Sterling Benefits, LLC

PREMIER PROVIDER OF EMPLOYEE & EXECUTIVE BENEFITS

Health Care Reform Overview

Issued: 4/16/2010

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Overview

As you know, this year has brought sweeping reforms to health care coverage. The new Patient Protection and Affordable Care Act, with over 2,000 pages of new federal law (and pending lawsuits), will impact many facets of the health care industry. As changes and clarification become available, we will continue to update you with information and the implications of the state and federal mandates.

The health reform package is made up of two parts: a bill that passed the Senate on Christmas Eve, passed the House on March 21, and was signed into law by the President on March 23, and a second piece of legislation: the House's reconciliation bill, which makes changes to the original law, passed both chambers on March 25, and was signed by the President on March 30.

Many of the provisions in the law will not take effect for several years. At the earliest, provisions that affect employer-sponsored health plans will take effect six months from the date of enactment – in late September. Even then, those early provisions will not affect plans until they renew for the next plan year.

The health reform law has thousands of pages and hundreds of provisions. So it's important to remember that before many of those provisions are put in place, additional laws and regulations will need to be developed. That could be a lengthy process.

Here are some highlights of the major provisions.

Individual responsibility

Starting in 2014, everyone must have coverage or pay a penalty, which will be enforced by the Internal Revenue Service. The penalties will be phased in over time:

- In 2014, an individual without insurance must pay whichever amount is greater: $95 or 1 percent of income.
- For 2016 and beyond, that penalty rises to $695 or 2.5 percent of income, whichever is greater (the $695 is indexed from 2016 on).
- Families will pay half the penalty for children, with a cap of $2,085 per family.
- There will be exemptions to this requirement, such as in cases of financial hardship and other limited circumstances.

Subsidies to buy insurance in new state exchanges will be available in the form of tax credits and cost-sharing assistance for people above Medicaid eligibility but below 400 percent of the federal poverty level. Medicaid eligibility will be increased to 133 percent of the federal poverty level.

Employer responsibility

New employer penalties and obligations

Starting in 2014, employers don't have to offer their employees health insurance coverage, but most of them with more than 50 employees will pay an assessment if they don't, or if they offer coverage that isn't affordable. Full-time and part-time employees are included when determining whether an employer has 50 employees (based on current full-time employee equivalency rules).

- Employers with 50 or more employees that do not offer "minimum essential coverage" will pay $2,000 for each employee over the first 30 employees if one of their employees gets a tax subsidy to buy insurance under an exchange.
- Employers with 50 or more employees that do offer minimum essential coverage but have at least one full-time employee receiving subsidized coverage under an exchange will pay whichever is less: $3,000 for each employee ("Free Rider Penalty") receiving a premium credit or $2,000 for each full-time employee.

Employers must provide "free choice" vouchers to employees with incomes below 400 percent of the federal poverty level if the employee's contribution to coverage is between 8 percent and 9.8 percent of income and the employee chooses to purchase coverage in the exchange. No penalties will be imposed on employers with respect to employees who receive these vouchers.

Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage. Employees may opt out.

New employer reporting requirements

- Beginning in 2011, employers will be required to disclose the value of health care benefits on an employee's annual W-2.
- Employers will be required to annually report data to the IRS:
  - Information on each fulltime employee (Name, address, social security number, months covered);
  - Waiting periods for health coverage;
  - Monthly premium for the lowest cost option in each category and the employer's responsibility;
  - The number of employees during each month;
- Employers will be required to notify employees:
  - About the availability of the exchange – for new employees, at the time of hiring; for current employees, by March 1, 2013;
  - They may be eligible for a subsidy under the exchange if the employer's contribution to the plan is less than 60 percent of total allowed costs of the benefits;
  - If the employee purchases coverage in the exchange, he or she will lose the employer's coverage contribution.
- In 2014, large employers will be subject to expanded 5500 reporting requirements to include information on the health insurance coverage of their employees.

Health plan changes

Under the new law, individuals and employers/employees have the right to keep the coverage they had as of March 23, 2010 and are exempt from many reforms. These individual and group health plans are considered "grandfathered plans." Collectively bargained plans that were ratified before the date of enactment are grandfathered until the date that the last collective bargaining agreement related to coverage ends.

Health plan changes that impact individuals and employers (both fully insured and self-funded plans unless otherwise noted) over the next few years:

IMMEDIATELY:

- **Federal rate review.** The Department of Health and Human Services (HHS) will establish a process for federal review of fully insured premium rate increases.

