

“What keeps you up at night?”

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Issues and impacts – What’s to come now that federal health care reform has been signed into law

By Laura L. Katz and Daniel D. Santos

SUMMARY

Last month, President Obama signed into law a comprehensive health care reform package that will have a substantial impact on the insurance industry, both in the short and long term.

OVERVIEW

After a grueling and unpredictable year-long struggle to pass comprehensive health care reform, the Obama administration and Congressional Democrats have succeeded in enacting the most significant piece of domestic policy in decades. On March 23, 2010, President Obama signed into law the Senate’s version of health care reform, H.R. 3590, the Patient Protection and Affordable Care Act (“PPACA”). On March 30, 2010, the President signed into law a companion bill to PPACA, H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (“HCERA,” HCERA and PPACA are collectively referred to at times as PPACA). As a House reconciliation measure, HCERA was designed to make certain changes to PPACA so that the overall reform package could be passed by the Congress. Neither PPACA nor HCERA received any Republican votes in favor of the legislation.

BASIC APPROACH

When President Obama took office in 2009, he established comprehensive health care reform as one of his primary domestic initiatives. With approximately 43 million individuals uninsured in the U.S., the President and Congressional Democrats set out to reform the health care system in a manner that would satisfy the following eight key objectives:

- guarantee consumer choice
- make coverage affordable
- protect families
- invest in prevention/wellness
- provide for portability

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- aim for universal coverage
- improve patient safety/quality of care
- long term fiscal sustainability

The PPACA's approach to reform is broad based, and includes a significant expansion of public health insurance programs including Medicaid and the Children's Health Insurance Program. PPACA mandates that most U.S. citizens and legal residents have health insurance. The new law also creates state-based health insurance exchanges through which individuals and small businesses can purchase coverage. Premium and cost-sharing credits will be available for individuals and families with income between 133 to 400 percent of the federal poverty level (“FPL”). Employers with more than 50 employees will be required to provide health insurance to their employees, or pay a penalty for full-time employees who receive tax credits for coverage through an exchange. The penalty is \$2,000 per year for each full-time employee over the first 30 employees, as long as at least one employee receives a tax credit. In addition, employers with more than 50 employees that offer coverage, but have at least one full-time employee receiving a premium tax credit, will have to pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Employers with more than 200 employees will be required to automatically enroll employees into health plans offered by the employer, but employees will have the option to opt out of coverage. The PPACA also imposes a number of new insurance market reforms on plans that offer coverage through an exchange, or in the individual or small group markets.

The Congressional Budget Office (“CBO”) estimates that PPACA will provide coverage to 32 million more people, resulting in more than 94 percent of Americans with health insurance. The CBO also expects the cost of PPACA to be \$938 billion over ten years. The costs of PPACA will be financed through a combination of savings from Medicare and Medicaid, along with the addition of various new taxes and fees. In all, the CBO anticipates that PPACA will reduce the federal budget deficit by \$143 billion over the next ten years.

MULTI-YEAR IMPLEMENTATION

Although PPACA is now the law of the land, implementation of comprehensive reform will not happen quickly, as the measures are designed to be phased in over the course of the next eight years

and beyond. Many of the most significant pieces of reform will not become effective until 2014. For example, the state health insurance exchanges will not become operational until January 1, 2014. The individual mandate to obtain health insurance, and the employer mandate to offer health insurance each do not become effective until 2014. Many important insurance regulatory requirements also do not become effective until 2014, including: a ban on insurers engaging in discriminatory practices allowing them to refuse to sell or renew policies due to an individual's health status; a prohibition on insurers excluding coverage for treatments based on pre-existing health conditions (becomes effective for children in 2010 as described below); and restrictions on the ability of insurers to charge higher premiums due to health status, gender or other factors. Increased access to Medicaid will also not occur until 2014, when Medicaid eligibility will be expanded to include all individuals under age 65 with incomes up to 133 percent of FPL.

Beyond 2014, states will be permitted to enter into health care choice compacts, under which one or more health insurers will be able to offer coverage in all states in a compact, but only be subject to the laws of the state where a particular policy is issued, subject to certain exceptions. Compacts may not go into effect before January 2016. However, by July 2013, the Secretary of the Department of Health and Human Services (“Secretary”), in consultation with the National Association of Insurance Commissioners, must issue regulations governing the compacts. Finally, the excise tax on health insurers issuing high-cost employer-sponsored coverage (*i.e.*, Cadillac plans) does not go into effect until January 2018.

IMMEDIATE IMPACTS

While many of the reforms will not occur for several years, some will become effective almost immediately upon enactment of PPACA. Highlighted below are some of the reforms of relevance to the insurance industry that will go into effect this year.

2010

- **Medical Loss Ratios.** Starting with plan year 2010, health insurers are required to report the ratio of premium dollars spent on clinical services, quality and other costs, and provide rebates to consumers for the amount of premiums spent on clinical services and

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quality that is less than 85 percent in the large group market, and 80 percent in the individual and small group markets.

