Health Care Reform

2010-2014

Presentation by:

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This presentation is intended to bring the small employer up-to-date and cover 2014 required implementation.

George Khoury and K-KICS Insurance Services do not provide Legal or Financial Advice.

We recommend you contact your legal council and tax accountant for advice.

Agenda for Today

- **2010 Affordable Care Act**
- **2011 Changes**
- **2012 Changes**
- **2013 Changes**
- **2014 Outlook**

Affordable Care Act

- Patient Protection and Affordable Care Act (PPACA) – signed on March 23, 2010
- Health Care and Education Reconciliation Act (Reconciliation Act) – signed on March 30, 2010

Health Care Reform – Which Plans Must Comply?

- New rules generally apply to group health plan coverage
- Exceptions
  - Excepted Benefits: Health FSAs, HRAs, Life, AD&D, Liability insurance, Dental-only, Vision-only, etc
  - Group health plans covering fewer than 2 employees
  - Retiree-only plans

Calendar Year 2010

Grandfathered Plans

- Existing plans = Grandfathered plans
  - A group health plan or health insurance coverage in which an individual was enrolled on the date the health care reform legislation was enacted
- Changes to plan design can cause loss of "grandfathered" status
- Each employer group can decide to retain its grandfather status at each subsequent plan anniversary
- Health Insurance Changes – Required Benefit changes:
  - Lifetime and annual limits prohibited on essential benefits
  - Pre-existing condition exclusions (19 years EE or Dep)
  - Rescissions prohibited (except for fraud)
  - Excessive waiting periods
- Required coverage of adult children up to age 26
- Reporting medical loss ratio

Grandfathered Plans

- **Prohibited Changes**
  - Significantly reducing benefits or contributions
  - Significantly raising co-payment charges or deductibles
  - Raising co-insurance charges
  - Adding or tightening annual limits
- **Special Rule for Insured Collectively Bargained Plans**
- **Additional Requirements**
  - Disclose grandfathered status
  - Status can be revoked if try to avoid compliance

Grandfathered Plans –

Permitted Changes

- Cost adjustments consistent with medical inflation
- Adding new benefits
- Modest adjustments to existing benefits
- Voluntarily adopting new consumer protections under the health care reform law
- Changes to comply with state or federal laws

Non-Grandfathered Plans -

Must implement

- Patient Protections
- Nondiscrimination rules for fully-insured plans
- New appeals process – mandatory internal and external
- Quality of care reporting
- Insurance premium restrictions
- Guaranteed issue and renewal of coverage
- Nondiscrimination based on health status/in health care
- Comprehensive health insurance coverage
- Limits on cost-sharing:
    - Preventive Care/Immunizations services must be covered at 100%
    - Emergency Room services must have the same cost sharing for network and non-network providers
- OB/GYN, Pediatrician, ER services – preauthorization or referral requirements prohibited
- Coverage for clinical trials

Restrictions on Lifetime and Annual Benefits

- **Lifetime Limits**
  - Notice and special enrollment required for individuals who reached lifetime limit
- **Restricted Annual Limits**
  - After September 23, 2010: $750,000
  - After September 23, 2011: $1.25 million
  - After September 23, 2012 (before January 1, 2014): $2 million
- **Waivers available for annual limit requirements**
  - Designed to help mini-med plans

Appeals Process Changes

- Apply to new plans
- Group health plans and health insurers must implement effective internal appeals process
- Plans and insurers must meet minimum requirements for external review (state or federal)
- Grace period until PY on or after January 1, 2012 for some rules

Essential Health Benefits

- **Defined:**
  - Ambulatory services,
  - Emergency services,
  - Hospitalization,
  - Maternity and newborn care,
  - Mental health and substance abuse services,
  - Prescription drugs,
  - Rehab services,
  - Lab services,
  - Wellness and disease management,
  - Pediatric care

