



# Health Reform Update

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# Agenda

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- Background
- Key elements
- Impact on stakeholders

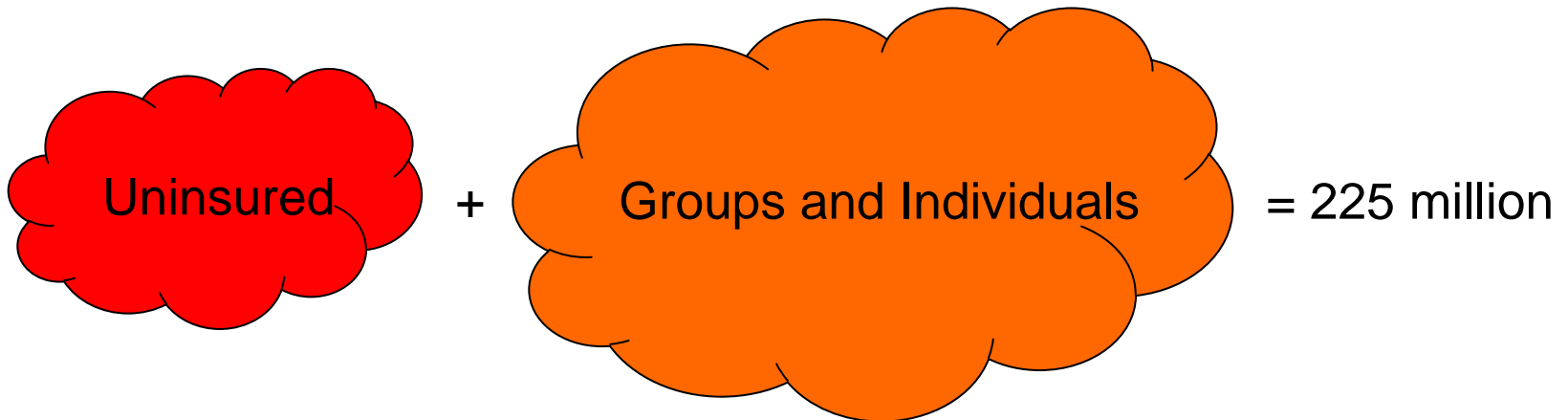
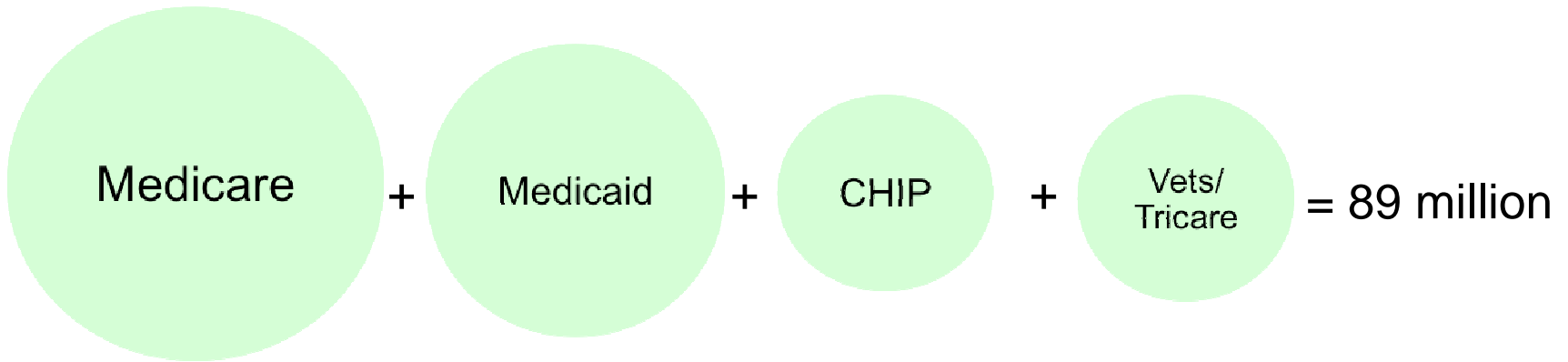
# Background – Sources of Coverage

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- Some have structured sources of coverage
  - 45 million have Medicare coverage
  - 36 million have Medicaid/CHIP coverage
  - 8 million have CHAMPVA/Tricare coverage
- Others have less structured sources of coverage
  - 162.5 million have group coverage (employers and unions)
  - 18 million have individual coverage
- Others have no coverage at all, structured or otherwise
  - 45 million don't have any coverage