- Beginning with tax year 2010, nonprofit Blue Cross Blue Shield plans must have a medical loss ratio of 85 percent or higher in order to benefit from the special tax treatment given to them under Section 833 of the Internal Revenue Code. This includes the deduction for 25 percent of claims and expenses, and the 100 percent deduction for unearned premium reserves.
- **Small Business Tax Credits.** The first phase of the small business tax credit for qualified small employers to make contributions to purchase health insurance for their employees begins in tax year 2010 (through 2013). A qualified small employer is one with 25 employees or less, and average annual wages of less than \$50,000. The credit phases out as firm size and average wage increases. The credit is up to 35 percent of the employer’s contribution. Small nonprofit organizations are eligible for up to a 25 percent credit.
 - The second phase of the small business tax credit becomes effective in tax year 2014 and later. The tax credit is for small businesses that purchase coverage through a health insurance exchange, and provides a credit of up to 50 percent if the employer contributes at least 50 percent of the total premium cost. Small nonprofit organizations are eligible for credits of up to 35 percent of the employer’s contribution.
- **Temporary High-Risk Pool.** Effective within 90 days of enactment of the PPACA, the Secretary must create a temporary national high-risk pool to provide insurance to individuals (U.S. citizens and legal immigrants) who have been uninsured for at least six months, and have a pre-existing medical condition. The program terminates in 2014 when the health insurance exchanges become operational.
- **Temporary Reinsurance Program.** Within 90 days of enactment of PPACA, the Secretary must establish a temporary reinsurance program for employers providing health insurance to retirees over age 55 who are not eligible for Medicare. The program will provide reimbursement to plans for 80 percent of retiree claims between \$15,000 and \$90,000. Plans are required to use the payments to lower costs for enrollees and the plan. The program expires in 2014.
- **Prohibiting Rescissions.** Insurers are prohibited from rescinding individual and group health coverage, except in cases of fraud or intentional misrepresentation. The prohibition becomes effective six months following enactment of PPACA.
- **Eliminates Lifetime Limits.** Prohibits individual and group health plans from placing lifetime limits on the dollar value of benefits for any insured. The prohibition becomes effective six months following enactment of PPACA. Grandfathered existing plans are required to eliminate lifetime limits by 2014.
- **Restriction on Annual Limits.** Beginning six months after enactment of PPACA, individual and group health plans will be restricted in their use of annual limits on the dollar value of benefits for insureds, as determined by the Secretary. Starting in 2014, individual and group plans will be prohibited from imposing annual limits.
- **Coverage of Preventive Health Services.** Individual and group health plans are required to provide first dollar coverage (*i.e.*, no cost-sharing) for preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention. The requirement becomes effective six months following enactment of PPACA.
- **Extended Dependent Coverage.** Individual and group health plans that provide dependent coverage for children must continue to make coverage available through age 26. The requirement becomes effective six months following enactment of PPACA.
- **Eliminates Pre-Existing Condition Exclusions for Children.** Beginning six months following enactment of PPACA, insurers will be prohibited from imposing pre-existing condition exclusions on children’s coverage.
- **Rate Increase Reviews.** Beginning with plan year 2010, the Secretary and the states must establish a process for reviewing increases in health insurance

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premiums, and require that plans justify increases. States shall report to the Secretary concerning trends in premium increases, and make recommendations to health insurance exchanges about whether a certain plan should be excluded from an exchange based upon an unjustified premium increase. States will be eligible for federal grants to support states' efforts to review and approve rate increases.

CHALLENGES TO COME

Although Congress began a two-week recess as soon as it passed health care reform, Congressional members from both parties have wasted no time in hitting the campaign trail to either defend or attack the new law. Given the bitter partisan debate in Congress and the sharp divide among Americans concerning health care reform, PPACA will undoubtedly face many challenges on its road to implementation. For example, between now and November's mid-term elections, Republican leaders have vowed to campaign to repeal and replace PPACA. In addition, 14 state attorneys general have joined in a lawsuit against the federal government challenging the constitutionality of PPACA, in particular the mandate that individuals must have health insurance or pay a fine. (Thirteen of the state attorneys general are Republicans, and the 14th (Louisiana) joined at the request of his Republican governor, Bobby Jindal.) Meanwhile, four Democratic governors (Colorado, Michigan, Pennsylvania, and Washington) have sent a letter to U.S. Attorney General Eric Holder stating that they oppose the lawsuit their attorneys general have filed challenging health reform. Moreover, the Democratic attorneys general of Nevada and Arizona have each resisted requests from their respective Republican governors to join the 14 other states in their constitutional challenge.

Utah is also considering whether to file a separate lawsuit that would challenge the constitutionality of the federal mandate that requires states to create health insurance exchanges. Utah is one of two states that already has an exchange. Virginia's Republican governor, Bob McDonnell, just signed into law a measure that directly conflicts with PPACA. The new Virginia law states that no Virginia resident shall be required to obtain or maintain a policy of individual insurance coverage, except as required by a court or the Virginia Department of Social Services.

Meanwhile, Congressional Democrats have become concerned about allegations from a handful of America's largest corporations, in which they claim that the new health reform law will have an adverse affect on their ability to provide employee health benefits. Rep. Henry Waxman (D-Calif.), Chairman of the House Committee on Energy and Commerce, has scheduled an investigative subcommittee hearing for April 21 to hear from companies regarding their assertions that the new law will cost them significant amounts in additional health insurance expenses.

Finally, PPACA implementation will be an enormous task for the federal agencies charged with overseeing these efforts, which include the Internal Revenue Service, the Department of Labor's Employee Benefits Security Administration, and the Department of Health and Human Services. If past experience is any indicator, it will likely be years before regulations implementing PPACA are fully promulgated.

WRAP-UP

Given the massive scope of the PPACA, this Alert is intended as an introductory publication addressing the high points of the new law as it pertains to the insurance industry, and to highlight some of the key provisions that will become effective in the near term. In the coming months, we anticipate publishing additional Alerts that will focus on issues pertaining to specific subgroups within the insurance industry, such as Medicare and Medicaid plans, long-term care providers, insurance producers, third-party administrators, and others. In the meantime, we will continue to study this new law and surrounding developments, and will provide you with relevant updates as they play out over the months and years to come.

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