

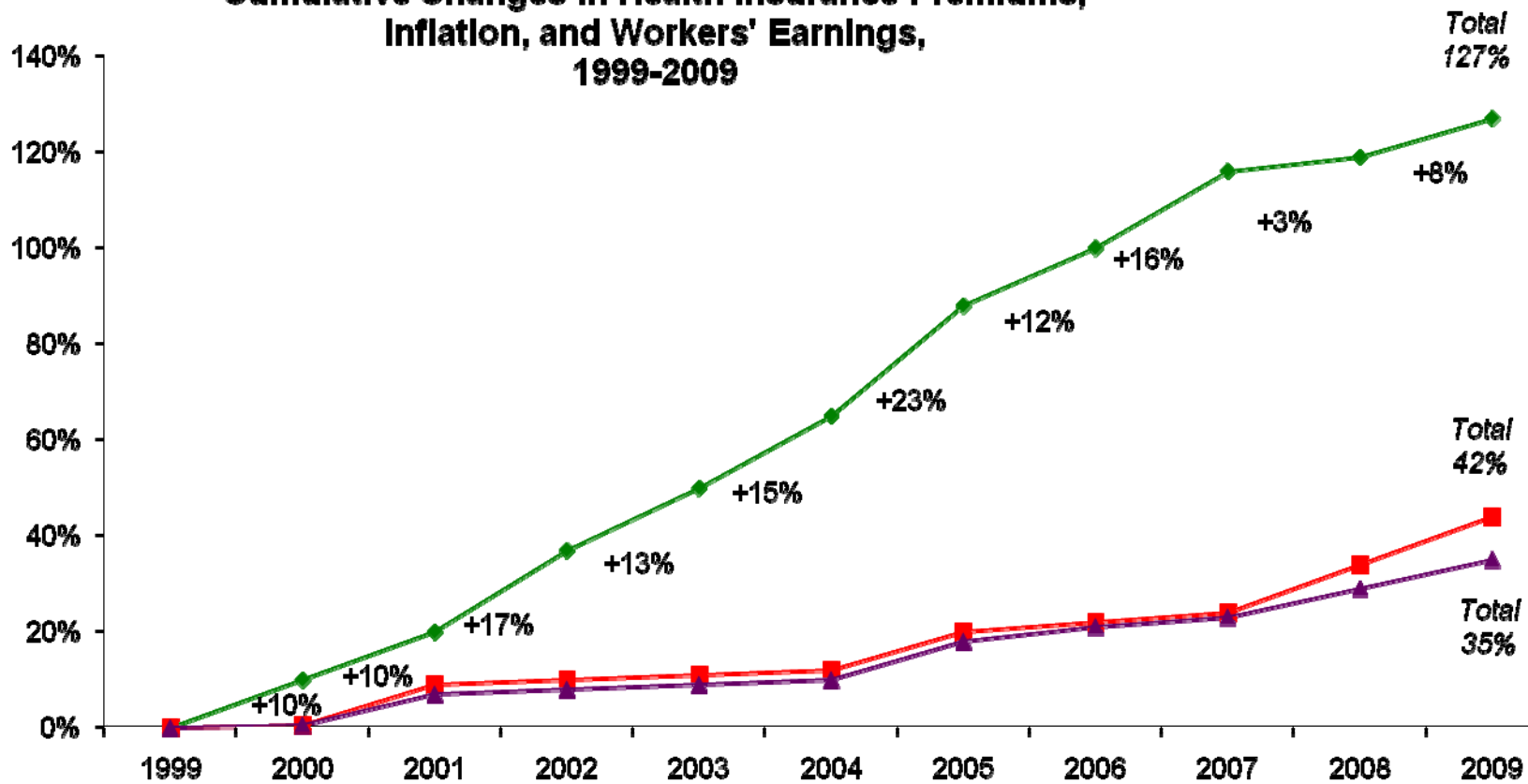
The Passage of Health Care Reform 2010 and Beyond

**Presented by:
Jamie R. Mills, CEBS
President, Mills Benefit Group
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Why did Health Care Reform Pass?

**Cumulative Changes in Health Insurance Premiums,
Inflation, and Workers' Earnings,
1999-2009**



◆ Health Insurance Premiums ■ Workers' Earnings ▲ Overall Inflation



Does this Bill Fix What is Broken? No.

