

Health Care Reform Analysis

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HEALTH CARE REFORM CHANGES BASED ON RECONCILIATION BILL (RB)

REGULATION	2010-2011 CHANGES	EBAC COMMENTS
<p>GRANDFATHERED PLANS</p>	<p>Under PPACA, group health plans in effect on the date of enactment are exempt from many of the health care reforms. The grandfather rule is not limited to individuals enrolled on the date of enactment, but rather:</p> <ul style="list-style-type: none"> • New employees (and their families) may be covered under an employer's grandfathered plan; and • Family members of current employees who are covered by the grandfathered plan may also be added. • Under PPACA, grandfathered plans <u>ARE SUBJECT TO</u> the following requirements: <ul style="list-style-type: none"> ○ Cost reporting and rebates ○ Limitation on lifetime and annual limits ○ Limitation on preexisting condition exclusions for certain dependents ○ Prohibition of Discrimination Based on Salary ○ Coverage of adult children until age 26; however, for years before 2014, the coverage requirement applies only if the adult child is not eligible to enroll in another eligible employer plan ○ PPACA also contains a delayed effective date for collectively bargained plans for many of the reforms. 	<p>Companies that have a health plan today were grandfathered and not required to comply with a lot of the regulations. However, there are a number of provisions that do apply to plan years starting October 1, 2010. If your plan year is a calendar year plan then your plan will need to be compliant with these provisions January 1, 2011.</p>

<p>ANNUAL AND LIFETIME LIMITS</p>	<p>Plans may not impose lifetime limits and only restricted annual limits, as determined by the Secretary of Health and Human Services (HHS), on the value of essential benefits (as defined by PPACA) for any participant or beneficiary. For plan years beginning on or after January 1, 2014, group health plans and group health insurers may not impose any annual limit. Otherwise permissible lifetime or annual limits may be imposed on specified covered benefits that are not essential health benefits. (New § 2711 of the PHSA)</p>	<p>We need more information to find out what type of annual limits can be applied since the lifetime limits are going away. If the annual limits are reasonable then they could negate the cost increase to the plan to change to the no lifetime limit.</p>
<p>COVERAGE OF PREVENTIVE CARE</p>	<p>Plans must provide first dollar coverage (i.e., no cost sharing) for certain evidence based preventive care (including well child care) and certain immunizations. (New § 2713 of the PHSA)</p>	<p>If you are not a Grandfathered plan you will have to comply with this change.</p>
<p>COVERAGE OF ADULT CHILDREN</p>	<p>Plans that cover dependent children must provide for coverage of married or unmarried children until age 26. There is no requirement to cover children of covered dependent children. The requirement is applicable even if the child is not a tax dependent. Up until 2014 the plan does not have to cover the adult child if they are eligible to enroll in other employer-sponsored health plan coverage. (New § 2714 of the PHSA)</p>	<p>This will be an added administrative burden trying to find out if the child has other employer coverage.</p>
<p>NONDISCRIMINATION RULES FOR INSURED PLANS</p>	<p>The nondiscrimination rules of Code Section 105(h) previously applicable only to self-insured health plans are extended to fully-insured group health plans. (New § 2716 of the PHSA)</p>	<p>If Grandfathered plans had to comply with this prior to 2014 this would be a deal killer. Any fully insured plan that excludes a class of employees will now have to pass the Section 105(h) test. However, if we find out that changing the Grandfathered plans benefits voids their Grandfathered status then we will have to deal with this prior to 2014.</p>

