Health Care Reform 101

What's Here Now and What's Coming

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Two laws

- Patient Protection and Affordable Health Care Act of 2010 (PPACA)
- Health Care and Education Reconciliation Act of 2010 (HCERA)

What's Here Now

- Temporary High Risk Pool
- Tax credit for small employers
- Early retiree reinsurance program

What's Here Now

<u>June - August 2010</u>

- Temporary High Risk Pool
  - —Health coverage for individuals with pre-existing conditions
  - —Must have been uninsured for at least 6 months
  - —Provides lower premium rates than current high risk pools
  - —Maximum cost-sharing limited to current HSA limit ($5950/individual; $11,900/family in 2010)
  - —Original implementation date was July 1, 2010; current date is August 1, 2010

What's Here Now

- Temporary High Risk Pool
  - Texas has declined offer to operate high risk pool established by PPACA
  - Texas Health Insurance Risk Pool website provides information on the national high risk pool and a link to Federal High Risk Pool website. See www.txhealthpool.org

What's Here Now

- Comparison of Federal and Texas High Risk Pools
  - Federal premiums will be about ½ of premiums for Texas high risk pool
  - Federal pool has no pre-existing condition waiting period
  - Texas pool has a 12-month pre-existing condition waiting period, reduced by insurance coverage in prior year

What's Here Now

- Tax credit for small employers
  - 25 or fewer FTEs with average annual wage less than $50,000
  - Company must pay at least ½ of employees' premiums
  - From 2010 through 2013, tax credits up to 35% of health care costs (25% for exempt organizations).
  - Starting in 2014, employers must purchase coverage through state health exchange to receive credit, and credits available for not more than 2 years.
  - Tax credits phase-out if more than 10 FTEs and/or average wages exceed $25,000/year.

What's Here Now

- Early retiree reinsurance program
  - Retired employees, 55 or older, not eligible for Medicare
  - Up to $5 billion funded by federal government
  - Program will reimburse eligible health plan for 80% of claims in a plan year that exceed $15,000 but do not exceed $90,000 (maximum reimbursement is $60,000)
  - Applications will not be accepted after $5 billion pool is exhausted

What's Coming

- Plan years that begin on or after September 23, 2010
  - Many changes for fully insured and self-funded plans
  - Distinctions between grandfathered and non-grandfathered health plans

Grandfathered *and* Non-Grandfathered Plans

– No lifetime limits for “essential health benefits”
– No annual limits for “essential health benefits” (except as determined by HHS)
– Pre-existing condition exclusions for children are eliminated
– Rescission prohibited, except for fraud or intentional misrepresentation

Grandfathered *and* Non-Grandfathered Plans

– Dependent coverage extended to age 26

– Health plans must report percentage of premium dollars for clinical services; if less than 85% for large plans or 80% for individual and small plans, must provide rebates to consumers in 2011

Non-Grandfathered Plans

- Internal Revenue Code section 105(h) testing for both insured and self-funded plans
- Cost-sharing eliminated for certain preventive services
- Internal and external appeal process must be established
- Discrimination based on salary prohibited

Non-Grandfathered Plans

- Emergency services must be covered at in-network cost-sharing, without prior authorization
- Individuals can designate primary care physician
- May not require authorization or referral for OB-GYN services

What's a Grandfathered Plan?

- Grandfathered plan is any group health plan or individual coverage existing on March 23, 2010.
- Interim final rule ("IFR"), published on June 14, 2010, lists changes that will cause loss of grandfathered status.
- Grandfathered status applies separately to each benefit package.

Grandfathered Plans - Permissible Changes

- Addition of new employees and family members
- Changes, including increases, to employee premiums
- Changes required to comply with federal or state law
- Changes to voluntarily comply with PPACA
- Change of third-party administrator

Grandfathered Plans – Permissible Changes

- HHS has requested comments on whether the following changes should impact "grandfathered" status:
  - Changes to plan structure, e.g., self-funded to fully insured
  - Changes to provider networks
  - Changes to prescription drug formularies

Grandfathered Plans – Impermissible Changes

- Change in insurance policy, certificate or contract of insurance, even if the insurance product was offered in the market prior to March 23, 2010.
- Elimination of benefits to diagnose *or* treat a condition

