Health Care Reform 101

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (Affordable Care Act), changing private and public health insurance in the United States. The U.S. Supreme Court will be ruling on the constitutionality of the Affordable Care Act in late June. The Court’s decision will have a major impact on the health care industry over the next decade.

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Though the Affordable Care Act significantly changed many aspects of the private and public health insurance markets, the law affects employers in three substantial ways.

The Employer Mandate
The law requires all large employers (those with 50 or more full-time employees) to provide minimum essential coverage to their employees or pay a “free rider” penalty if an employee(s) receives a federal subsidy to purchase health insurance through a state Exchange. Under two penalty structures, the “free rider” penalty amount depends on whether the employer offers health coverage or if the group plan is considered “unaffordable” for the employee and does not meet a certain actuarial value. If an employer does not offer coverage, the penalty could cost employers $2,000 times the total number of full-time employees, minus the first 30 employees. If an employer offers coverage that is unaffordable, the penalty could cost employers $3,000 per employee that receives a federal subsidy.

The Individual Mandate
The Affordable Care Act requires that all individuals – with a few exceptions – purchase minimum essential coverage or pay a penalty starting in 2014. Employer group plans, individual coverage, grandfathered plans* and federal programs – such as Medicare and Medicaid – each satisfy the individual mandate. If an individual doesn’t maintain coverage, however, the penalty amount equals whichever is higher: a flat dollar amount (increasing in value from $95 in 2014 to $695 in 2016) to a percentage of income (1% in 2014 to 2.5% in 2016).

Health Insurance Exchanges
In 2014, the Affordable Care Act will require states to create state health insurance Exchanges – marketplaces where individuals and small businesses can purchase health insurance coverage. The state Exchanges must offer four levels of coverage based on actuarial value (the percentage of covered expenses paid by the plan): Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%). In addition, for people 30 years or younger, state Exchanges must offer a lower cost catastrophic coverage health plan, including preventive benefits. In 2017, states will have the discretion to allow large employers (those with 100 or more employees) to participate in a state Exchange.

* A grandfathered plan is a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers.
In addition to the three key elements above, the Affordable Care Act required employer group health plans and health insurance issuers, including grandfathered* group health plans, to make a variety of changes in 2010 including:

- Covering adult children up to age 26 in a parent’s plan
- Eliminating preexisting conditions exclusion for enrollees under age 19
- Prohibiting lifetime limits and restricting annual dollar limits (annual dollar limits prohibited in 2014)
- Requiring preventive care coverage with no cost sharing
- Requiring a minimum loss ratio of 85% for large fully insured plans
- Barring rescissions of health insurance coverage

The U.S. Supreme Court Ruling
In November 2011, the U.S. Supreme Court agreed to hear oral arguments on four issues. These arguments included:

1. Whether requiring individuals to purchase health insurance is constitutional
2. Whether the individual mandate can be separated from the rest of the law, if it is found to be unconstitutional
3. Whether the Court can rule on a tax that no one has paid yet, and
4. Whether the Federal government can require states to expand their Medicaid programs.

The U.S. Supreme Court heard arguments in late March and is expected to issue a final ruling in late June. This ruling will be significant for the future of health care in the U.S. Our clients will need our help to navigate their response to the Supreme Court decision, both to remain compliant and also to ensure their employees have the coverage they need.