- Does little bend the cost of medical care
- Most of the delivery system reforms in the bill such as wellness, prevention and improved quality programs are small scale
 - CBO does not score them as providing substantial deficit reduction
- Medicare cuts do very little to improve efficiency of patient care or reward quality.
- Reduces availability of Medicare advantage programs
- **Huge Financial Incentive for employers to drop coverage and pay the penalty**
 - **Pay vs. Play will become common language**
- Modified rating to all fully insured groups regardless of size
- Rating Factors are too narrow
- Provides a ridiculous CLASS act that requires employees to buy into a “quasi long term care plan”
 - Must pay in for 5 years before becoming eligible
 - Artificial surplus of \$ 73 billion over the first 10 years.
 - In the 2nd 10 years when claims are paid and premiums are underpriced, American Academy of Actuaries feel the program will be unsustainable and a financial albatross for the country.
 - Double counting of these funds: 1st as offset for health care bill and 2nd the revenue to pay the long term care claims.

- Improve patient safety and quality care
 - Really not addressed
- Assure **affordable** quality health coverage for all Americans
 - Absolutely not: Access but not affordable enough.
 - The individual will pay a penalty if they do not have coverage, but the penalty is far less in cost than the actual cost of an individual plan of insurance.
 - No IRS requirement or interest charge for not paying the penalty
 - Potential trade of one set of uninsured with another if the employer sponsored health care plans were eliminated.
 - Strong financial benefit for employers to terminate their employer sponsored health care plans.
- Maintain coverage when you change or lose your job
 - Not if you work for a small employer. No COBRA if less than 20 lives
 - You would be able to obtain new coverage
- End pre-existing condition clauses
 - Yes



Final Bill H.R. 3590



Final Bill

■ Expand Access

- Require most U.S. Citizens to have health insurance.
- Create American Health Benefit Exchanges through which you could purchase insurance
- Small employers could buy through exchange
- Provide credits to individuals and families with income between 100% and 400% of federal poverty level.
- Expand Medicaid for those up to 133% of federal poverty level:

Comments:

■ Expand Access

- Citizens and legal residents are required to have “qualifying health coverage”.
- Those without coverage pay a tax penalty of greater of \$695 per year up to a maximum of three times that amount (\$2,085) to the following schedule or 2.5% of household income
 - \$95.00 in 2014 or 1%
 - \$325.00 in 2015 or 2.0%
 - \$695.00 in 2016 or 2.5%
- After 2016, the penalty will be increased by the cost-of-living adjustment.
- Exemptions will be granted for whom the lowest cost option exceeds 8% of an individuals income, and those with incomes below the tax filing threshold.

Current Definition of Medicaid: (A huge expansion of Medicaid)

Provides coverage for necessary health care services for FIP and SSI recipients and other low-income families and for low-income individuals who are under 21 years of age, pregnant, disabled, blind, or age 65 and older.

Final Bill:

- New Definition:
 - All individuals under age 65 with incomes up to 133% of FPL.: Huge Increase of participants
- Financing of Medicaid: \$\$
 - 100% federal funding from 2010 to 2016
 - After 2017: Shared funding with the states through a federal medical assistance percentage increase
 - States are currently considering suing the Federal Government due to the inability to fund the enhanced Medicaid program without significant tax increases.
 - Pay at 100% of Medicare reimbursements effective

States: High costs

- Who is going to provide the services?
 - Limited physicians accepting Medicaid
- After Federal government limits the payment of 100% of Medicare, who will pay the difference?
- How will States suffering huge deficits be able to add that many new people into the system?
- How will current revenues pay for the increase in the additional participants in Medicaid?
- States must enroll the new Medicaid beneficiaries no later than 1/1/2014 and longer into current programs if the exchange is not complete.
- States can create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% of FPL, in stead of individuals receiving premium subsidies to purchase in the exchange.
- States can get a 5 year waiver from 1/1/2014, if they can demonstrate that it provides health coverage to all residents as comprehensive as the coverage available under the exchange.
- Standardize enrollment and disenrollment between plans (similar to Medicare Advantage)

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia		Minimum wage \$7.25	400% of FPL	Between 8-9% of income on monthly basis	Average Employee Contributions for Health Care: 2009
Persons in family	Poverty guideline	New eligibility for 133% for Medicaid	100%-400% qualify for tax credit assistance for health care under reform		
1	\$10,830	\$14,403	\$43,320	\$3,465	\$800
2	14,570	\$19,378	\$58,280	\$4,662	\$3,936-\$4,643
3	18,310	\$24,352	\$73,240	\$488	3,936-\$4,643
4	22,050	\$29,326	\$88,200	\$588	3,936-\$4,643
5	25,790	\$34,300	\$103,160		
6	29,530	\$39,274	\$118,120		
7	33,270	\$44,249	\$133,080		
8	37,010	\$49,223	\$148,040		

Employers that offer health care must provide free choice vouchers to each employee who is required to contribute between 8% and 9.89% of the employees household income toward the cost of coverage, if the employees household income is less than 400% of FPL and the employee does not enroll in the employers plan. The voucher must be equal to what the employer would have paid for the employees coverage either single/family based upon the exchange election. If the employer has multiple elections he has to pay the amount he would pay to the most expensive plan. Employee can pick a lower priced plan in the exchange and keep the excess without being taxed.



