Legislative Update on The Implementation Of Health Reform

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The Senate Bill in 2010

- Lifetime limits on the dollar value for all fully insured and self-insured groups and individual plans including grandfathered plans are prohibited within six months of enactment.
- Annual limits will be allowed prohibited completely by January 1, 2014 and regulations will be out soon describing very limited use until then.
- Eliminates Management “carve out” plans unless “grandfathered”.

The Senate Bill in 2010

- For all group and individual health plans, mandates coverage of specific preventive services with no cost sharing.
  - Grandfathered plans are exempt
- All group and individual health plans, including self-insured and grandfathered plans, will have to cover pre-existing conditions for children 19 and under for plan years beginning on or after six months after date of enactment.
- All group and individual plans, including self-insured plans and grandfathered plans, within six months of enactment, will have to cover dependents up to age 26.
  - Dependents could be married and would be eligible for the group health insurance income tax exclusion as long as they don't have another source of employer-sponsored coverage.

The Senate Bill in 2011

- The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10% to 20%.
- OTC drugs no longer be reimbursable under HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor.
- Small employers (less than 100 lives) will be allowed to adopt new “simple cafeteria plans.”
- Creates a new **public long-term care program**
  - Employers are expected to enroll employees unless they opt out
  - Employees will be able to opt out of participation in this program

The Senate Bill in 2012

- The Department of Labor begins annual studies on self-insured plans using Form 5500.
- All employers must include on their W-2s the aggregate cost of employer-sponsored health benefits.
- Group plans must report to HHS and plan participants on whether benefits provided meet criteria to be establish secretary on improving health outcomes, reducing medical errors, and wellness and health promotion activities.
- All plans must provide new summary of benefits to enrollees at specified times.
  - Can be no more than 4 pages in length
  - Must be cultural and linguistically appropriate

The Senate Bill in 2012 and 2013

- A new federal tax on fully insured and self-funded group plans, equal to $2 per enrollee, takes effect to fund federal comparative effectiveness research takes effect in 2012.
- $2,500 Cap on Medical FSA contributions annually indexed for inflation begins.
- All employers must provide notice to employees of the existence of state-based exchanges.
- Must provide 1099's on all vendors they purchase at least $600 annual

The Senate Bill in 2014

- Imposes annual taxes on private health insurers based on net premiums.
- Coverage must be offered on a guarantee issue basis in **all** markets and be guarantee renewable.
- Exclusions based on preexisting conditions would be prohibited in all markets.
- Redefines small group coverage as 1-100 employees.
  - States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.

The Senate Bill in 2014

- All individual health insurance policies and all fully insured group policies 100 lives and under (and larger groups purchasing coverage through the exchanges) must abide by strict modified community rating standards
- Premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geography
- Kansas currently allows upwards of (7:1) for age. To illustrate effect on premium…
- $40 (12 yr old) x 7 = $280 (64 year old); $280 + $40 = $320 (combined premium); $320/4 = $80 (12 yr) x 3 = $240 (64 yr); $80 + $240 = $320 (combined premium)

The Senate Bill in 2014

- Geographic regions to be defined by the states and experience rating would be prohibited. Claims experience cannot be used in setting premiums… healthy groups will be charged more to offset the costlier "sick" groups.
- Wellness discounts are allowed for group plans under specific circumstances…which have not be determined as yet.

The Senate Bill in 2014

- Requires each **state** to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including new federally administered multi-state plans and non-profit co-operative plans.
  - In addition the states must create “SHOP Exchanges” to help small employers purchase such coverage.
  - The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange.
  - States may choose to allow large groups (over 100) to purchase coverage through the exchanges in 2017

The Senate Bill in 2014

- Requires all American citizens and legal residents to purchase qualified health insurance coverage. The purpose is to prevent adverse selection from occuring, yet…
- Penalty for non compliance to either a flat dollar amount per person or a percentage of the individual's income, whichever is higher.
  - In 2014 the percentage of income determining the fine amount will be 1%, then 2% in 2015, with the maximum fine of 2.5% of taxable (gross) household income beginning in 2016.
  - The alternative is a fixed dollar amount that phases in beginning with $95 per person in 2014; $325 per person in 2015; to $695 in 2016.

The Senate Bill in 2014

- Creates sliding-scale tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL **to buy coverage through the exchange.**
- Subsidies also available for those making 250% FPL or less for cost sharing such as co-pays and coinsurance, in addition to the premium subsidies.
- Essential benefits packages are defined
  - Based on actuarial equivalents
  - Defines cost-sharing, mandates, and minimum covered benefits
  - Self-funded plans may not be subject to all requirements, but may not meet employer mandate requirements if they don't comply
  - Allows catastrophic-only policies for those 30 and younger.

The Senate Bill in 2014

- Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 30% of premiums with DHHS able to raise to 50%
- Establishes a 10-state pilot program to apply the rules to HIPAA bona fide wellness program rules to the individual market in 2014-2017 with potential expansion to all states after 2017.
- New federal study on wellness program effectiveness and cost savings.

The Senate Bill in 2014

- Allows states to apply for a waiver for up to 5 years of requirements relating to:
  - qualified health plans,
  - exchanges,
  - cost-sharing reductions,
  - tax credits,
  - the individual responsibility requirement,
  - and shared responsibility for employers,
  - provided that they create their own programs meeting specified standards.

