

# Health-Care Reform

## Patient Protection and Affordable Care Act

### PPACA

#### What Happened?

Speak of the House, Pelosi stated, pass the bill and then we will figure out what is in it.

- On March 21, the House passed HR 3590, the bill passed by the Senate on December 24, 2009, with a 219-213 vote.
- The House and Senate have also passed a reconciliation bill, HR 4872, with a packages of “fixes” to the Senate bill.
- President Obama has now signed both bills into law.
- These Acts are now the law of the land, but that is not the end of the story

#### There is confusion and implementation overload!

- *There are 5 Waves of Effective Dates*
- Some effective dates become effectively immediately or for plan years starting on/after September 23
- *PPACA applies to Fully-Insured and Self-Insured Plans*
- The President says you can keep your plan, *but being grandfathered means making “no” changes!*
- There is an *Employer Mandate for groups with more than 50 employees*

#### The immediate issues are:

- Grandfathered Health Plans
- Small Business Tax Credit
- Medical Loss Ratios
- Dependent Coverage
- Temporary High Risk Pool

#### Grandfathered Health Plans: WHAT IS A GRANDFATHERED PLAN?

- A grandfathered health plan is coverage provided on a fully-insured or a self-insured basis and which was in existence on March 23, 2010.
- Grandfathered health plans may permit newly hired or newly enrolled employees and their families to enroll in the plan after the grandfather date without jeopardizing the plan's grandfathered status.
- In addition, an employee who had previously declined coverage prior to the grandfather date can enroll himself or herself and eligible family members in a grandfathered health plan after such date.

What causes you to lose Grandfathered Status:

- Changing the plan to eliminate all or substantially all benefits to diagnose or treat a particular condition, or to eliminate benefits for any necessary element to diagnose or treat a condition.
- Increasing any percentage cost-sharing requirement (e.g., coinsurance).
- Increasing a fixed-amount cost-sharing requirement, other than a copayment (e.g., a deductible or out-

of-pocket limit), if the total percentage increase in the cost-sharing requirement exceeds the "maximum percentage increase" (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15 percentage points).

- Changing Insurance Carriers

Grandfathered Rule delays *limited* number of health reform provisions, perhaps permanently:

- Primary provider designation rules
- Direct access to ob-gyns and pediatricians
- NO Discrimination by compensation
- Emergency room benefits (no prior auth./no differential)
- 100% minimum preventive benefits
  - Includes Folic Acid supplements and counseling for women to stop smoking.
- Revised appeals process
- Guaranteed renewal/issue & rating restrictions
- Clinical trial coverage

- Union plans may claim grandfathered status

#### Small Business Credit:

- Eligible small businesses are eligible for phase one of the small business premium tax credit.
  - Small employers with less than 25 employees that contribute at least 50% toward employees' health insurance may be eligible for a tax credit based on number of employees and average payroll
  - Businesses do not have to have a tax liability to be eligible
  - Non-profits are eligible
  - Average salary must be \$50,000 or less
  - The credit is potentially available for a total of 6 years.
  - [www.irs.gov](http://www.irs.gov) has several useful resources

#### Medical Loss Ratio:

- By January 1, 2011, carriers must report to the Secretary of HHS the ratio of incurred losses to earned premiums.
- Minimum loss ratio requirements will be established for insurers in all markets. Applies to all fully-insured and grandfathered plans.
- The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below).

#### Dependents Covered until age 26:

- On May 10, the IRS and the Departments of Labor and HHS issued interim final regulations for group health plans and health insurers concerning dependent coverage.
- All group and individual plans, including self-insured plans, within six months of enactment, will have to cover dependents up to age 26.
  - Required for grandfathered plans.
  - Insurance Companies cannot charge more for the dependent
  - 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.

### Dependents Covered until age 26: (Louisiana Law changes things)

- HB 244 was passed by the Louisiana Legislature and signed by the Governor becoming Act 912.
- Act 912 states that “fully-insured” plans must have a 30 day waiting period from 9/23/10 to allow dependents up to age 26 to come back onto their medical plans.
- Act 912 included individual medical, group medical and dental policies
- Act 912 extends the coverage to grandchildren.

