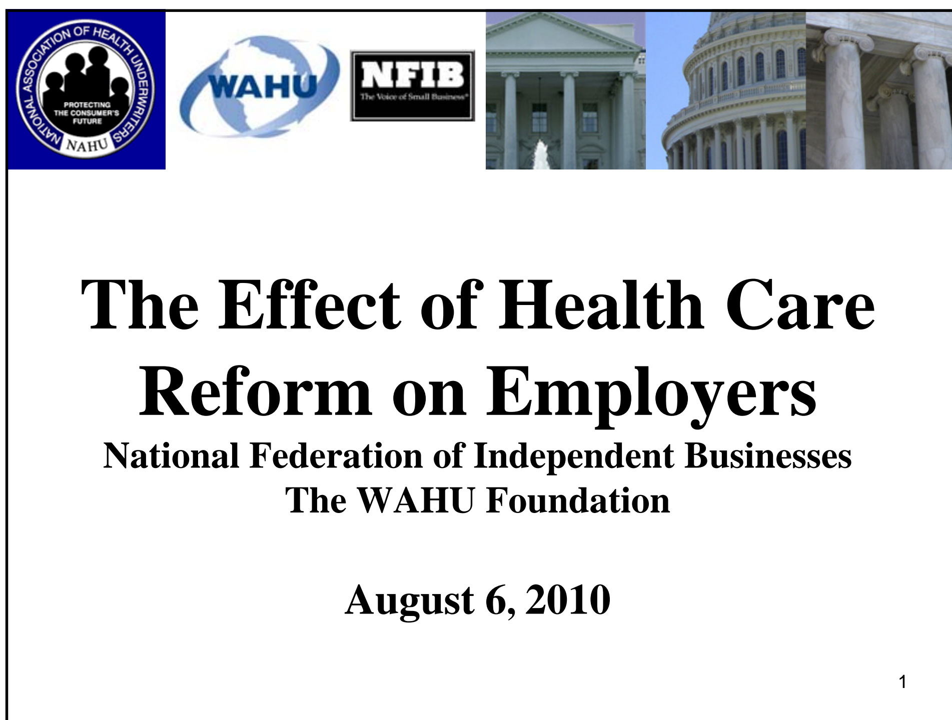

Current Status

- On March 21, the House passed HR 3590, the bill passed by the Senate on December 24, 2009, with a 219-213 vote. Signed into law on March 23.
- The House and Senate have also passed a reconciliation bill, HR 4872, with a packages of “fixes” to the Senate bill, thus creating the Patient Protection and Affordable Care Act (PPACA).

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Important Implementation Warning

It is important to note that the National Association of Insurance Commissioners (NAIC), Center for Medicare and Medicaid Services (CMS), Department of Labor (DOL), Department of Treasury (DOT), and the Department of Health and Human Services (DHHS) will need to issue guidance after enactment on many issues which will impact everyone's understanding of these measures. There are some questions you may have today and in the near future that cannot be answered.

3

What the PPACA Bill Does Immediately

Grandfathered Plans

- A plan is "grandfathered" if it existed on March 23, 2010
- "Grandfathered" status means that the plan avoids compliance with some, but not all, of the health care reform mandates
- Individuals and employer group plans that wish to retain their grandfathered status can make only limited changes as prescribed by regulations
- If you lose your grandfathered status, that DOES NOT NECESSARILY MEAN you will be forced into an Exchange in 2014.

5

Taxes

- Eligible small businesses are eligible for phase one of the small business premium tax credit.
- For 2010-2013, maximum credit is 35% (25% for tax-exempt businesses)
- For 2014, maximum credit for up to two years of 50% (35% for tax-exempt businesses)
- Credit phases out between 10 and 25 employees and between $25,000 and $50,000 average annual wage

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Ombudsman Program

- Provides grants to States to provide support for offices of health insurance consumer assistance.
- $30 Million in 2010
- Wisconsin Family Benefits Counselor Bill (AB878 & SB633)

Premium Rate Review

- Establishes federal review of health insurance premium rates.
- Secretary of HHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases beginning in plan year 2010 to prevent unreasonable increases and publicly disclose such information.
- Carriers that have a pattern of unreasonable increases may be barred from participating in the exchange.
- In addition, $250,000,000 is appropriated for state grants to increase their review and approval process of health insurance carrier premium rate increases.

