# Overview of Health Care Reform

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Dial-In

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- Landscape Today
- The Exchange, Multi-State Plans, & CO-OPs
- Insurance Market Reforms & "Essential" Benefits
- Employer & Individual Mandates
- Revenue Raisers

# The Landscape Today

- House and Senate have passed far reaching bills that share many similarities
- Key differences exist, including CO-OPs/OPM vs. public plan, state vs. federal exchanges, scope of employer responsibilities, taxes/financing, effective dates
- House and Senate must reconcile differences via formal conference or “ping pong”
- Senate bill expected to be the base bill
- Future is still uncertain, but final action likely in February

# The Exchange

- A mechanism to facilitate purchase of health insurance coverage that satisfies requirements for affordability and quality
- Key difference with House:  State vs. Federal
- Senate Bill = American Health Benefit Exchanges
  - Primarily state based.  States are required to establish exchanges; governed by the states and the Secretary of HHS.  States may waive the Exchange requirement with approval from HHS. States may also create local or regional (interstate) exchanges with HHS approval.
  - State insurance commissioner reviews plans and determines whether a plan is available for sale through an Exchange.  Insurers in the Exchange must agree to offer at least one silver and one gold level plan.
  - All plans offered through an Exchange must be "qualified."  States will develop procedures for certification; HHS will issue criteria for the certification.
  - Federal credits for individuals for up to 400% of poverty level and Free Choice Vouchers for certain employees to purchase coverage through an Exchange will be available.

# Multi-State Plans & CO-OPs

- Senate Bill
  - No provision for a public option like the House, but:
  - Multi-State Plan
    - OPM will contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit.
    - Each multi-state plan must be licensed in each state in which it is offered and must meet the requirements of a qualified health plan. States may require more restrictive age-rating.
  - State based CO-OPs
    - Consumer Operated and Oriented Plan – States can allow the formation of non-profit, member-run insurance companies that could receive Federal start-up funds if certain conditions are met.

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# Insurance Market Reform – Senate
## *Essential Benefits*

- 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

- Applicable to plan years beginning 6 months after enactment (likely 1/1/11 for calendar year plans).
- Applicable to individual & group markets (insured & self-funded).
  - No annual or lifetime limits on "essential benefits."
  - Must cover preventive care without cost-sharing.
  - Must cover dependents to age 26.
  - Must cover OB-GYN without referral or prior authorization.
  - Must allow emergency services without prior authorization and regardless whether participating provider.
  - Must allow participant to designate pediatrician as child's primary care provider.

# Insurance Market Reform - Senate
## *Plan Design Changes (All)*

- Applicable for plan years beginning on or after 1/1/14.
- Applicable to individual & group markets (insured & self-funded).
  - No Pre-Existing Condition Exclusions
  - May not discriminate based on health status.
  - Permitted wellness reward increased from 20% to 30% of cost of coverage (Secretary has discretion to increase to 50%).
  - Cost-sharing limits tied to HSA amounts ($5,000 individual / $10,000 family).
  - No waiting period exceeding 90 days.

# Insurance Market Reform - Senate
## *Plan Design Changes (Insured)*

- Applicable for plan years beginning on or after 1/1/14
- Guaranteed Access & Renewability
- Must offer essential benefits (individual & small group markets)
- For individual & small group market (& large group market 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)

- Within 24 months of enactment, all plans must provide summary of benefits under standards provided by Secretary.
  - Limited to 4 pages with 12-point font and be understandable to average reader.
  - Must use uniform definitions (set by Secretary), and state whether meet essential benefits and meet 60% actuarial value.
  - If make material modification, must notify participants 60 days in advance.
  - Penalty for failure to comply - $1,000 per failure.
  - Secretary to issue standards within 12 months of enactment.
- Beginning 1/1/11, insurer must annually report percentage of premium spent on non-claims costs (medical loss ratio) and provide annual rebate to enrollees if medical loss ratio is less than designated amount.

# Insurance Market Reforms - Senate

## *New Appeals Procedures*

- Plans must have internal and external appeals process.
- Must cover benefits until appeals process is resolved.
- For external review, must follow NAIC Uniform External Review Model Act or standards set by Secretary.
- Secretary may deem external review process in operation on date of enactment to comply with section.

# Insurance Market Reform- Senate

## *Other Provisions*

- Section 105(h) (nondiscrimination rules for highly compensated employees) extended to insured plans (1/1/11 for calendar year plans).
- New Administrative Simplification Rules
  - Secretary to adopt final rule for unique health plan identifier (by 10/1/12).
  - New transaction standard for Electronic Funds Transfer (to be adopted by 7/1/12 and effective 1/1/14).
  - Health plan to certify compliance with transaction rules and document that subcontractors also comply.  Penalty for failure to certify/document of $1 per covered life per day.  Certification begins 12/31/13 – 12/31/15.

# Insurance Market Reform - Senate
## *Transition Provisions*

- Secretary to establish temporary state high risk pool for those with pre-existing condition exclusions.
  - If Secretary finds insurer or employer plan has steered individual to high risk pool, plan must reimburse pool.
  - To be established within 90 days of enactment and run until 1/1/14 (when Exchange is established).
- Secretary to establish temporary retiree reinsurance program.
  - Would reimburse claims of retirees age 55 and older who are not Medicare eligible and who incur a claim between $15,000 - $80,000. Program will reimburse 80%.
  - To be established within 90 days of enactment and run until 1/1/14 (when Exchange is established).

# Insurance Market Reforms
## *House Bill Only*

- Immediate change to pre-existing condition exclusion rules before ban takes effect (can only look back 30 days and apply 6 months).
- Retiree coverage may not be reduced unless also reduced for actives.
- Must provide COBRA until individual becomes eligible for other group coverage or until Exchange is established.
- Uniform COB and subrogation standards to be set by Health Choices Commissioner.
- Prompt pay rules similar to Medicare Advantage.
- Individual policies only may be sold through Exchange.

