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Health Reform After the Supreme Court What Comes Next?

An Update on the Path To Full Implementation

July 26, 2012

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The Supreme Court Decides

- National Federal of Independent Business v. Sebelius
- June 28, 2012
- Chief Justice Roberts, joined by Justices Ginsburg, Sotomayer, Breyer and Kagan
- Constitutional issues considered
  - Individual Mandate
  - Medicaid Expansion

The Supreme Court Decides

- We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation's elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions.

The Supreme Court Decides

- The Framers created a Federal Government of limited powers, and assigned to this Court the duty of enforcing those limits. The Court does so today. But the Court does not express any opinion on the wisdom of the Affordable Care Act. Under the Constitution, that judgment is reserved to the people.

QUIZ 1: Which issue was NOT part of the Supreme Court opinion?

- R. ERISA Preemption
- S. Constitutional power of Congress to adopt the individual mandate as part of its power to regulate interstate commerce
- T. Same as S. but as part of Congress' power to collect taxes
- U. Applicability of the Anti-Injunction Act
- V. Severability of the individual mandate from the rest of the health care reform law

2010 Provisions That Apply Only To Non-Grandfathered Plans

- For plan years beginning on or after September 23, 2010
  - No cost sharing for immunization or preventive care
  - No discrimination in favor of highly compensated individuals
  - Must provide appeal process for coverage determinations including external review
  - Must allow individuals to choose pediatrician for child's primary care physician
  - Must allow females to choose gynecologist or obstetrician without referral
  - Must allow emergency services without preauthorization and treat as in-network

2010 Provisions That Apply To All Plans

- For plan years beginning on or after September 23, 2010
  - No annual limits on essential benefits for group health plans (Secretary may allow restricted annual limits on benefits through January 1, 2014)
  - No lifetime limits on essential benefits
  - No rescissions (except for fraud or misrepresentation)
  - Must provide rebates if plan does not meet required medical loss ratio
  - No preexisting condition exclusions for individuals under 19 years old
  - If the plan covers dependents, it must offer coverage to adult children of insured up to age 26 (not applicable until 2014 for grandfathered plans if the dependent is eligible for another employer-sponsored health plan other than that of a parent)

2012 Provisions That Apply Only To Non-Grandfathered Plans

- For plan years beginning on or after August 1, 2012, nongrandfathered plans must provide first-dollar coverage for an expanded list of required women's health preventive services
  - In network
- These services include all FDA-approved contraceptive methods and sterilization procedures
  - Exceptions for plans that currently do not cover contraceptives because of their sponsors' religious beliefs

2014 Provisions That Apply Only To Non-Grandfathered Plans

- For plan years beginning on or after January 1, 2014
  - Guaranteed issue (insured plans)
  - Guaranteed renewability (insured plans)
  - Coverage for clinical trials
  - No discrimination based on health status
  - No discrimination on health care providers acting within the scope of their license
  - Must cover essential benefits (only applies to small group markets)
  - Must follow cost sharing limits

2014 Provisions That Apply To All Plans

- For plan years beginning on or after January 1, 2014
  - No annual limits on essential benefits (where Secretary has allowed restricted annual limits)
  - No preexisting condition exclusions (regardless of age)
  - Waiting periods limited to 90 days

Loss of Grandfathered Plan Status

- The following changes that reduce benefits or increase costs for participants will cause a plan to lose its grandfather status
  - elimination of all or substantially all benefits to diagnose or treat a particular condition
  - any increase in a percentage cost-sharing requirement, such as an individual's coinsurance, above the amount that applied on March 23, 2010
  - an increase in a fixed-amount cost-sharing requirement that applied on March 23, 2010 other than a copayment (for example, deductible or out-of-pocket limit) by a total percentage that is more than the medical inflation percentage rate plus 15%

Loss of Grandfathered Plan Status

- an increase in a fixed-amount copayment that applied on March 23, 2010 by more than the greater of $5 (increased for medical inflation) or the medical inflation percentage rate plus 15%
- a decrease by an employer in its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the employer's contribution rate for the coverage period that included March 23, 2010
- the imposition of a new overall annual limit or a decrease in the amount of an existing annual limit on the dollar value of benefits

Looming Tax Increases

- Additional Medicare Tax
  - Starts in 2013
  - Rate is 0.9%
  - Applies to Married Filing Jointly filers with combined wages, other compensation and self employment income of more than $250,000
  - Employer withholding begins, per employee, on wages in excess of $200,000 in a calendar year
  - Employer is not required to notify affected employees

QUIZ 2: What is the "employer match" rate for the Additional Medicare Tax?

