Health Care Reform:
Where Do We Go From Here?

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Faith M. Williams
Bricker & Eckler LLP
Health Care Reform

• The Courts and Congress
• Key Provisions of the Law
  – Overview
  – Implications for the Health Care System
• Implications for P&C Insurers
• Implications for Employers
  – Initial Steps to Employer Compliance
  – Thinking Ahead
  – Survival Tips
Overview

• The “Health Care Reform Act” is actually two separate acts, totaling more than 2000 pages.

• Acronyms: PPACA, ACA, or simply “Health Care Reform”

• Reading the Act is just the beginning
  – At least 40 provisions require federal rulemaking
  – Estimates are that there will be over 1,000 rules issued by the federal government.
  – So far, only a small number of rules have been issued; so many portions of the new law await clarification.
The Courts and Congress

• Several Lawsuits Filed
  – Key question: Is the mandate that individuals buy health insurance Constitutional?
  – So far, 4 decisions have been handed down:
    • 2 Courts upheld the mandate
    • 2 Courts invalidated the mandate
  – Ultimately will end up before the U.S. Supreme Court (late in 2011 or in 2012?)
The Courts and Congress

• Constitutionality of the Individual Mandate
  – Commerce Clause lets Congress regulate “economic activity”
  – Opponents of Mandate: Congress can’t regulate inactivity
  – Proponents of Mandate: There’s no such thing as inactivity in the health care system.

Historical Note: Individual Mandate was originally proposed by Republicans – to improve the private HC system
The Courts and Congress

- The U.S. House voted recently to repeal HCR; but the Senate rejected this
- The House has promised to consider “defunding” agencies/programs/efforts related to implementation of the law
  - Presumably, the Senate will oppose
  - Could these efforts force a showdown between the House and Senate? With the President?
The Courts and Congress

• Some changes may be agreed to by all
  – Examples:
    • Repeal of 1099 reporting requirement (under which all business must file Form 1099 reports related to annual payments to anyone totaling $600 or more in a calendar year)
    • Changes to the CLASS Act (long-term care) provisions
Key Provisions of the Law
Key Provisions of the Law: Overview

Purpose: To ensure universal access to health care coverage at an affordable price

• **Access:** An additional 16 million people are expected to be covered under Medicaid and CHIP, and 24 million people are expected to be covered through insurance “exchanges”
  – Eliminating Barriers to Coverage
  – Individual Purchase Mandate
  – Medicaid Eligibility Expansion
  – Health Insurance Exchanges (information clearinghouses and marketplaces for individuals and businesses)
Key Provisions of the Law: Overview

- **Cost**: CBO estimates the cost at $940 billion over 10 years.
  - Funds will come primarily from increased revenues (taxes) and reduced fees to health care providers.
Key Provisions of the Law: Overview

- Implementation will occur over ten-years
- Many insurance reforms and other changes that impact employers take effect soon
- Hospitals, physicians, and other health care providers have been working for the past year to be in compliance
- States, which have responsibility for implementing significant portions of HCR, have started their work
Key Provisions of the Law: Implications for the Health Care System

- HCR emphasizes
  - Primary care
  - Coordination of care
  - Disease management
  - Continuum of care
  - Quality of care, including outcomes-based care, reduction of hospital readmissions
Key Provisions of the Law: Implications for the Health Care System

• Increased shifting of risk to health care providers
  – Accountable Care Organizations
  – Capitated or bundled payments
  – Financial penalties for “bad” outcomes

• Incentives to avoid institutionalized care (e.g., development of hospitals and nursing homes “without walls”)

• Many pilot and demonstration projects

Bottom Line: More people will be covered and more health care will be provided, but at a lower payment level per case/per person
Implications for P&C Insurers
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How does HCR affect OAMIC members as insurers?
• So far, all affects appear to be indirect
• Workers Comp: Likely to be more impacted than other lines, but still only indirectly
  – Fewer uninsured Americans, and greater focus on wellness could be advantages
  – But, increased demand for physicians could strain the health care delivery system
Implications for P&C Insurers

