



# Navigating Health Care Reform

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Groom Law Group

Dial-In

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GROOM LAW GROUP



# Overview

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- Health Care Reform legislation enacted March 23, 2010; amended March 26, 2010
- Beginning 2014, individuals will
  - Be required to have health care coverage
  - Be eligible for federal assistance to purchase health coverage, if meet certain criteria
  - Be able to purchase coverage through a state-run insurance Exchange.
- Employer responsibility
  - Beginning in 2010, small employers (no more than 25 full-time equivalent employees) will be eligible for tax credits for providing health coverage
  - Beginning in 2014, large employers (more than 50 full-time equivalent employees) may be penalized if an employee receives federal assistance to purchase health coverage in an Exchange



# Overview

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- In the meantime, employer-sponsored coverage, as well as coverage provided by health care insurance companies must conform to a number of benefits and other mandates
  - New plans must comply with all of the new requirements
  - “Grandfathered” plans must comply with a number of the new requirements
- New nondiscrimination requirements (Code Sec. 105(h))
- FSA/HSA/HRAs changes beginning as early as 2011
- New Taxes and Fees



# Insurance Market Reform

## *Essential Benefits*

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- Secretary to define, but must include categories listed below.
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity & newborn care
  - Mental health and substance use disorder services
  - Prescription drugs
  - Rehabilitative & habilitative services & devices
  - Laboratory services
  - Preventive & wellness services and chronic disease management
  - Pediatric services, including oral & vision care



# Insurance Market Reform

## *Grandfathered Plans*

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- Grandfathers individual & group coverage in effect on date of enactment.
  - Allows enrollment of new employees or family members after date of enactment.
  - No prohibition on making plan changes.
- Grandfathers collectively bargained plans under CBA ratified before date of enactment until date on which last CBA relating to coverage terminates.
- Many exceptions (as noted in slides).



# Insurance Market Reform

## *Date of Enactment*

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- Annual Rate Review (individual & group markets)
  - Secretary & states to establish process for annual review of “unreasonable increases in premiums for health insurance coverage.”
  - Insurer must submit prior justification for “unreasonable” premium increases and post on website.
  - State to provide Secretary with trends on premium increases and whether particular insurer should be excluded from Exchange based on pattern or practice of excessive or unjustified premium increases.



# Insurance Market Reform

## *90 Days of Enactment*

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- State High Risk Pool
  - Secretary to establish high risk pool for individuals with pre-existing conditions who do not have creditable coverage.
  - Will run through 1/1/14 (when Exchange is up and running)
  - If Secretary finds insurer or employer has encouraged individuals to disenroll in order to join high risk pool, insurer/employer must reimburse expenses.
- Early Retiree Reinsurance
  - Secretary to establish temporary retiree reinsurance program to reimburse claims of retirees age 55 and older who are not Medicare-eligible. Program would pay 80% of eligible claims.
  - Plan only may use reimbursement to reduce costs (premiums, copayments, out-of-pockets costs, etc.).



# Insurance Market Reform

## *Six Months from Enactment*

### *(Even for Grandfathered Plans)*

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- Annual & Lifetime Limits (insured & self-funded)
  - No annual or lifetime limits on “essential” benefits (ok for nonessential benefits).
  - Lifetime – applies to new & grandfathered group & individual coverage.
  - Annual – applies to new & grandfathered group coverage.
  - May have annual limits on certain “restricted” benefits set by Secretary, prior to 1/1/14.
- No Rescissions (insured & self-funded)





# Insurance Market Reform

## *Six Months from Enactment*

### *(Even for Grandfathered Plans)*

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- Dependent Coverage to age 26 (insured & self-funded)
  - Must cover adult child to age 26 (regardless of student status, whether married).
  - Not required to cover child of adult child dependent.
  - Prior to 1/1/14, group not required to cover if dependent is eligible to enroll in employer-sponsored coverage.
  - Secretary to issue regulations to define “dependent.”
- No PCE for enrollees under age 19 (insured & self-funded)
  - Applies to all enrollees as of 1/1/14.



# Insurance Market Reform

## *Six Months from Enactment*

### *(But Not for Grandfathered Plans)*

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- Preventive Health (insured & self-funded)
  - Must cover preventive health without cost sharing
- Nondiscrimination Based on Income (insured)
  - May not discriminate in favor of highly paid individuals under IRC 105(h) (for insured coverage – already applies to self-funded)
- Choice of Providers (insured & self-funded)
  - Must allow child to designate pediatrician as primary care provider.
  - May not require authorization or referral for participating OB-GYN.



# Insurance Market Reform

## *Six Months from Enactment (But Not for Grandfathered Plans)*

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- Emergency (insured & self-funded)
  - Must cover emergency services without prior authorization and treat as in-network.
- Appeals & External Review (insured & self-funded)
  - Must have internal review process.
  - Must have external review that either meets NAIC Uniform External Review Model Act or standards set by Secretary. Secretary may deem external review process in operation on date of enactment as compliant.
  - Must provide continued coverage pending outcome of appeals.