Small Employer Tax Credit

- **Qualifying small employers that provide health care coverage to employees are eligible for tax credit**
  - Have fewer than 25 full-time equivalent (FTE) employees
  - Pay wages averaging less than $50,000 per employee per year
  - Has a "qualifying arrangement" (pays premiums for each employee in a uniform percentage that is at least 50 percent of the cost of coverage)
- **Amount of Credit**
  - **Credit based on premiums paid by employer for health insurance coverage**
  - **Credit amount = up to 35 percent of premium costs paid (25 percent for tax-exempt employers)**
    - On Jan. 1, 2014, increases to 50 percent (35 percent for tax-exempt employers)
  - **Depends on employees and wages**
    - The credit phases out gradually for:
    - Employers with average wages over $25,000 and
    - Employers with more than 10 FTEs

Calendar Year 2011

Medicare Benefits

Medicare Drugs:

- Provide a $250.00 rebate to beneficiaries who reach drug expense $3,610 coverage gap (donut Hole)
- Phases out coverage gap by 2020
- Premium increased for higher income retirees
- Medicare Advantage funding frozen for 2011
- Increase Medicare Advantage premium for 2012 t reduce enrollment
- When in Coverage Gap, reduce Brand Name drug by 50%

Simple Cafeteria Plan

- **Some small employers can provide a simple cafeteria plan for employees**
  - 100 or fewer employees during one of the last 2 years
- **Strict contribution, eligibility and participation requirements apply**
  - Employer contributes minimum amount
  - All employees with 1,000 hours of service can participate and elect any benefit
- **Nondiscrimination rules will be treated as satisfied**

Limits on OTC Reimbursements

- **Apply to Health FSAs, HRAs, HSAs and Archer MSAs**
- **Medicine or drugs only treated as qualified medical expense for tax exclusion if they are prescribed or are insulin**
  - This means no reimbursement for OTC medicine or drugs without a prescription (except insulin)
  - New rules do not apply to OTC devices or supplies
- **Debit cards can be used for prescription OTC medicines or drugs**

Increased HSA Penalty Tax

- **HSA distributions not used for medical expenses previously subject to tax of 10 % and inclusion in gross income**
  - Not monitored by employer
  - Taxation between employee and IRS
- **Tax amount increased to 20 % if funds not used for medical expenses**

Medical Loss Ratio

- **MLR rules:** Insurers must spend 80% (small groups) - 85% (large groups) of premiums on medical care and quality improvement (not admin costs) or give rebates

- **HHS issued final rule**
  - Adopted NAIC recommendations
  - Outlines items counted as medical care/health care quality improvement (and items that are not)
  - Provides rules for rebates

MLR Rebates

- **Issuer must provide rebate (and notice) if MLR requirements not met**
- **Due by the August 1 after reporting year**
- **Issuers are generally required to provide rebate directly to policyholder (employer)**
- **Policyholder must use rebate for benefit of enrollees**
  - Permitted to use in ways that are not taxable to enrollees, such as through reduced premiums

Calendar Year 2012

Uniform Summary of Benefits and Coverage

- **Applies to grandfathered and non-grandfathered plans**
- **Final standards issued in February 2012**
- **Template, instructions and glossary provided**

  refer to CCIIO.CMS.GOV/RESOURCES
- **Compliance deadline**
  - Issuers must provide to health plans effective Sept. 23, 2012
  - Plans and issuers must start providing to participants and beneficiaries for open enrollment periods/plan years beginning on or after Sept. 23, 2012

SBC Standards

- **Appearance**
  - Cannot be longer than 4 double-sided pages
  - 12-point or larger font
- **Language**
  - Easily understood language
  - "Culturally and linguistically appropriate manner" – interpretive services and written translations upon request.
- **Content Requirements**
  - Uniform definitions of standard terms
  - Exceptions, reductions and limitations on coverage
  - Cost-sharing provisions

SBC Standards

- **Content Requirements (continued)**
  - Renewability/continuation of coverage
  - Examples of common benefits scenarios
  - Statement that outline is a summary of the plan
  - Contact information for obtaining plan/SPD
- **Final Regulation Requirements:** must include
  - Internet address or contact info for obtaining a list of network providers (if PPO Network)
  - Internet address or contact info for information about Rx coverage
  - Internet address for obtaining the uniform glossary of terms
  - Premium / cost of coverage information not required