PRE-EXISTING CONDITION EXCLUSIONS	With respect to children under age 19, plans may not impose a pre-existing condition exclusion or limitation. (New § 2704 of the PHSA)	We do not consider this a cost driver since a lot of the insurers only check pre-existing coverage on a random basis.
PATIENT PROTECTIONS	Plans that require or provide for a designation of a primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. PPACA also requires plans to comply with requirements regarding access to emergency services and obstetrical and gynecological care and to allow designation of a pediatrician as a primary care provider for children. (New § 2719A of the PHSA)	Not sure how this is going to affect HMO plans. Their whole model is to make the plan participant use a physician from their network.
W-2 REPORTING REQUIREMENT	In addition, employers must include the value of all such coverage on the employee's W-2. The W-2 reporting requirement applies for all tax years beginning on or after January 1, 2011.	Just another added employer expense.
CLAIMS PROCEDURES	Plans must establish an internal claims appeals process that (i) provides notice in a culturally and linguistically appropriate manner of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals, (ii) allows claimants to review the entire claim file and present evidence, (iii) allows claimants to continue receiving coverage during the appeals process, and (iv) initially incorporates the claims review procedures set forth in Department of Labor regulations that apply to plans covered by ERISA. Plans must also establish review process that complies with applicable state law and that, at a maximum, includes the consumer protections set forth in the Uniform External Review Model Act developed by NAIC or, in the case of self-insured plans, meets similar requirements as provided by Security of HHS. The Secretary of HHS may deem the existing external review process of a group health plan to be in compliance with the provisions of the bill. (New § 2719 of the PHSA)	Based on what we have read we should receive a lot of help from the insurers with these claim procedures.

OVER-THE-COUNTER REIMBURSEMENTS	Effective for tax years beginning on or after January 1, 2011, over-the-counter medicines or drugs are not eligible for reimbursement under an FSA, HRA, or HSA without a doctor's prescription.	This is disappointing since you want to encourage the use of over the counter medication.
HSA DISTRIBUTIONS	The excise tax for nonqualified distributions from HSAs is increased to 20%, effective for distributions after December 31, 2010.	
SAFE HARBOR RULES FOR CAFETERIA PLANS OF SMALL EMPLOYERS	A new safe harbor from the nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained by eligible employers to the extent certain requirements are met, such as (i) all "nonexcludable" employees are eligible to participate and (ii) certain minimum contribution requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two preceding years (provided it is a full year). The safe harbor applies for tax years beginning on or after January 1, 2011.	
CREDIT FOR SMALL EMPLOYERS	Effective for taxable years beginning on in 2010, small employers with fewer than 25 "full-time equivalent" employees and average annual wages of less than \$50,000 are eligible for a tax credit equal to a portion of the employer's cost to provide health insurance.	More to come on this provision.
MEDICARE PART D DRUG DISCOUNTS	Beginning in 2011, drug manufacturers will be required to provide a 50% discount to Medicare Part D beneficiaries on brand-name drugs and biologics in the donut hole coverage gap.	
MEDICARE TESTING PART D PREMIUMS	Beginning in 2011, Medicare Part D premiums will be set higher than the standard level for those with incomes above \$85,000 for individuals and \$170,000 for couples.	

COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT (CLASS)	Beginning 2011, the government is creating a limited long-term-care (LTC) program.	We do not have a lot of details on this program other than it would be offered to every employer. We are checking with some of the life and disability insurers to see if they will have any part in administering this program.
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REGULATION	2012 CHANGES	EBAC COMMENTS
UNIFORM EXPLANATION OF COVERAGE	<p>The plan administrator (in the case of a self-insured plan) or the insurer (in the case of a fully-insured plan) must prepare and distribute a paper or electronic summary of coverage to all applicants and all enrollees, both at the time of initial enrollment and annual enrollment. This is in addition to the Summary Plan Description otherwise required by ERISA. The summary must satisfy certain uniform standards developed by the Secretary of HHS, including but not limited to: (i) no more than four pages in length with print no smaller than 12 point font, (ii) written in a culturally and linguistically appropriate manner, and (iii) containing certain contents related to the covered benefits, exclusions, cost sharing, and continuation. HHS must establish the standards within 12 months of the date of enactment and the summary must be provided within 24 months after the date of enactment. In addition, the plan or the issuer (as applicable) must notify enrollees of material changes to the coverage reflected in the most recent summary no less than 60 days in advance of the effective date of such coverage. Failure to comply may result in a \$1,000 penalty for each failure. (New § 2715 of the PHSA)</p>	<p>Most plans already provide a summary in addition to the SPD so we don't think this will be too much of a change.</p>

