Hawai‘i’s Brighter Future? The Affordable Care Act and the Prepaid Health Care Act

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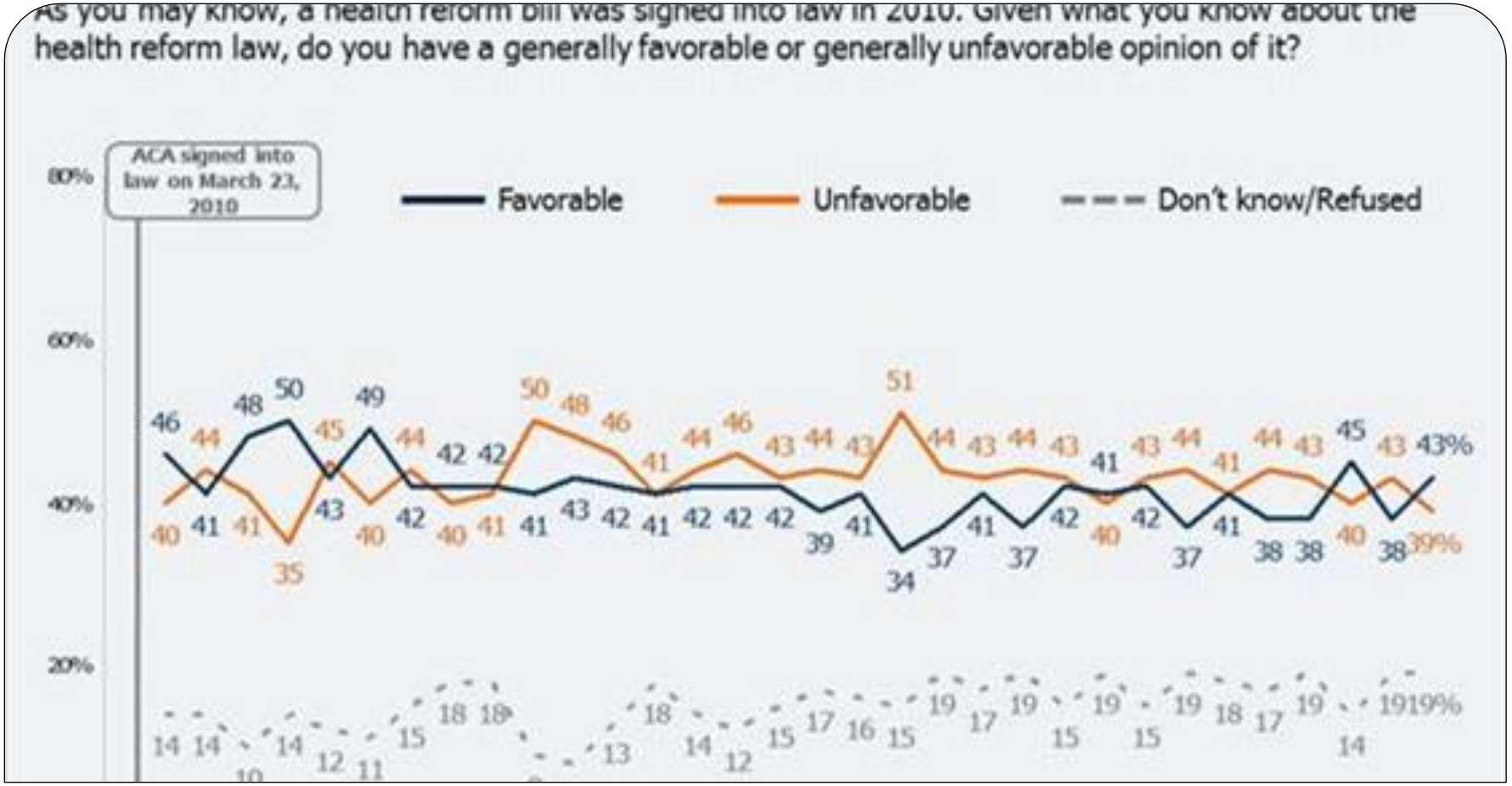
Health Reform

PHCA

- PHCA – An employer mandate to provide health insurance coverage to workers over 20 hours a week
- Qualified plans established an expectation of quality coverage in Hawai‘i

Patient Protection & Affordable Care Act

- Transforming Health Care through Affordability, Accountability, & Access Measures
  - Insurance Reform
  - Health Care as a Collective Responsibility (government, employer, individual)
  - Expanding Access Across Populations
  - Reducing Costs
  - Improving Quality
  - Tying Payment to Outcomes & Quality Measures
  - Creating Opportunities for State Initiatives
  - Strengthening workforce



Love it or hate it, health reform under the ACA is here.