# Insurance Market Reform

*Two Years from Enactment*

*(Even for Grandfathered Plans)*

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- Summary Documents (insured & self-funded)
  - Within 24 months of enactment, must provide summary of benefits using format set by Secretary (including uniform definitions). Secretary to develop standards within 12 months.
  - Limited to 4 pages and must state whether provides minimum essential coverage and whether meets 60% actuarial value.
  - In addition to ERISA SPD requirements.
  - Must provide 60-day *prospective* notice of plan changes.
  - Secretary to issue regulations with standardized definitions (including UCR and emergency).



# Insurance Market Reform

*As of 1/1/14*

*(Even for Grandfathered Plans)*

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- No Pre-Existing Condition Exclusions (insured & self-funded)
  - Applies earlier for enrollees under age 19.
- Limit on Waiting Periods (insured & self-funded)
  - Waiting period cannot exceed 90 days.
- HIPAA Wellness Reward increased from 20% to 30% (and Secretary has discretion to increase to 50%)



# Insurance Market Reform

*As of 1/1/14*

*(But Not for Grandfathered Plans)*

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- May not discriminate based on health status (insured & self-funded).
- Cost-sharing limits tied to HSA amounts (\$5,000 individual / \$10,000 family) (insured & self-funded).
- For small group market, deductible limit is \$2,000 individual / \$4,000 family (insured).
- Expanded coverage of clinical trials (may not impose additional conditions) (insured & self-funded).
- Must cover “essential benefits” (insured / individual & small group markets only).



# Insurance Market Reform

*As of 1/1/14 – Insured Only*  
*(But not for grandfathered plans)*

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- Guaranteed Access & Renewability
- Rating Restrictions (individual & small group markets; large group if offered through Exchange)
  - May not vary rate except for:
    - Individual versus family
    - Rating Area
    - Age (limit of 3 to 1)
    - Tobacco Use (limit of 1.5 to 1)



# Employer Mandate

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- Applies to employers who employed an average of at least 50 full-time employees on business days during the preceding calendar year (full-time employee = average of 30 hours per week).
- Must pay a fee if coverage IS NOT offered to full-time employees AND any full-time employee receives premium assistance from federal government.
  - \$2,000 annual fee for each full-time employee employed (minus the first 30 employees)
- Must pay a fee if coverage IS offered to full time employees BUT any full-time employee still receives premium assistance from federal government.
  - the lesser of \$3,000 annual fee for each employee receiving premium assistance OR \$2,000 annual fee per employee for each full-time employee employed (minus the first 30 employees)
- Generally effective beginning in 2014.





# Employer Mandate - *Other Provisions*

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- Automatic Enrollment
  - Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage with the opportunity to opt-out.
- Notification To Employees Regarding Exchange (effective 3/1/13)
- Cafeteria Plan
  - Exchange coverage is considered “qualified” under a cafeteria plan only for qualified employers that are permitted to offer a choice of Exchange plans to their employees.
- W-2 Reporting
  - Employers must report, for information purposes, the aggregate cost of employer-sponsored coverage on an employee's W-2.



# Employer Mandate – *Vouchers*

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- Free Choice Voucher: Used by "Qualified Employees" to purchase qualified health plan coverage through the Exchange.
  - Qualified employees: those whose required contribution for minimum essential coverage through the employer's plan exceeds 8% but is less than 9.5% of the employee's taxable income for the year, whose household income is less than 400% FPL and who do not participate in a health plan offered by the employer.
  - Amount: The most generous amount the employer would have contributed for self-only (or family, if applicable) coverage under the employer's plan.
- Employers may deduct the amount paid in vouchers as an amount paid for personal services.
- Employees that receive free choice vouchers do not trigger the fee on employers who have employees receive coverage through an Exchange.



# Individual Mandate – *Penalty*

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- Individuals are required to maintain "minimum essential coverage" for each month beginning in 2014. Failure to maintain coverage for the entire year will result in a penalty. The monthly penalty is 1/12<sup>th</sup> of the greater of:
  - For 2014, \$95 per uninsured adult in the household or 1% of household income over the filing threshold,
  - For 2015, \$325 per uninsured adult in the household or 2% of household income over the filing threshold, and
  - For 2016 and beyond, \$695 per uninsured adult in the household or 2.5% of household income over the filing threshold.
- The penalty will be one-half of the amounts listed above for individuals under 18.
- The total household penalty may not exceed: (i) 300 percent of the per adult penalty or (ii) the national average annual premium for bronze level health coverage offered through the Exchange.



