July 20, 2010

What Health Care Reform Means for Community Action Agencies

By Brittany Clement, CAPLAW

The recently passed health care reform legislation has wide-ranging implications for consumers, employers, insurers, and government at every level. This article summarizes the most important changes for community action agencies and their clients and when those changes go into effect. For more information, view CAPLAW's health care reform timeline and links to outside resources on CAPLAW's health care reform page.

Health care reform is groundbreaking in several ways. First, it creates an individual mandate whereby individuals are required to have health insurance or pay an annual fee. Second, employers will face new requirements, such as offering coverage or paying a fee, automatically enrolling new employees into health plans, and including the cost of health care on employees' W-2 forms. Third, it establishes new insurance mandates, such as coverage of adult children up to age 26, abolition of lifetime and annual dollar limits, and mandatory inclusion of those with pre-existing conditions. Additionally, health care reform impacts public programs such as Medicare and Medicaid, and requires states to set up health insurance exchanges where individuals and small businesses may purchase insurance in a centralized location.

To fully understand how these provisions apply to specific health plans, employers and insurers must determine whether their plans are grandfathered or non-grandfathered. Grandfathered plans are health plans in existence on March 23, 2010, the date when health care legislation was enacted. Non-grandfathered plans are plans enacted after March 23, 2010, or plans that implemented certain modifications following the legislation's enactment.

Renewing a plan, adding family members to a plan, or adding additional employees to a plan will not affect its grandfathered status. Plans will lose grandfathered status by eliminating all or substantially all benefits to diagnose or treat a particular condition; increasing participants' coinsurance by any amount; increasing deductibles by more than medical inflation plus 15 percentage points; increasing copayments by the greater of $5, as adjusted for inflation, or medical inflation plus 15 percentage points; decreasing the employer's contribution toward the cost of coverage by more than 5 percent of the contribution rate in effect on March 23, 2010; or making certain adverse changes to lifetime and annual benefit limits.

The following new insurance mandates, unless otherwise noted, apply to both grandfathered and non-grandfathered plans, and take effect at the beginning of the first plan year after September 23, 2010. For many employers and insurers, this will be January 1, 2011:

- Private insurers that provide dependent coverage of children must provide coverage to adult children until the children turn 26 years old, regardless of marital or student status. From the beginning of the 2011 plan year through the 2013 plan year, grandfathered group health plans may deny coverage to dependent children under age 26 who are eligible for health insurance from another employer.

- Insurers may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary. From the beginning of the 2011 plan year through the 2013 plan year, insurers may not establish annual limits less than $750,000 for the 2011 plan year, $1.25 million for the 2012 plan year, and $2 million for the 2013 plan year. Beginning in 2014, insurers may not establish annual limits on the dollar value of benefits at all.

- Insurers may not deny coverage to children under the age of 19 with a pre-existing condition. Starting in 2014, insurers may not deny coverage to any U.S. citizen or legal resident with a pre-existing condition.

- Insurers may only rescind health plans in cases of fraud or intentional misrepresentation of material fact, and must provide 30 days notice before rescinding coverage.

The following new insurance mandates also take effect in the first plan year after September 23, 2010, and apply only to non-grandfathered plans:

- Plans may not discriminate in favor of highly paid employees, such as offering plans to executive staff only.

- Plans must provide an external appeal process for denied claims.

- Plans must provide 100 percent coverage of preventive care, such as immunizations and certain screenings.

- Plans that provide emergency services may not impose cost-sharing requirements for out-of-network emergency services that exceed in-network cost sharing.

- Plans must provide participants greater freedom in designating primary care providers. This includes designating pediatricians as primary care providers for children and granting women access to obstetricians and gynecologists without a referral.

Reforms that go into effect on January 1, 2011, include:

- Employers must include the cost of health insurance on employees' W-2 forms. This provision applies to 2011 W-2s that must be distributed to employees by January 31, 2012.

- Employees who contribute to health reimbursement arrangements or flexible spending accounts may not receive reimbursements for purchasing over-the-counter drugs through these accounts. Employees who contribute to health savings accounts or Archer medical savings accounts may no longer receive tax-free reimbursements on over-the-counter drugs. Employees must use such accounts to purchase prescription drugs and insulin only.

Many of the biggest reforms go into effect on January 1, 2014. These include the individual mandate, employer penalties for failing to provide affordable health insurance, and the state-run health care exchanges.

The individual mandate will require individuals to maintain health care coverage for themselves and their dependents. Failure to maintain health insurance will result in an annual tax penalty. In 2014, this penalty will be the greater of 1 percent of taxable household income, or $95 per adult without coverage and $47.50 per child under 18 without coverage, up to a maximum penalty of $285 per family. In 2016, this penalty will increase to the greater of 2.5 percent of taxable household income, or $695 per adult without coverage and $347.50 per child under 18 without coverage, up to a maximum of $2,085 for a family.

Employers with 50 or more employees must offer affordable health insurance comparable to plans offered in an exchange or pay an annual fee. If such an employer does not offer health insurance to its employees and at least one full-time employee receives a premium tax credit in an exchange, the employer must pay $2,000 a year for each of its full-time employees, excluding the first 30 full-time employees. If an employer offers a health care plan but an employee's premium contribution exceeds 9.5 percent of the employee's income, the employer must pay the lesser of $3,000 a year for each employee receiving a tax credit through the exchange or $2,000 a year for each of its full-time employees, excluding the first 30 full-time employees.

The state exchanges will centralize the purchase of health plans for individuals and small businesses. Individuals who purchase insurance through an exchange may receive a premium tax credit to lower the cost of insurance if their household income does not exceed 400 percent of the federal poverty line ($43,320 for individuals and $88,200 for families of four). Exchanges will offer varying levels of coverage, with the lowest level covering at least 60 percent of benefit costs for all enrollees.

Additional insurance mandates also go into effect in 2014. These include:

- Employers and health insurance issuers may not apply waiting periods to begin coverage exceeding 90 days.
- Insurers must remove all annual limits on essential benefits.
- Insurers must remove all limits on individuals with pre-existing conditions.
- Insurers may not vary premium rates based on factors other than age, premium rating area, family composition, and tobacco use.

Health care reform also affects public programs, including Medicaid and Medicare. Individuals at or below 133 percent of the federal poverty line, including adults without dependent children, will now be eligible for Medicaid. States must expand Medicaid eligibility on January 1, 2014, but may do so before this date. For Medicare recipients, health care reform will gradually close the gap in prescription-drug coverage known as the "donut hole." Currently, individuals on Medicare must pay all drug costs, which could reach $3,610, after reaching their annual limit and before reaching catastrophic coverage. In 2010, individuals who reach the donut hole will receive a $250 rebate. Between 2011 and 2020, Medicare recipients will receive gradual discounts on prescription-drug costs while in the "donut hole" until it is closed.

CAPLAW will continue to provide health care reform information as more federal agencies issue guidance and effective dates of provisions draw nearer. Stay tuned to CAPLAW's health care reform page.