consumer with detailed information about the grounds for denying coverage and must make its claim file available to the consumer. The consumer can ask for a formal hearing at which he can present evidence.

Emergency Service[17]

If the plan covers emergency service, no prior authorization can be required.

Primary Care Doctors[18]

Patients can choose their own primary doctors - it can be a pediatrician or ob/gyn.

Community Needs Assessment[19]

For tax years after March 23, 2012, non-profit hospitals are required to complete Community Needs Assessments and make public reports of their plans in response to the assessments.

Accountable Care Organizations[20]

Accountable Care Organizations are new entities which are being formed by alliances of healthcare providers who, in combination, will provide care for a patient population funded by Medicare, with the goal of economizing and sharing the savings with the Accountable Care Organizations. At this point, some 154 have been approved by the government; 4 are in Ohio.

No Medicaid Reimbursement for Nosocomial Infections[21]

Medicare routinely denies payment for certain procedures on the premise that the care should not have been necessary. Now these denials will be extended to Medicaid patients. Specifically to be denied payment are the following types of care:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
6. Manifestations of Poor Glycemic Control
7. Catheter-Associated Urinary Tract Infection
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection
10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)

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Medical Loss Ratio Rebates

To attempt to promote efficiency in health care, the Act generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers. Payments of this nature are already being issued by insurers. Regulations specify how such rebates must be disbursed when received by employers[22].

Provisions just underway:

Explanations of Coverage[23]

Beginning on the first day of the first open enrollment period that begins on or after September 23, 2012, health insurers are required to utilize a 'Uniform Explanation of Coverage[24],' intended to assure 'apples-to-apples' comparisons of coverage across the country.

W-2 Reporting[25]

For employers which issued at least 250 W-2 forms in January, 2012, they are required to issue W-2 forms which report health insurance costs during January, 2013. The reporting includes the full cost of the premiums, regardless of how much is paid by the employer.

$2,500 Limit on Flexible Spending Accounts[26]

Beginning with plan years after January 1, 2013, there is a $2,500 maximum annual limit on employee contributions to health care flexible spending accounts ('FSAs').

Provisions to look for in the future:

Discrimination in Favor of Highly Compensated Employees[27]

Penalties for new plans that discriminate in favor of highly compensated employees have been postponed indefinitely until IRS promulgates new regulations defining the parameters, perhaps during 2013. This has the potential for having serious consequences to an employer who does not comply, since the statutory penalty is $100 per day per employee.

Notice of Health Care Exchange Options

Employers must provide a written notice to newly-hired and current employees informing employees: 1) that health care exchanges are available, the services provided by the exchange, and how to contact the exchange; 2) if the employer pays less than 60% of the costs of benefits, that the employee may be eligible for a premium tax credit and a cost-sharing reduction if the employee purchases health insurance from an exchange; and 3) if the employee purchases health insurance through an exchange, that amount is excludable from the employee's federal income tax liability. This provision was scheduled to begin March 1, 2013. However, there are no regulations in effect; Ohio has decided not to implement an exchange; and the federal exchange is not yet underway. Therefore, employers at this point have nothing to report.

90-Day Limitation on Waiting Periods[28]

In plan years beginning on or after January 1, 2014, a group health plan shall not apply any waiting period that exceeds 90 days.

The Mandatory Coverage Provisions

As the foundation of the new law, beginning in 2014, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. Tax credits to help afford insurance payments will become available for those with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. (400% of the poverty line is roughly $43,000 for an individual or $92,000 for a family of four.)

The employer counter provisions provide that an applicable large employer (for this purpose, an employer with 50 or more full-time equivalent employees [based on 30 hours per week]) could be subject to an assessable payment if any full-time employee is certified to receive one of those applicable premium tax credit or cost-sharing reduction payments. Generally, this may occur where either:

(1) The employer does not offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; or

(2) The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that either is unaffordable relative to an employee's household income or does not provide minimum value.

