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ObamaCare ...What's Coming

Over the past few years, I've spent a lot of time analyzing and discussing the federal Patient Protection and Affordable Care Act ("PPACA"). Of course, many of us, including the President himself, simply refer to the law and its pervasive reach as "ObamaCare." In this article, I'll use both terms interchangeably.

Until now, only the less intrusive and relatively inexpensive parts of the law have been implemented. In 2014, the rubber will really hit the road! That's when the bulk of the law is slated for implementation, and that's when employers and individuals will need to hold on to their hats!

For better or worse, here's a list of the changes that are scheduled to be implemented in the coming year. This article should not be construed as offering legal advice or guidance; rather it is a quick and dirty summary of many complex components of the law. It is intended to encourage additional inquiry and analysis, rather than provide definitive answers to complicated questions raised by this extraordinarily convoluted law.

- **Employer "play" or "pay" penalty tax:** Employers that employed an average of at least 50 full-time employees ("FTE") on business days during the preceding calendar year must offer "affordable minimum essential coverage" to employees and their dependents, or pay a penalty tax. Generally, an FTE is an employee who averaged at least 30 hours of service per week. If the employer doesn't offer any coverage, the employer will pay a penalty tax of $166.67 per employee per month ($2,000 per year); however, the first 30 FTEs are exempt from the calculation of the penalty. If the employer offers coverage, but the coverage isn't deemed "affordable" or it doesn't qualify as "minimum essential coverage," the employer will pay a penalty of $250 per employee per month ($3,000 per year), for any employee who receives premium tax credits. In both instances, the key to triggering the penalty is that at least one FTE must enroll in a Qualified Health Plan ("QHP") on the insurance exchange (discussed below), and receive a premium tax credit or a cost-sharing reduction.
- **Individual mandate:** Most taxpayers will be assessed a penalty for any month during which they (or their spouse or dependents) lack "minimum essential coverage." The exact amount of the penalty will depend on the taxpayer's specific household income, and it will be the greater of a flat dollar amount or a percentage of income amount ($95 or 1% in 2014; $325 or 2% in 2015; and $695 or 2.5% in 2016 and thereafter). The penalty will be calculated monthly, and it will generally be assessed for each individual, spouse and dependent without coverage.
- **Individual and Small Business Health Options Program ("SHOP") Exchanges:** Health insurance marketplaces run by the government will serve as a vehicle for insurance companies to offer QHPs to individuals and employees of small employers (*i.e.*, employers with 100 or fewer employees). Individuals who are eligible for a premium tax credit or a cost-sharing reduction subsidy must purchase their health insurance through an Exchange in order to receive the credit or subsidy.
- **Preexisting condition exclusions are prohibited:** Health plans and insurers will be entirely prohibited from excluding coverage for preexisting conditions, and they will be required to eliminate any preexisting condition restrictions to plan entry. (Note: These preexisting condition prohibitions were applied to children up to age 19 beginning in 2010.)
- **Employer waiting periods cannot exceed 90 days:** Group health plans and insurers will be prohibited from applying a waiting period of more than 90 days. This requirement applies to grandfathered and non-grandfathered plans. (Note: "Grandfathered plans" are plans that were in existence on March 23, 2010, and that have not been modified except for minor changes allowed under PPACA.)
- **Guaranteed availability and guaranteed renewability of coverage:** Health insurers that offer individual or group insurance are required to accept every employer and individual that applies for coverage. Grandfathered plans are exempt from this requirement.
- **Fair health insurance premiums:** Insurers in the individual and small employer markets can only vary premium rates with respect to a particular plan or coverage based on the following four factors: (1) coverage category (*e.g.*, individual versus family coverage); (2) geographic rating area; (3) age (but not more than a 3:1 ratio); and (4) tobacco use (but not more than a 1.5:1 ratio). Grandfathered plans are exempt from this requirement.

Down the Pike in 2014?

- **Nondiscrimination against individuals for health-status related factors:** Group health plans and health insurers are prohibited from discriminating against an individual with regard to eligibility or coverage based on a health-status related factor. In other words, healthy and unhealthy individuals of similar ages must be charged the same premium (subject to the aforementioned four permissible rating factors). Grandfathered plans are exempt from this requirement.
- **Essential health benefits:** Health insurers in the individual and small group market must ensure the policies include coverage for "essential health benefits," and must limit cost sharing. The essential health benefits package must include coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services (*e.g.*, pediatric dental care and vision services). Grandfathered plans are exempt from this requirement.
- **Annual and lifetime limits are prohibited:** Annual and lifetime dollar limits will no longer be allowed on "essential health benefits." Although this requirement is limited to "essential health benefits," it virtually eviscerates annual and lifetime limits altogether because the overwhelming majority of medical care will qualify as "essential."
- **Cost-sharing limits:** Group health plans (including self-insured plans) are required to limit the amount members pay for deductibles, co-insurance, co-payments, out-of-pocket amounts, and similar charges. Under this provision of PPACA, annual deductibles cannot exceed $2,000 for an individual and $4,000 for two-party or family coverage. Likewise, out-of-pocket maximums cannot exceed $6,250 for individuals and $12,500 for two-party or family coverage. (Note: These OOP amounts are subject to an inflationary adjustment for 2014.) Cost sharing does not include premiums, balance billed amounts for non-network providers, or amounts paid for non-covered items and services. Grandfathered plans (and possibly non-grandfathered large group health plans) are exempt from this requirement.
- **Annual fee on health insurers:** Starting in 2014, "covered entities" engaged in the business of providing health insurance will be required to pay an annual fee. Although the amount of the fee has not yet been determined, we do know the total assessment will need to generate $8 billion in 2014. That amount will increase every year, and it will most assuredly be passed along to employers and insured individuals. Self-insured plans are exempt from this requirement, but fully-insured plans (including grandfathered plans) are not.
- **Reinsurance Payments:** From 2014 through 2016, all fully-insured and self-funded plans will be assessed a fee of $63 per covered life per year. (Note: The term "covered life" includes dependents as well as employees.) The stated purpose of these payments is to help reduce the uncertainty of insurance risk in the individual market by partially offsetting the influx of high-cost individuals that will be moving into the private individual health insurance market.
- **Automatic Enrollment:** Certain large employers with more than 200 FTEs will be required to automatically enroll new full-time employees in one of the employer's health benefit plans (subject to any allowable waiting period). Affected employers should note that this requirement might be postponed until after 2014.
- **Clinical Trial Coverage:** Group health plans, which include self-funded plans, must provide coverage to individuals who are participating in approved clinical trials. Grandfathered plans are exempt from this requirement.
- **Non-discrimination against health care providers:** Group health plans and insurers cannot discriminate against health care providers acting within the scope of their professional license. Grandfathered plans are exempt from this requirement.
- **W-2 Reporting of Health Insurance Coverage:** Employers must determine the cost of applicable employer-sponsored coverage that is provided to each employee, and report that cost on each employee's Form W-2. Currently, employers that filed fewer than 250 Forms W-2 for the preceding calendar year are exempt from this requirement.

  Because of PPACA's overwhelming complexity and the mountain of regulations interpreting the law that have been (and are yet to be) issued, I would recommend that employers carefully monitor the law before taking action or making decisions, and that they maintain grandfather status if possible.

As Always ...

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