Nationally, public opinion on the Affordable Health Care Act is divided. Yet very few people know much about it.

Health Reform Timeline 2010-2020

2010

Insurance Reforms:

- No Lifetime benefits limits-based on dollar amounts.
- No coverage cancelations
- Dependent coverage to age 26.
- New internal and external appeal processes.
- No pre-existing condition exclusions for dependent children.
- New health plan disclosure and transparency requirements.

Dependant coverage up to age 26 is mandated.

New Programs:

- Temporary retiree reinsurance program.
- National risk pool
- Small business tax credit.
- $250 rebate for Medicare members who reach the "doughnut hole."

2011

Insurance Reforms:

- New uniform coverage documents and standard definitions.
- Minimum medical loss ratios.

Medicare Reforms:

- Medicare Advantage cost-sharing limits.
- Medicare beneficiaries who reach the doughnut hole get a 50% discount on brand name drugs.
- Medicare Advantage plans begin having payments frozen.

Employers are required to report the value of health care benefits on employees' W2 tax statements.

- Primary care doctors and general surgeons practicing in underserved areas to get a 10% bonus.

Other:

- Yearly fee for brand-name drug manufacturers.
- Voluntary long-term care insurance program.
- Increased funding for community health centers to provide care for low income uninsured people

2012

Hospitals, doctors and payers encouraged to join forces in "accountable care organizations."

Hospitals with high rates of preventable readmissions facing reduced Medicare payments.

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2013

- Individuals making $200,000 a year or couples making $250,000 would have a higher Medicare payroll tax of 2.35% on earned income. A new 3.8% tax on unearned income, such as dividends and interest, also added.
- Contributions to flexible spending accounts limited to a $2500 a year. The threshold for deducting medical expenses on taxes raises to 10%.

Individuals making $200,000 a year have a higher Medicare pay-

- Medical device manufacturers have a 2.9% sales tax on medical devices; with exemptions for some like eyeglasses, contact lenses and hearing aids.
- No more deduction for expenses allocable to Medicare Part D subsidy for employees who maintain prescription drug plans for their Medicare Part D– eligible retirees.

2014

Coverage mandates & Subsidies:

- New Individual and employer coverage responsibilities.
- New Individual affordability tax credits and expanded small business tax credits.

Health Insurance Exchange & Insurance Reforms:

- State individuals and small group health insurance exchanges operational.
- No more lifetime and yearly dollar limits for essential benefits.

Pre-existing condition exclusions are prohibited.

- Guaranteed issue, guaranteed renewability, modified community rating and minimum benefit standards.

New taxes on health insurers.

Medicaid & Medicare Reform:

- Medicaid expanded to cover low-income individuals under age 65 up to 133% of the federal poverty level-about $28,300 for a family of four.

2018

New tax ("Cadillac tax") on employer-sponsored health plans that offer policies with generous coverage levels.

"Cadillac tax" is imposed.

2020

Doughnut hole coverage gap in Medicare prescription benefit is fully phased out. Seniors continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage.

SOME CHANGES HAVE BEEN WELCOME AND SEAMLESS, BIG CHANGES AHEAD!

In the beginning…
PHCA – An employer-based program

- 1974 Hawai‘i enacted the Prepaid Health Care Act
- 1974 ERISA enacted and preempted Hawai‘i’s PHCA (*Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), aff'd. mem., 454 U.S. 801 (1981), PHCA was held to be preempted by ERISA).
- 1983 Congress exempts Hawai‘i’s PHCA from ERISA preemption.
- Hawaii is the only state with an ERISA exemption for employer sponsored health care.

The ERISA exemption allowed Hawai‘i to deliver health care to a sizeable portion of its population in manner that was unique to this state for over thirty years.