### High Risk Pool:

- PPACA created a national temporary high-risk pool to provide coverage for people who cannot obtain current individual coverage due to preexisting conditions.
- The 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.
- Financed by a \$5 billion appropriation.
- 20 states, including Louisiana, declined to participate
- Individuals who have a pre-existing condition and have *not had creditable coverage for previous 6 months* are eligible

### What happened first:

- Requires the states and the Secretary of HHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. The roll out date for this is 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
- Lifetime limits on the dollar value of benefits for any participant or beneficiary for all fully insured and self-insured groups and individual plans including grandfathered plans are prohibited within six months of enactment.
- Annual limits will be allowed prohibited completely by January 1, 2014 and regulations will be out soon describing very limited use until then.
- Health coverage rescissions, within six months of enactment, will be prohibited for all health insurance markets except for cases of fraud or intentional misrepresentation.
- All group and individual health plans, including self-insured plans, will have to cover preexisting conditions for children 19 and under for plan years beginning on or after six months after date of enactment. Grandfathered status applies for group health plans
- For all group and individual plans, including self-insured plans, emergency services covered in-network regardless of provider.
- Enrollees may designate any in-network primary care physician as their primary care physician.
- New coverage appeal process.

- Federal grant program for small employers providing wellness programs to their employees will take effect on October 1, 2010
- For all group and individual health plans, including grandfathered plans, mandates coverage of specific preventive services with no cost sharing
- 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 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.
- Extends current law provisions (Section 105(h)) prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans.
- Early Retiree Reinsurance Program
  - Available to insured & self-funded plans in June 2010 even if
  - insurer pays claim / reimburses employer
  - 80% of retiree & family claims between \$15,000 and \$90,000
  - Over age 55, but not eligible for Medicare
  - Local / state governments eligible
  - Payments under the program must be used to lower costs of the plan.
  - Regulations released May 5<sup>th</sup> & application expected by June
  - Plan must have:
    - Provisions to contain costs for certain conditions (over \$15,000)
    - An agreement with carrier or TPA to release claims info
  - If eligible, complete application ASAP, and submit claims ASAP -- funded with \$5 billion until exhausted

### **Effective Plan Years On Or After October 1, 2010:**

- No Pre-ex Exclusion for Child < 19
- No Lifetime or Annual Limits
- 60-Day Prior Notice of Plan Changes
- No insurance Policy Rescission
- Access to Providers
- No Discrimination on Compensation (Insured)
- Deductibility for Part D subsidies is eliminated in 2013, but this results in an immediate accounting impact.
- 100% Minimum Preventive
- Children to Age 26
- Revised Appeals Process
- MEWA Registration (now)

### **Effective On Or After January 2011:**

- Starting with the 2011 tax year, employers will have to report the value of health care coverage provided to each employee on their W-2 form. The first W-2 with benefit information would be issued at the end of January 2012. (Recently Delayed)
- If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage,
- Employers are directed to exclude contributions to Health FSAs, HSAs and Archer MSAs, but HRA contributions would be included. The value of health care coverage would be based on the COBRA cost of coverage rules contained in §4980B of the Internal Revenue Code.
- No Reimbursement of Over-the-Counter Medications by Health HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor.
- The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10 to 20%.
- Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out, "CLASS"
  - Employers are expected to enroll employees unless they opt out
  - Employees will be able to opt out of participation
  - Questions about financial viability
  - Sen. Kent Conrad described as "Ponzi scheme of the first order"
- Section 2952 of PPACA requires HHS to provide research and education related to postpartum depression, and conduct a longitudinal study of relative mental health consequences for women resolving a pregnancy in various ways in fiscal year 2010. The Act also establishes a grant program for states to provide education and services to women with (or at risk of) postpartum depression, and funds the program at \$3 million in fiscal year 2010 and authorizes funding in 2011 and 2012.

### Effective 2012:

- Group plans – including self-insured plans – must report to HHS on whether benefits under the plan improve health outcomes, reduce medical errors, and encourage wellness and health promotion activities. *This report must also be provided to plan participants.*
- All plans must provide new summary of benefits to enrollees
  - *Can be no more than 4 pages in length*
  - *Must be cultural and linguistically appropriate*
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### Effective 2013:

- \$2,500 Cap on Medical FSA contributions annually indexed for inflation begins.
- Additional 0.9% Medicare Hospital Insurance tax on self-employed individuals and employees with respect to earnings and 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.
- New Tax: 3.8% Medicare contribution on certain unearned income from individuals with AGI over

\$200,000 (\$250,000 for joint filers)

- Two new taxes will raise approximately \$200 billion
- The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI “Adjusted Gross Income” 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.
- All employers must provide notice to employees of the existence of state-based exchanges.