- E. 0.00%
- F. 0.45%
- G. 0.90%
- H. 1.45%

Looming Tax Increases

- Surtax on Unearned Income of Higher Income Individuals
  - Starts in 2013
  - Medicare contribution tax
  - Rate is 3.8%
  - Applies to lesser of
    - Net investment income
    - Excess of modified adjusted gross income over $250,000 for married filing jointly

Looming Tax Increases

- Higher Threshold for Deducting Medical Expenses
  - Taxpayers under age 65 can deduct unreimbursed medical expenses that are more than 10% of adjusted gross income
  - If taxpayer or spouse is 65 before December 31, 2012, 7.5% floor continues to apply through 2016

Medical Loss Ratio Rebates

- Insurers must spend a minimum percentage of premium dollars on medical services and activities designed to improve health care quality
  - 80% for Individual and Small Group markets
  - 85% for Large Group markets
- Aggregated market data in each state
- Not specific to a particular group health plan's experience
- Fully insured policies/not self funded plans
- Paid to policyholder of ERISA plans by August 1
- Notices to subscribers

QUIZ 3: For MLR purposes, a Texas employer is a small employer if it averages ___ or fewer employees during the preceding year?

- A. 10
- B. 20
- C. 50
- D. 100

MLR: ERISA Issues

- Plan assets
- Fiduciary responsibility
- Prohibited transaction
- Trust

MLR: ERISA Issues

- "Ordinary notions of property rights"
- Policyholder
  - Plan
  - Employer
- Carefully analyze the terms of:
  - the governing plan documents
  - the parties' understandings and representations
- Source of money for payment of premiums

MLR: ERISA Issues

- Other factors
  - Costs to the plan to allocate rebate
  - Ultimate benefits of reallocation
  - Competing interests of classes of participants
  - Adverse tax consequences
    - IRS FAQs issued April 2, 2012
  - De minimus dollar amounts

MLR: ERISA Issues

- Use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants
- Permissible uses
  - Future participant premium payments
  - Benefit enhancements
  - Cash distribution
- Consider plan amendment

Reduced Limit On Flexible Spending Account Balances

- Health FSA contributions by employees will be limited to $2,500 per year starting in the 2013 plan year
- Not applicable to dependent care assistance (day care) benefits
- Grace period amounts that remain after the 2012 plan year for up to 2-1/2 months are not affected

QUIZ 4: Plan amendments to comply with the new limit on salary reduction contributions to health FSAs must be made by December 31 of which year?

- W. 2012
- X. 2013
- Y. 2014
- Z. 2015

W-2 Reporting

- Applies to employers that were required to file 250 or more W-2 forms in the preceding year
- Applies to 2012 W-2s that are distributed to employees starting in 2013
- Report total cost of group health benefit plan coverage
- Box 12, Code DD
- Informational only/Reported cost is not taxable
- Employee coverage only is reported

W-2 Reporting

- Does not apply to
  - “excepted benefits”, such as accident, disability income, supplemental liability and workers compensation insurance
  - Stand-alone dental and vision plans
  - HRA, HSA and Health FSA amounts
  - Employee assistance plans, wellness programs and on-site medical clinics if the employer does not charge a premium

W-2 Reporting

- Total cost includes
  - Employer portion
  - Employee portion
    - Pre-tax
    - After-tax
- Cost of coverage
  - Any reasonable method that is applied consistently for all employees who terminate employment during the year

QUIZ 5: Which of the following is not a reasonable method in IRS Notice 2012-9 for calculating the cost of plan coverage for W-2 reporting purposes?

- E. COBRA Applicable Premium Method
- F. Premium Charged Method
- G. Multi Year Coverage Average Premium Method
- H. Modified COBRA Premium Method

Summary of Benefits and Coverage

- Provide improved information to consumers to
  - better understand the coverage they have; and
  - allow them to compare their coverage options across different types of plans and insurance products
- Fully insured and self insured plans
- Grandfathered and nongrandfathered plans

Summary of Benefits and Coverage

- Key Documents
  - Template
  - Glossary

Summary of Benefits and Coverage

- A description of the coverage
- The exceptions, reductions, or limitations on coverage
- The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations
- The renewability and continuation of coverage provisions
- Coverage examples (common benefits scenarios for having a baby (normal delivery) or managing Type 2 diabetes (routine maintenance, well-controlled)
- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage

Summary of Benefits and Coverage

- A contact number to call with questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained
- An Internet address (or other contact information) for obtaining a list of the network providers, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage, and an Internet address where an individual may review the Uniform Glossary, and a disclosure that paper copies of the Uniform Glossary are available
- A uniform format, four double-sided pages in length, and 12-point font

QUIZ 6: Premium or cost of coverage information must be included in the SBC.

