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HealthCare Reform 2010

Patient Protection and Affordable Care Act



AGENDA

- ***Department of Health and Human Services Determinations***
- ***Near Term Changes***
 - ❖ *June 23, 2010*
 - ❖ *September 23, 2010*
 - ❖ *January 1, 2010*
- ***Longer Term Changes***
 - ❖ *2012 – 2018*
- ***Grandfathered Plans***
 - ❖ *Eligible plans*
 - ❖ *Provisions that will not apply*
 - ❖ *Changes that will result in loss of grandfathered status*
- ***Uncertainties Abound***
- ***Financial Impacts on Employers***
- ***Questions and Answers***

Health Reform in Progress:

Current Bill Mentions the Health and Human Services Secretary over 1,000 times to make determinations on guidelines for requirements outline in the 2,000+ pages of law.

Each of these 1,000 determinations will have a big effect on the reach of each requirement.

So Far only a few have been Determined:

Dependants to the age of 26

Grandfathering

Reinsurance for Retirees

Health Insurance Portals for Exchanges

Pre-Ex Conditions under age 19

No Lifetime Dollar Limits

Annual Dollar limits

Next to be Determined is the Medical loss ratio requirements expected by the end of August.

Near Term Changes, Key Provisions and Plan Changes

June 23, 2010

- ✓ Tax credits for small businesses
 - ✓ Employers with less than 25 full-time employees and average wages below \$50,000 that provide qualified health plan coverage are eligible to receive a health insurance federal tax credit
 - ✓ Credit of up to 35% on health premiums (50% in 2014) for eligible small employers or 25% for tax-exempt small employers
 - ✓ Link to the IRS for more Information: <http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6>
- ✓ Immediate access to high-risk pools for uninsured
- ✓ Temporary reinsurance program for early retirees

September 23, 2010

- ✓ Bans pre-existing condition exclusions for dependents under age 19
- ✓ Prohibits lifetime/"restrictive" annual dollar maximums
- ✓ Mandates dependents can join parents' policies up to age 26 (if not eligible for other employer coverage)
Most large insurers in this area have initiated 6/1/2010.
- ✓ Qualified health plans to provide first-dollar coverage for certain preventive services
- ✓ Retiree changes related to Medicare retiree drug subsidy tax - Early retire medical plan impact
- ✓ Accounting employee reinsurance program
- ✓ Market reform changes must be implemented for the first plan year starting 6 months after effective date
- ✓ No referral need to see OB-GYN
- ✓ No Out of network Higher cost for ER care
- ✓ Claims Appeals: New rules for processing claims

January 1st, 2011

January 1, 2011

- ✓ Employers required to disclose value of health benefits on W-2 IRS form
- ✓ OTC drugs/medications no longer reimbursable under health FSA, HRA or HSA, unless prescribed by physician
- ✓ New federal voluntary Long-Term Care program established (CLASS Act)*
- ✓ Requires small group market insurance plans to spend 80% of premium on medical services
- ✓ Must provide first-dollar coverage for evidence-based preventive care (not for grandfathered plans)
- ✓ Penalty on withdrawal of HSA funds for non-medical expenses increased to 20%
- ✓ Pre-existing Conditions - Not permitted for children under 19 years of age
- ✓ A voluntary program for long-term care coverage
- ✓ Wellness Grants - Employers (with less than 100 employees who work 25 or more hours per week) that do not offer wellness programs on date of enactment are eligible for federal grants if they establish an eligible wellness program (Includes nonprofits, only \$200,000 Million for entire U.S. made available, will be made available through the Department of Health and Human Services. Application process, and definition of Wellness program has not been outlined as of yet.)

2012 and Beyond

March 23, 2012

- ✓ Uniform explanation of coverage notice
- ✓ Quality of care reporting

January 1, 2013

- ✓ Medicare payroll tax increased by 3.8% and expanded to unearned income for high-income individuals (\$200,000 for individuals, \$250,000 for couples)
- ✓ Additional hospital insurance tax of 0.9% on high-income individuals (\$200,000 for individuals, \$250,000 for couples)
- ✓ New comparative effectiveness fee of \$2 per participant (Charged to Healthcare providers, and charges will be rolled down to Employer Premium Costs)
- ✓ Annual contributions to health FSAs limited to \$2,500 annually (Indexed to CPI as of January 1, 2014)

March 1, 2013

- ✓ Exchange Notification - Employers to notify employees at time of hire of the availability of exchanges and their potential eligibility for a subsidy.

January 1st, 2014

2014

- ✓ Individual mandate to obtain health coverage; provides subsidies for families up to 400% of poverty level
- ✓ Requires auto-enrollment of employees into employer health care coverage (For Groups over 200 lives) and notification of related-employee options*
- ✓ Bans pre-existing conditions for all employees; bans waiting periods greater than 90 days
- ✓ Establishes state-based insurance exchanges (Some states may elect to open their Exchange earlier ex. Ohio)
- ✓ Employers with more than 50 full-time equivalent employees must offer insurance coverage or face a penalty (full-time defined as an employee working an average of 30 hours per week)
- ✓ Complete elimination of annual limits
- ✓ Out-of-pocket expense will not exceed HSA-related coverage
- ✓ Deductibles cannot exceed \$2,000 single and \$4,000 family as indexed
- ✓ Employers permitted to increase employee reward for participation in wellness programs to 30% of total plan cost - HHS may increase to 50%
- ✓ Pre-existing Conditions not permitted for all plan enrollees
- ✓ Clinical Trials must be included in coverage

