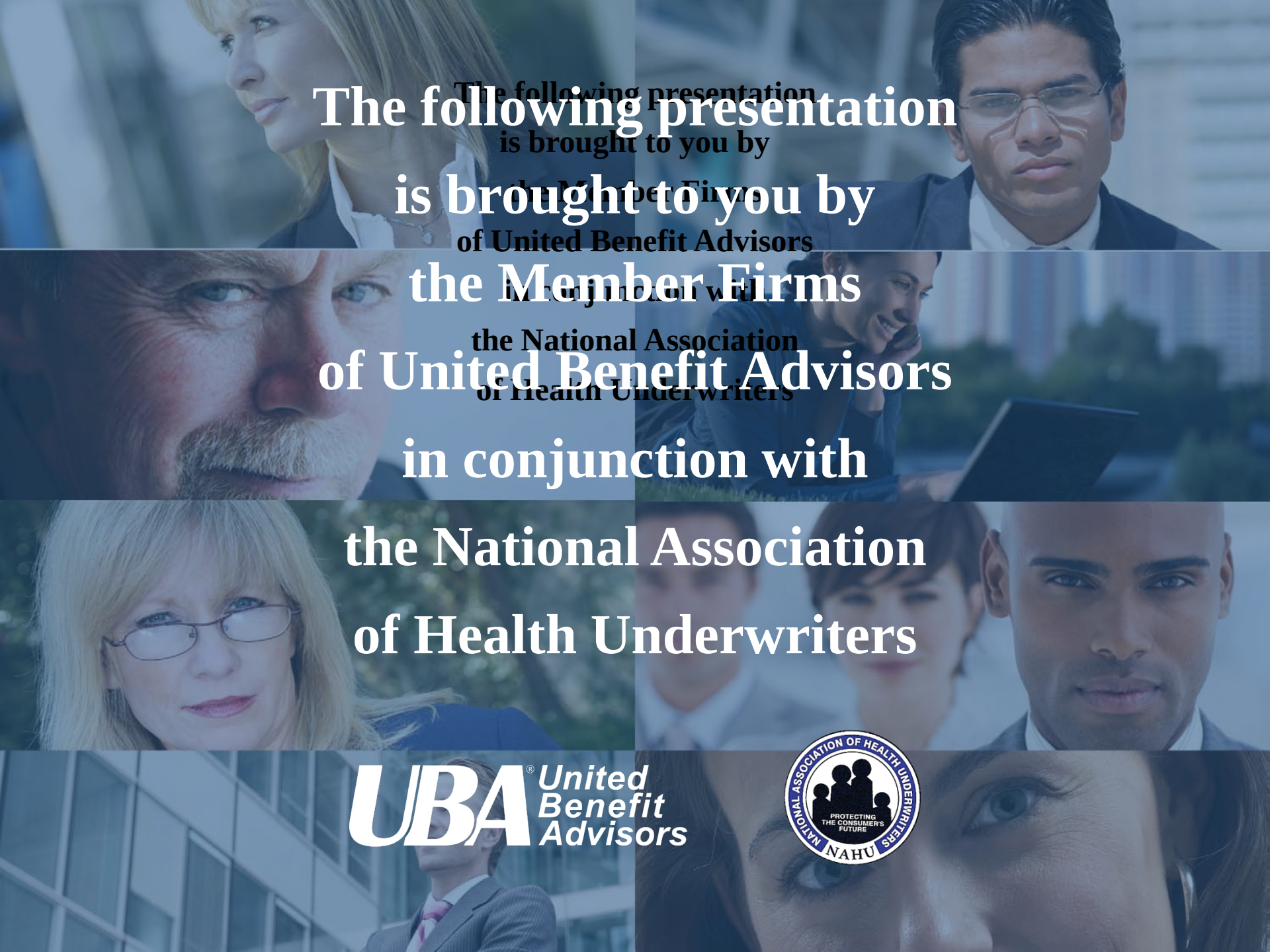

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NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS
PROTECTING THE CONSUMER'S FUTURE
NAHU

Legislative Update on The Implementation Of Health Reform

National Association of Health Underwriters

April 1, 2010

Setting the Course for Responsible Health Care Reform

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
- President Obama has signed both bills.

What the Senate Bill Does Immediately

- Individuals and employer group plans that wish to keep their current policy on a grandfathered basis can if the only plan changes made are to add or delete new employee/dependents or part of a collective bargaining agreement.
- There are a number of provisions that will be added as consumer protections during 2010.
- These changes will not impact grandfathered status but may increase cost.

The Senate Bill in 2010

- Eligible small businesses are eligible for phase one of the small business premium tax credit.
  - Small employers with less than 25 employees may be eligible for a tax credit on a sliding scale based on number of employees and average payroll, of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost.
  - Average salary must be $50,000 or less.
  - Businesses with no tax liability and non-profits are eligible for the credit.

The Senate Bill in 2010

- Temporary reinsurance program for employers that provide retiree health coverage for employees over age 55 begins within 90 days of enactment.
- All group plans will be required to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals within six months of enactment.
- Deductibility for Part D subsidies is eliminated in 2013, but this results in an immediate accounting impact.

The Senate Bill in 2010

- Creates high-risk pool coverage for people who cannot obtain current individual coverage due to preexisting conditions.
  - Employers and Insurers 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.
- It will be financed by a $5 billion appropriation.

The Senate Bill in 2010

- 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.

The Senate Bill in 2010

- 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.