ENSURING QUALITY OF CARE	Plans must annually report to HHS and to enrollees (during each open enrollment period) regarding benefits under the plan that improve health, such as case management, disease management, and wellness and health promotion activities. HHS is to develop the reporting standards within two years of the enactment date. (New § 2717 of the PHSA)	I doubt we will get any help from the insurers with this reporting requirement. The expense to employers to provide all of this government data is going to be quite large and very time consuming.
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REGULATION	2013 CHANGES	EBAC COMMENTS
FSA CAP	Effective starting in 2013, there is a \$2,500 cap on contributions to a health FSA. The cap is indexed to the CPI starting in 2014.	This is an unfortunate tax.
HI TAX CHANGES	Beginning in 2013, individuals with wages above \$200,000 for a single return and \$250,000 for a joint return would be subject to an additional 0.9% tax on wages in excess of these thresholds. RB Alert: Under the Reconciliation Bill, such individuals would also be subject to a 3.8% tax on their net investment income (to the extent that total income exceeds the thresholds). This new tax would be effective starting in 2013.	Another tax to help fund this high cost program.
CER FEE	To fund comparative effectiveness research, effective for each policy year ending after September 30, 2012, a fee equal to \$2 (\$1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of covered lives is imposed. The fee applies to accident or health insurance policies other than policies covering benefits exempt under HIPAA. The fee also applies to self-insured plans.	Another health care tax.

ELECTRONIC TRANSACTION STANDARDS	Plans must implement certain electronic transaction standards and certify compliance to HHS. The timing of certification varies depending on the type of transaction. For example, the health plan must certify compliance with electronic fund transfer, health claim status, and health care payment and remittance advice standards established by PPACA by no later than December 31, 2013. Compliance with other standards, such as the health claims or equivalent encounter standard, is due no later than December 31, 2015.	We are not sure how much of this reporting burden can be handled by the insurance carriers. For clients already sending electronic files to the carriers this could be added cost to reconfigure the electronic files.
TAX ON MEDICAL DEVICE MANUFACTURERS	Beginning in 2013, the law will impose an excise tax of 2.3%, expected to be pass through to employer plans and other payers, on the sale of medical devices, with certain exceptions.	
DEDUCTION OF RETIREE MEDICAL COSTS	Effective for tax years beginning on or after January 1, 2013, the deduction previously permitted for amounts allocatable to the Medicare Retiree Part D subsidy is eliminated.	Even though this is going away in 2013 companies have to recognize the lost asset on their P&L in 2010. That's why so many companies (AT&T, John Deere, etc.) have already announced the charge they will have to report in 2010.

REGULATION	2014 CHANGES	EBAC COMMENTS
HIGH RISK POOLS	<p>Until the high risk pool established under PPACA for individuals with pre-existing conditions is terminated in 2014, a group health plan must reimburse the high risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to disenroll from the group health plan. (§ 1101 of PPACA)</p>	<p>I don't see this happening with any of our clients.</p>
HEALTH CARE EXCHANGES	<p>PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014. Although generally directed at individuals, the exchange-related provisions in PPACA impact employers in the following ways:</p> <ul style="list-style-type: none"> • Beginning in 2017, states may allow <i>all</i> employers of any size to offer coverage through the exchange. Prior to 2017, only small employers (employers with 100 employees or fewer) may participate. For years before 2016, a state may limit small employers to those with 50 or fewer employees. • Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan; however, exchange-related coverage that is not offered by the employer may not be offered through the employer's cafeteria plan. 	<p>For the next three years this part of the Bill will garner the most interest. There are a lot of questions as to how the exchanges will be priced and whether they will be priced competitively.</p>

