HEALTH CARE REFORM
ANSWERS & ADVICE

10 HEALTHCARE REFORM MISCONCEPTIONS

MORRIS & REYNOLDS HAS CERTIFIED REFORM EXPERTS AVAILABLE TO HELP ANSWER YOUR QUESTIONS

There are many misconceptions and misunderstandings about America's new health care reform law, the Patient Protection and Affordable Care Act (PPACA). At the dawn of America's healthcare reform efforts, here is an initial top ten list of misconceptions on exchanges, the individual mandate, preventive healthcare, fines, penalties and more.

1) The public health insurance marketplace (exchange) is the only place to purchase individual health insurance in 2014 that is subject to the various reform provisions.

False. The new marketplaces are the only places where individual health insurance coverage can be purchased with federal subsidies/ tax credits. However, individual health insurance plans purchased off (from your agent and insurer directly) the PPACA marketplace in 2014 contain the same provisions such as guaranteed-issue, no pre-existing condition exclusions, community rating, essential health benefits, limits on out-of-pocket expenses, etc. Coverage purchased off the PPACA marketplace exchange is not subsidy-eligible, though.

2) The individual mandate and associated penalty applies to everyone.

False. The individual mandate does not apply to individuals who cannot afford coverage because the cost exceeds 8% of their household income. It also does not apply to prisoners, Native Americans eligible for care through the Indian Health Service, immigrants who are in the country illegally, people whose religion objects to having insurance, members of a healthcare-sharing ministry or individuals who experience a short coverage gap of less than three consecutive months.

3) All Preventive care is covered at 100%

False. Reform laws include a provision that requires (non-grandfathered) health insurance policies to cover certain prescribed to preventive healthcare services at 100% (no copay or deductible).

Some preventive services ordered by a doctor may not necessarily be included on the PPACA list of prescribed preventive services, thus not covered at 100%. Additionally, insurers are not required to provide 100% coverage for eligible preventive care that is provided by non-network providers.

4) All of the healthcare reform provisions apply and affect all health insurance plans at the same time, regardless of the type of plan, how the plan is insured/funded and when then plan renews.

False. Certain provisions of the law that affect individual and fully insured small group plans (i.e., fewer than 50 employees) do not affect fully insured large-group plans (i.e., 50 or more employees). Also, group plans that are partially self-funded are not subject to a number of PPACA provisions.

So-called *grandfathered plans* do not have to comply with a number of provisions, provided they continuously maintain grandfathered status. Finally, a health insurance policy's anniversary date determines when certain provisions apply to a plan.

Many provisions become effective upon the plan's first anniversary date, "on or after January 1, 2014." Many small-group plans were offered (and accepted) the option of an "early renewal" effective 12/1/2013. Such plans will not have to comply with a number of reform provisions until their plans renew in 2114.

5) An employer that is subject to the employer shared-responsibility provision (often called "pay or play" or "the employer mandate") that does not offer affordable coverage is automatically penalized.

False! False! False! This is perhaps the most misunderstood (and incorrectly explained) provision of the entire law. There are two types of penalties and different amounts associated with each. Both penalties are triggered specifically by at least one employee doing BOTH of the following:

- Verifying and being eligible for a federal subsidy;
- Purchasing coverage on the public marketplace/exchange.

Unless or until at least one employee takes both of these actions, the employer faces no penalty. There is a significant difference between employer shared-responsibility exposure and actual penalty. It's extremely important for affected employers to understand, and perhaps even calculate, both.

6) Insurers are cancelling certain health insurance policies that are not "PPACA-compliant," leaving customers uninsured.

True & False. The majority of non-grandfathered small-group (fully insured) and individual policies in place prior to 2014 do not meet several PPACA requirements (community rating, 10 essential health benefits, out-of-pocket maximum, etc.). In order to be compliant, insurers sent "cancel and replace" notices to affected customers, and replaced those policies with compliant coverage, plans as close to what was in place, along with some alternatives.

In many cases, because the PPACA requirements increase the cost of coverage, the replacement plans include higher out-of-pocket limits and/or higher premiums. So, yes, policies are being cancelled, but customers are being offered replacement coverage in order to prevent them from being uninsured.

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7) ***An individual who meets the PPACA Federal Poverty Level income requirement is automatically eligible for a subsidy for health insurance coverage purchased of a public marketplace/exchange.***

False. An individual who works 30 hours a week or more for an employer of any size that offers health insurance that meets PPACA's affordability and minimum coverage requirements is NOT eligible for a subsidy, regardless of his income. This does not mean that affected employees are forced to accept their employer's health insurance coverage offering.

Such individuals can still purchase alternative coverage (e.g., spouse's plan, individual health insurance coverage purchases on or off of the marketplace/exchange, Medicare, Tricare, etc.). They simply are not eligible for a subsidy. In most cases, if an employee opts to decline his employer's health insurance offering, he forfeits the employer's premium contribution.

8) ***The employer mandate compels employers with 50 or more full-time (30 hours per week) employees to offer health insurance coverage to an employee and all of their dependents or face penalty exposure.***

False. This provision of PPACA addresses the offering of health insurance to eligible employees and "their dependents under the age of 26." Employers are not required to offer coverage to the spouses of their employees. As a result, some employers are considering limiting the offer of health insurance benefits to only their employees and eligible dependents.

UPS recently announced that it is no longer extending the offering of coverage to employees' spouses. In addition, some employers are requiring employees who choose to include their spouse on their plan to pay significantly more premium IF their spouse is eligible for coverage through their employer.

9) ***Reform will be funded exclusively by a combination of fines/penalties placed on individuals and employers and additional taxes assessed on health insurance companies.***

True & False. While it is true that reform relies on revenue from fines imposed on both individuals and employers, along with a number of new taxes assessed on insurance companies and self-funded employers, there are several other new fees and taxes associated with PPACA funding.

The Chamber of Commerce has published a list of 18 specific PPACA fees, penalties and loss of tax deductions (Click Here), which, combined with other sources of funding, are projected to provide the necessary funding of PPACA. These include separate taxes for things like artificial tanning and medical devices.

The cost of reform is projected by the Congressional Budget Office at $1.7 trillion over a 10-year period. There is much disagreement over the potential effects of reform on the federal budget. Suffice it to say, PPACA will draw from a number of funding sources in order to fulfill its intended purpose and objective.

10) ***PPACA's minimum loss ratio provision requires insurance companies to issue refunds to each affected policyholder if the claims paid out on their specific policy were less than 80% of the premiums collected (or 85% for large-group customers).***

False. While the reform law does include the referenced MLR provision, which requires insurance companies to issue refunds to customers if the claims paid amount is less than the applicable premium collected percentage (80% or 85%), the refunds ARE NOT POLICY-SPECIFIC.

Insurance companies are allowed to pool their insured customers together into approved "blocks" of business and, based on the performance of these blocks of business, the insurers are required to calculate claims to premium ratios and, if applicable, issue refunds. So while a particular insured individual or employer group may actually have a claims-to-premium loss ratio that is less than 80% (or 85%), if the block of business they are a part of meets or exceeds the 80% (or 85%) figure, there is no refund payable.

There's a tremendous amount of information pertaining to PPACA that must be read, understood, translated and communicated. THERE IS A SIGNIFICANT DIFFERENCE BETWEEN EMPLOYER SHARED-RESPONSIBILITY EXPOSURE AND ACTUAL PENALTY. IT'S EXTREMELY IMPORTANT FOR AFFECTED EMPLOYERS TO UNDERSTAND, AND PERHAPS EVEN CALCULATE, BOTH.

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