IN 90 DAYS:

- **Internet portal.** By July 1, an Internet portal will be created for consumers and small businesses to shop for health Insurance.
- **High-risk pool.** $5 billion has been appropriated to create a temporary high-risk insurance pool to help adults with pre-existing conditions get coverage if they have been uninsured for six months. The program will be effective through 2013.
- **Reinsurance for early retirees.** A temporary reinsurance program will be established for employers providing coverage to early retirees over age 55 who are not eligible for Medicare. The federal government will provide $5 billion to fund the program. Participating employers or insurers will be reimbursed 80 percent of retiree claims between $15,000 and $90,000. The program will be effective through 2013.

IN SIX MONTHS:

Effective for new plans and plans renewed six months after the law's enactment date, unless otherwise noted (includes "grandfathered plans"):

- **Lifetime and annual limits.** Plans may not impose lifetime limits on the dollar value of essential benefits. Annual limits will be restricted (to be determined by HHS). Restricted annual limits do not apply to grandfathered individual plans.
- **Rescissions.** No rescissions are permitted, except in cases of fraud or intentional misrepresentation.
- **Coverage for adult children.** Children may stay on their parents' policies until age 26 if coverage isn't available through their work, regardless of their marital status. Any employer contribution toward the premium for a child through age 26 is a tax-deductible business expense for the employer and not taxable income for the member.
- **Pre-existing conditions.** Plans may no longer impose pre-existing condition exclusions for children under 19 (does not apply to grandfathered individual plans).

Effective for new plans and plans renewed six months after the law's enactment date (does not include "grandfathered plans"):

- **Preventive services.** New policies must cover the full cost of preventive care as recommended by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care for women.
- **Appeals.** New minimum requirements for internal and external claims appeals processes.
- **Patient protections.** Plans that require or provide for a primary care provider (PCP) designation must allow each member to designate any in-network PCP, or pediatrician for children, accepting new patients. Plans may no longer require an authorization or referral to an Ob-Gyn. Prior authorization or increased cost-sharing for emergency services is also prohibited.
- **Nondiscrimination rules.** Nondiscrimination rules that apply to self-funded health plans are expanded to group fully insured health plans. Plans cannot base an employee's eligibility or continued eligibility on hourly or annual salary.

IN 2011:

- **Medical loss ratio (MLR).** An insurer must publicly report on its MLR and spend at least 85 percent of large group premiums and 80 percent of individual and small group premiums on medical services, or provide rebate payments to enrollees.
- **Spending accounts.** Health savings accounts (HSAs) and flexible spending accounts (FSAs) may no longer be used to purchase over-the-counter drugs unless prescribed by a doctor. Increases tax for nonqualified HSA withdrawals from 10 percent to 20 percent, and for Archer MSA withdrawals from 15 percent to 20 percent.
- **HHS studies.** HHS is required to study the group health plan markets to compare employer characteristics and determine whether the new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure. HHS and the Department of Labor must also collect information on self-funded plans. These studies could lead to additional employer reporting requirements.
- **Uniform explanation of coverage.** Within 12 months of the law's enactment, HHS, in consultation with the National Association of Insurance Commissioners, will develop uniform standards and definitions for summaries of benefits and coverage explanations. Within 24 months of enactment, group health plans must provide enrollees and applicants with coverage documents that meet these standards.

IN 2012:

- **Comparative effectiveness fee.** A new fee is imposed on individual and group health plans to fund comparative effectiveness research ($1 per participant through 2013; $2 per participant through 2019).
- **Release of Medicare claims data.** The private sector may purchase standardized data extracts of Medicare Parts A, B and D claims data to combine with their own claims data to evaluate provider performance measures on quality, efficiency, and the effectiveness of care.

IN 2013:

- **FSA contributions.** Contributions to flexible spending accounts are limited to $2,500 a year.

IN 2014:

The federal definition of a large employer is an employer with 101 or more employees, whereas a small employer is defined as 1-100 employees. States can modify the definition of a large employer to 51 or more employees and small employer to 1-50 employees until January 1, 2016.

- **Pre-existing conditions.** Individual and group health plans can no longer impose pre-existing condition exclusions for any person of any age (does not apply to grandfathered individual plans).
- **Annual limits.** Annual limits on essential health benefits are prohibited (does not apply to grandfathered individual plans).
- **Guaranteed issue.** Health insurers must accept every individual and employer who applies for coverage.
- **Rating restrictions.** Rating restrictions go into effect for new individual and fully insured small group plans. Insurance companies cannot base premiums on health status, claims experience or gender. Premiums can only vary by:
    - Age (no more than 3:1)
    - Geography
    - Family size
    - Tobacco use (no more than 1.5:1)
- **Merged markets.** States are allowed to merge the individual and small group markets.