## **Effective 2014:**

Effective for Plan Years Beginning On Or After January 2014 (Except as Noted)

- 90-Day Max. Waiting Period
- No Pre-Ex Exclusion
- Non-Discrimination/Wellness Safe Harbor
- Guaranteed Issue
- Guaranteed Renewal
- Rating Restrictions
- Vouchers
- Benefit Mandates – clinical trial coverage, essential benefits package, dependent coverage
- State and Federal Exchanges
- New Co-Ops and Multi-State Plans (2014)
- Insurance Carrier Taxes (2014 Tax Year)
- No Provider Discrimination
- Employer Mandate
- Automatic Enrollment (Assumed to be 2014)
- Cadillac Tax (2018)

### **Changes to Fully-Insured Plans:**

#### **Carrier Impacts**

- Guaranteed Issue & Renewal
- Health Status Cannot Affect Risk/Premium Rating
- Modified Community Rating
- No Rescission of Policy
- Oversight of Premium Increases
- Enrollee Rebates Based on Loss Ratio

#### **Benefit Impacts**

- No Pre-Ex Exclusions < Age 19
- No Pre-Ex Exclusions
- No Lifetime or Annual Limits
- FSA -- OTC and \$2,500 cap
- 100% Minimum Preventive Care
- Wellness Benefits
- Emergency Room Access

- **Provider Access Rules (ob-gyn, pediatric, etc.)**
- **Clinical Trial Coverage**

#### **Plan Sponsor Impacts**

- **Essential Plan & Vouchers**
- **Penalties / Costs**

#### **Eligibility Impacts**

- **Full-time Employees**
- **Children Covered to Age 26**
- **No Income (hourly vs. salaried) Distinctions**
- **Max. 90-Day Waiting Period**

#### **Administrative Impacts**

- **Reporting on Plan Information**
- **Four-page Mini Summary**
- **Revised Appeals Process**
- **MEWA Registration**
- **Plan Document Revisions**
- **60-Day Prior Notice of Plan Changes**
- **W-2 Reporting of Value**
- **Automatic Enrollment (over 200 employees)**

#### **Changes to Self-Insured Plans:**

#### **Benefit Impacts**

- **No Pre-Ex Exclusions < Age 19**
- **No Pre-Ex Exclusions**
- **No Lifetime or Annual Limits**
- **FSA -- OTC and \$2,500 cap**
- **100% Minimum Preventive Care**
- **Wellness Benefits**
- **Emergency Room Access**
- **Provider Access Rules (ob-gyn, pediatric, etc.)**
- **Clinical Trial Coverage**

#### **Plan Sponsor Impacts**

- **Essential Plan & Vouchers**
- **Penalties / Costs**

#### **Eligibility Impacts**

- **Full-Time Employees**
- **Children Covered to Age 26**
- **[Current law – Code Section 105(h) non-discrimination rules]**

- **Max. 90-Day Waiting Period**

## **Administrative Impacts**

- **Reporting on Plan Information**
- **Four-page Mini Summary**
- **Revised Appeals Process**
- **MEWA Registration**
- **Plan Document Revisions**
- **60-Day Prior Notice of Plan Changes**
- **W-2 Reporting of Value**
- **Automatic Enrollment (over 200 employees)**
  
- **Imposes annual taxes on private health insurers based on net premiums.**
  - Taxes do not apply to self insured plans or government entities
  - Projected to generate \$60 billion over 10 years
  - 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.**
  
- **Full prohibition on any annual limits or lifetime limits in all group (even self-funded plans) or individual plans.**
  
- **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.
  
- **All individual health insurance policies and all fully insured group policies 100 lives and under (and larger groups purchasing coverage through the exchanges) must abide by strict modified community rating standards**
  
- **Premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geography**
  
- **Geographic regions to be defined by the states and experience rating would be prohibited.**
  
- **Wellness discounts are allowed for group plans under specific circumstances.**
  
- **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.**
- - 2014 -- individuals and small groups
  - 2016 -- employers with up to 100 employees
  - 2017 -- states may expand to groups over 100 employees
  
- **Within 1 year, the Secretary must provide grants to states to create exchanges – Louisiana has applied.**
  
- **State's must have a plan in place by 1/1/2013 for their exchange.**
  
- **Exchanges will have to be self sustaining by January 1, 2015 when grants expire**

- An exchange may operate in multiple states if each state agrees and HHS Secretary approves
- New individual and group qualified health plans may be offered inside and outside the exchange, but the premiums must be the same.
- Premium and cost sharing subsidies will only be available through exchanges.
- Secretary of HHS will establish procedures for agents and brokers to enroll individuals in exchanges

#### 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,
  - taxpayers with income under 100 percent of poverty, and those who have a hardship waiver
  - members of Indian tribes,
  - those who were not covered for a period of less than three months during the year
  - People with no income tax liability
- Penalty for non compliance to either a flat dollar amount per person or a percentage of the individual's income, whichever is higher.
- 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.
- The alternative is a fixed dollar amount that phases in beginning with \$325 per person in 2015 to \$695 in 2016.
- Enforcement may be a problem. The IRS has indicated that it will not impose liens or levy assets, but would only withhold from tax returns. This coupled with lack of open enrollment or waiting periods increases the likelihood of adverse selection.