What PPACA Does 90 Days After Enactment

High Risk Pool

- Creates high-risk pool coverage for people who cannot obtain current individual coverage due to preexisting conditions (uninsured for 6 months prior). Employers cannot put people in the pool (would pay penalty).
- This national program can work with existing state high-risk pools and will end on January 1, 2014, once the Exchanges become operational and the other preexisting condition and guarantee issue provisions take effect. Wisconsin may likely start new pool for compliance reasons (HIRSP is Creditable Coverage).
- It will be financed by a $5 billion appropriation.

Reinsurance Pool for Early Retirees

- Temporary reinsurance program for employers that provide retiree health coverage for employees over age 55. Reimburse employers 80% of claims between $15,000 to $90,000, indexed for inflation.
- Plan must have cost-containment provisions, and reimbursements must not be used to reduce employer contributions below pre-program level.
- Ends at the earlier of exhaustion of $5 billion appropriation or December 31, 2013.
- Program opened June 1, 2010, with applications accepted starting June 29, 2010.

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What PPACA Does In 2010

Discrimination

- Effective for plan years beginning on or after 9/23/2010
- All non-grandfathered insured group plans will be required to comply with rules similar to Internal Revenue Code Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals as to eligibility and benefits
- Self-funded group health plans have been subject to 105(h) rules since 1978

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Exchange

- Requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site by July 1, 2010.
- Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.
- Wisconsin Set Up “Office of National Health Care Reform”. Stated intention to develop small group and individual exchange prior to 2014.

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Lifetime & Annual Limits

- Effective for plan years beginning on or after 9/23/2010
- Lifetime limits on essential benefits for any participant or beneficiary for all fully insured and self-insured groups and individual plans are prohibited.
- "Restricted" annual limits will be allowed for grandfathered plans for plan years beginning before January 1, 2014; all annual limits will be prohibited after that

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Dependent Coverage

- Effective for plan years beginning on or after 9/23/2010
- All group and individual plans, both grandfathered and non grandfathered, insured and self-funded, will have to cover dependents up to age 26.
- The reconciliation package:
  - Extended this requirement to grandfathered plans.
  - Established that dependents could be married and would be eligible for the group health insurance income tax exclusion.
  - Established through 2014, grandfathered group plans would only have to cover dependents that do not have another source of employer-sponsored coverage.

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Rescissions & Pre-Existing Conditions

- Effective for plan years beginning on or after 9/23/2010, for both grandfathered and non-grandfathered plans
- Rescissions of health coverage will be prohibited except for cases of fraud or intentional misrepresentation.
- Plans cannot impose a preexisting condition exclusion for enrollees under age 19

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Preventative Services

- For non-grandfathered group and individual health plans, mandates coverage of specific preventive services with no cost sharing.

  Minimum covered services include:
  - Evidence-based items or services, rating of A or B by US Preventative Services Task Force (USPSTF).
  - Immunizations by Advisory Committee of CDC.
  - Preventative care and screenings for infants, children, adolescents & women by Health Resources & Services Administration (HRSA).
  - Breast cancer screening, mammography and prevention and other preventive care screening for women by USPSTF & HRSA

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Preventative Services – Cont'd

- Most plans are unlikely to currently cover the level of preventive care specified, particularly for children and adolescents, especially at the first-dollar level (This will be one of the most significant/costly change for most plans).
- Unclear if dental and vision for children will be included in the preventive care requirements.
- Effective for plan years beginning on or after 9/23/2010

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Coverage Appeals, PCP & Emergency Services

- Effective for plan years beginning on or after 9/23/2010
- For non-grandfathered plans only
  - Requires plans to have coverage appeals process
  - Allows enrollees to designate any in-network doctor as their primary care physician (including OB/GYN and pediatrician), if plan requires the designation of a PCP.
  - Mandates coverage of emergency services at in-network level regardless of provider and without preauthorization.