• Auto Coverage: Med Pay Provisions
  – No direct effects
  – Contractual obligations to pay under Med Pay provisions will continue
  – Because of the relatively low limits for Med Pay, any changes in reimbursement rates by gov’t programs or health insurers should not affect med pay
Implications for Employers
Implications for Employers

• Many health plan reforms take effect for plan years beginning on or after 9/23/10
  – mandatory benefits
  – changes in plan administration
  – employer reporting requirements

• Other changes take effect in 2011, 2012, 2013

• In 2014: Large employers must either offer coverage or pay a penalty; individual mandate takes effect
Group Health Plan Reforms apply to:

- Health Insurance “Issuers” (Insurers and HMOs)
- Group Health Plans
  - Fully-insured plans
  - Self-funded plans
  - Governmental plans
Dependent Coverage Requirement (Effective Plan Years Beginning on or after 6/1/10)

- Ohio Law: employee must be allowed to pay for coverage for adult child until age 28
- Ohio law applies to:
  1. Coverage issued by insurance companies and HMOs
  2. Insurance programs offered by MEWAs
  3. Public employee benefit plans
- Ohio law does not apply to ERISA self-funded group health plans
- Federal tax issue because Ohio law more expansive than federal law
Dependent Coverage Requirement (Effective Plan Years Beginning on or after 9/23/10):
Must provide dependent coverage to an adult child until age 26
  – Grandfathered plans--only required to extend coverage if adult child does not have access to another eligible employer-sponsored group health plan
  – Employer may not charge surcharge
Group Health Plan Reforms

Effective Plan Years Beginning on or after 9/23/10:

- No lifetime limit on “essential benefits”:
- Prohibition against rescissions (except for fraud or intentional misrepresentation)
- No Pre-existing condition limits for children under age 19
- Employees must be provided with prior notice of cancellation of coverage
- Must provide employees with 60 days prior notice of material changes to group health plan
Group Health Plan Reforms

Effective Plan Years Beginning on or after 9/23/10:

- Fully insured group health plans may not discriminate in favor of highly compensated employees with respect to eligibility to participate in the plan or as to benefits**
- Coverage of preventive health services without cost sharing requirements**
- Must include claims and appeals procedure and employees must receive continued coverage pending outcome of appeals process**

**Does not apply to grandfathered plans
Effective Plan Years Beginning on or after 9/23/10:

- Must include patient protection provisions:
  1. Must permit participant to chose primary care physician
  2. Cannot require pre-authorization for OB/GYN care
  3. Cannot require pre-authorization of emergency care provided out-of-network
  4. Emergency care must be covered both in and out of network, if covered by group health plan

**Does not apply to grandfathered plans**
Group Health Plan Reforms

Effective plan years beginning on or after 1/01/12:

• Must provide summary of benefits not to exceed four pages

• Large employees (>200 full-time employees) must automatically enroll employees in the plan unless they opt out and automatically re-enroll participants
  – Effective upon issuance of regulations

  *This is expected to have a major impact on the number of employees covered under provider-sponsored plans*
Group Health Plan Reforms

Effective plan years beginning on or after 1/01/14:

• Must provide dependent coverage to adult child until age 26 even if the adult child has access to other group coverage
• No pre-existing condition limits for anyone
• Maximum waiting period for enrollment: 90 days
• No annual limits on “essential health benefits”
• No provider discrimination**
• Coverage for participation in approved clinical trials**

**Does not apply to grandfathered plans
Grandfathered Plans

• A grandfathered plan is group health plan – whether insured or self-funded – in which at least one individual was enrolled on 3/23/10
  – Almost every plan starts out as a grandfathered plan
• BUT, certain changes to the plan or insurance coverage can cause the plan to lose its grandfathered status
• Special rules for collectively bargained plans (not discussed in this presentation)
Advantages of Grandfathered Plans

Grandfathered plans are subject to some requirements immediately, have a delayed effective date for others, and are permanently exempted from others.