Providing the SBC to Participants and Beneficiaries

- **Plans must provide SBC to Participants and Beneficiaries**
  - For each benefit package offered or which they are eligible
  - Annually at renewal (or 30 days before new plan year if automatic renewal)
  - With enrollment application materials
  - If no written enrollment materials, when the participant is first eligible to enroll
  - Before the first day of coverage (if there have been changes to the SBC)
  - To special enrollees within SPD timeframe
  - Upon request

Updating the SBC

- **Material modifications not in connection with renewal must be described in a summary of material modifications (SMM) or an updated SBC**
- **Material Modification**
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits
- **Must be provided at least 60 days BEFORE modification becomes effective**

Providing the SBC to GHPs

- Final rules
- Issuers must provide SBC to GHPs:
  - Upon application
  - Before the first day of coverage (if there have been changes to the SBC)
  - When a policy is renewed or reissued
  - Upon request

Providing the SBC

- **Must be provided:**
  - To applicants (at the time of application)
  - To enrollees (upon enrollment and re-enrollment)
- **May be provided in paper or electronic form**
  - Must satisfy rules for electronic disclosure
- **Penalties**
  - $1,000 for each willful failure to provide
  - $100 per day per individual excise tax

MISCELLANEOUS PROVISIONS

Women's Preventive Services

Additional preventive services for women covered at 100% effective first plan renewal as of August 1, 2012

Comparative Effectiveness Research Fee

- Used to fund the Patient Centered Outcome Research Institute
- Fees applies to plan years beginning on or after 10/2/11 and continues through 2019
- First payment due July 31, 2013
- Annual fee begins at $1 per participant and increases in future years

Calendar Year 2013

Miscellaneous Provisions

- Employer Reporting on W-2
  - Employers must disclose aggregate cost of employer-sponsored health coverage on Forms W-2
  - Deadlines delayed:
    - Optional for 2011 tax year
    - **For small employers – optional for 2012 tax year and beyond**
  - Includes group health plan coverage, whether paid by employer or employee
  - Does not include Contributions to certain types of plans (FSA, HRA, HSA, Dental, Vision)

Miscellaneous Provisions

- Taxes and Fees
  - Medical Device Excise Tax added 2.3%
  - Increase Medical Care expense exemption to 10% from 7.5%
  - Medicare Hospital Insurance Tax added 0.9%
  - Exchange Notice

Provide notification to all active employees about the Exchange no later than 10/1/2013. New employees within 14 days of start date.

- Summary of Benefits and Coverage

Update the SBC to include reference to the exchange

2014 is upon us

Do you know what needs to be done ?

EVERY CITIZEN MUST HAVE INSURANCE

Miscellaneous Provisions

- **3-Year Transitional Reinsurance Fees**
  - Employer sponsored plans will incur an annual fee of $63 per covered life beginning 2014.
- **Pre-existing Condition Exclusions (Impacts)**
  - Pre-existing condition exclusions prohibited for all enrollees.
  - Will result in individuals turning on and off insurance in light of minimal penalties for not having coverage.
- **Waiting Periods**
  - Waiting periods over 90 days prohibited.
- **Annual Dollar Limits**
  - Annual limits on the dollar value of essential benefits prohibited.
  - Not applicable to FSAs, HSAs and integrated HRAs.

Miscellaneous Provisions

- **HIPAA Wellness Incentives**
  - Codifies HIPAA wellness incentives, but differential increased from 20% to 30%. May be implemented prior to 2014.
- **Extension of Child Coverage to Age 26 – Grandfathered Plans**
  - Grandfathered plans must cover children up to age 26 regardless of eligibility for other employer coverage.
- **Clinical Trials**
  - Must cover routine patient costs in connection with participation in trials.
- **Provider Non-discrimination**
  - No discrimination against a provider who is acting within the scope of license.

Miscellaneous Provisions

- **Auto Enrollment**
  - Auto enrollment required with employee having ability to opt out of coverage.
  - Not effective until after regulations released.
  - Regulations will not be issued before 2014.

- **Health Insurance Industry Tax**
  - $8B in 2014 increasing to $14.3B in 2018; trended after 2018.

- **Exchange Reinsurance Program**
  - $25B tax on insurers and Third Party Administrators (TPAs) from 2014 to 2016.