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If the employer does not offer coverage and at least one employee receives a premium tax credit or cost sharing subsidy on a health insurance exchange (based on having income below 400% of the federal poverty level), the employer will owe a penalty payment in the amount of $2,000 annually for the total number of full time equivalent employees minus thirty.

If the employer offers coverage which does not cover at least 60% of the covered health expenses for a typical person and at least one employee receives a premium tax credit on a health insurance exchange, the employer will owe a penalty payment in the amount of $3,000 for each full time equivalent employee receiving a tax credit up to a maximum amount equal to $2,000 annually for the total number of employees minus thirty [that is, the employer will not be punished more than it would have if it had offered no coverage at all].

If an employer offers coverage for at least 60% of the covered health expenses for a typical person but at least one of its employees is required to pay more than 9.5% of household income for the coverage and at least one employee receives a premium tax credit on a health insurance exchange, the employer owes a penalty payment in the amount of $3,000 for each full time equivalent employee receiving a premium tax credit up to a maximum amount equal to $2,000 annually for the total number of employees minus thirty.

Notwithstanding the Supreme Court's decision last summer concerning the individual mandate, that case did not actually address this employer mandate. However, the employer mandate is the subject of a court challenge filed by Liberty University which neither the District Court, nor the Court of Appeals found viable. In Case No. 11-438, the Supreme Court issued a decision on November 26, 2012, remanding the case back to the Fourth Circuit Court of Appeals for hearing on the merits. That challenge still remains pending at this writing.

Mandatory Enrollment for Large Employers

Rather than a default position of waiting for an employee to take the initiative to enroll in coverage, the federal law provides that employers with more than 200 employees should assume the employee wants coverage and enroll him. The Act has no specific date for compliance; but there have been no regulations issued to direct compliance, and this part of the program has been held in abeyance[29].

Endnotes

1 Guidance describing how the tax credit is calculated is available from IRS in Notice 2010-44, published in Internal Revenue Bulletin 2010-22, June 1, 2010.
2 The Wage & Hour division of the Department of Labor has a Fact Sheet available describing this requirement, available at http://www.dol.gov/whd/regs/compliance/whdfs73.htm.
3 Details about who is eligible and how the program works are available at https://www.ohiohighriskpool.com/global/docs/OHRP%20FAQs%20(Web).pdf
4 45 CFR ß147.108(b)(2).
5 45 CFR ß147.128(a)(1).
6 45 CFR ß147.126(a)(1).
7 45 CFR ß147.126(d).
8 45 CFR ß147.126(d)(3).
9 The waivers are supposed to expire in 2014. These can be tracked at: http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html
10 45 CFR ß147.120.
11 Guidance describing what expenses are allowable is available from IRS in Notice 2010-59, published in Internal Revenue Bulletin 2010-39, September 27, 2010.
12 45 CFR ß147.140(g).
13 Documentation concerning what general healthcare procedures are included within the preventive care requirements is available at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
14 45 CFR ß147.130(a).
15 These suits are being tracked at http://www.becketfund.org/hhsinformationcentral/
16 45 CFR ß147.136.
17 45 CFR ß147.138(b).
18 45 CFR ß147.138(a).
19 Guidance describing the assessment requirements is available from IRS in Notice 2011-52, published in Internal Revenue Bulletin 2011-30, July 25, 2011.
20 42 CFR Part 425.
21 42 CFR ß447.26.
22 Department of Labor Technical Release 2011-04, December 2, 2011.
23 45 CFR ß147.200.
24 The format can be viewed at: http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf.
25 Guidance describing the calculations is available from IRS in Notice 2011-28, published in Internal Revenue Bulletin 2011-16, April 18, 2011.
26 Guidance describing how this applies is available from IRS in Notice 2012-40, published in Internal Revenue Bulletin 2012-26, June 25, 2012.
27 IRS Notice No. 2011-1, published in Internal Revenue Bulletin 2011-2, January 10, 2011.
28 Application of the waiting period limitation is discussed in Department of Labor Technical Release No. 2012-01, February 9, 2012.
29 Department of Labor Technical Release No. 2012-01, February 9, 2012.