*Source: EBRI analysis of 2007 CPS data*

# Background – Seeking Greater Structure



# Background – Yes, we have legislation...

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- Patient Protection and Affordable Care Act (PPACA)
  - Pub Law 111-148
  - Signed into law Mar 23, 2010
  - Includes substantive health reform provisions AND amendments to those provisions
- Health Care and Education Reconciliation Act (HCERA)
  - Pub Law 111-152
  - Signed into law Mar 30, 2010
  - Amends various PPACA provisions

*“The difference between death and taxes is death doesn't get worse every time Congress meets!” Will Rogers*

# Key Elements

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- Grandfathered plans
- Coverage reforms
- Insurance reforms
- Exchanges
- Individual mandate
- Employer “free-rider” surcharge
- Other employer requirements
- Subsidies
- Medicaid, CHIP and Medicare
- Financing

# Grandfathered Plans

- PPACA §1251 – “For group health plans or health insurance coverage in which an individual was enrolled on DOE, this subtitle and subtitle A shall not apply to such plan or coverage”
  - Original intent was to protect existing plans from new requirements
  - Plans do not lose grandfathered status merely because additional family members or new employees may enroll
- But scope of the grandfathered plan rule is already eroding...
  - PPACA §10103(d) – “Provisions of PHSA §§ 2715 and 2718 shall apply to grandfathered plans for plan years beginning on/aft DOE”
  - HCERA §2301 - “Provisions of PHSA §§ 2708, 2711, 2712 and 2714 shall apply to grandfathered plans; for 2711 and 2704, effective date is first plan year to which such provisions otherwise apply”

*Should we assume that rules for grandfathered plans won't change again?*

# Coverage Reforms – Grandfathered Plans

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- Effective 1<sup>st</sup> plan year beginning on/aft DOE + 6 months
  - No preexisting condition exclusions for children under age 19
  - No lifetime limits; reasonable annual limits (n/a to nonessential benefits)
  - Dependent coverage required up to age 26 unless dependent eligible for other employer coverage (tax-free) (yes, even if married)
  - No rescission/termination of coverage without prior notice
  - For insured grandfathered plans, no discrimination in favor of HCIs
- Effective no later than 24 months after DOE
  - Uniform explanations of coverage
- Effective 1<sup>st</sup> plan year beginning on/aft Jan 1, 2014
  - No waiting periods exceeding 90 days
  - No preexisting condition exclusions (at all)
  - No annual limits (n/a to nonessential benefits)
  - Dependent coverage required up to age 26 (even if married)

# Coverage Reforms – Non-GF Plans

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- Effective 1<sup>st</sup> plan year beginning on/aft DOE + 6 months
  - No preexisting condition exclusions for children under age 19
  - No lifetime limits; only reasonable annual limits
  - Dependent coverage required up to age 26 unless dependent eligible for other employer coverage (tax-free) (yes, even if married)
  - No rescission/termination of coverage without prior notice
  - For insured plans, no discrimination in favor of HCs
  - Cover preventive health benefits without cost-sharing
  - Internal appeals and external review requirements
  - Patient protection requirements
- Effective no later than 24 months after DOE
  - Uniform explanations of coverage
  - Annual reports regarding quality standards

# Coverage Reforms – Non-GF Plans

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- Effective 1<sup>st</sup> plan year beginning on/aft Jan 1, 2014
  - No waiting periods exceeding 90 days
  - No preexisting condition exclusions (at all)
  - No annual limits
  - Dependent coverage required up to age 26 (even if married)
  - No discrimination against providers acting within scope of license
  - Cost-sharing can't exceed high deductible health plan limits
  - Coverage for individuals in approved clinical trials

# Insurance Reforms

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- Insurers in individual and small group markets must comply with all coverage reforms (again, based on grandfather plan/policy status)
- And, if not grandfathered, must comply with additional requirements generally effective with first plan year beginning on/aft Jan 1, 2014
  - Fair premiums – rating band limits (for age, 3:1; for tobacco use, 1.5:1)
  - Guaranteed availability and guaranteed renewal
  - “Essential health benefits” package
  - Risk adjustment
  - Annual review process for premiums
  - Minimum loss ratios; rebates to enrollees if ratios not met (2011)
  - Coverage and cost-sharing transparency and disclosure (2011)
  - Interstate sales compacts (2013)