#### Employer Mandate:

- PPACA does not explicitly mandate an employer to offer employees acceptable health insurance.
- Employers do not have to provide coverage, but if even one employee receives a tax credit through the exchange, the employer will be penalized.
  - Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.
  - When determining whether an employer has 50 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.
  - This does not mean that part-time employees must be covered.

- Employers with at least 50 full-time equivalent employees will face penalties and a number of coverage obligations.
- “Full-time employees” are defined as those working 30 or more hours per week. The number of full-time employees excludes those full-time seasonal employees who work for less than 120 days during the year
- The hours worked by part-time employees are included in the calculation of a large employer, on a monthly basis. This is done by taking their total number of monthly hours worked divided by 120
- If an employer does not provide coverage and one employee receives a tax credit through the exchange, the employer will pay a penalty for all full-time employees
- Employers that provide coverage that is deemed unaffordable would be assessed the lesser of \$3,000 for each full time employee who obtains a premium credit in a health insurance exchange or \$2,000 for all FTE employees
- Regardless of whether or not a large employer offers coverage, it will be potentially liable for a penalty *if at least one of its full-time employees obtains coverage through an exchange and* receives a premium credit. Part-time workers or full-time equivalents are not included in penalty calculations.
- An employer will not pay a penalty for any part-time workers, even if that employee receives a premium credit.
- Avoid \$2,000 penalty by offering plan to all full-time employees
- Avoid \$3,000 penalty by offering a *voucher* to anyone who is impoverished and their individual’s required contribution toward the plan premium would exceed 9.5% of their household income
- Employer contribution is not set at a certain level
- Individuals who *are offered* employer-sponsored coverage can only obtain premium credits for exchange coverage if they are not *enrolled in their* employer’s coverage because their employer’s coverage meets either of the following criteria:
  - The individual’s required contribution toward the plan premium would exceed 9.5% of their household income
  - or the plan pays for less than 60%, on average, of covered health care expenses.
- Employee can also keep amounts of the voucher in excess of the cost of coverage; any excess is paid to employee and taxable to employee

### 2014: Essential Benefits

Essential benefits packages are defined:

- Specific plan design -- yet to be determined
  - Based on typical employer-sponsored health plan design
  - Bronze, silver, gold, and platinum coverage at 60%, 70%, 80%, and 90% benefit payment levels, respectively

- No required employer contribution percentage or amount\

### QHBP To Include:

- Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse treatment, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and rehabilitative services and devices
  - Laboratory services
  - Wellness & preventive services
  - Chronic disease management
  - Pediatric services (oral and vision care)
- 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.
    - Implementation date is unclear, may change to earlier via regulation
    -
  - PPACA prevents states from excluding tobacco cessation drugs from the medications covered by their Medicaid programs and requires Medicaid to cover smoking cessation treatment for pregnant women (including medication and counseling with no cost-sharing requirements) starting in 2014. States that voluntarily cover all recommended preventive services and immunizations for all Medicaid enrollees will get an increase in their federal reimbursements.
  - Section 4207 of PPACA amends the Fair Labor Standards Act (“FLSA”) and requires employers to provide nursing mothers with reasonable break time when they need to express breast milk and a place to do so, other than a bathroom, that is “shielded from view and free from intrusion by coworkers and the public.”
  - Because Congress did not specify an effective date for this requirement, it went into effect March 23, 2010, when the president signed the bill. Although the new law applies to employers of any size, those with fewer than 50 employees can be exempt if they can demonstrate that doing so “would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer’s business.”

### Effective 2018:

#### **CADILLAC TAX:**

- 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.

### In Conclusion:

- Acts have been signed, but health care will remain volatile political issue

- Attorney General's in 20 states have filed suit challenging constitutionality of individual mandate, including Louisiana.
- States are also considering legislation to prohibit federal mandates
- Outcome of suits and legislation uncertain, but federal and state policymakers will continue implementation
- Federal rulemaking and state efforts will impact market as well
- Who you vote for in November – DOES MATTER!

B. Ronnell Nolan, HIA  
President, The Nolan Group  
LAHU Lobbyist  
[TheNolanGroup@aol.com](mailto:TheNolanGroup@aol.com)  
(225) 921-6711

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