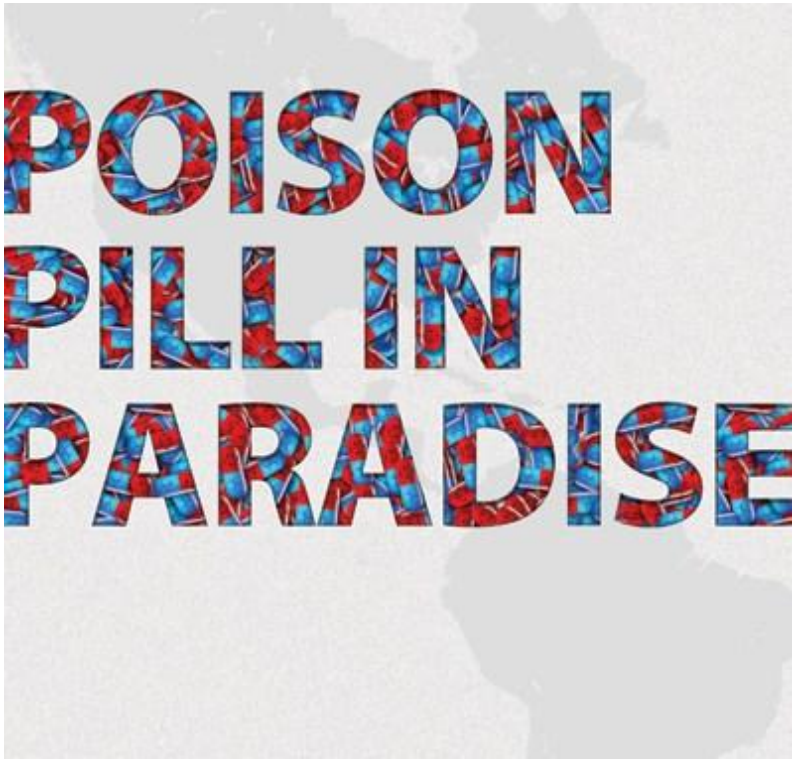
It wasn't paradise, but pretty good before the ACA

- Over 90% of Hawai'i population had health insurance
- Our uninsured were mostly adults between 19-64 (77%) and children (21%)
- Disproportionately Native Hawaiian & Pacific Islander (14%)
- Disproportionately Neighbor Islands
- 1/3 of uninsured were working
- ½ were below 200% of the Federal Poverty Level

In 2011, nationally, about 16% of the population lacked health insurance and the rate was increasing.

PHCA Vulnerability After the ACA: Death By Its Own Hand?

- By its terms, the PHCA sunsets when federal law establishes mandatory or voluntary pre-paid health care that is "at least as favorable"
- Hawai'i's ERISA waiver "froze" PHCA in 1983. No substantive amendments are permissible.
- Although the 2010 State Legislature repealed the sunset provision, we do not know if that repeal was permissible under the terms of our ERISA waiver.



Did we ride off into the sunset?

- ERISA's preemption waiver froze Hawai'i to the 1974 law, invalidating "**any amendment of the Hawai'i Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.**"
- PHCA sunsets when federal law "**provides for voluntary prepaid health care for the people of Hawai'i in a manner at least as favorable as the health care provided by this chapter, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawai`i.**"

Great law school questions: Is ACA as favorable as the PHCA? Is Hawai'i's repeal of the sunset provision valid under the terms of Hawai'i's ERISA waiver?

Did the ACA Actually "Save" PHCA

(b) Rule of Construction Regarding Hawaii's Prepaid Health Care Act.--**Nothing in this title … shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act… under … Employee Retirement Income Security Act.**

- Does not exempt Hawai'i from the ACA
- Does not deny Hawai'i citizens or employers the rights/burdens of the ACA
- Does not obligate the federal government to coordinate or alter ACA requirements
- Does not give the PHCA superiority over the provisions of the ACA in a conflict
- Does not ensure compatibility