# Insurance Market Reforms

## *Grandfathered Plans*

- **Senate**
  - Grandfathers individual & group coverage in effect on date of enactment.
  - Grandfathers collectively bargained plans under CBA ratified before date of enactment until date on which last CBA relating to coverage terminates.
  - Does not apply to summary documents and Medical Loss Ratio requirements.

- **House**
  - Grandfathers individual coverage in effect on 1/1/13 as long as no change to “any” terms.
  - Grandfathers employment-based coverage in effect on 12/31/12 for 5 years.

# Employer Mandate - Senate

- 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).
- Amount of fee depends on whether "qualifying coverage" is offered to full time employees AND whether any employee receives premium assistance from federal government.
  - No qualifying coverage + at least one employee receiving premium assistance = $750 annual fee for each full-time employee employed.
  - Qualifying coverage + at least one full-time employee receiving premium assistance = the lesser of $3,000 for each employee receiving premium assistance OR $750 per employee for each full-time employee employed.
- Employers that require a waiting period before enrollment longer than 60 days will pay $600 for each full-time employee.
- Generally effective beginning in 2014.

- 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
  - Plans provided through the Exchange are qualified under a cafeteria plan only for qualified employers that is permitted to offer a choice of Exchange plans to their employees.
- W-2 Reporting
  - Employers must include the aggregate cost of employer-sponsored coverage on an employee's W-2.

- 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 9.8% 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.
- Employers that provide free choice vouchers will not be assessed a penalty with respect to those employees that receive vouchers.

# Individual Mandate – Senate

## *Penalty*

- 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 1/12th of the greater of:
  - A flat dollar amount (the lesser of $95 (for 2014), $495 (for 2015), $750 (thereafter) for all applicable individuals without coverage or 300% of those amounts for the calendar year), or
  - 0.5% of the taxpayer's household income (for 2014), 1.0% (for 2015), 2.0% (for years after 2015).
- The penalty will not be higher than the national average premium for qualified health plans which have a bronze level of coverage for the applicable family size involved.
- The penalty will be one-half of the amounts listed above for individuals under 18.

# Individual Mandate - Senate
## *Minimum Essential Coverage*

- 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 - Senate

## *Exceptions*

- 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.

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## *"Cadillac Plan" Tax*

- 40% excise tax on high cost health plans in Senate bill
  - High cost = $8,500/single; $23,000/family
    - Tax imposed on amounts in excess of limit
    - Limits indexed based on CPI-U plus 1% (not medical inflation)
    - Higher limits for "qualified retirees" and "high risk" professions
    - Limits increased for 17 highest cost states for first 3 years
  - Effective in 2013
  - Applies to insured and self-insured health plans

## *"Cadillac Plan" Tax*

- 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, dental, and vision plans are included (LTC, accident/disability, and fixed indemnity plans paid with after tax-dollars are excluded)
  - Heavy opposition from unions, but White House support

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## *FSAs, HSAs, HRAs*

- 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
  - House bill: effective in 2013
  - Senate bill: effective in 2011
- Restrictions on the reimbursement of over-the-counter (“OTC”) drugs from FSA, HSA, or HRA, effective in 2011
  - House bill: Prohibition on all reimbursements of OTC drugs
  - Senate bill: 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

# Revenue Raisers

## *Nondiscrimination Requirements*

- Nondiscrimination requirements for all group health plans, effective beginning in 2011 (for calendar year plans)
  - Senate bill extends section 105(h) (self-insured plan nondiscrimination requirements) to fully-insured plans
  - Requirements included complex eligibility tests and benefits tests
  - Violations result in some or all of benefits being taxed to highly compensated individuals (HCIs)

# Revenue Raisers

## *Individuals*

- 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
  - Replaces tax on cosmetic surgery (“Botax”)
  - Effective for services performed after July 1, 2010

# Revenue Raisers

*Individuals*

Additional Taxes on High Income Individuals

- Senate – 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
- House – Surtax of 5.4% of modified adjusted gross income that exceeds $1 million
- Could be some combination of two taxes in final bill

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# Revenue Raisers

## *Employers*

- Repeal deduction for the subsidy for employers who maintain prescription drug plans for Medicare Part D eligible retirees (contained in both House and Senate bills)
  - Effective for tax years beginning after December 31, 2010
  - Results in subsidy being taxable to employer
  - Immediate accounting charge
    - Big issue to employers
  - Question of whether employers will eliminate prescription drug plans – especially since Part D “donut hole” is being reduced

- New fees on health care companies beginning in 2010
  - Pharmaceutical manufacturing companies ($2.3 billion)
  - Medical device manufacturers
    - 2010, 2011, 2012, 2013, 2014, 2015, 2016 -- $2 billion
    - 2017 and thereafter -- $3 billion
    - House has 2.5% tax on sale of medical device after 12/31/12
  - Health insurance companies (certain nonprofits exempted)
    - 2010 -- $2 billion
    - 2011 -- $4 billion
    - 2013 -- $7 billion
    - 2014, 2015, 2016 -- $9 billion
    - 2017 and thereafter -- $10 billion
- Fee is allocated based on market share
  - Fee be probably be passed on to consumers as higher health care costs

# Revenue Raisers
## *Employers*

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?
  - Effective tax years after December 31, 2009
  - Will this result in reduction in compensation?

- Corporate Information Reporting
  - Information returns (e.g., 1099s) will be required for payments over $600 made to corporations
  - Effective for payments made after December 31, 2011
  - In Senate bill; no similar provision in House bill

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