


# Health Care Reform: What Employers Need to Know

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## Agenda

### Background

### Important definitions

### Employer plan related health reform provisions by effective date

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## Background

### Health reform legislation contained in two separate bills

- Patient Protection and Affordable Care Act - signed into law 3/23/2010
- Health Care and Education Affordability Reconciliation Act of 2010 – signed 3/30/2010
- Collectively referred to as “Health Reform”
- Health Reform amends a number of Federal laws
  - » ERISA, Public Health Services Act, Internal Revenue Code, Fair Labor Standards Act, and others

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## Background

- Effective dates for various provisions range from effective on date of enactment to effective 2018
- Some effective dates are based on plan years, others on calendar or tax year
- Many provisions require regulatory agencies to issue rules and guidance
  - » Expect significant guidance to be released by DOL, HHS and IRS

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## Definitions

### What is a Health Plan?

- Most rules apply to fully-insured and self-funded health plans offered by public or private employers that provide hospital, medical and surgical coverage
    - » Some rules apply specifically to the insurer not directly to the employer
    - » Most rules do not apply to “excepted benefits” such as dental only plans
- (Whalen Note: Be sure that “excepted benefits,” such as dental and vision plans, are separate plans outside the health plan. Otherwise changes to these plans may affect grandfathered status and the percentage range allowed to qualify the health plan as “affordable.”)*

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## Definitions

### Grandfathered Plans (Any group health plan in effect on 3/23/2010)

- Must have continuously covered someone since March 23, 2010
- Renewal and some modification of coverage can be made to grandfathered plan
- New employees and dependents can be added to grandfathered plans
- Changes made to a plan to comply with Federal or State legal requirements, voluntary changes to comply with the provisions of PPACA, and a change in Third Party Administrators (TPA) for a self-funded plan generally will not result in the loss of grandfathered plan status

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## Definitions

### What Grandfather Plans Can't Do

- Can't raise co-insurance charges i.e. if insured is required to pay 20% of hospital bill, this percentage can't increase
- Can't increase co-pay more than the greater of \$5 (adjusted annually for medical inflation) or medical inflation plus 15 percentage points
- Can't reduce employer contribution more than 5 percentage points
- Can't increase deductible more than medical inflation plus 15 percentage points
- Can't reduce any insurer annual dollar limit in place as of March 23, 2010
- Can't use a merger, acquisition or business restructuring for the purpose of covering new individuals under a grandfathered plan
- Can't change carriers if you are fully insured
- Can't move employees to a grandfathered plan with lower benefits
- Can't make a significant cut to benefits such as eliminating benefits for a particular condition

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## Definitions

### What Grandfathered Plans Can Do

- Add family members or new employees
- Disenroll employees
- Make changes as a result of state or federal regulations
- Make changes to voluntarily adopt some or all of the law's requirements
- Change third party administrator if you are self-funded
- Increase premiums

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## Definitions

### Grandfathered Plans - Notice Requirements

- In order to maintain its grandfathered plan status, a group health plan must disclose to participants and beneficiaries that it is being treated as a grandfathered plan
- An appropriate notice must be included in any plan materials provided to participants and beneficiaries describing the benefits provided under the plan (e.g., summary plan descriptions, benefit booklets, and open enrollment materials)
- The regulations provide model language which, if included in the appropriate documents, will be deemed to satisfy the notice requirement

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## Temporary High Risk Pool for Uninsurable Individuals

- Medical Mutual selected to operate pool
- Applications started August 1<sup>st</sup> with coverage effective date of September 1<sup>st</sup>
- Completed applications received after August 15<sup>th</sup> will be effective October 1<sup>st</sup>
- Approximately \$152 million for Ohio out of \$5 billion total
- Eligible persons will pay a standard market rate
- As of September 1<sup>st</sup> approximately 330 enrolled in program

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## Temporary High Risk Pool Eligibility Requirements

- Must be a citizen or national of the U.S. or lawfully present in the U.S. and an Ohio resident
- Must be uninsured for six (6) months prior to the date you apply for coverage
- Cannot be eligible for coverage under the federal Medicare program, the Ohio Medical Assistance Program, the Ohio Children's Health Insurance Program or an employer-sponsored group health plan, unless you are subject to a mandatory initial waiting period
- Must have a qualifying pre-existing condition as evidenced by a denial of coverage by two insurers or documentation from a health professional of a qualifying pre-existing condition

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## High Risk Pool Questions

- Go to [www.ohiohighriskpool.com](http://www.ohiohighriskpool.com)
- Call 1-877-730-1117
- Go to Ohio Department of Insurance website [www.insurance.ohio.gov](http://www.insurance.ohio.gov) and click on High Risk Pool FAQs

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## 2010/2011

### Effective plan years beginning after 9/23/10

- Rules that apply to grandfathered plans
  - » Children covered to Age 26
  - » Pre-existing condition limitations for children under 19
  - » Lifetime and annual plan limits
- Rules that do not apply to grandfathered plans
  - » Section 105 nondiscrimination rules apply to fully-insured plans
  - » No cost sharing for certain preventive care

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## 2010/2011

### Children covered to age 26

(plan yr > 9/23/10 & gf plans)