Grandfathered plans are **not subject to:**

- Certain mandatory benefits
- Certain administrative requirements
Grandfathered Plans

Grandfathered Plans are **not** subject to the following:

- Expansion of the nondiscrimination requirements to fully insured plans
- New internal and external claims and appeals procedures
- Patient protection provisions (e.g., prohibition on limiting the types of providers that may be designated as a primary care provider)
- Coverage for preventive care
A plan will lose its grandfathered status if it does **any** of the following:

- Eliminates all or substantially all benefits to diagnose or treat a particular condition
- Reduces the employer contribution rate by more than 5% below the contribution rate on 3/23/10
- Exceeds certain limits on increases to cost-sharing requirements
- Imposes new or lower annual or lifetime limits on benefits
Maintaining Grandfathered Status

Changes that **will not** jeopardize grandfathered status include the following:

- Enrolling new employees
- Enrolling family members of current or new employees
- Changes to comply with state or federal law
- Changes to voluntarily comply with the Act
- Expanding or increasing benefits
- Contracting with a different TPA, if self-insured
- Contracting with a different insurer, if fully insured
Grandfathered Plans: Administrative Requirements

- All plan materials given to participants that describe benefits must include:
  - A statement that the plan believes it is grandfathered; and
  - Contact information for questions
  - Model language provided in the regulations
- The plan or insurer must maintain records documenting the terms of coverage that were in effect on 3/23/10, and all subsequent documents of changes to the plan
- Documents must be available for examination
To Remain Grandfathered or Not?

• Don’t assume that because your plan is grandfathered you should maintain that status.
• Many plans may find that it is more cost effective to change benefits, cost sharing and the employer contribution than to remain grandfathered.
• Predictions are that fewer plans will remain grandfathered each year, with most abandoning grandfathered status by 2014.

NOTE: These rules continue to change!
2010 Changes

Effective 3/23/10:

• Small employer tax credit is available

• Employers must allow a reasonable break time and shielded area for nursing mothers
2011 Changes

Effective 1/01/11:

• Limits reimbursement from FSA, HRA and HSA for over-the-counter drugs (prescription required for reimbursement)

• SIMPLE cafeteria plan for small employer (<100 employees)

• Penalty for non-medical distribution from HSA increased from 10% to 20%

• Must report aggregate cost of applicable employer-provided coverage on Form W-2
2012 Changes

Effective plan years beginning on or after 1/01/12:

• Must report health care provider reimbursement arrangements to HHS that do the following:**

  1. Improve health outcomes through implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives

  2. Implement activities to prevent hospital readmissions through comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by appropriate health care professional

**Does not apply to grandfathered plans
Effective plan years beginning on or after 1/01/12:

3. Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the plan or coverage.

4. Implement wellness and health promotion activities.

HHS has 2 years to issue regulations that contain quality reporting requirements for group health plans and health insurance issuers.
2013 Changes

Effective for tax years beginning after 12/31/12:

- Amount of salary deferrals to health flexible spending account (FSA) limited to $2,500
- Additional 0.9% Medicare tax imposed on wages and self-employment income in excess of $200,000 ($250,000 married filing jointly; $125,000 married filing separately)
  - Employer has obligation to withhold if the employee receives wages in excess of $200,000
2013 Changes

Effective 1/01/13 for new employees but not later than 3/01/13 for current employees:

- Employers subject to the FLSA must provide employees with written notification regarding:
  1. “Health insurance exchanges” and how to access them
  2. If the employer’s share of costs is <60%, that the employee may be eligible for a premium tax credit and a cost sharing reduction if the employee purchases through an exchange
  3. If the employee purchases through an exchange, the employee may lose the employer contribution and that all or a portion of such contribution may be excludable from gross income
2014 Changes

Effective plan years beginning on or after 1/01/14:

• Must offer “free choice voucher” to eligible employees
• Wellness program maximum reward/penalty raised to 30% (potentially up to 50%)
• Employers must certify to the IRS whether they offer minimum essential coverage to full-time employees and their dependents
Employer Penalties
Effective After 12/31/13

• Employers are not required to offer coverage, *BUT* large employers who don’t will pay a penalty in 2014
  – Penalty will be $2,000 - $3,000 per employee
Two situations will result in penalty for large employer:

1. Large Employer Does Not Offer Health Coverage

2. Large Employer Does Not Offer Affordable Health Coverage
Employer Penalties
Effective After 12/31/13

• Large Employer: 50 or more full-time employees on business days during preceding calendar year
• Full-time: 30 or more hours per week
  – Must include full-time equivalent employees for any month (aggregate number of hours of service / 120)
Large Employer Not Offering Health Coverage