Grandfathered Plans – Impermissible Changes

- Increase in percentage cost-sharing requirement (coinsurance) by any amount above March 23, 2010 level
- Increase in deductible or out-of-pocket maximum by more than medical inflation, plus 15%

Grandfathered Plans – Impermissible Changes

- Increase in co-payment by more than $5 (adjusted for medical inflation) or medical inflation plus 15%, whichever is greater
- Decrease in employer contribution rate for any tier of coverage by more than 5% below rate on March 23, 2010

Grandfathered Plans- Impermissible Changes

- Changes in annual limits:
  - If no previous limit, then cannot impose annual limit
  - If previous lifetime limit (but no annual limit), annual limit cannot be lower than lifetime limit
  - If previous annual limit, then cannot decrease annual limit

Grandfathered Plans

- Administrative requirements:
  - Plan must include a statement in plan materials delivered to participants that the insurer or plan “believes” that it is grandfathered under PPACA.
  - Plan must also provide the plan administrator’s contact information, as well as contact information for the DOL (if ERISA plan) or HHS (if non-ERISA plan).
  - IFR provides model language that can be used to satisfy disclosure requirement.

Grandfathered Plans

- Transition rules:
  - Changes made prior to March 23, 2010 will not affect grandfathered status.
  - If plan changes were made after March 23, 2010 but before issuance of the IFR and "only modestly exceed" the limits set by the IFR, the agency will "take into account good-faith efforts to comply with a reasonable interpretation of [PPACA]" in deciding whether grandfathered status is affected.
  - If more significant changes were adopted after March 23, 2010 but before issuance of IFR which exceed or contravene limits set in IFR, the insurer or plan can revoke the change by the first plan year on or after September 23, 2010 and not lose grandfathered status.

What's Coming—January 1, 2011

- Cafeteria Plans (FSAs)
  - Costs for purchasing over-the-counter drugs may not be reimbursed through health flexible spending account (FSA) or health reimbursement arrangement (HRA) or through HSA or Archer HSA
    - Exceptions: insulin and prescribed drugs, even if available over the counter

What's Coming – January 1, 2011

- Health Savings Accounts (HSAs)
  - Penalty for distribution from a health savings account (for anything other than qualified health expense) increased from 10% to 20%
  - Penalty for distribution from Archer HSA increased from 15% to 20%

What's Coming—January 1, 2011

- Simple Cafeteria Plan
  - Available to small employers
  - Not required to satisfy discrimination tests

What's Coming—January 1, 2011

- Small Employer:
  - 100 or fewer employees during either of 2 preceding years
  - An expanding employer can sponsor a Simple Cafeteria Plan until it has 200 or more employees

What's Coming—January 1, 2011

- Simple Cafeteria Plan requirements:
  - All employees with 1,000 hours of service must be allowed to participate
  - May exclude
    - Employees under age 21 who do not have one year of service
    - Employees covered under collective bargaining agreement
  - Annual Employer contribution must be equal to either:
    - 2% of compensation, or
    - amount not less than the lesser of :
      - (1) 6% of compensation, or
      - (2) twice participant's salary reduction contribution

What's Coming – January 1, 2011

- Annual W-2 Reporting
  - Employer required to report "aggregate cost" of "applicable employer-sponsored coverage" on employee's W-2
  - "Applicable employer-sponsored coverage" means:
    - Coverage under group health plan made available by employer, regardless of whether employer or employee pays costs

What's Coming – January 1, 2011

- Includes coverage under health FSAs, HSA, and HRAs, except
  - Contributions to HSAs and Archer HSAs
  - Employer contributions to FSAs

What's Coming – January 1, 2011

- "Aggregate cost"
  - Not included in employee's taxable income
  - Reporting will verify medical coverage for mandates

What's Coming—January 1, 2011

- Wellness Programs
  - 5 year grants for small employers that establish wellness programs
- Long-Term Care
  - National voluntary insurance program established

What's Coming—January 1, 2013

- COOP Program
  - Consumer Operated and Oriented Plan (COOP) program established to support non-profit, member-owned health insurance companies in 50 states and District of Columbia