- Coverage required regardless of whether they qualify as a tax dependent or full-time student
- Applies even if child is married
- Children must not be eligible for coverage under another employer's group health plan
  - » Beginning on 2014 coverage required even if child is eligible for another employer group plan
- The Department of Labor (DOL) released interim final regulations on May 10, 2010, which prohibits charging older children a different premium than other dependent children are charged on the plan

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## 2010/2011

### Ohio Law - children covered until age 28

Effective July 1, 2010

- Law applies to group policies for dependents including COBRA and state continuation, and individual policies that include coverage for dependents including conversion, open enrollment basic and standard plans
- The employer is not required to pay for any part of the dependent cost

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## 2010/2011

### Pre-existing condition limitations for children under 19

(plan yr > 9/23/10 & gf plans)

- Plans may not impose pre-existing limitations on children under 19
- HHS has stated plans also cannot deny coverage due to a pre-existing condition
  - » Important note – This rule does not require a plan to provide dependent coverage – it governs how the plan operates if it offers coverage to dependents
  - » Ohio Emergency Rule – Requires every insurer offering under age 19 coverage to participate in open enrollment initially from 9/23/2010 – 11/15/2010 and then for the entire months of July and January going forward

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## 2010/2011

### Plan limits (plan yr > 9/23/10 & gf plans)

- No lifetime limits
- Plans can have “restricted annual limits” to be defined by HHS
  - » No annual limits for essential health benefits permitted beginning in 2014
    - » This refers to the plan coverage limit (i.e. \$3 million, \$5 million, etc.) not the out-of-pocket maximum

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## 2010/2011

### Plan provisions that do not apply to grandfathered plans (we think!)

- Preventive Care Coverage
  - » Effective for plans beginning 1/1/2011
  - » Plans must cover certain preventive care with no cost sharing (deductibles or co-pays)
  - » Includes immunizations, annual check-ups, healthy child visits, breast cancer screenings and other services determined by U.S. Preventive Task Force.
- Section 105 nondiscrimination rules will apply to fully insured plans
  - » Likely to severely limit “executive only” plans on a tax free basis

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## 2010/2011

### FSA, HSA, HRA changes

- Over the counter drugs not an eligible expense for FSA, HRA, HAS
  - » Effective 1/1/2011
  - » Insulin and OTC that are prescribed by MD are still eligible
  - » Unclear how this will apply to grace periods for 2010 FSA plans
- HSA penalty for withdrawal for non-medical expenses increased from 10% to 20%
  - » Effective 1/1/2011

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## 2010/2011

### Coverage for older dependents is not taxable to the employee

- Applies to any child who has not reached age 27 by the end of a tax year
- Effective March 23, 2010 (Now!)
- State tax may still apply

### Tax credit for small employers

- 35% (non-profits 25%) credit for tax years 2010-13. 50% (non-profits 35%) for plans purchased through exchange beginning in 2014
  - » Full credit for employers with 10 or fewer employees and average annual wages of less than \$25,000
  - » Partial credit for employers with up to 25 employees and average annual wages up to \$50,000
  - » Determine you credit at: [www.bcsnc.com/taxcredit](http://www.bcsnc.com/taxcredit)

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## 2010/2011

### Early retiree reinsurance program

- Federal government to reimburse plans 80% of claim costs between \$15,000 - \$90,000 per year for early retirees 55-64
- Program ceases by 1/1/2014 or when \$5B funding is exhausted

### New W-2 reporting

- Report aggregate cost of health coverage on W-2
- Optional for tax year 2011, will be mandatory for later years

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## 2013

### Employee annual contributions to a Section 125 health FSA capped at \$2,500

- Effective Date 2013 tax year
- ### Additional 0.9% payroll tax
- Effective tax year 2013
  - Applies to taxpayers with earned income above \$200,000 (single return) or \$250,000 (joint return)
  - No employer match required

### Additional 3.8% tax

- On unearned income of AGI over \$200,000 (single return) and \$250,000 (joint return)

### Employee notice requirement

- Beginning March 2013
- Employers must provide notice with information regarding state insurance exchange and premium tax credits and cost reductions that may be available to individuals

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## 2014

### 2014 Summary

- Health Benefit Exchanges
- Subsidies for low and middle income individuals
- Employer penalties
  - » For not providing coverage
  - » For providing limited or unaffordable coverage
- Free-choice vouchers
- Employer health coverage reporting
- Limit on waiting periods
- Wellness plan changes
- Automatic enrollment

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## 2014

### State-based health insurance exchanges

- Coverage for individuals and employers up to 100, however, state may limit to 50 employees through 2016; and beginning in 2017 may expand above 100 employees
- Carriers must offer standardized plan options (i.e. Platinum, Gold, Silver and Bronze) – Catastrophic plan available to those under age 30
- Exchange will administer subsidies and cost sharing reductions for eligible individuals
- Plans will need to meet certain requirements
  - » Guarantee issue and renewable basis
  - » No health underwriting
  - » No preexisting condition exclusions
  - » Limits on premium rating "bands"
  - » Some rules can vary by state