Health Benefit Exchanges: January 1, 2014

- Effective 2014, a state-based American Health Benefit Exchanges and Small Business Health Options Program are established and administered by a governmental agency or non profit organization through which individuals and small businesses with up to 100 employees can purchase coverage.
- States are permitted to allow businesses with more than 100 employees to purchase coverage in the programs.
- Beginning in 2017, States may form regional Exchanges and allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.
- Funding will be available to States to establish Exchanges beginning in 2011 and continuing until January 2015.
- Create 4 benefit categories of plans plus a separate catastrophic plan .
 - Bronze: 60/40 plan with out of pocket tied to current H.S.A. plans of \$5,950/\$11,900
 - Silver: 70/30 plan with same maximum out of pocket
 - Gold plan: 80/20 plan with same maximum out of pocket
 - Platinum plan: 90/10 with same maximum out of pocket
 - Catastrophic plan: up to age 30: Same as current H.S.A for deductibles but includes preventive at 100%
 - Limit deductibles in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
 - Other plans can be offered in addition to the government design.
 - Must be guarantee issue and renewability
 - Rating variations based only on age with a 3:1 ratio, premium rating area, family composition and tobacco use(limited to a 1.5 to 1). Not other risk factors outside of tobacco use.

Health Care Choice Compacts, National Plans and Co-ops

- States will be permitted to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (No compacts until 2016)
 - Likely most will be in exchanges by 2016.
- The compact will only be regulated by the state where the policy is written and issued.
- Consumer Operated and Oriented plan (Co-op)
 - Foster creation of non profit member run health insurance companies in all 50 states and District of Columbia
 - Cannot be an existing insurance carrier
 - Cannot be currently sponsored by State or local governments
 - All of its activities must be consistent of the issuance of qualified health benefit plans in each state which it is licensed.
 - I could see physician organizations forming CO-OP
 - POWM



Employer: Responsibilities: More than 50 employees: This is not 50 on a plan, but 50 employees: Huge incentive to drop coverage.

- Employers **who do not offer coverage** and have at least 1 employee who receives a premium tax credit (1 employee between 100% and 400% of FPL who purchases through the exchange) will be assessed a fee of \$2,000 per employee, excluding the first 30 employees.
 - Currently does not offer coverage: **This will increase their costs.**
 - 100 employees = \$200,000 penalty
- Employers who currently offer coverage but have at least 1 employee who receives a premium tax credit (1 employee between 100% the lesser of either \$ 3,000 per employee who leaves the employer plan and goes to the exchange or \$2,000 per employee.
 - Current: 100 employees = \$1,000,000 of premium/cost
 - Penalty: \$200,000
 - If an employer drops coverage: Penalty is \$200,000
 - Assume 5000 employees: = \$50,000,000 (50 million)
 - Penalty: \$10,000,000 (10 million)
 - **Savings to the employer: \$40,000,000 (40 million)**
 - No requirement to provide this savings to any employee except those eligible for the voucher.
 - The penalty is a bargain compared to current health care costs.
- Low paying employers who currently cover health care, will want to immediately move employees to exchange and pay the penalty.
- Employers with more than 200 employees will be required to automatically enroll employees and have opt out procedures if they have other coverage.

Small Employers: Less than 50 employees/25 employees

- Exempt from all penalties and requirements for vouchers.
 - Small employers will be careful not to go above the 50 employee limit.
- Employers with less than 25 employees and an average wage less than \$50,000
 - 2010- 2013: provide a tax credit of up to 35% of the employers contribution towards the employee's health insurance premium if the employer contributes at least 50% of the total premium or 50% of a benchmark premium.
 - Incentive for employers to keep the wages down so the average is less than \$50,000.
 - Credit phases out as the firm size grows and wages increase.
 - After 2014, small employers who purchase through the Exchange will have a tax credit of up to 50% of the employer's contribution towards the employees health care.
 - This will last until 2016
 - Will move most small employers into the exchange.
 - After the tax incentive is eliminated, the penalty of \$2,000 would be much less costly.



If Employers Drop the Plan: Where does the Penalty/Tax Go?

- To the Government.
- Does not go to the employees who now will have to go purchase individual plans.
 - Only those who are 400% below the FPL, will get some form of assistance and/or a “choice voucher” to help them purchase coverage.
- If employers drop the health care plans, employees lose their health coverage, employers save a considerable amount of money, employees must go out and purchase the coverage on the same income they are currently earning. *Will they purchase the coverage or are we trading people who will be uninsured.*
 - Government Comment: Employers will pass the savings they receive by eliminating their health care programs to the employees who will then use their new increased wages to purchase a plan.
 - **No requirement to provide the savings to the employee via a voucher or credit.**
 - **Most employers who currently offer health care will look to see what their competition is doing.**
 - **Many will provide some of the savings for them to buy in the exchange.**
 - Government Comment: If the employer provides the savings to their employees, the government will have higher payroll tax collection, which will help fund the plan.
- The premium for individual plans can be paid pre-tax, which is not available now.
- There is no control over the employee purchasing the coverage and therefore the income would be taxable.
- There is a penalty but it is not going to be enforced as non payment of taxes.