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Minimum Loss Ratio (MLR)

- Minimum loss ratio requirements will be established for insurers in all markets.
- The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below).
- The calculation is independent of federal or state taxes and any payments as a result of the risk adjustment or reinsurance provisions.
- Carriers will have to issue a premium rebate to individuals for plans that fail to meet the minimum MLR requirements.

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Minimum Loss Ratio Cont'd

- Allows the Secretary of DHHS to make adjustments to the MLR percentage if it proves to be destabilizing to the individual or small group markets.
- The National Association of Insurance Commissioners (NAIC) is required to establish uniform definitions regarding the MLR and how the rebate is calculated by December 31, 2010.

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Other

- New Restrictions on Not-For-Profit Hospitals
- Grants for small employer-based wellness programs effective October 1, 2010
  - $200 Million FY 2011-2015
- Physician payments decrease 21% for Medicare effective March 1, 2010 (until Congress passes "Doc-Fix" to preserve or increase payment)

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What PPACA Does By 2011

HSA's, FSA's & HRA's

- The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10 to 20%; for Archer MSAs from 15 to 20%.
- OTC drugs (except insulin) no longer be reimbursable under HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor.
- Changes the definition of medical expense for purposes of employer-provided health coverage to the definition for purposes of the itemized deduction for medical expenses.

Medicare, Medicaid & Other

- Deduction for Part D subsidy eliminated
- 10% Bonus for primary care physicians and general surgeons
- Medicare Advantage plans payment levels frozen.
- CLASS ACT - Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out.
- "Annual Fee" tax on Rx Drugs of $4.8 Billion, allocated according to market share.
- Federal Studies
  - Large group to determine impact and migration to self-fund
  - The Department of Labor will begin annual studies on self-insured plans using data collected from Form 5500.

What PPACA Does By 2012

Employer & Plan Requirements

- All employers must include on their W-2s the aggregate cost of employer-sponsored health benefits, beginning with W-2s for taxable year 2011 (generally issued in early 2012)
- If employee receives health coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.
- All group health plan, self-funded and insurers must submit to DHHS and enrollees quality information reports.

Uniform Plan Summaries

- All employers and group and individual health insurers (including self-funded plans) will have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees in addition to SPDs
  - when they apply for coverage,
  - when they enroll or reenroll in coverage,
  - when the policy is delivered,
  - and identify any material modification is made to the terms of their coverage.
- The summary and explanation can be provided electronically or in written form, and there is a $1000 per enrollee fine for willful failure to provide the information.
- Regulations due by March 23, 2011; distribution by March 23, 2012

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Taxes, Medicare & Other

- 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.
- Massive cuts to Medicare Advantage Plans
- Medicare Payment penalties for hospitals with the highest readmission rates for selected conditions.
- Health Insurance Company employees may not be paid more than $500,000 per year.

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What PPACA Does By 2013

Taxes

- Additional 0.9% Medicare Hospital Insurance tax on self-employed individuals and employees with wages received during the year above $200,000 for individuals and above $250,000 for joint filers (not indexed). Self-employed individuals are not permitted to deduct any portion of the additional tax.
  - Reconciliation measure levied a new 3.8% Medicare contribution on certain unearned income from individuals with AGI over $200,000 ($250,000 for joint filers)
- "Annual Fee" excise tax on medical devices of 2.3% of the price for which the medical device was sold.

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Other

- The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI to 10% of AGI for regular tax purposes.
  - The increase would be waived for individuals age 65 and older for tax years 2013 through 2016.
- $2,500 Cap on Medical FSA contributions annually indexed for inflation begins.
  - Originally in 2011—delayed by the reconciliation bill.
- Requires all employers provide notice to their employees informing them of the existence of an Exchange.

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What PPACA Does By 2014

Taxes & Medicaid

- "Annual Fee" tax on health insurance, allocated according to net premiums.
  - Begins at $8 Billion in 2014; $11.3 Billion in 2015 & 2016; $13.9 Billion in 2017; $14.3 Billion in 2018; and indexed to medical cost growth thereafter.
  - The reconciliation package delayed the tax from 2011 to 2014 and eliminates existing exemptions for certain insurers from the Senate-passed bill.
- Allows states to expand eligibility to 133% of Federal Poverty Level (FPL) for adults.
  - Wisconsin already allows up to 200%

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Insurance Regulation

- 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, including self-funded.
- Full prohibition on any annual limits or lifetime limits in all group (even self-funded plans) or individual plans.
- Waiting periods in excess of 90 days are prohibited.