IN 2014 CONTINUED:

- **Clinical trials.** Coverage of routine patient care costs is mandated for participation in approved clinical trials (does not apply to grandfathered plans).
- **Exchanges.** State health insurance exchanges are up and running for small businesses and individuals to buy insurance. States can allow large employers to participate beginning in 2017.
- **Brokers.** HHS will establish procedures, which may include rate schedules for broker commissions, for a state to allow brokers to:
  - Enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an exchange in the state;
  - Assist individuals in applying for premium tax credits and cost-sharing assistance for plans sold through an exchange.
- **Essential benefits.** Essential benefit plan is created, which mandates the level of benefits that must be included in plans offered in the exchange, as well as in the individual and small group markets outside the exchange. Deductibles are limited to $2,000 for individuals and $4,000 for families in the small group market (self-funded plans and grandfathered plans are exempt from this requirement).
- **Cost-sharing limits.** Cost sharing imposed under health plans is limited to current health savings account amounts (does not apply to grandfathered plans).
- **Waiting periods.** Waiting periods cannot exceed 90 days.
- **Wellness.** Expands health plan wellness incentives up to 30 percent of total coverage costs (up to 50 percent with HHS approval).
- **Reinsurance.** A temporary reinsurance program will be established for the individual market and funded by individual and group health plan assessments ($25 billion in 2014-2016).

IN 2016:

- **Health choice compacts.** States can form health choice compacts to allow insurers to sell individual policies in any state participating in the compact.

IN 2018:

- **Taxes.** A new excise tax goes into effect for high-value, "Cadillac" health plans: 40 percent for amounts over $10,200 for individuals and $27,500 for family plans, paid by insurance companies and plan administrators.

Medicare and Medicaid-related provisions

- **Part D donut hole.** Provides a $250 rebate for Part D enrollees who enter the "donut hole" coverage gap (2010 only). Beginning in 2011, there will be a 50 percent brand discount on drugs in the gap. Members will pay less for generic drugs in the gap as well: 93 percent in 2011, which phases down to 25 percent by 2020. The donut hole is eliminated by 2020.
- **Retiree drug subsidy.** Beginning in 2013, employers may no longer deduct the retiree drug subsidy when offering qualified coverage under Medicare Part D.
- **Medicaid.** Beginning in 2014, states are required to provide premium assistance and wrap-around benefits to any Medicaid beneficiary who is offered employer-sponsored coverage, if it is cost-effective to do so.
- **Medigap.** The National Association of Insurance Commissioners will create new model plans for benefit packages C and F that include nominal cost sharing. The new models will be available in 2015.

Small business tax credits

Beginning in 2010, small businesses with fewer than 25 employees and average wages of less than $50,000 get a tax credit for their contributions to buying health insurance for employees. The tax credit starts at up to 35 percent and increases to 50 percent in 2014 when the exchange is operational. A full tax credit may be available to small businesses with fewer than 10 employees and average wages of less than $25,000.

Revenue-raising provisions

- Starting July 1, 2010, imposes a 10 percent tax on tanning services.
- Beginning in 2011, the pharmaceutical industry will pay annual industry fees. The fee will be phased in and will hold steady at $2.8 billion a year after 2019.
- Beginning in 2013, manufacturers of medical devices will pay a 2.3 percent excise tax on sales of medical devices.
- Beginning in 2013, the Medicare payroll tax rate will increase by 0.9 percent for individuals who make more than $200,000 and couples that make more than $250,000.
- A new 3.8 percent tax will be added on income from interest, dividends, annuities, royalties and rents for those at the same income threshold.
- Beginning in 2014, a non-deductible premium tax will be imposed on insurers and third-party administrators ($8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. After that, it will increase in an amount proportional to overall premium growth).

Miscellaneous

- **Administrative simplification.** The law also requires HHS to adopt a single set of operating rules for electronic transactions to create uniformity (e.g., health claims or equivalent encounter information, eligibility and claims status, enrollment and disenrollment, premium payments, and referral certification and authorization). Group health plans will have to certify compliance with these standards.
- **CLASS Act.** Creates a new government-run voluntary long-term care insurance program (CLASS Program). Employers must automatically enroll employees and facilitate payroll deductions. Employees may choose not to participate.
- New Employee Legal Rights Against Employers. Creates new legal rights and whistleblower protections for employees to charge their employers with discrimination having to do with health benefits, based upon federal laws such as the Age Discrimination Act, the Rehabilitation Act, the Civil Rights Act, the Fair Labor Standards Act, and others. The Act prohibits employers from discriminating against an employee who has received a premium subsidy or reduced cost-sharing, while another provision protects individuals against discrimination in terms of exclusion from participation in benefits.

Health Care Reform Glossary

Adult Children – In this paper, the term means children, whether natural, adopted or foster, who are older than age 18. It is important to note that adult children eligible to become enrolled on their parents' plan do not have to be "dependents" of their parents, as defined by the IRS. Adult children eligible to be added to their parents' health coverage may be married, living separately and/or self supporting, but must not be eligible for other employer-sponsored health coverage.