Navigating Health Care Exchanges

- **Minimum Benefit Package**
  - Bronze, Silver, Gold and Platinum Plans with actuarial values of 60% - 90%.
  - Catastrophic Plan for individuals under 30.
  - Plans must cover Essential Health Benefits (HHS continues to clarify).
  - Large employer plans offered outside the Exchanges may not be required to offer Essential Health Benefits.
- **Guaranteed Issue and Renewability**
  - Also includes interim high risk pool for currently uninsured (starting 90 days after enactment.)

Navigating Health Care Exchanges

- **Required Service Categories & Coverage**
  - Mandatory statutory list, to be supplemented by Secretary of HHS.
  - Limited to insured plans.
- **Maximum Deductibles and OOP Limits**
  - Deductibles generally limited to $2,000/$4,000 (indexed)
  - Out of Pocket (OOP) maximum same as for Health Savings Accounts (HSA) - compatible High Deductible Health Plans (HDHP).
- **Community Rating – Limits on Age Rating**
  - 3 : 1 ratio maximum (50% surcharge also permitted for tobacco use.)

Navigating Health Care Exchanges

- **Exchanges**
  - State-based exchanges for individuals and small employers (under 101 employees).
  - Federal government will make available Federally Facilitated Exchanges through Qualified Health Plans (QHP) for states that have declined to set up exchanges.

- **Low Income Premium Subsidy in the Exchange**
  - Medical eligibility expanded to 133% of Federal Poverty Level (FPL).
  - Subsidies available between 133% and 400% of FPL.
  - Employees are only eligible for subsidies if employer coverage is below minimum value or contributions are unaffordable.

Mandates - Pay or Play

- **Determine If You Are A Large Employer**
  - An “employer” is the entity that is the employer of an “employee” as determined under a common-law test.
  - Employers with < 50 full-time employees - Not a Large Employer
    Employer mandate penalty, for the most part, does not apply.
  - Employers with > 50 full-time employees - Large Employer
    Employer mandate Pay or Play rules apply.
  - A “large” employer is an employer who employed an average of at least 50 full-time employees, including Full-Time Equivalent (FTE) employees, on applicable business days during the preceding calendar year.

Mandate - Pay or Play

- Dependents Who Must Be Offered Coverage
  - Employers must offer coverage to full time employees and their dependents defined as an employee's child who has not yet attained age 26.
  - Definition does not include a spouse or a domestic partner.

- Minimum Value of Employer Coverage or "Unaffordable" Employer Coverage
  - Employees under 400% of FPL eligible for subsidized exchange coverage if actuarial value of employer plan is below 60%.

    Or
  - If employee contributions for single coverage exceed 9.5% of household Adjusted Gross Income (AGI).

Mandates - Pay or Play

- Pay or Play Penalty for Not Offering Coverage if at Least One Employee gets Subsidy in Exchange.
  - If an employer offers Minimal Essential Coverage (MEC) to all full-time employees and dependents (with a few exceptions), a $2,000 annual tax (indexed) times the number of Full-time Equivalent (FTE) Employees applies to all with the exception of the first 30 FTEs.
  - FTE is defined as working 30 or more hours per week.
  - No part-time employee coverage requirement.

Mandates - Pay or Play

- Pay or Play Penalty for Not Offering Coverage if at Least One Employee gets Subsidy in Exchange.
  - If an employer offers Minimal Essential Coverage (MCE) to all full-time employees (and their dependents) but at least one full-time employee obtains federally-subsidized coverage through an Exchange, the employer must pay:
    - An annual tax of $3,000 (indexed) per subsidized full time employee.

    Or

    - $2,000 for each full time employee less the first 30 FTEs.

Note: Penalties are determined on a month by month basis.

Tax Penalties generally are not eligible as deductions.

Mandates - Pay or Play

- Employer Reporting Requirements
  - Reporting must be provided to both Secretary of HHS and employees regarding minimum Health Plan coverages.
- Individual Penalty for Failure to Have Health Coverage
  - Greater of 1.0% of Adjusted Gross Income AGI or $95/person in 2014, 2.0% or $325/person in 2015, 2.5% or $695/person in 2016; indexed.
  - Family dollar amount capped at 300% of individual penalty.

