Pennsylvania Association of Health Underwriters

Advisors and Advocates for Employers, Employees and Health Care Consumers

Timeline for Health Care Reform

March 30, 2010

The Patient Protection and Affordable Care Act and **The Health Care and Education Affordability Reconciliation Act of 2010** are now law. While these laws addressed some needs, many believe that these new laws missed an opportunity to directly address health care costs. Unless one addresses reducing the cost of health care there is no real Health Care Reform. That being said, let's look at the timeline of what was actually passed.

Immediate

- Tax credits for employers (phase one) begins now.
  - Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit.
  - For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.
  - The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000.
  - The credit phases-out as firm size and average wage increases.
  - Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
- Changes to coverage in grandfathered policies (in existence March 2010) means that they must be in full compliance with new law.
- States must have ombudsman program.

July 2010

Insurance Industry Requirements

- Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
- Create a temporary "High-Risk Pool" for people who cannot obtain current individual coverage due to preexisting conditions. $5 Billion have been allocated. Program ends January 2014.

Government Programs

- 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. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage, and existing state high-risk pool options.

Taxes, Subsidies, and Grants

- Extends the tax exclusion for employer provided health coverage to a person who is eligible for coverage under the employer's plan and who is not a spouse or dependent.
- Imposes 10% tax on indoor tanning services.

October 2010

Insurance Industry Requirements

- No lifetime limits on health plan coverage
- No denial of coverage to children with preexisting conditions
- Raises the age of a dependent for health plan coverage to 26 (dependent may be married). This rule does not apply to a dependent that have another source of employer sponsored health insurance.
- Restricts rescissions (the practice of dropping people from the plan when they get sick) in all insurance markets
- Federal review of health insurance premium rates
- Creates a temporary reinsurance program for employer health plans providing coverage for non-Medicare eligible retirees aged 55-64 and their families.
- Annual benefit limits on coverage would be limited to DHHS-defined non-essential benefits.
- Mandated coverage of emergency services at in-network level regardless of provider
- Allows enrollees to designate any in-network doctor their primary care physician (including OB/GYN and pediatrician)
- Prohibits discrimination in coverage or premium based on salary
- Requires plans to have coverage appeals processes
- Requires that a summary of coverage be provided to applicants and enrollees
- Mandated coverage of specific preventive services with no cost sharing
- Requires insurance companies to report medical loss ratios.

Government Programs

- Establish an office of health insurance consumer assistance or ombudsman program to advocate for people with private coverage in the individual and small group markets.
- Authorizes FDA to approve FOBs (follow-on biologics).
- Establishes Patient-Centered Outcomes Research Institute.

Taxes, Subsidies, and Grants

- $250 rebate to Medicare beneficiaries reaching Part D coverage gap in 2010; phases out rebate and replaces with 25% coinsurance program after 2010.
- Cost Shift - Cuts $130 Billion from Medicare Advantage and $70 Billion from regular Medicare
- Creates grants for small employer-based wellness programs.

January 2011

Insurance Industry Requirements

- Minimum loss ratio requirements for insurers in all markets
- Prohibits over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs
- Employers must start reporting the value of health benefits on W-2 forms.
- Requires insurance companies to begin providing rebates related to medical loss ratios.
- Develop standards for insurers to use in providing information on benefits and coverage.
- 50% discount on prescriptions filled in Part D coverage gap.
- Begin phase-in of subsidies of 75% of generic drug cost for prescriptions filled in the Part D Coverage gap.

Employer Requirements

- Elimination of employer deductible subsidy under Medicare Part D (2013) will have an immediate impact on employers' liability and income statements. FAS109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability.

Government Programs

- Revised payments to Medical Assistance begin, phased in over 3 years.
- Creates payment innovation center within Center for Medicare Services.
- (**Class Act**) Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out.

Taxes, Fees, Subsidies, and Grants

- Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).
- Freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
- Imposes $2.5 billion fee on pharmaceutical manufacturing sector.
- Increases funding to community health centers by $11B over five years.
- Excise tax on brand name drugs begins.
- Impose an additional 5.4% surtax on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000.
- Permit only prescribed drugs to be reimbursable through a HSA, Archer MSA, HRA, or FSA for medical expenses.

