Legal Q&A
By Cori Eggeling, TML Law Clerk

The federal Patient Protection and Affordable Care Act (sometimes referred to as "health reform" and/or "Obamacare") has been the subject of much discussion in recent times. The legislation is lengthy and complex, and much misinformation and political controversy has surrounded its passage. With this Q&A, the League has attempted to describe generally what the Act does as concisely as possible, with no political bent whatsoever.

What is the federal Patient Protection and Affordable Care Act?

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Act). The law enacts various health coverage reforms, most of which will be implemented by 2014. The stated purposes of the Act are:

1. To decrease the cost of health care in the United States.
2. To improve the quality of health care in the United States.
3. To make health care more accessible in the United States, particularly to the currently uninsured.

The Act is supposed to both decrease health costs and improve accessibility to health care by incentivizing every person in the United States to have health coverage and providing programs to make that happen. The logic behind the Act's reforms is that, if every person has health insurance:

1. The cost of health care will go down because health care providers (and therefore insurance companies) will no longer be required to bear the cost of providing care to the uninsured.
2. Health care will be more accessible because individuals will no longer be denied care based on their inability to pay.

How does the Act ensure that each person will be covered by insurance?

The Act implements new programs and regulations to ensure that every person has coverage. The major programs and regulations include: (1) the mandatory creation of health benefit exchanges; (2) coverage for pre-existing conditions; (3) extended young adult coverage; (4) the use of consumer operated and oriented plans to provide coverage; (5) improved incentives for small businesses to provide health coverage to their employees; and (6) an expansion of Medicaid. A brief overview of each program follows.

- **Health Benefit Exchanges**
  The Act requires individual states to develop their own system of "health benefit exchanges." [If a state opts out of establishing its own exchange(s), the federal government will implement an exchange program in that state.] Exchanges are

organizations (either governmental or non-profit) that will be established to develop a more organized, efficient, and competitive market for buying health insurance.

Exchanges will be available for both individuals and small-businesses (those with up to 100 employees) as a tool to compare rates and benefits, and to better inform consumers of the plans available to them from both public and private providers. They will also help individuals determine which additional services they are eligible for, such as tax credits, expanded Medicaid coverage, and government programs like the Children's Health Insurance Program.

Beginning in 2014, exchanges will essentially be a "database" to help individuals and small businesses obtain coverage. Insurance and other providers will choose to participate in exchanges, and consumers will have access to all of the providers' plan information and costs in a standardized format. Consumers can then ask questions, choose the plan that is best for them, and enroll in that plan, all through the exchange.

- **Pre-Existing Conditions**
  The Act's pre-existing condition prohibition will make health care available to uninsured individuals who have been denied health insurance due to a pre-existing condition.

  The Act currently prohibits individual providers from discriminating against children with pre-existing conditions. For adults, pre-existing condition insurance plans are available from the government, and such plans will remain available until 2014. At that time, all providers will be prohibited from discriminating against all consumers with pre-existing conditions.

- **Young Adult Coverage**
  The Act mandates that children be allowed to stay on a parent's health care plan until the age of 26. Factors such as being married, not living with their parents, attending school, not being financially dependent on their parents, or being eligible to enroll in their employer's plan will not affect children's eligibility.

- **Co-ops**
  Consumer operated and oriented plans (co-ops) are private, non-profit organizations that will be established to sell insurance according to the same rules as other health coverage providers. What may make co-ops different from other providers is that they will be run by their customers. In theory, this means that the needs and concerns of customers are a co-op's top priority. Within co-ops, members elect a board of directors, which must be composed primarily of individuals who are customers enrolled in the co-op plan.

  Because co-ops will be non-profit, any profits are required to be used to lower premiums, improve the quality of health care, increase health benefits, contribute to the stability of coverage for members, and/or expand enrollment. Few specifics of how co-ops will operate are currently available.