The Senate Bill in 2010

- All group and individual plans, including self-insured plans and grandfathered plans, within six months of enactment, will have to cover dependents up to age 26.
- The reconciliation package:
  - 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.

The Senate Bill in 2010

- 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.

The Senate Bill in 2010

- For all group and individual plans, including self-insured plans, emergency services covered in-network regardless of provider.
- Enrollees may designate any in-network doctor 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

The Senate Bill in 2010

- For all group and individual health plans, including grandfathered plans, mandates coverage of specific preventive services with no cost sharing.
- Minimum covered services are specified based on existing federal guidelines on specific topics
- This could be a significant cost change for many plans.
  - Unclear if dental and vision for children will be included in the preventive care requirements.
  - Impact may be immediate in 2010 or in 2014 with essential benefits package.

The Senate Bill in 2011

- The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10% to 20%.
- OTC drugs no longer be reimbursable under HSAs, FSAs, HRAs and Archer MSAs unless prescribed by a doctor.
- Small employers (less than 100 lives) will be allowed to adopt new “simple cafeteria plans.”
- Creates a new **public long-term care program** and **requires all employers to enroll employees**, unless the employee elects to opt out.

The Senate Bill in 2012

- The Department of Labor will begin annual studies on self-insured plans using data collected from Form 5500.
- All employers must include on their W2s the aggregate cost of employer-sponsored health benefits.
  - If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage,
  - Excludes all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.
  - Applies to benefits provided during taxable years after December 31, 2010.

The Senate Bill in 2012

- Group plans including self-insured must report to HHS on whether benefits provided meet criteria to be establish secretary on improving health outcomes, reducing medical errors, and wellness and health promotion activities.
  - This report must also be provided to plan participants.
- All plans must provide new summary of benefits to enrollees at specified times.
  - Can be no more than 4 pages in length
  - Must be cultural and linguistically appropriate

The Senate Bill in 2013

- 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.
- 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)

The Senate Bill in 2013

- 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.
- All employers must provide notice to employees of the existence of state-based exchanges.

The Senate Bill in 2014

- 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 takes effect in 2012.
- Imposes annual taxes on private health insurers based on net premiums.
  - The reconciliation package delayed the tax from 2011 to 2014 and eliminates existing exemptions for certain insurers from the Senate-passed bill.
  - However, it also significantly increases the amount of fees once they become effective.

The Senate Bill in 2014

- 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.

The Senate Bill in 2014

- 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.

The Senate Bill in 2014

- 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 may choose to allow large groups (over 100) to purchase coverage through the exchanges in 2017

The Senate Bill in 2014

- 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

The Senate Bill in 2014

- 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 $325 per person in 2015 to $695 in 2016.

The Senate Bill in 2014

- 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.

The Senate Bill in 2014

- The employer responsibility requirements take effect for companies that employ more than 50 Full time Employees
  - Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.
  - When determining whether an employer has 50 employees, part-time employees must be taken into consideration based on aggregate number of hours of service.
- 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.
- Fine for noncompliance is $2000 per employee annually, but first 30 employees not counted (i.e., if the employer has 51 employees and doesn't provide coverage, the employer pays the fine for 21 employees).

The Senate Bill in 2014

- An employer with more than 50 employees that **does offer** coverage but has at least one FTE receiving a tax credit in the exchange will pay *the lesser of* $3,000 for each of those employees receiving a tax credit or $2,000 for each of their full-time employees total.
- An individual who has employer sponsored coverage available and has family income up to 400% of FPL is eligible for a tax credit through the exchange instead of employer coverage if-
  - the actuarial value of the employer's coverage is less than the minimum standard
  - or the employer requires the employee to contribute more than 9.5% of the employee's family income toward the cost of coverage.
- Waiting periods in excess of 90 days are prohibited.

The Senate Bill in 2014

- The third prong of the employer responsibility requirements.
- Requires employers to provide a voucher to use in the exchange instead of participating in the employer-provided plan in limited circumstances.
  - Employees must be ineligible for subsidies
  - An affordability test is required
  - Voucher to be provided must be adjusted for age
  - Employee can keep amounts of the voucher in excess of the cost of coverage

The Senate Bill in 2014

- Essential benefits packages are defined
  - Based on actuarial equivalents
  - Defines cost-sharing, mandates, and minimum covered benefits
- Multiple levels available based on actuarial equivalents
- Self-funded plans may not be subject to all requirements, but may not meet employer mandate requirements if they don't comply
- Allows catastrophic-only policies for those 30 and younger.

The Senate Bill in 2014

- 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**

The Senate Bill in 2014

- 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%
- 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.
- New federal study on wellness program effectiveness and cost savings.

Health Reform in 2014

- Expansion of Medicaid program for all individuals making up to 133% of FPL.
- Mandatory state by state employer premium assistance programs begin for eligible individuals who have access to employer sponsored coverage.
- States can also create a separate non-Medicaid plan for those with incomes between 133% and 200% of FPL that don't have access to employer sponsored coverage.

The Senate Bill in 2014

- 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.

The Senate Bill Beyond 2014

- 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.
  - 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.
  - Premium values are indexed to CPI
  - Allows plans to take into account age, gender and certain other factors that impact premium costs

Thank you for your participation in this important presentation.

United Benefit Advisors (UBA) and the National Association of Health Underwriters (NAHU) are leaders in ensuring that millions of Americans have the health care coverage they need to access quality health care and are committed to helping shape policies that guide positive health care reform.

If you have questions or need additional information regarding your benefits strategy, contact your local UBA Member Firm at www.UBAbenefits.com

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