PROHIBITION ON PRE-EXISTING EXCLUSION LIMITATIONS	No preexisting condition exclusions or limitations are permitted. (§ 2704 of the PHSA)	If you dump a large uninsured population into the exchanges or into employer plans that have previously been insured through Medicaid programs and the individuals have a pre-existing condition this regulation could raise health care costs.
NO DISCRIMINATION BASED ON HEALTH STATUS	Essentially, the same rules that currently exist under HIPAA are included in PPACA. PPACA does, however, raise the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20% of the COBRA cost of coverage to 30% of the COBRA cost of coverage for those participating in the program (and allows the Secretaries of DOL, HHS and Treasury leeway to increase the percentage to 50%). (§ 2705 of the PHSA)	
PROHIBITION ON DISCRIMINATION AGAINST PROVIDERS	No discrimination against a provider who is acting within the scope of his/her license is permitted. This does not mean, though, that a health plan must contract with any willing provider. (§ 2706 of the PHSA)	Not quite sure what ramifications this will have if any.
COST-SHARING LIMITATIONS	Certain cost-sharing requirements must be satisfied such that the out-of-pocket (OOP) expense does not exceed that applicable to Health Savings Account (HSA) related coverage, and deductibles do not exceed \$2,000 for single coverage and \$4,000 for family coverage (as indexed). (§ 2707 of the PHSA)	We had initially read that the HSA out of pockets were being limited but they are keeping them as they are today. We are glad the HSA did not go away. We believe the deductible limit mentioned only applies to the small group market but we are not 100% sure at this time. More to come on this.

LIMITATION ON WAITING PERIODS	Plans may not impose a waiting period in excess of 90 days. There is also an excise tax penalty under PPACA for waiting periods imposed on full-time employees (i.e., employees working more than 30 hours per week) greater than 90 days (see “Employer Responsibility” below for a discussion of the penalty).	For employers with a large hourly workforce this is not a welcome regulation.
INDIVIDUAL RESPONSIBILITY	<p>Effective January 1, 2014, individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax. Self-insured plans and insurers will be required to report certain coverage-related information to the individual and to the IRS. Under PPACA, individuals generally pay the greater of a flat dollar amount and a percentage of income payment. The flat dollar amount penalty is \$95 in 2014, \$495 in 2015 and \$750 in 2016 and thereafter. The percentage of income limit is 0.5% in 2014, 1.0% in 2015, and 2.0% in 2016 and thereafter.</p> <p>RB Alert: As under PPACA, individuals generally pay the greater of a flat dollar amount and a percentage of income payment under the Reconciliation Bill. The flat dollar amount penalty is \$95 in 2014 under both PPACA and the Reconciliation Bill. The Reconciliation Bill reduces the flat dollar amount to \$325 in 2015 and to \$695 in 2016 and thereafter. The percentage of income limit is increased to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter.</p>	This should be easy for the IRS to audit because of the mandate to report the value of the health care coverage on the W-2.
AUTOMATIC ENROLLMENT	Large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program should include adequate notice and the opportunity for an employee to opt out of the “auto” coverage and elect another option, or opt out altogether. (§ 1511 of PPACA)	This could add additional admin duties on the employer’s HR staff.

<p>NOTIFICATION OF AVAILABILITY OF EXCHANGE AND SUBSIDIES</p>	<p>Employers must notify each employee at the time of hiring of the following: (i) the existence of the exchange, (ii) that the employee may be eligible for a subsidy under the exchange if the employer’s share of the total cost of benefits is less than 60% and (iii) that if the employee purchases a policy through the exchange, he or she will lose the employer contribution to any health benefits offered by the employer (except as set forth in the free choice voucher requirement). (§ 1512 of PPACA)</p>	<p>As we have mentioned before this Bill is going to require a lot of administration.</p>
<p>EMPLOYER PENALTIES</p>	<p>Notwithstanding the obligation to comply with the reform requirements identified above, there is generally no requirement for employers to offer the same coverage that insurers offering coverage in the exchange must offer. In fact, there is generally no requirement for employers to offer any coverage; however, employers with 50 or more full-time employees (“Applicable Employer”) are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees.</p>	
	<p>Applicable Employers who fail to offer any full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any employee enrolls in and receives a subsidy for the exchange. The penalty is determined on a monthly basis and is the product of the applicable number of full-time employees of the employer for that month (including those employees who did not receive a subsidy for the exchange) and 1/12 of the applicable payment amount, which is \$2,000 under PPACA. This regulation disregards the first 30 employees. Thus, for example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount.</p>	<p>Companies will be allowed to drop health coverage and pay the \$2,000 penalty. I am not sure taking this approach will allow companies to attract and retain employees.</p>