**Implementation date subject to change based on interpretation of the final legislation—may occur as early as 2011*

2014 and Beyond

2014

- ✓ Free Rider Provision - Applies to employees working 30+ hours/week
 - ✓ Employer pays \$3,000 for each employee with coverage <60% of allowed costs or if employee pays >9.5% of their household income for health coverage
 - ✓ Employers not offering health coverage pay \$2,000 per employee
 - ✓ First 30 employees not included in calculation of assessment

- ✓ Employer Voucher - Applies to employees working 30+ hours/week
 - ✓ Employers would convert health coverage subsidy to cash for any employees who:
 - Pay between 8% and 9.8% of their household income for health coverage; whose household income is less than 400% of poverty line; opt out of employer-sponsored coverage for coverage in an Exchange-based plan

2018

- ✓ 40% excise tax on high-cost health plans that exceed \$10,200 for individual and \$27,500 for family coverage

**Implementation date subject to change based on interpretation of the final legislation—may occur as early as 2011*

Tax Provisions

2013

- ✓ Medicare Surtax
 - Adjusted gross income >\$200K for individuals and >\$250K for couples
 - Additional surtax of 0.9% on wages
 - Additional surtax of 3.8% on investment income
 - Additional taxes on higher-income individuals replaces lost revenue from delayed enactment of high-cost excise tax (estimated \$210 billion)

2018

- ✓ High-Cost Plan Excise Tax
 - 40% excise tax on health plans whose annual cost exceeds: \$10,200 single/\$27,500 family
 - Cost includes all health plans, including FSAs or HRAs, ER HSA contributions
 - Higher thresholds for retirees and high-risk professions; age/gender differences
 - Indexed to CPI-U (urban) (+1% in 2019)

Grandfathered Plans effective prior to March 23, 2010

- Grandfathering relief allows certain plans in effect on the reform act's enactment date to avoid many of the new rules.
- Any group health plan or individual coverage that was in effect on the date of the new law's enactment.
- Provisions that do not apply to Grandfathered plans:
 - Preventative Care paid at 100% without cost sharing.
 - Free choice of OB-GYN. No referral needed
 - Restrictions and limitations for emergency services
 - Claims Appeals: New rules for processing claims appeals do not apply to grandfathered health plans. (Internal process, Notification to employee, Allow access to personal file for Insurance appeal, External review)
 - Section 105(h) The application of the IRS Section 105(h) to insured group health plans. (Discrimination testing applied to Partially self insured plans)
- Additional Provisions will not apply, but these were the most pressing:

Grandfathering Status Update: 6/10

Changes that will result in loss of grandfathered status:

- Significant cut or reduction in benefits (e.g., elimination of benefits to cover care for a particular condition)
- Increase in co-insurance rates
- Significant increase in cost-sharing co-payment charges (no more than the greater of \$5 [adjusted annually for medical inflation] or a percentage equal to medical inflation plus 15pp)
- Significant increase in deductibles (exceeding medical inflation +15%)
- Significant reduction in employer contributions (exceeding 5 percentage points)
- Tightening of an existing or adding a new annual dollar limit (unless replacing a lifetime dollar limit with an annual dollar limit at least as high as the lifetime limit)
- Merger, acquisition or similar business restructuring – if principle purpose is to cover new individuals under the grandfathered plan. (So Companies cannot be bought in order to take advantage of their Grandfathered status)
- Switching carriers under an insured plan (unless the insured plan is covered by a collective bargaining agreement – does not apply to changes in administrators for ASO plans)
- Moving employees to a grandfathered plan with lesser benefits

Grandfathering Status Update: 6/10

Interim Final Regulations

- Outstanding questions remain and clarification is required on multiple aspects of the regulations including:

Items that may trigger loss of grandfathered status:

- Change in networks
- Change in formularies
- Change in funding arrangement

Grandfathering Status Update: 6/10

Changes that will not result in loss of grandfathered status:

- Addition of family members or new employees
- Disenrollment of individuals covered under the plan as of 3/23/10
- Changes required to comply with state or federal regulations
- Voluntary adoption of PPACA customer protections
- Changes in third party administrators (subject to certain limitations)

Uncertainties Abound

Employer Groups >100

- How will employers react to penalties for not providing coverage?
- How great will the cost shift from public programs to commercial plans be?
- What is that impact of increased administrations and reporting requirements?
- How will regulations on grandfathered status impact employer choice?
- How much will the costs go up from annual fees on industry, pharmaceutical and excise taxes on “Cadillac” plans?

Employer Groups <100 and Individuals

- How will the combination of exchanges, tax subsidies, mandates, insurance regulations and market trends transform the <100 market?
- Will the individual and <100 become one market?
- How will individuals react to the mandate?

Government

- Will the government uphold the reduction in Medicare reimbursements?
- Can states support the expansion of Medicaid coverage in the long-term?
- What if all of this costs more than expected?
- Can the government afford to have employers opt-out coverage?

Estimated Financial Impact for Employers

Item	Expected Medical Cost Impact*
NEAR-TERM:	
No cost-sharing on preventive care: If preventive care is not currently covered**	3% -4%
Remove existing cost-sharing from preventive care**	1% - 2%
Dependent age increase to 26 (Post – 9/20/10)	1.5% - 2.0%
Remove lifetime maximum	0.1% - 0.5%
Remove pre-existing for enrollees under 19	Immaterial
LONGER-TERM:	
Cost shift due to public programs	TBD
Tax assessments and fees	TBD



Questions?

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