# Exchanges

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- Eligible individuals and small groups can purchase coverage through State-based exchanges (2014)
  - Small group is 1 – 50 employees in 2014 and 2015, and 1-100 employees in 2016
  - States can expand to employers with >100 employees on Jan 1, 2017
- State-licensed insurers are required to participate
- Plans must satisfy standards
  - Bronze, silver, gold and platinum plans must cover 60%, 70%, 80% and 90% of benefit costs, subject to out-of-pocket limits
  - Plans must cover “minimum essential benefits”
  - High deductible plan with health savings account permitted
- HHS will develop uniform standards for exchanges
- State insurance commissioners will provide oversight

# Individual Mandate

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- Individuals are required to have health coverage for themselves and family members under age 18 (2014)
- Health coverage must cover “minimum essential benefits”
- Penalties for noncompliance – lesser of monthly penalty amounts or national average premium for bronze coverage
  - Monthly penalty amounts are greater of:
    - Flat dollar amount, which is lesser of sum of applicable dollar amounts (for adults, \$95 in 2014, \$325 in 2015 and \$695 in 2016; half these amounts for children) or 300% of adult penalty, or
    - Applicable percentage of household income (in 2014, 1%; in 2015, 2%; in 2016 2.5%)
  - Penalties do not apply to individuals with income below tax filing threshold, with affordability waivers, or who weren't covered for less than 3 months

# Employer “Free-Rider” Penalties

- Free-rider penalties (2014)
  - If large employer doesn’t offer health coverage and at least one FTE receives tax credits, penalty is \$2,000 per FTE (but first 30 FTEs aren’t counted)
  - If large employer offers health coverage but coverage doesn’t pay at least 60% of costs or contributions exceed 9.5% of income, penalty is lesser of: \$750 per FTE, or \$3,000 per FTE receiving a tax credit (employer can reduce penalty by offering voucher)
- Key definitions
  - “Large employer” means an employer with at least 50 FTEs (and PTEs are counted as FTEs based on PTE hours per month/120)
  - “FTE” means an employee working 30+ hours per week

*No penalties for employers with less than 50 FTEs*

# Other Employer Requirements

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- Free choice vouchers (2014)
  - Employers offering health coverage must offer voucher to employees with incomes less than 400% of FPL if contributions for employer plan are between 8% and 9.8% of employee's household income and employee does not enroll in employer plan
  - Vouchers are equal to amount employer would have provided toward employee's coverage (self-only or family, depending on employee's election) under option for which employer paying largest cost
  - Cost determined under rules similar to COBRA rules, adjusted for age and coverage tiers
  - Employers pay vouchers to Exchange; if coverage through Exchange is less than voucher amount, Exchange pays difference to employee
- Auto-enrollment (we think 2014)
  - Employers with more than 200 employees offering health coverage must automatically enroll employees in the plan, and employees may opt-out
- Wellness plans – rewards may be increased to 30% of cost (2014)

# Other Employer Requirements (con't)

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- Participant fees (first plan year ending after Sep 30, 2012)
  - \$1 per participant for first plan year ending after Sep 30, 2012; \$2 per participant for plan years through 2019 (fee sunsets after 2019)
  - Fees are used to fund comparative effectiveness research
- Reporting requirements
  - W-2 reporting of value of health coverage (2011 tax year)
  - Coverage reporting for large employers (2014)
    - Report must describe: whether employees were offered coverage; length of waiting period; premiums for lowest cost options; employer's share of total plan costs; number of FTEs; and name, address and TIN of each FTE and months of coverage (if any) for each FTE
    - Employer must also furnish written statement to each FTE named in report and include information shown about that individual
  - Information notices to employees (Mar 1, 2013) - Notices must provide information about Exchanges; whether employer plan share of costs is less than 60% of total costs; information about tax credits; information about free choice vouchers

# Other Employer Requirements (Optional)

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- Federal long-term care program (Jan 1, 2011)
  - Employers can choose whether to participate; participating employers must auto-enroll employees and facilitate payroll reduction for pre-tax premiums (estimated at \$65 per month)
  - Employees can opt out; late enrollees and those re-enrolling will pay higher premiums
  - Program would pay \$50 per day benefit for nonmedical services after 5 years of participation
  - HHS would adjust premiums to ensure solvency for 75 years
- Reinsurance program for retiree coverage
  - Reimburses 80% of claims between \$15k and \$90k for pre-Medicare retirees over age 55
  - Only \$5B in funding available
  - Effective within 90 days of DOE; ends on Jan 1, 2014