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## Minimum “Essential Benefits” must be offered in the Exchange or by employer

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health/substance use disorder service
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Prevention/wellness/chronic disease services
- Pediatric services including oral and vision care
- Limits on out-of-pocket costs
- Limits on small group plan deductibles

States that exceed essential benefits have to pay for increased costs

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## Ohio Exchange Planning Timeline

- Health Benefits Exchange Planning Task Force
  - Appointed by Director of Ohio Department of Insurance – includes employer, union, consumer, insurer, agent and provider representatives
  - Phase I: Preliminary Planning and Recommendation, October 2010 – February 2011
  - Phase II: Implementation Grant Recommendations and Strategic Planning, March – September 2011
- States must ensure that Exchanges are self-sustaining by January 1, 2015

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## 2014

### Subsidized coverage and cost sharing reduction for individuals purchasing coverage through the exchange

- Available for individuals with income up to 400% of Federal Poverty Level (FPL)
  - » Currently \$43,320 for individuals and \$88,200 for family of four
  - » Premiums as % of income
    - Up to 133% FPL - 2%
    - 133-150% FPL - 3-4%
    - 150-200% FPL - 4-6.3%
    - 200-250% FPL - 6.3-8.05%
    - 250-300% FPL - 8.05-9.5%
    - 300-400% FPL - 9.55%
- Not available to individuals offered qualifying employer provided coverage at “affordable cost”
  - » Affordable is defined as employee premium no more than 9.5% of the employee’s household income

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## 2014

### “Play or Pay” Penalty

- Applies to employers with 50 or more employees
  - » Part-time employees counted on a pro-rated basis

*And if these conditions apply*

  1. Employer does not offer minimum essential coverage to all its full-time employees
  2. Coverage is offered but plan design covers less than 60% of all claim costs
  3. Employer offers “unaffordable” coverage
    - » Remember unaffordable is defined as employee’s premium is more than 9.5% of the employee’s household income

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## 2014

### Play or Pay (cont.)

- **Background**
  - » Employers not required to offer health insurance but will pay a penalty if certain conditions are met
  - » Full-time employees defined as 30 hours per week
  - » In no case are employers required to provide coverage to part-time employees
  - » Penalty applies only if an employee is eligible for a subsidy or cost sharing reduction and purchases coverage through an exchange
  - » Penalty formula is different for an employer who offers minimum essential coverage to full-time employees than for an employer who does not offer health coverage

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## 2014

### Play or Pay (cont.)

- **Employers who offer coverage to full-time EEs**
  - » Penalty = \$3000/yr (\$250/mo.) for each employee receiving subsidy and purchasing coverage in exchange
- **Example**
  1. 100 employees - Employee mo. prem. S=\$150 F=\$400
  2. 5 employees qualifying for subsidy and purchasing coverage through an exchange
    - 2 FT single employees earning \$18,000/yr
      - » \$1500 mo income + \$150 premium = 10% of income
    - 3 FT employees with families earning \$42,000/yr
      - » \$3500 mo income + \$400 premium = 11.4% of income
  3. Employer Penalty = \$1250/mo

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## 2014

### Play or Pay (cont.)

- **Employers who do not offer coverage to FT EEs**
  - » Penalty = \$2000/yr (\$166.67/mo) times the total number of FTEs not counting first 30 employees, if at least one employee qualifies for a subsidy.
- **Example**
  1. 100 employees
  2. 1 employee qualifies for subsidy and purchases coverage through an exchange
  3. Employer Penalty - 70 x \$166.67 = \$11,666.90/mo

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## 2014

### Free Choice Voucher

- **If employer pays any portion of plan's cost, employer must offer "free choice vouchers" to qualified employees**
  - » **Qualified employee**
    - Employee contribution between 8% - 9.5% of household income
    - Income not greater than 400% of FPL
- **Amount of voucher equals amount employer would have paid for coverage**
- **Employee can credit voucher towards cost of exchange-provided coverage**

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## 2014

### Reporting Requirements

- Employers with more than 50 employees
- Any employer where the employee's share of the cost of such coverage exceeds 8% of the employee's wages
- Must file annual report including:
  - » If employer offers full-time employees minimum essential coverage
  - » the name of each employee and dependent covered
  - » the number of full-time employees
  - » the length of any waiting
  - » the monthly premium of lowest cost option

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## 2014

### Other Changes

- Limit on waiting periods
  - » No waiting periods longer than 90 days
  - » Applies to grandfathered plans
- Automatic Enrollment
  - » Employers with 200 or more employees must automatically enroll new employees in a plan
  - » Effective date of this provision unclear and could be earlier

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## 2018

### Excise tax on high-cost health plans – “The Cadillac Tax”

- 40% excise tax on cost of health benefits over \$10,200 annually for individuals and \$27,500 for other than individual coverage
  - » Adjusted for age and gender demographics of the group
  - » Limits may be adjusted if health care inflation rate exceed expected level between now and 2018
  - » HRA, HSA and FSA employer contributions included
  - » Cost of separate dental and vision coverage excluded

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## One Last Last Note

One of the most controversial provisions of the Health Reform Legislation

The 10% excise tax on indoor tanning services!



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