# Individual Mandate - *Minimum Essential Coverage*

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- Minimum essential coverage includes:
  - Medicare part A,
  - Medicaid,
  - CHIP,
  - TRICARE,
  - VA,
  - Eligible employer-sponsored coverage,
  - Individual health plans,
  - Grandfathered health plans, and
  - Such other coverage as designated by HHS.



# Individual Mandate - *Exceptions*

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- Exceptions to the individual responsibility requirement:
  - religious exemptions,
  - individuals not lawfully present in the United States,
  - incarcerated individuals,
  - those who cannot afford coverage (required contributions toward coverage exceed 8% of household income),
  - taxpayers with income under 100 percent of the poverty level,
  - those who have received a hardship waiver, and
  - those who were not covered for a period of less than three months during the year.



## *“Cadillac Plan” Tax*

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- 40% excise tax on health insurers, employers and/or persons administering self-insured plans on amounts in excess of high cost health plan limits
  - High cost = \$10,200/single; \$27,500/family (increased by a “health cost adjustment percentage”)
    - Tax imposed on amounts in excess of limit
    - Limits indexed based on CPI-U (not medical inflation) [beg. 2020]
    - Higher limits for “qualified retirees” and “high risk” professions
    - Limits may be increased by age and gender characteristics
  - Effective in 2018
  - Applies to insured and self-insured health plans



## *"Cadillac Plan" Tax*

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- 40% excise tax on high cost plans (continued)
  - Includes employee-paid portion
  - Tax imposed on insurer, employer, or person administering plan benefits
    - Unclear who is administering self-insured plan benefits
  - Employer required to calculate excess benefit amounts and allocable share of each provider and notify provider and IRS
  - FSAs, HSAs, HRAs are included (dental, vision, LTC, accident/disability, and fixed indemnity plans paid with after tax-dollars are excluded)



## *Nondiscrimination Requirements*

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- Nondiscrimination requirements for all group health plans, effective beginning in 2011 (for calendar year plans)
  - Extends section 105(h) (self-insured plan nondiscrimination requirements) to fully-insured plans (but not to grandfathered plans)
  - Requirements include complex eligibility tests and benefits tests
  - Amendment to PHSA with conforming amendments to Code and ERISA
  - Appears tax consequence of violations is HIPAA group health plan \$100/day excise tax, not taxation of benefits





## Medicare Part D

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- Repeal deduction for the subsidy for employers who maintain prescription drug plans for Medicare Part D eligible retirees
- Effective beginning in 2013
  - Results in loss of employer deduction to extent of subsidy
  - Immediate accounting charge
    - Big issue for employers
  - Question of whether employers will make significant changes to retiree prescription drug programs



## *FSA, HSA, HRA*

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- W-2 reporting of value of employer-sponsored health benefits, effective in 2011
- Employee salary reduction contributions to FSAs limited to \$2,500, indexed to CPI-U, effective 2013
- Restrictions on the reimbursement of over-the-counter ("OTC") drugs from FSA, HSA, or HRA, effective in 2011
  - Exemption for prescribed OTC drugs; difficult to administer
- Increase additional tax on distributions from HSAs that are not used for qualifying medical expenses from 10% to 20% of the distribution, effective in 2011



## *Individuals*

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### Additional Taxes on High Income Individuals

- Additional HI payroll tax of 0.9% for wages in excess of \$250,000 (joint filers) and \$200,000 (all others)
  - Effective for remuneration received after December 31, 2012
  - Also 3.8% tax on same filers on investment income



## *Individuals*

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- Itemized deduction for medical expenses
  - Floor for claiming goes from 7.5% to 10% of AGI
  - Effective tax years beginning after December 31, 2012
    - Delayed effective date to 2017 for those age 65 or over
- Tax on indoor tanning services
  - 10% of amount paid
  - Effective for services performed after July 1, 2010



# Health Care Company Fees

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- New fees on health care companies beginning in 2011
  - Pharmaceutical manufacturing companies
    - 2014 -- \$8 billion; 2015, 2016 -- \$11.3 billion; 2017 -- \$13.7 billion; 2018 -- \$ 14.3 billion
  - Medical device manufacturers
    - 2.9% tax on sale of medical device after 12/31/12
  - Health insurance companies (certain nonprofits exempted)
    - 2014 -- \$8 billion; 2015 -- \$11.3 billion; 2016 -- \$11.3 billion; 2017 -- \$13.9 billion; 2018 -- \$14.3 billion; Thereafter – indexed to medical cost growth
- Fee is allocated based on market share
  - Fee expected to be passed on to consumers as higher health care costs



# Health Insurance Company Compensation

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## Health Insurance Company Compensation

- Denial of deduction for compensation in excess of \$500,000 for health insurance providers
  - Applies to deferred compensation also
  - No performance-based compensation exception
  - Applies to more than top-5 executives
    - Officer, director or employee
    - Anyone who provides services to insurer
      - What does this mean for doctors?



# Health Care Reform

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# Questions?