Cost-Sharing Assistance – An individual eligible for a reduction in cost-sharing under a health plan must have income between 100 and 400 percent of federal poverty, and must have enrolled in an exchange plan. Cost-sharing is reduced on a sliding scale based upon income.

Essential Health Benefits – The act defines certain categories of benefits as "essential health benefits" (See Section 1302 of the Act). In general, essential health benefits are those that must be included in private health insurance sold in the exchange. The categories of essential health benefits are a) Ambulatory patient services, b) Emergency services, c) Hospitalization, d) Maternity and newborn care, e) Mental health and substance use disorder services, including behavioral health treatment, f) Prescription drugs, g) Rehabilitative and habilitative services and devices, h) Laboratory services, i) Preventive and wellness services and chronic disease management, j) Pediatric services, including oral and vision care.

Exchange – A state-based agency or non-profit entity responsible beginning in 2014 to perform the following functions: assist in consumer and small employer education about health plan choices; assist consumers in enrollment; assist with financial handling of premium tax credits, cost-sharing reduction and free choice vouchers; certify health plans as qualified to sell in the exchange

Free Choice Voucher – A "free choice voucher" is essentially the value of the largest employer contribution to premium, credited to an employee who chooses to obtain health coverage in the exchange. There are conditions that must be satisfied before an employee is eligible for a free choice voucher. If the value of the free choice voucher exceeds the cost of health coverage for the employee who obtains exchange coverage, the excess funds must be paid to the employee.

Free Rider Penalty – If an employer offers employer-sponsored health coverage to employees that either (a) has an actuarial value of less than 60 percent, or (b) requires the employee to spend more than 9.5 percent of the employee's income on health coverage, qualifying the employee for health coverage in the exchange, the employer will be penalized $3,000 for each employee who receives exchange coverage (and premium tax credit and/or cost-sharing limitations).

Full-Time Employee – The act defines a "full-time employee" as working 30 or more hours per week, determined on a monthly basis.

Grandfathering – This term refers to the ability of a health plan to escape legal requirements of the act that would otherwise be applicable. In general, if an employer maintains the exact same health plan it did on March 23, 2010, most (but not all) of the health plan provisions will be "grandfathered" and need not be altered.

HIPAA – The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations issued there under.

Minimum Essential Coverage – As defined in the act, "minimum essential coverage" means any employer-sponsored health coverage. This term is not equivalent to the term "essential health benefits".

Premium Tax Credit – This term refers to the amount of tax credit an individual with income between 100 percent and 400 percent of federal poverty level may receive towards the cost of premium for health plans in the exchange.

Preventive Care – The definition of "preventive care" includes the following:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resource and Services Administration;
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph;
5. for the purposes of this act, and for the purposes of any other provision of law, the current recommendations of the U.S. Preventive Service Task Force regarding breast cancer screening, mammography and prevention shall be considered the most current other than those issued in or around November 2009.

Regulations – When a federal law is enacted, many times there are provisions in the law needing clarification. Federal agencies are responsible for issuing federal regulations (also called federal rules) that interpret the federal law and provide clarification. Regulations, once final, have the force of law.

Reinsurance – In this paper, the term means the federal government's reimbursement to the employer of certain large medical expenses incurred by the employer's retiree health plan.

Self-funded health plan – This refers to a health plan that is fully funded by monies from the employer and is not an insurance arrangement.

Wellness program – The program an employer offers to its employees to encourage healthy behaviors, such as weight loss or smoking cessation.

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IMPORTANT: This document is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Links - Further Reading

HR 3590 – Patient Protection and Affordable Care Act.
HR 4872 – Health Care and Education Reconciliation Act.
Health Reform
HHS – The U.S. Department of Health and Human Services.
IRS – The federal Internal Revenue Service.
White House Fact Sheets

Timing is Everything

It is important to note that most of the provisions that will have a major impact on the health insurance marketplace — such as the new framework for health insurance products and the employer mandate to offer coverage — are not scheduled to go into effect until 2014. However, some of the provisions that have been less publicized in the media have effective dates in 2010 or are even retroactive to the beginning of 2010.

Many of the deadlines discussed in this document are calculated from the date of the act's enactment, March 23, 2010. For example, most of the effective dates in 2010 apply to plan years beginning on or after six months after the date of enactment (or September 23, 2010). It is also important to note that many of the provisions in the act instruct federal agencies such as Health and Human Services and the IRS to define details, issue implementation guidelines or regulations, and resolve ambiguities. Such a process is typical with enacted legislation, and while a few guidelines have been issued, many of the provisions with near-term implementation dates have yet to be defined.