March 2011

Government Programs

- Mandatory federal study on the impact the market reforms in the bill will have on the large group market
- Mandatory annual studies by the federal Department of labor on self-funded plans
- Repeal implementation of Worldwide Interest Allocation Disclosures to facilitate identification of individuals likely to be ineligible for low income subsidies under the Medicare Prescription Drug program to assist Social Security Administration's outreach to eligible individuals.

July 2011

Insurance Industry Requirements

- Rules adopted for simplifying health insurance administration by adopting a single set of operating rules for eligibility verification and claims status.

January 2012

Taxes, Fees, Subsidies, and Grants

- New federal premium tax on fully-insured and self-insured group health plans to fund comparative effectiveness research program begins. Applies the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets
- Reduce Medicare payments for preventable hospital readmissions

March 2012

Insurance Industry Requirements

- Group plans must report to HHS reimbursement structures that improve patient safety, wellness etc.

Employer Requirements

- Employers must provide a four-page summary of benefits and coverage explanation; any changes to be notified to employees within 60 days after plan change (penalties).
- Requires all employers provide notice to their employees informing them of the existence of an Exchange.

July 2012

Government Programs

- Electronic funds transfer and health care payment and remittance rules adopted

January 2013

Insurance Industry Requirements

- Limits FSA contributions for medical expenses to $2,500
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Applies to deferred compensation going back to 2009).

Government Programs

- Administrative simplification rules become effective Jan 1.
- Electronic funds transfers and health care payment and remittance rules become effective. .
- Medicare pilot program begins to test bundled payments.

Taxes, Fees, Subsidies, and Grants

- Makes available tax credits for qualified small employer contributions to purchase coverage for employees. Would apply to small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for their employees.
- 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.
- Increases Medicare payroll tax from 1.45% to 2.35% on earnings over $200,000 for individuals and $250,000 for married couples filing jointly. The employer amount remains 1.45%.
- Imposes excise tax of 2.9% on the sale of any taxable medical device.
- Federal subsidies of 25% of brand name drug cost phase-in begins
- Elimination of employer deductible subsidy under Medicare Part D. This will have an immediate impact on employers' liability and income statements. FAS 109 require employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability).

July 2013

Government Programs

- Create the Consumer Operated and Oriented Plan (CO-OP) program. Appropriate $6 billion to finance program and award loans and grants to establish CO-OPs.
- Regulations issued permitting states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact.
- States must ensure Medicaid pays primary care providers at least 100% of Medicare reimbursement. Additional Federal funding available to comply.

January 2014

Insurance Industry Requirements

- Requires all individual health insurance policies and all fully insured group policies to abide by strict modified community rating standards with 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. Wellness discounts are allowed for group plans under specific circumstances.
- Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited in all markets.
- Prohibits any annual limits or lifetime limits in group 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.
- Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.
- Establishes standards for qualified coverage, including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. Allows catastrophic-only policies for those 30 and younger.
- Health plans, including self-funded employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.
- Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums.
- Grandfathered group plans may only impose annual limits as determined by HHS. Must eliminate pre-existing condition exclusions for adults.
- Require risk adjustment in the individual and small group markets.

Employer Requirements

- Employer mandate begins.
- Require employers to give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.
- Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of $2,000 per year for each full time employee they don't cover (First 30 employees exempt from coverage. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.
- An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay $600 for any full-time employee subject to more than a 60-day waiting period.
- Requires employers of 200 or more employees to auto-enroll all new employees into any available employer sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.
- Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.

Individual Requirements

- Requires all American citizens and legal residents to purchase qualified health insurance coverage. Exceptions are provided for religious objectors, individual's not lawfully present and 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 and those who were not covered for a period of less than three months during the year.
- Violators are subject to an excise tax penalty of 1% of household income in 2014 and 2% of household income in 2015, and 2.5% of household income in 2016 (capped at the annual cost of the average bronze level premium plan (60%) offered through the exchanges). There is a fixed dollar alternative tax phasing in at $325 in 2015 and $695 in 2016.
- Individual mandate phased-in.