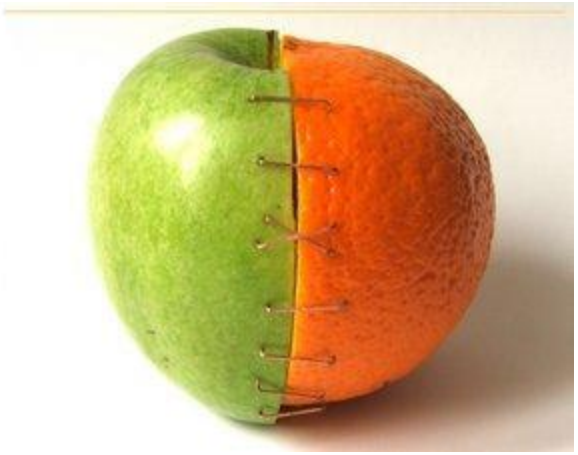
The ACA Gives States Some Latitude and Invites Statutory Constructions That Preserve State Laws

- No interference with state regulatory authority
- Rule of construction to allow benefits in excess of essential health benefits
- Empowering consumer choice and state discretion
- State flexibility to allow innovation

Making Them Work Together

Side-by-Side Versus Integration of Laws

- Hopeless side-by side comparisons
- Bridgeable differences versus fatal differences
- Building on ACA provisions providing state flexibility and latitude



Examples of Approach Differences

PHCA– How insurance is distributed

- Employer Based:
  - Applies to employers with one or more employees working 20 hours.
  - Leaves out (among others) dependents, part-time workers, and those outside the workforce
- Others:
  - Individual Market (by choice if available)
  - Government programs (Medicare; Medicaid; VA; EUTF etc.)
  - Uninsured

ACA – How people get insurance

- Employer based "shared responsibility" or penalty:
  - Over FTE 200. Automatically enroll employees or PENALTY
  - Over 50 FTEs. Offer adequate and affordable coverage under the ACA or PENALTY
  - Creates Small Employers (SHOP) Exchange (Hawai'i can expand to large Employers in 2017)
  - Less than 25 FTE eligible for Tax Incentives
  - Includes dependents
  - BOTTOM LINE: 50 OR LESS, NO MANDATE!
- Others
  - **Individual Mandate and American Health Benefit Exchange**
  - Government programs (Medicare; Medicaid; VA; etc.)
  - **Subsidies up to 400%** of poverty level
  - **Medicaid Expansion** to 133% of poverty level
  - Uninsured

Employee eligibility differences

PHCA

- ≥ 20 hours
- Excluded:
  - work less than twenty hours per week;
  - Federal, State, and County workers;
  - agricultural seasonal workers;
  - insurance or real estate salespersons paid solely by commission;
  - individuals working for son, daughter, or spouse; and children under age 21 working for father or mother.

ACA

- Full-time (≥30 hours) (while part time employees are tallied on a pro rata basis to determine company size, penalty provisions are only triggered by full-time FTE seeking premium subsidies)
- Includes state and local governments
- Excluded:
  - Employers with less than 50 Full-time-employees
  - Not subject to penalty for seasonal; part time

Strength of Plans Is Different

PHCA

- 393-7(a) plans – equal to largest subscriber plans (assumed equivalent of platinum)
- 393-7(b) plans – demonstrate that it provides sound basic care. If more limited than (a), employer contributes ½ the cost of dependents as well (assumed equivalent of gold)

Small Business Health Options Program (SHOP)

- Metal Plans (bronze -60%; silver- 70%; gold 80%; platinum 90%)
- Metal = actuarial value of plan based on cost sharing between insured and insurance
- **ACA requires that a qualified health SHOP insurer must offer at least one QHP in silver (70%) level and one at gold level (80%)**
- Strategy is to use state discretion to keep bronze and silver out of the SHOP/PHCA exchange market. Limited availability to silver to employers who are exempt from PHCA.
- Individual Exchange has greater choice, including less robust plans. All metal levels plus a limited catastrophic plan for low-income young adults available on the individual exchange

Benefit Differences

PHCA

- Match the prevalent plan and enumerated in the PHCA and state mandated benefits
- PHCA benefits include inpatient hospital stays, outpatient services, surgery and ER services, diagnostic lab services, maternity and substance abuse coverage.
- State mandates include coverage for IVF, mammograms, hospice care, medical foods and diabetes coverage
- No differences for self-insurers

ACA

- 10 essential benefits at a minimum (State can pick a benchmark & can supplement it to meet essentials)
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
- Self insurers have far fewer regulatory requirements

Share of premiums different

PHCA

- Employer contributes ½ of premium cost
- Employee's share cannot be more that 1.5% of employees wages

ACA

- Not premium allocation based
- Employer must provide a plan that covers at least 60% of the cost of "minimal essential coverage" and the employees share for individual health care should not exceed 9.5% of employees household income.