- **Improved Options for Small Businesses**

The Act provides that small businesses with up to 25 employees that pay average annual wages below $50,000 and provide health coverage, may qualify for a small business tax credit of up to 35 percent (up to 25 percent for non-profits) to offset the cost of providing coverage.

Additionally, most small businesses with fewer than 100 employees can shop for insurance in the state exchanges, which are predicted to provide more choices and lower prices. Employers with fewer than 50 employees are exempt from "new employer responsibility policies." These policies will require, among other things, that employers with 50 or more employees who work at least 30 hours per week must provide their employees insurance or be subject to certain penalties.

Also, employers with fewer than 50 employees don't have to pay a penalty if their employees get tax credits through an exchange.

- **Expansion of Medicaid**
  Medicaid is a joint federal-state program in which each state operates its own Medicaid system that must conform to federal guidelines in order for the state to receive matching funds and grants. In Texas, Medicaid costs account for more than 20 percent of the state's budget. Medicaid eligibility has been based on categories, such as pregnant women, children, parents, seniors, and people with disabilities.

  The Act expands the eligibility criteria and also offers more federal dollars to states to help fund Medicaid programs. Prior to the Act, the federal government generally set minimum income eligibility thresholds for each category, and states had flexibility to expand beyond these minimums.

  In January 2009, median eligibility levels for children were at about 235 percent of the poverty level, but eligibility for parents was much more restrictive. The Act creates a national floor of coverage at 133 percent of poverty (around $14,000 for an individual and $29,000 for a family of 4) for all individuals. This will mean a large expansion in Medicaid coverage for parents and adults without dependent children in many states. Medicaid services will be made available through the state exchanges. In July 2012, Governor Rick Perry—along with several other Republican governors—announced that he does not intend to allow the expansion of Medicaid in Texas.

  The federal government will fully fund the costs for those who become eligible for coverage in 2014. Full federal funding will continue until 2016, after which the federal portion will decrease to around 90 percent by 2020.

Which of the Act's reforms were immediate, and which will be phased in over time?

The following provisions are examples of reforms that were immediate upon the Act's passage:

- Eliminating the lifetime dollar limit on benefits that some plans had in place, with some exceptions.

- Requiring insurers offering group or individual coverage to provide a report on the ratio of incurred losses or incurred claims to premiums. Beginning in 2011, the Act requires rebates to covered persons if spending on health care after accounting for taxes, fees (and after January 1, 2014, for risk adjustment, risk corridor payments, and reinsurance payments) is less than 85 percent in the large group market and 80 percent in the case of insured plans in the individual and small group markets.
- Requiring insurers and group health plans to cover certain preventive screening services and immunizations recommended for infants, children, and adolescents.
- Requiring insurers and group health plans to maintain current standards for breast cancer screening.
- Requiring health insurance issuers that offer group or individual coverage, as well as group health plans that provide coverage to dependents, to provide coverage for dependent children who are under age 26.
- Prohibiting group health plans and health insurance issuers offering group or individual coverage from imposing pre-existing condition exclusions on children under the age of 19.
- Prohibiting rescission or cancellation of coverage, with certain exceptions.
- Beginning in the 2010 plan year, requiring the federal government—in conjunction with the states—to have a process for annual review of premium rate increases for insurers offering group or individual coverage in order to identify "unreasonable increases in premiums for health insurance coverage." The Act also requires the disclosure of information related to rate increases along with justifications on providers' Internet Web sites.