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Insurance Regulation – Cont'd

- Strict Modified Community for all individual health insurance policies and all fully insured group policies 100 lives and under (and larger groups purchasing coverage through the exchanges). Premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited.

- 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.

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Exchanges

- 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 can also apply for a modification waiver from HHS.
  - States may choose to allow large groups (over 100) to purchase coverage through the exchanges in 2017
  - The reconciliation package would allow U.S. territories to create Exchanges and clarify for funding purposes a U.S. territory that establishes an Exchange will be treated like a state for funding purposes.

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Exchanges – Cont'd

- Creates sliding-scale tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL **to buy coverage through the exchange.**
  - The reconciliation provides slight increases to the subsidy amounts for all subsidy-eligible individuals and increases the cost-sharing subsidies for those making 250% FPL or less.
  - However, beginning in 2019, a failsafe mechanism is applied that reduces overall premium subsidies if the aggregate amount exceeds 0.504 percent of GDP.

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Employer Mandate

- The employer responsibility requirements take effect for companies that employ more than 50 full-time equivalent employees
- Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.
  - When determining whether an employer has 50 full-time equivalent employees, the reconciliation bill changed the calculation of employees so that part-time employees must be taken into consideration based on aggregate number of hours of service.
- Fine for noncompliance is $2,000 per FTE annually, but first 30 FTEs not counted (i.e., if the employer has 51 FTEs and doesn't provide coverage, the employer pays the fine for 21 employees).

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Employer Mandate – Cont'd

- An employer with more than 50 full-time equivalent employees that does offer coverage but has at least one FTE receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those FTEs receiving a tax credit or $2,000 for each of their FTEs total.
- An individual with family income up to 400% of FPL is eligible for a premium assistance tax credit if the actuarial value of the employer's coverage is less than 60% or the employer requires the employee to contribute more than 9.5% of the employee's family income toward the cost of coverage.
- Special provisions applicable only to the construction industry were eliminated by the reconciliation bill.

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Employer Mandate – Cont'd

- Requires employers to give a voucher to lower income employees to use in the individual market or exchange instead of participating in the employer-provided plan.
  - The employee's contributions to the employer health plan are between 8% and 9.8% of the employee's household income and
  - The employee does not enroll in the employer's plan
  - The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange, but is taxed on the excess amount

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Employer Mandate – Cont'd

- Health plans, including self-funded employer plans and public programs, must provide coverage documentation to both covered individuals and the IRS.
- 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 regulation

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Individual Mandate

- Requires all American citizens and legal residents to purchase qualified health insurance coverage. Exceptions are provided for :
  - religious objectors,
  - individuals not lawfully present
  - incarcerated individuals,
  - those who cannot afford coverage,
  - taxpayers with income under 100 percent of poverty,
  - members of Indian tribes,
  - those who have received a hardship waiver
  - those who were not covered for a period of less than three months during the year
  - People with no income tax liability

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Individual Mandate – Cont'd

- Penalty for non compliance to either a flat dollar amount per person or a percentage of the individual's income, whichever is higher.
  - Capped at the value of a bronze-level premium in the Exchange
- 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 capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family beginning in 2016.
- The alternative is a fixed dollar amount that phases in beginning with $95 per person to $695 by 2016.

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Wellness

- 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%, but does not apply to grandfathered plans
- New federal study on wellness program effectiveness and cost savings.

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Other

- 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.

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Other – Cont'd

- 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.
  - Delayed from 2013 by reconciliation bill.
  - Transition relief would be provided for 17 identified high-cost states.
  - Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs. Stand-alone vision and dental are excluded from the calculation.
  - Reconciliation bill reduced the formula for indexing the thresholds even further (to just inflation, not inflation plus 1%) so that more plans will fall under the tax faster, but also allows plans to take into account age, gender and certain other factors that impact premium costs.

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Reinhart Boerner Van Deuren, S.C.

National Federation of Independent Businesses

Wisconsin Association of Health Underwriters

Dan Schwartzer
Gail Olsen