Penalties are different

PHCA

- Various penalties per day or per violation
- Responsibility for uninsured costs to employee

ACA

Two Employer Penalties

- Failure of an Employer of over 50 workers to provide a plan ($2000 per employee excluding first 30 FTE)
- Failure of an Employer of over 50 to provide an adequate or affordable plan (less than 60% actuarial value or employee cost is > 9.5% of household income) ($2-3000 for each employee)
- Penalty triggered by an FTE receiving a Premium Credit in the Exchange NO PENALTY IF NO ONE OBTAINS A SUBSIDY ON THE INDIVIDUAL PLAN.

Bridge-building

EMPLOYERS MUST SATISFY BOTH THE ACA AND PHCA

- All Hawai‘i employers falling under both laws must meet the requirements of both
- Employers of <50, must comply with the PHCA even thought not mandated by the ACA
  - < 25 Buy through SHOP to obtain tax incentives and competitive pricing
  - < 50 Buy through SHOP to obtain competitive pricing

ACA SHOP EXCHANGE PLANS MUST SATISFY PHCA REQUIREMENTS

- The ACA allows the State to choose a Benchmark plan among its dominant plan, at least through 2016
- Offer PHCA compliant plans (gold and platinum) in the SHOP. Silver (non-compliant) only to those employers exempt from PHCA.
- Employers who share premiums in accord with PHCA always exceed ACA mandate
- Noncompliance incurs penalties under both laws
- SHOP Plans supplemented to meet State mandates

Who might challenge PHCA?

- Small businesses. Under the ACA, employers with <50 FTE (30 hour) workers are not required to provide insurance and suffer no penalty. But under the PHCA they must continue to offer insurance.
- Any business subjected to both PHCA & ACA penalties
- National businesses who don't want to comply with the PHCA

Bottom Line: Without the PHCA, small employer workers might lose coverage at work. They would have to buy their coverage on the American Benefit Exchange (Individual) to satisfy the mandate of insurance. Their choices would include inferior products.

Individual Mandate Highlights

- Individuals without employer-sponsored insurance are mandated to obtain insurance or pay penalty. Penalty is > of $695 (individual)-$2085 (family) or 2.5% of income capped at 'bronze' plan level (CBO estimates 1.4% of population will pay a penalty)
- Exclusions for religious exemptions; American Indians; incarcerated; ministry sharing plans, among others.
- Mandated but not subject to penalty: low-income below tax filing threshold; brief uninsured periods; insurance exceeds 8% of income
- Individuals below 400% of federal poverty level are eligible for subsidies on the Exchange to limit the cost of insurance

Hawai‘i Benefits from Both the PHCA and ACA

- **More people have access to insurance**
  - Medicaid Expansion (although the jury out on overall effects: Presumptive Eligibility; Disproportionate Share Hospitals reductions; moving private insureds to Medicaid)
  - Individual plan purchasers (access & affordability)
  - Federal subsidies for low income individual plan purchasers (400% of federal poverty level to keep costs below 2%-9.5% of income)
- **Reforms to Health Care Industry** that only federal government could achieve
  - Insurance reforms – dependents; lifetime caps; non-discrimination; medical benefit ratio
  - Affordability and Quality of Care Reforms -- Payments tied to efficiencies; quality; outcomes; strengthening primary care and community workforce
- **Employer-sponsored benefits**– no significant added burdens in Hawai‘i
  - Small businesses tax incentives (businesses less than 25 employers)
  - Small business market (access & affordability)

Still Left Behind

- **Undocumented immigrants** (ineligible for Medicaid or the exchanges)
- Eligible but not signed up for Medicaid
- Gamblers (don't participate in the exchanges, risk the tax penalty)
- The working poor (can't afford the exchange even with the subsidies, but above income is above Medicaid level) (no penalty incurred if insurance amounts to >8% of household income)
- Religious exemptions
- **5 year immigrants & COFA migrants** (although as lawfully present, eligible for subsidies through the Exchange) remain Hawai'i's responsibility (non-qualified Medicaid immigrants under PRWORA)

Nationally, it is estimated that 6% of nonelderly will not have insurance under the ACA.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