# Subsidies

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- Tax credits for low-income individuals (2014)
  - Available when household income is between 100% - 400% of FPL
  - Credit amount is linked to “benchmark” plan
    - Credits reduce premiums to specified percentages of income
    - Credits limit cost-sharing to specified percentages of plan costs
  - Employees eligible for employer coverage are NOT eligible for tax credits unless employer plan pays less than 60% of total plan costs OR employee’s required contribution exceeds 9.5% of household income
- Tax credits for small employers (2014)
  - 50% tax credit available for small employers (25 or fewer FTEs) with average wages less than \$50,000
  - Employer must offer health coverage and pay 50% of cost
  - Tax credit is available only as an offset to tax liabilities

*35% small employer tax credit effective 2011 - 2013*

# Medicaid, CHIP & Medicare

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- Medicaid – expands coverage to all individuals under age 65 with incomes up to 133% of FPL (with federal financing for newly-eligible)
- CHIP – requires States to maintain eligibility levels and provides additional federal financing
- Medicare
  - Eliminates Part D “donut hole” (2010 – 2020)
  - Freezes Medicare advantage payments (2011) and reduces payments in future years (2012 and beyond)
  - Establishes independent payment advisory board to recommend reductions in Medicare spending
- Medicaid and Medicare – reduce disproportionate share hospital (DSH) payments by \$35M

# Financing

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- 40% nondeductible excise tax on high-cost health plans (2018)
  - Thresholds are \$10,200 for individual coverage and \$ 27,500 for family coverage; higher thresholds for retirees over age 55 and individuals in high-risk professions (and note all multiemployer coverage is treated as family coverage); thresholds are indexed to CPI-U
  - Includes employer and employee contributions for all health coverage (including health FSAs), but not separate dental and vision coverage
  - Employer must calculate value of coverage and report to insurance carriers or administrators
  - Tax is assessed on insurance carriers or administrators but will be passed through
- Medicare taxes for high-income individuals (2013)
  - High-income means AGI over \$200k (single) or \$250k (joint)
  - Additional .9% HI assessment on wages over \$200k/\$250k
  - New 3.8% HI assessment on investment income

# Financing (con't)

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- Industry fees
  - Drug manufacturers (\$27B over 10 years) (2011)
  - Medical device manufacturers (\$20B over 10 years) (2013)
  - Health insurers (\$60B over 10 years) (2014)
- Tax changes
  - \$500k deduction limit on health insurance exec comp (2009)
  - 10% excise tax on indoor tanning services (2010)
  - \$2,500 cap on health FSA contributions (2013)
  - 20% excise tax on non-health distributions from HSAs (2011)
  - No reimbursement for over-the-counter medications (2011)
  - Medicare Part D subsidy becomes taxable (2013)
  - Medical expenses deductible only if exceed 10% of AGI (2013)

# Impact on Individuals

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- Increased decision-making responsibility
  - Where will I get coverage and how much will it cost?
    - Through my employer or union?
    - Through an exchange?
    - What if I don't want coverage?
    - Can I wait until I get sick to enroll?
  - How do I get tax subsidies?
  - What happens if I move?
  - What happens if I lose my job?
  - Am I comfortable serving as my own advocate?

*What is the reaction to mandatory health coverage?*

# Impact on Plan Sponsors

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- The Perfect Storm
  - Excise tax on high-cost plans
  - Availability of health coverage offered through exchanges
  - Loss of control over plan design, and new administrative costs
- Employers will evaluate whether to provide coverage
  - What is cost of providing coverage (given new benefit and administrative requirements) vs. penalty cost?
  - Answers will vary by industry, size, workforce and location
  - Remember, no penalties for employers with fewer than 50 FTEs

*No guarantee that employers will provide coverage...*

# Impact on Insurers

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- Individual mandate greatly expands market for health insurance plans, affecting revenue and competition
- Additional regulation (including oversight of rate increases) may reduce profitability and eliminate low-margin insurers
- Insurers will allocate resources to maximize profitability
  - Greater emphasis on individual products offered by exchanges?
  - Less emphasis on group products or administrative services for groups?

*Further market consolidation of insurers is likely...*

# Impact on Healthcare Providers

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- Individual mandate
  - Ensures that most individuals have a source of payment, but
  - Exposes providers to more insurer oversight and infrastructure
- Provider economics
  - What is impact on reimbursement rates, and how do providers respond?
  - At what point do providers drop out of insurer networks?
  - What are incentives to modify current fee-for-service model?

*Providers may decide to operate outside system...*

**Questions?**