What's Coming—January 1, 2013

- Health Insurance Administration
  - Simplify health insurance administration by adopting single set of operating rules for:
    - eligibility
    - claims status
    - electronic fund transfers
    - health care payment and remittance

What's Coming—January 1, 2013

- Health Care Providers
  - Must disclose financial relationships between health entities, physicians, hospital, pharmacists, other providers, and manufacturers and distributors of certain drugs, devices, biologicals and medical supplies

What's Coming—January 1, 2013

- Tax Changes
  - Increase threshold for itemized deduction for medical care from 7.5% of AGI to 10% of AGI
    - Waive increases for individuals age 65 and older (2013-2016)
  - Increase Medicare Part A tax rate from 1.45% to 2.35% on earnings over $200,000 for individuals ($250,000 for married couples)
  - 3.8% assessment on unearned income for higher income tax payers

What's Coming—January 1, 2013

- Contributions to health FSA limited to $2500/year (does not include amount employer may contribute)
- Eliminates tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments

What's Coming—January 1, 2014
"Everyone" is Covered

“Everyone” does not include

- Illegal residents
- Exceptions to required coverage may be granted for
  - Financial hardship
  - Religious objections
  - American Indians
  - No coverage for less than three months
  - Incarcerated individuals

Multi-State Health Insurance Exchanges

- Individuals and small employers may purchase insurance coverage from Exchanges
- Small Employers
  - 100 or fewer employees, although State may choose to limit availability to employers with 50 or fewer employees
  - Coverage will be provided by insurance companies
  - Must offer specific coverage levels
  - Must include "essential health benefits"

“Play or Pay” Mandate

- U.S. citizens and legal resident must have qualifying coverage or pay a tax penalty.
- Penalty is greater of $695/year up to maximum of 3 times that amount, or 2.5% of household income.
- Penalty phased-in over three years.

"Play or Pay" Mandate

- Large employers must provide minimum essential coverage that is affordable or pay penalty
  - "Large" means 50 full-time employees or more
  - "Full time" means 30 hours
  - "Affordable" means required contribution for the coverage must not exceed 9.5% of employee's household income
  - Coverage must provide "minimum value"—at least 60% of plan's total costs
- Penalty is $2,000 annually for each FTE (excluding first 30 employees)

"Play or Pay" Mandate

- Penalty for large employer who offers minimum essential coverage under employer plan but still has employee enrolled in state health exchange plan is lesser of:
  - $3,000 annually for each employee receiving premium credit, or
  - $2000 for each FTE (excluding first 30 employees)

“Play or Pay” Mandate

- Employers with less than 50 employees are exempt from penalties.

“Play or Pay” Mandate

- Employers with more than 200 employees must automatically enroll employees in employer-sponsored health plan (if one exists).
- Employees must be given notice and opportunity to opt out.

Vouchers

- Large employers who contribute to health plan costs must provide “free choice vouchers” to employees whose income does not exceed 400% of FPL and whose share of premium is more than 8%, but less than 9.8% of household income.

Vouchers

- Vouchers must be equal to amount paid by employer for coverage.
- Employees can use vouchers to purchase health plan coverage from state health exchange.

What's Coming—January 1, 2014

- Non-grandfathered plans
  - New policies must comply with one of four benefit categories
  - May not impose waiting period of more than 90 days

What's Coming—January 1, 2014

- Grandfathered plans
  - No pre-existing condition exclusions
  - No annual benefit limits
  - May not impose waiting period of more than 90 days

What's Coming –January 1. 2014

- Grandfathered and Non-Grandfathered Plans
  - Limit deductibles in small employer market to $2,000 for individual coverage or $4,000 for family coverage
  - Significantly reduce out-of pocket limits for families with incomes below 400% FPL
  - For others, out-of-pocket limits may not exceed $5,950 for individual coverage or $11,900 for family coverage

What's Coming – January 1, 2014

- Wellness programs
  - Allow employers to provide rewards from 30%-50% of cost of wellness program and for meeting certain health-related standards

What's Coming – 2015 and Later

- Excise tax imposed on "Cadillac" plans in 2018
- "Cadillac" plan is employer-sponsored health plan with aggregate values that exceed:
  - $10,200 for individuals, or
  - $27,500 for families

Special Thanks to

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