The following provisions are examples of reforms that will be phased in on January 1, 2014:

- **Health Insurance Exchanges**: Starting in 2014, consumers will be able to buy health coverage directly through state exchanges, which will offer a choice of health plans that meet certain benefits and cost standards.
- **Individual Requirement to Have Insurance**: Most individuals who can afford it will be required to obtain basic health insurance coverage or pay a penalty to help offset the costs of caring for the uninsured.
- **Tax Credits**: Tax credits will become available for those with income between 100 percent and 400 percent of the poverty line who are not eligible for other affordable coverage. (In 2010, 400 percent of the poverty line is around $43,000 for an individual or $88,000 for a family of four.)
- **Annual Limits on Insurance Coverage**: New and existing plans will be prohibited from imposing annual dollar limits on the amount of coverage an individual may receive.
- **Small Business Health Insurance Tax Credit**: Small business tax credits will begin, in which the credit may be up to 50 percent of the employer's contribution to provide coverage for employees.
- **Discrimination Due to Pre-Existing Conditions or Gender**: Insurance providers will be prohibited from refusing to sell coverage or renew policies because of any individual's pre-existing conditions. Also, in the individual and small group market, the Act will eliminate the ability of insurance companies to charge higher rates due to gender or health status.

Does the Act impose a penalty on a person who does not have health insurance coverage?

According to a recent U.S. Supreme Court decision (discussed below), the Act does not impose a "penalty" for failure to maintain coverage. Rather, the Court concludes that the Act imposes a "tax to encourage certain behaviors." Beginning on January 1, 2014, a fee will be assessed on most individuals who do not obtain health coverage. This tax is called the "shared responsibility payment" and is frequently referred to as the "individual mandate" to buy coverage.

The Internal Revenue Service (IRS) will send a notification by June 30 of each year to such individuals. The notification will provide information on how to obtain coverage and how to enroll through a person's state insurance exchange. Upon receiving the notification, individuals who refuse to obtain health coverage will be taxed unless they meet certain exemption criteria.

The Act may exempt an individual from the requirement to obtain coverage or pay the tax if, among other things, the person:

- Would have to pay more than eight percent of his or her income for health insurance.
- Has income below the threshold required for filing income taxes.
- Qualifies for certain religious exemptions.
- Is an undocumented immigrant.
- Is incarcerated.
- Is a member of an Indian tribe.
- Has a single gap in coverage lasting less than three months in a year.

What will be the amount of the tax on individuals who refuse to obtain coverage?

The total penalty for the taxable year will not exceed the national average of the annual premiums of a bronze level health plan offered by state exchanges. (Note: Coverage in state exchanges will be offered at four levels with complex actuarial values that are based on the amount the provider pays. For example, bronze plan coverage will generally be paid at 60 percent; silver at 70 percent; gold at 80 percent; and platinum at 90 percent.)

The amount of the penalty is determined using the greater of two amounts: a specified percentage of income or a specified dollar amount.

The percentage of income will be phased in over time starting at one percent in 2014. In 2015, it will increase to two percent. In 2016 and beyond, it will increase to two-and-a-half percent and higher.

The dollar amount will be phased in over time as well, starting in 2014 as $95 per adult, and $47.50 per child (up to $285 for a family). In 2015, it will increase to $325 per adult and $162.50 per child (up to $975 for a family). In 2016, it will increase to $695 per adult and $347.50 per child (up to $2,085 for a family). In years following 2016, it will increase annually according to the cost of living.

Will there be a tax on an employer, including a city, that refuses to provide coverage to its employees?

The Act does not mandate that employers provide health coverage. However, it may impose taxes in certain cases on those with 50 or more employees that refuse to do so. Employers with fewer than 50 employees are not subject to a tax if the tax would "impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business."

Larger employers (generally those with more than 100 employees) that do not provide coverage to their employees, or that provide coverage that is unaffordable, will be assessed a tax if any one of their employees receives a tax credit when buying insurance individually in an exchange. The employer tax is $2,000 multiplied by the number of workers in the business in excess of 30 workers (with the penalty amount increasing over time).

Larger employers that offer coverage could be subject to the tax as well. Employers who provide coverage that does not on average cover at least 60 percent of the cost of covered services for a "typical population" (or the premium for the coverage exceeds 9.5 percent of an employee's income) and has employees that receive a tax credit will be required to pay a penalty of $3,000 up to a maximum of $2,000 times the number of workers in excess of 30 workers. ("Typical population" means the medical services generally required by average citizens without any pre-existing conditions or additional specialty medical services.)

