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Federal Health Care Reform: What's Happening And Where Are We Going?

Anthony H. Szczygiel
University at Buffalo School of Law, szczygie@buffalo.edu

in the **public service**

By Anthony Szczygiel

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Last spring, Congress passed sweeping medical insurance and health care reform legislation, the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148. Critics have argued that the law went too far or did not go far enough. It may be helpful to step back and review the law, see what has happened with the reforms over the past year, and what we can expect over the next three years.

Congress made substantial changes to PPACA almost immediately through the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. I will be citing to the very helpful consolidated version of those laws prepared by the Office of Legislative Counsel, Compilation of Patient Protection and Affordable Care Act as amended through May 1, 2010, available at: http://docs.house.gov/energycommerce/ppacacon.pdf.

Expanding Medical Insurance Coverage

The number of U.S. citizens without medical insurance has been high for many years, but the recent recession has dramatically increased those numbers. Three PPACA initiatives aim to not just reverse that trend but provide medical insurance coverage for more than 90 percent of United States citizens.

The federal/state Medicaid and Children's Health Insurance programs will expand to cover most low-income individuals. Not later than 2014, PPACA will widen the scope of adults covered by Medicaid to include all citizens with incomes up to 138 percent of the federal poverty level (FPL). States may opt for a higher income standard, up to 200 percent of the FPL. The Medicaid application process will be simplified, in part by eliminating the asset test for eligibility. PPACA §§ 2001 and 2002. These changes will affect every state's Medicaid program. However, the changes will be most noticeable in states with limited Medicaid coverage, unlike New York.

Employer-provided medical insurance will continue and the number of individuals covered through such insurance plans is expected to grow. Employers are encouraged rather than mandated to provide medical insurance. PPACA §1511 through 1515. Among the inducements are a small employer tax credit, PPACA §1421; and an interim reinsurance for early retirees program, PPACA §1102.

Finally, individuals who otherwise would lack medical insurance will be able to enroll in more affordable insurance plans offered through state or regional Health Insurance Exchanges. The Exchanges should operate as a transparent, regulated marketplace, with mandated consumer assistance features to help people compare and contrast the variety of offerings, including the Medicaid options. PPACA §§ 1311 and 1321.

PPACA relies on various carrots and sticks for this third initiative to achieve its goals. The inducements feature a significant premium assistance tax credit to help make medical insurance affordable for individuals. Individuals with income up to 400 percent of the FPL are eligible for these tax credits. PPACA §1401. Coupled with this are significant changes to the business practices of medical insurers. A sample of medical insurance market reforms includes the following:

- insurers will have to offer policies to almost all who apply, with limited ability to exclude based on preexisting conditions;
- policy premiums will be community rated, that is the individual's premium will not be based on the person's past or projected claims experience or that of a small group; and
- the loss ratio for medical insurance must be 85 percent or higher, thus limiting the amount of premiums the insurers can retain for administrative purposes or profits. PPACA §§ 1001 and 1003.

The "stick" is an individual mandate to obtain insurance. There will be exceptions for people uninsured for three months or less; those who do not earn enough to have to file federal income tax return or who cannot afford the premiums despite the tax credits; unauthorized immigrants; Native Americans and those who object on religious grounds. The sanctions for failure to insure feature a penalty (or tax) of $695 per year for an individual, phased in from 2014 to 2017. Compliance will be largely voluntary. PPACA §§ 1501 and 1502.

Again, critics have argued that the mandate is too little or too much. The insurance lobby argued for a more severe penalty, on the basis that allowing the young, healthy and wealthy to not participate in the private medical insurance market could cause that market to fail. Conservative critics argued that Congress lacks the constitutional power to impose any personal mandate to purchase insurance. This legal issue dominates the lawsuits challenging PPACA. At least 24 lawsuits have been filed challenging some portion of the health care reform legislation, and 21 of these focus on the individual mandate. The *Washington Post* has a listing of the cases, with details of the claims and the name of the presiding judge at: http://www.washingtonpost.com/wp-srv/special/ health-care-overhaul lawsuits/?sid=ST2010121305036:.

One district court decision held that Congress could not regulate "inactivity," that is the decision not to buy or otherwise procure insurance. Other courts have held that the Commerce Clause enables this federal mandate. Still more have decided that the legal challenge is premature. The U.S. Supreme Court will almost certainly have to decide the constitutional issue, though not in the immediate future.

The Rest of the Story

The vast majority of the PPACA provisions are not being legally challenged. Two significant medical insurance changes should have been in place for most policies as of January 1, 2011. Insurance plans with dependent coverage for children must cover those children up to their 26th birthday, whether or not the child lives with the parents, or is a student. Lifetime dollar limits no longer can cap total payments promised under a policy, and in many cases, annual limits are eliminated as well. PPACA § 1001.

Over half of PPACA's many pages are devoted to encouraging improvements in medical and health care. It provides funding for new and better coordinated research. Electronic medical records are further encouraged as are new models for delivering care. Many of these research projects and demonstration programs are focused on the challenge of dealing with chronic health conditions. As one intriguing addition, PPACA authorizes a voluntary public long-term care insurance program, the CLASS Act. PPACA §§ 8001, 8002. Individuals who have paid premiums for at least five years (three of these while employed) will be entitled to a daily payment if and when they meet threshold standards similar to those in private long-term care insurance policies, such as needing assistance with a specific number of activities of daily living. As with many PPACA initiatives, the details of the program are in development.

These initiatives face significant implementation problems, as federal and state administrators, insurers, employers and consumers are confronted with extensive changes to our extremely complicated medical insurance system. For example, federal agencies are developing new rules to implement the changes to the insurance market, and to the federal medical insurance programs such as Medicare and Medicaid. See, e.g.,

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Multi-agency Interim Final Rule, Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 FR 37188 (June 28, 2010). Each state must develop a Health Insurance Exchange that will be ready for business on January 1, 2014, in addition to revising its Medicaid program.

In short, the PPACA beat goes on. A huge amount of work is going on, at many levels, to implement or respond to PPACA provisions. A good number of reliable sources are dedicated to providing PPACA implementation time lines as well as updating developments, by topic or State. See e.g., Henry J. Kaiser Family Foundation, Health Reform Gateway, http://healthreform.kff.org; American Cancer Society, Cancer Action Network,, http://www.acscan.org; and Federal Health Care Reform Implementation in New York State, http://www.healthcarereform.ny.gov.

Anthony Szczygiel is a professor at the University at Buffalo School of Law, where he has taught since 1982 and currently teaches Elder Law and Health Law. He also supervises the Foster Elder Law Clinic that works closely with Legal Services for the Elderly, Disabled or Disadvantaged of WNY. The major focus of the clinic's work is legal issues related to long-term care.

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Depression is a treatable illness and the right combination of medications and therapies can significantly improve the quality of life for those who suffer from it.

Help and support are just a phone call away. The Lawyers with Depression Support Group meets monthly to share stories and fellowship. The group meets every other Friday (except holidays). See the calendar on the back page for meeting dates. Meetings are held at Bar Headquarters, 438 Main Street, Sixth Floor, at 12:30 pm and lunch is provided. There is no need to pre-register.

If you or a colleague are struggling with depression, there is no need to suffer in silence. For further information, visit www.lawyerswithdepression.com or contact Daniel T. Lukasik at 852-1888. All calls are strictly confidential. We invite you to join us and share your story.

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