<p>EMPLOYER PENALTIES (Continued)</p>	<p>Applicable Employers offering coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy are subject to a penalty equal to the product of the total number of such employees (i.e., employees receiving the credit) and 1/12 of \$3,000 (400% of the applicable payment amount, which is \$750). The amount of the tax in this instance is limited to 1/12 of \$750 multiplied by the total number of the employer’s full-time employees. Note that an employee who is offered employer coverage is not eligible for a credit unless the employee’s required premium for the coverage exceeds 9.5% of the individual’s household income or the plan’s share of allowed costs under the plan is less than 60%.</p>	<p>This tax is designed to prevent an employer from playing the game of dumping employees in the exchange.</p>
<p>REPORTING REQUIREMENTS</p>	<p>Applicable Employers must also report to the Secretary of Treasury each year, certifying (i) whether coverage is offered to full-time employees, (ii) the waiting period for any such coverage, (iii) the number of full-time employees of the employer during each month, and (iv) the name, address and TIN of each full-time employee and the months during which they were covered under the plan. (§ 10108 of PPACA)</p>	<p>More reporting requirements. I doubt we will be able to get the insurers to report this for us.</p>
<p>“FREE CHOICE VOUCHERS”</p>	<p>Employers that offer minimum essential coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income does not exceed 400% of the federal poverty level and the required contribution under the employer’s plan would be between 8 and 9.8% of their income. Free choice vouchers are excludible from employees’ incomes and deductible by the employer. Voucher recipients are not eligible for tax credits through the exchange. (§ 10108 of PPACA)</p>	<p>This will be a challenge to administer.</p>

REGULATION	2018 CHANGES	EBAC COMMENTS
<p>TAX ON HIGH COST COVERAGE</p>	<p>Beginning in 2013, a nondeductible 40% excise tax is imposed on the monthly value of high cost coverage in excess of 1/12 of \$8,500 for single coverage and 1/12 of \$23,000 for family coverage, indexed to CPI + 1 beginning in 2014. The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, construction, mining) and those employed to install electrical or telecommunication lines is increased to \$8,850 for individual coverage and \$26,500 for family coverage. The limit for employees in “high cost states” (as determined by HHS) is increased to 120% in 2013, 110% in 2014 and 105% in 2015. “High cost states” are each of the 17 states estimated by HHS to have the highest average cost (based on aggregate premiums) during 2012 for employer-sponsored health plans. In calculating the tax, the value of coverage for retirees under age 65 and coverage for retirees age 65 or older may be combined.</p> <p>RB Alert: The Reconciliation Bill makes the following changes to PPACA:</p> <ul style="list-style-type: none"> • The tax is delayed until 2018. • The thresholds for the tax are increased to \$10,200 for single coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and employees in high risk professions). These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018. The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter. An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer’s age and gender demographics are not representative of a national average. The transition rule for high cost states does not apply. 	<p>At least we will have time to prepare for this tax burden.</p>

<p>TAX ON HIGH COST COVERAGE (Continued)</p>	<ul style="list-style-type: none"> • The higher family threshold applies to both single and family coverage offered under a multiemployer plan. <p>“Coverage providers” are defined to include the following:</p> <ul style="list-style-type: none"> • In the case of fully-insured plans, the health insurer • In the case of HSA or MSA contributions, the employer making the contributions • In the case of a self-insured plan, the person who administers the plan (e.g., the third-party administrator) <p>In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (and may also include HSA contributions). The coverage provider’s applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider’s coverage to the total value of employer-sponsored coverage. Although the coverage provider is responsible for paying the tax, the employer must calculate the tax, including each coverage provider’s applicable share, and notify each coverage provider. The coverage subject to this rule includes the following:</p> <p>The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee, except</p> <ul style="list-style-type: none"> • accident and disability insurance • long-term care • hospital indemnity and/or specified disease coverage that is paid for with after-tax dollars • Both nonelective and salary reduction contributions to a health FSA • Employer contributions (presumably including salary reductions) to an HSA 	
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