How will the government track who does and does not have coverage?

Coverage will be tracked through reports that are required to be submitted annually along with IRS tax filings.

Who is responsible for reporting coverage?

Every entity that provides coverage for another individual is responsible for reporting that information with its tax return.

Individuals who obtain their own coverage will be responsible for submitting proof of coverage to the IRS. Health coverage providers will provide the proper proof of insurance documentation to be submitted.

For individuals who obtain coverage through their employer, the employer will complete the required reporting for the employee to the IRS.

Who challenged the Act in court, and on what basis?

Twenty-six states, as well as private individuals and business organizations, brought action against the federal Health and Human Services, the Treasury, and the Labor Departments and their Secretaries, challenging the constitutionality of the Act. A federal district court in Florida held that the Act's expansion of Medicaid is constitutional. However, it also held that the Act's

individual mandate provision exceeded congressional authority and declared the entire Act invalid.

The government appealed the individual mandate holding, and the plaintiffs appealed the Medicaid expansion issue. The United States Court of Appeals for the Eleventh Circuit affirmed that the individual mandate is unconstitutional and affirmed the constitutionality of the Medicaid expansion. The appeals court holding was then appealed to the U.S. Supreme Court.

On what basis did the Supreme Court uphold the law?

In *National Federation of Independent Business v. Sebelius*, a majority of the Court, in a 5-4 decision, upheld the Act as constitutional by citing the power of Congress to levy taxes. Even though Congress did not label the "shared responsibility payment" (a.k.a. the "individual mandate") a tax, the Court determined it to be one because of the following factors:

- Collection is administered by the IRS.
- Coverage status is reported when filing federal tax returns.
- It is not applicable to individuals not required to file tax returns.
- It is calculated based on amount of taxable income, number of dependents, and tax filing status.
- The individual payment "produces at least some revenue for the government," which is an "essential feature of any tax."

According to the Court, Congress is not requiring Americans to purchase something. Rather, the Act penalizes them for not purchasing something. Thus, the individual payment was held to be a tax rather than a penalty and the authority of Congress is found in their power to tax (and not in the Commerce Clause). Because a majority found the individual mandate to be constitutional, the question of whether the individual mandate would be severable from the rest of the Act did not have to be decided.

What did the dissent argue?

The dissenting opinion argued that the Act's individual mandate and Medicaid expansion overstepped federal powers entirely, both in "mandating the purchase of health insurance and in denying non-consenting states all Medicaid funding." Holding that the individual mandate constitutes a penalty and cannot be upheld under Congress' taxing power because Congress framed the mandate as a penalty rather than a tax, the dissent stated "even if the Constitution permits Congress to do exactly what we interpret this statute to do, the law must be struck down because Congress used the wrong labels." Addressing the Medicaid expansion, the dissent argued that it is unconstitutionally coercive of the states.

If my city already provides health coverage for me, how will the law affect me?

That remains to be seen.

Nothing in the law appears to require cities to dramatically change the ways in which they currently provide health coverage to their employees. Cities should be able to continue to self-insure, self-fund, and/or participate in risk pools, such as the TML Intergovernmental Employee Benefits Pool, so long as those entities meet certain conditions. However, it appears that city health pools may not be eligible for certain federal subsidies that would otherwise be available for small employers under the Act. State league-sponsored health pools are currently attempting to change this feature of the Act through federal legislation.

Most employers that currently provide health coverage will probably continue to so do so. In those cases, the Act's largest impact will be on premiums. Some believe that the Act will eventually cause premiums to decrease, while others believe the opposite.

If an employer decides to stop providing coverage, its employees will have to seek coverage elsewhere. The cost of such coverage under the Act's provisions can't currently be calculated.

Editor's Note: *Ms. Eggeling prepared this Q&A under the supervision of the League's general counsel.*