Government Programs

- Requires each state to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including the federally administered multi-state plans and non-profit co-operative plans. A catastrophic-only policy would be available for those 30 and younger. 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 DHHS.
- Medicaid Expansion:
  - To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), establishes that the federal government will pay 100% of the cost of the new expansion population until 2016, not 2017. Starting in 2017, all states except for the expansion states (including Nebraska), will then have to begin to have to pay a phased in amount of the cost of covering the expansion population, so that the federal government's match is 90% in 2020 and the out-years.
  - For states that already cover adults with incomes above 100%, the law reduces the amount the States are currently paying to cover this population by 50% in 2014 and gradually increases the amount of the federal share, so that by 2019, all states are paying the same amount for the non-pregnant adult Medicaid population.
- Medicaid eligibility level is increased to 150% FPL
- Requires states to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost effective to do so, under terms outlined already in current law.
- Gives states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars
- 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.
- Establishes a 10-state pilot program to apply the rules to HIPAA bona fide wellness program rules the individual market in 2014-2017 with potential expansion to all states after 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.
- Provisions relating to American Health Benefit Exchanges effective January 1, unless otherwise noted.
- Creates essential health benefits package. All health plans except grandfathered individual and employer-sponsored plans, required to offer at least the essential health benefits package.
- Allow states the option of merging the individual and small group markets.
- States permitted to create a Basic Health Plan for uninsured individuals between 133-200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchange.

Taxes, Fees, Subsidies, and Grants

- Annual fees on private health insurers based on net premiums and third party agreement fees received will be $8 billion in 2014-2016, and $13.9 billion in 2017 $14.3 billion in 2018 and indexed to the amount of premium growth in subsequent years. Does NOT apply to self-insured plans.
- Creates sliding-scale premium assistance tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL to buy coverage through the exchange
- Premium and cost-sharing subsidies to individuals.
- For tax years 2014 and beyond, employer tax credit Phase II begins.
- Imposes $8 billion fee on insurance sector.
- Appropriates $1 billion to DHHS to implement Health Care Reform.
- Appropriates $11 Billion dollars in additional funding for community health centers over 5 years.

July 2014

Government Programs

- Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, plan premium payments and referral certification and authorization rules adopted.

2015

Government Programs

- CHIP program must be reauthorized.
- Creates state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges for individuals & small businesses with up to 100 employees.

Taxes, Fees, Subsidies, and Grants

- Imposes $11.3 billion fee on insurance sector through 2016.

2016

Government Programs

- Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, plan premium payments and referral certification and authorization rules.
- States may allow businesses with more than 100 employees to purchase coverage in the SHOP exchange.

Taxes, Fees, Subsidies, and Grants

- Imposes $3.5 billion fee on pharmaceutical manufacturing sector.
- Imposes $13.9 billion fee on insurance sector.

2017

Government Programs

- States may choose to allow large groups (over 100) to purchase coverage through the exchanges.

2018

Government Programs

- IPAB recommendations submitted if Medicare per capita spending exceeds GDP per capita plus 1%.

Taxes, Fees, Subsidies, and Grants

- (**Cadillac Tax**)The 40% excise tax on insurers of employer-sponsored health plans (both fully-insured and self-insured) with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (indexed annually by CPI) would begin. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs. Stand alone dental and vision coverage is exempt from the tax.
- Imposes $4.2 billion fee on pharmaceutical manufacturing sector.
- Imposes $14.3 billion fee on insurance sector.

2019

Taxes, Fees, Subsidies, and Grants

- Imposes $2.8 billion fee on pharmaceutical manufacturing sector.
- Failsafe mechanism - Individual Subsidies could be reduced if aggregate amount exceeds .504 percent of GDP.

This summary is intended to inform our clients, business partners, and friends with guidance on the new health reform law. This summary, however, does not constitute legal advice.