The Senate Bill Beyond 2014

- 40% excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for singles and from $27,500 for families takes effect in 2018.
  - Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs.
  - Stand-alone vision and dental are excluded from the calculation.
  - Premium values are not indexed for inflation.
  - Allows plans to take into account age, gender and certain other factors that impact premium costs

Employer Responsibilities

- The employer responsibility requirements take effect for companies that employ more than 50 Full time Employees
  - Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.
  - When determining whether an employer has 50 employees, part-time employees must be taken into consideration based on aggregate number of hours of service.
- If an employer **does not** provide coverage and one employee receives a tax credit through the exchange, the employer will pay a penalty for all full-time employees.
- Fine for noncompliance is $2000 per employee annually, but first 30 employees not counted (i.e., if the employer has 51 employees and doesn't provide coverage, the employer pays the fine for 21 employees).

Employer Responsibilities

- An employer with more than 50 employees that **does offer** coverage but has at least one FTE receiving a tax credit in the exchange will pay *the lesser of* $3,000 for each of those employees receiving a tax credit or $2,000 for each of their full-time employees total.
- An individual who has employer sponsored coverage available and has family income up to 400% of FPL is eligible for a tax credit through the exchange instead of employer coverage if-
  - the actuarial value of the employer's coverage is less than the minimum standard
  - or the employer requires the employee to contribute more than 9.5% of the employee's family income toward the cost of coverage.

Employer Responsibilities

- The third prong of the employer responsibility requirements.
- Requires employers to provide a voucher to use in the exchange instead of participating in the employer-provided plan in limited circumstances.
  - Employees must be ineligible for subsidies
  - Employees share of premium must be more than 8% to 9.8% of family income that is less than 400% of FPL
  - Employee can keep amounts of the voucher in excess of the cost of coverage
  - Employer must notify employees of the Exchange

Employer Responsibilities

- Waiting periods in excess of 90 days are prohibited.
- Requires ALL employers to file annual report on their health insurance enrollment.
- Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan.
  - Waiting periods subject to limits may still apply.
  - Employees may opt out if they have another source of coverage.
  - Implementation date is unclear, **may change to earlier via regulatio**

Employer Responsibilities

- Employers expected enroll employees into Federal Long Term Care program with option to “opt out”
- Must file the value of health insurance benefits on W-2’s
- Must file 1099s on all vendors when purchases reach $600 annual.

Taxes in Health Care Reform

- 10% tax on Indoor Tanning in 2010…harms those small businesses. Premium neutral.
- Elimination of Part D retiree tax deduction… AT&T $1 Billion loss in 2010.
- Small Employer tax credit…35% in 2010
- $2.3 Billion on Pharmaceuticals in 2010 will increase by $4.8 Billion over next 10 years
- $2 Billion tax on medical devices...increases to $3 Billion in 2017.

Taxes in Health Care Reform

- OTC drugs no longer be reimbursable under HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor…2011
- The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10% to 20%...2011.
- $2,500 Cap on Medical FSA contributions annually indexed for inflation begins…2012.

Taxes in Health Care Reform

- Federal tax on fully insured and self-funded group plans, equal to $2 per enrollee, takes effect to fund federal comparative effectiveness research takes effect in 2012.
- Increases the health deduction threshold from 7.5% to 10% of AGI…2013.
- Increases Medicare tax for self-employed or individuals earning more than $200,000 or $250,000 for joint filers from 1.45% to 2.35%. Does not change the employer contribution amount. Also has 3.8% tax on certain unearned income.

Taxes in Health Care Reform

- $500,000 deduction limit for CEO's of health insurance companies.
- Tax on uninsured individuals…1%, 2%, 2.5% … 2014
- Employer tax…$2000 per EE for not providing insurance…2014.
- Employer tax…$3000 per EE for providing insurance, but EE buys elsewhere with subsidy.

Taxes in Health Care Reform

- Tax on insurance companies begins with $8 Billion in 2014; $11.3 Billion in 2015 & 2016; $13.9 Billion in 2017; $14.3 Billion in 2018 and will make adjustment each year thereafter.
- A 40% excise tax on “rich” plans valued at $10,200 for an individual & $27,500 for families. Includes in the calculations reimbursements from FSA’s, HRA’s and employer contributions to HSA’s…2018.

Medicare/Medicaid Expansion

- Expands Medicaid eligibility to 133% of FPL
- Adds premium assistance to pay subsidies for EE's to buy insurance in the exchange…creates the $3000 fine.
- States can create a non-Medicaid plan for individuals earning 133 to 200% FPL… expansions create "Crowd Out" effect.
- Medicare Advantage takes most of the $500 Billion in cuts…cuts benefits…raises premiums.

In Summary

- Health care insurance market “reforms” will increase premiums by causing “adverse selection”.
- Taxes will increase insurance premiums.
- Medicaid Expansion increases premiums through the “Crowd Out” phenomenon.
- Employer requirements and penalties could encourage employers to drop insurance.
- Will definitely change the benefits that employers offer.
- Could lead to more uninsured, not less.

Questions?

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