Employer Tools

- **Does My Plan Provide Minimal Value?**
  - HHS has issued an "actuarial value" calculator.
  - Although this calculator is not the same as a "minimum value" calculator, it is expected to produce a similar result.
  - Thus, an employer may want to used the actuarial value calculator on a preliminary basis, to estimate whether its plan provides minimum value.

Following is a Sample Calculator

Employer Tools

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
OOP Maximum ($)			
OOP Maximum if Separate ($)			

Click Here for Important Instructions

	Tier 1			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☑	☑		
Specialist Visit	☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		
Rehabilitative Speech Therapy	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		
Skilled Nursing Facility	☑	☑		

Solutions: Test Your Plan

- Does Your Plan(s) Pass the Two Safe Harbor Laws?
  - The two safe harbor laws are:
    - Your plan(s) meet the minimal essential benefits for all full time employees and their eligible dependents.
    - Are your minimal plan contributions 9.5 % or less of the lowest paid Full Time Equivalent employee?

Test to Ensure this is the case

Solutions: Evaluate Your Employee Population

- Determine How Many Full Time Equivalent (FTE) Employees You Have
  - There is a look back period that begins 3 to 12 months prior to your 2014 renewal date.
  - Review and select the look back period for your plan(s).
  - Determine how many FTE employees you will have

- Do You Need to Modify This Number for Financial and Business Reasons?
  - How will HHS evaluate plans with regards to changes in FTE's, workforce reduction etc?
  - Employer will need to demonstrate changes were not done to avoid or minimize Employer Shared Responsibility.

Ensure That Your Decisions Do Not Have Punitive Consequences

Solutions: Evaluate Dependent Coverage

- Do You Want to Cover Dependent Spouses Under Your Plan(s)?
  - If yes, how much should the contribution be for each plan?
  - How will this decision impact employee morale and HR?
- You Must Cover Dependent Children Up To Age 26
  - How much should the contribution be for dependents for each plan?

Note: The regulations do not mandate a minimum contribution for dependents thus far.

Solutions: Evaluate Employee Compensation for Possible Subsidies

- Categorize Your Employees by Hours Worked and Wages Earned
  - Calculate salary of lowest paid Full Time Equivalent employee using 30 hours to establish contributions.
  - Ensure that employee contribution does not exceed 9.5% of lowest paid employee annual salary for employee contribution of said plan.

Consider Offering 60% Actuarial Value Plan at Minimum Monthly Contribution and Offering Buy-Up Plans.

Solutions: Evaluate Health Plans

- Plan(s) Evaluation
  - Evaluate your benefit plan to ensure it complies with the Minimal Essential Benefits defined as 60% of the actuarial value.
  - Fully insured plans should meet the minimal requirements of the actuarial value.
  - Self-funded Plans should be reviewed to ensure they are in compliance.
  - Pay attention to adding HRA and HSA benefits to existing plans as they can impact the value of the plan.
  - Consider offering multiple plans to accommodate employees with applicable benefit design and cost.

Solutions: Evaluate Health Plans

- Sample Plans
  - Bronze Plan - Minimum 60% of Actuarial value
  - Silver Plan – Exclusive Provider Organization - EPO Plan
    Covers in network only with no choice accommodations
  - Gold Plan – Preferred Provider Organization - PPO Plan Covers PPO providers with out of network benefits
  - HMO Plan – Minimum 60% of Actuarial value

- Offering multiple plans will allow for flexibility within plan designs providing both Safe Harbor Test are Satisfied

Questions and Answers - Q & A

- Are My Employees Eligible for Subsidies Through the Exchanges?
  - Probably not, providing your plan meets the following requirements
    - Plan offers major medical coverage that meets the definition of minimally essential coverage.
    - Does not charge a full time equivalent employee a contribution that exceeds 9.5% of the Federal Poverty Level (FPL) for employee coverage.

Questions and Answers - Q & A

- How will Dependents be Covered in Light of the Exchanges?
  - They will have many choices.
  - Dependent spouses working 30+ hours will in many cases be eligible for benefits under their employer's group health plan.
  - Dependent children under the age of 26 should be eligible for benefits under their parent's group health plans (providing their parents both meet the definition of a FTE employee).
  - Exchanges may be an option.

QUESTIONS?

THANK YOU!