• An “assessable payment” (i.e., a tax) is imposed if:
  – Employer does not offer full-time employees minimum essential coverage; and
  – At least 1 employee receives coverage through an exchange and receives a premium tax credit or cost sharing subsidy

• Assessable payment: $2,000 per year for each FTE (not deductible)
Employer Penalties  
Effective After 12/31/13

• An employer plan is not “affordable” if:
  – The plan provides less than 60% coverage for total allowed costs; or
  – The employee’s required contribution exceeds 9.5% of the employee’s household income

• Employee will not be eligible for premium tax credit or cost sharing subsidy if:
  – Employee’s household income exceeds 400% of the federal poverty line
Cadillac Tax:

- A 40% excise tax imposed on health coverage providers to the extent that the aggregate value of employer-sponsored health coverage for an employee exceeds $10,200 for an individual or $27,500 for a family
- Penalty is not deductible
- Effective for tax years beginning 1/1/18
Health Plan Compliance

- Many benefits changes are required for plan years beginning on or after 9/23/10
  - For calendar year plans this will be 1/01/11
- Many apply even if you are “grandfathered”
- Compliance issues slightly different for fully insured and self-funded plans
Steps to Compliance

- By now, you should know whether your plan is grandfathered
- If it is grandfathered, determine whether you want to maintain grandfathered status
Initial Steps to Compliance: Fully Insured Plans

• Your health insurer is also required to comply with the benefit mandates
  – Your insurer should automatically make adjustments to benefits to include new mandates
    • Many large insurers have implemented some benefit changes early
  – Contact your broker or health insurer to discuss implementation, costs and alternatives
Steps to Compliance: Self-Funded Plans

• If your TPA provides plan design, the TPA should revise plan design to include new mandates
• But unlike an insurer, a TPA is not required to comply with mandates – it is your responsibility as plan sponsor
• Contact your TPA to determine when revised plan design will be available
• Have revised plan design reviewed by legal counsel to determine compliance
• Update TPA service agreement to cover additional responsibilities
Initial Steps to Compliance: Plan Documents & Administration

- Changes in plan documents will be required for both fully insured and self-insured plans.

- If you are fully insured and assume the insurance policy is your plan document, you may be wrong.

- Consult with your legal counsel to determine if your documents are in compliance.
Future Steps and Decisions

Continue offering coverage or pay the penalty (starting in 2014)?

• Employers are NOT required to offer coverage

• *BUT* large employers who don’t will pay a penalty in 2014

• Penalty $2000-$3000 per employee
Other Issues

• The “1099 Issue”
  – Requires each business to issue Form 1099 to any vendor from whom it purchases goods costing $600 or more during a calendar year
  – Efforts underway to modify or repeal this

• New “Sales Tax” on Sale of Residential Real Estate?
  – Rumor is widespread – but not totally accurate!
  – There is a new 3.8% tax on the net investment income of high income persons
    - Applies to individuals with income over $200,000/year ($250,000 for joint filers)
    - The first $250,000 of profit ($500,000 for joint filers) on the sale of a principal residence is excluded
Survival Tips

• Stay in touch with new developments
• Identify reliable sources of information
• Don’t believe everything you read or hear
  – There is a lot of inaccurate information
• Don’t be too quick to react
  – Beware of rumors and check on accuracy
Survival Tips

• Consult with your professional advisors
• Develop a reasonable interpretation of unclear provisions based on the information available
• Make a good faith effort to comply
• Be consistent until clarification is issued
• Be flexible and don’t get upset when the rules change midstream
Reliable Resources

• Your professional advisors
  – Accountants
  – Attorneys

• HHS Website: www.healthreform.gov

• Bricker & Eckler Website: www.bricker.com/reform

• Sign up to receive health care reform information from Bricker & Eckler:
Questions?

Faith M. Williams
fwilliams@bricker.com
614.227.2374

Bricker & Eckler LLP
100 South Third Street
Columbus, Ohio 43215
www.bricker.com