- S. True
- T. False

Summary of Benefits and Coverage

- For delivery to members of group plans with open enrollment periods
  - the first day of the first open enrollment period beginning on or after September 23, 2012
- For delivery to members that enroll other than through an open enrollment period (including special enrollees)
  - the first day of the first plan year on or after September 23, 2012
- Electronic delivery and internet posting

Summary of Benefits and Coverage

- Plans and issuers must provide notices in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language, as determined based on American Community Survey data published by the U.S. Census Bureau

Quiz 7: Which of the following is NOT a language into which the SBC may be required to be translated?

- A. Spanish
- B. Tagalog
- C. Chinese
- D. Navajo
- E. French Canadian

Patient Centered Outcomes Research Trust Fund

- Fee to fund research to evaluate and compare the health outcomes and clinical effectiveness, risks and benefits of
  - Medical treatments
  - Services
  - Procedures
  - Drugs
- Applies to
  - Insured plan—Issuer liable
  - Self-insured plan—Plan sponsor liable

Patient Centered Outcomes Research Trust Fund

- Policy years ending after September 30, 2012
- Does not apply in policy years ending after September 30, 2019
- $1 for the first year (and $2 for later years) times the average number of lives covered under the plan (including dependents)
- Due July 31, 2013
- IRS Form 720

Fully Insured Plan Discrimination Rules

- Impacts executive only benefits and management carve out plans
- Rules similar to Code Section 105(h) rules that apply to self-insured plans with respect to
  - Eligibility
  - Benefits
  - Controlled group testing
  - Highly compensated individual
- Not applicable to grandfathered plans
- Section 4980D Excise Tax
  - $100 per day, per violation
  - Not applicable to small employers (2 to 50 employees)
- Enforcement suspended since December 2010

Exchange Notices

- Employers are required to provide their employees with written notice about the exchanges by no later than March 1, 2013
- Content of Exchange Notice
  - Information about the existence of the Exchange, including a description of the Exchange services and how an employee may contact the Exchange
  - If the employer's share of the cost of coverage is less than 60 percent, a statement that the employee may be eligible for premium tax credits and cost-sharing reductions if purchasing coverage through the Exchange
  - If the employee purchases coverage through the Exchange, a statement that the employee will lose the employer contributions and that employer contributions are excludable from income tax

Employer Shared Responsibility Excise Tax

- Shared Responsibility Penalties
  - Play OR Pay
  - Play AND Pay
- Applies to employers that employed an average of at least 50 full-time (or full time equivalent) employees on business days during the preceding calendar year
  - works on average at least 30 hours per week

Employer Shared Responsibility Excise Tax

- Play OR Pay
- An employer that does not offer health coverage to its full-time employees and their dependents is subject to a nondeductible "play OR pay" penalty if any full-time employee enrolls for coverage through an Exchange and qualifies for the premium tax credit or reduced cost-sharing
- $2000 for each full time employee over 30

Employer Shared Responsibility Excise Tax

- Play AND Pay
- Applies if a large employer offers its full-time employees (and their dependents) the opportunity to enroll in coverage but the coverage does not provide “minimum value” or is “unaffordable” and one or more full-time employees receive subsidized coverage through an Exchange
- Penalty is $3,000 for each full-time employee receiving subsidized coverage through an Exchange

Quiz 8: How much is the flat dollar amount of the individual mandate penalty in 2014 per uninsured person?

- A. $95
- B. $325
- C. $695
- D. $895

Cadillac Plans

- High-Cost Employer Plans
- Excise tax imposed on the aggregate value of employer-sponsored health coverage in excess of:
  - $10,200 for individual coverage
  - $27,500 for family coverage
- Tax is imposed
  - Insured plans—on insurer
  - Self-insured plans—on third party administrator or employer
- 40% rate
- Beginning in 2018

Miscellaneous Provisions

- Effective in 2015 for 2014: Notice regarding whether health coverage qualifies as minimum essential coverage
- Pending DOL Guidance (not before 2014): Automatic enrollment required for employers with more than 200 full time employees

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