Trading the Uninsured?

- More individuals who are currently uninsured will qualify for Medicaid due to the higher income levels.
- As employers eliminate their plans, the 400% of FPL becomes a very important number. Those individuals will get assistance.
- Those who are above the 400% of FPL, will not get assistance and have to purchase health care.
 - Single at : \$43,320 would not qualify. Will they pay \$4,800 for health insurance or penalty?
 - If they can purchase it at any time without a pre-existing, why not wait until there is an issue.
 - Pay cash for services until someone is really sick.
 - Anti-selection against the plans will get severe.
- As employers eliminate their plans, there will be more individuals who previously had coverage who will become uninsured.
- As long as the savings is so great to the employers, they may drop coverage. To compete on a global basis, this might prove necessary.
- As long as the penalty is significantly below the cost of health care on an individual basis, individuals may not purchase the coverage.
 - They are anticipating about 15 million will remain uninsured but 32 million will elect the coverage.
 - Most of the new insured 32 million will fall under the enhanced guidelines for Medicaid.

Retiree Health Care:

- Effective 90 days after enactment and extending until January 1, 2014, a temporary reinsurance program is established for employers providing health coverage to retirees over age 55 who are not eligible for Medicare.
- The program will reimburse employers or insurers 80% of retiree claims between \$15,000 and \$90,000.
 - Payments will be used to reduce the costs for enrollees in the employer plan.
 - \$5 billion dollar appropriation
- Elimination of employer deductible subsidy under Medicare Part D. - 2013
 - Immediate impact on employers liability and income statements
 - FAS 109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability.
- Incentive to maintain the plans until the exchanges are up and running.
- Basically assuming after exchanges are up and running, there will no longer be anyone offering retiree health care.

Medical Loss Ratio

- Require Health plans to report the proportion of premium dollars spent on clinical services, quality and other costs and provide rebates to the consumers for the amount of the premium spent on the clinical services and quality that is less than 85% for plans in the large market and 80% in the individual and small group market.
 - Medical Loss ratio must be reported in 2010
 - Rebates if the medical loss ratio's are not met: January 1, 2011.
- What are the clinical services? Who determines if the clinical service is appropriate and has a valid argument for being a clinical service?



Grandfathered plans

- A grandfathered plan is a plan in effect on the date of the Health Care Reform legislation and includes existing participants and well as subsequently enrolled participants
- If you make any changes on your health care plan you are no longer grandfathered.
 - We do not have the final guidelines on what is a “change”. Is it a copay? Does premium changes count?



Effective dates of Changes

2010: Within 6 months of enactment (renewal following)

- 2010:
 - All individual and group policies must provide dependent coverage for children through age 26:
 - No Student Requirement
 - Can be married although the spouse cannot be on the plan
 - This is excludable income for the parent and not taxable for the child. No imputed income.
 - Until 2014, current plans would not have to cover dependents if they have another source of employer sponsored health care.
 - No lifetime limits Emergency Services, hospitalization, ambulatory services, maternity and newborn care, mental health and substance abuse
 - No pre-existing condition exclusions for children.
 - No rescinding of coverage except for fraud.
 - Establish an internet website for help residents identify health coverage options by July 1, 2010.
 - Develop a standard format for presenting information on coverage options (Government or Employer)
 - No co-payments on preventive care
 - Full mental health parity

Effective dates of Changes

■ 2011:

- No over the counter medications for Flexible Spending Accounts
- OTC will be honored if they are prescribed by a physician.
- Excise Tax for HSA distributions are increased from 10% to 20% for non medical expenses.
- Employers must note the cost of the employer sponsored health care on the W-2. This is for tax year 2011, so it will be done in January 2012.

■ 2012:

- New federal premium tax will be assessed against fully insured and self-funded plans to finance a research program evaluating and comparing health outcomes and clinical effectiveness.
- Premium Tax will be \$ 2.00 per covered life. (Only \$1.00 per covered life the first year.
 - Life is not employee: It is each person covered under your plan.
 - Could be increased after 9/30/2014, to reflect increases in national health care costs.

Effective dates of Changes

■ 2013

- FSA contributions for medical Flex will be capped at \$2,500
 - Adjusted for inflation after 2013.
- Cap on itemized deductions for Medical expenses. Currently it is 7.5% and will increase to 10%.
- Payroll Taxes:
 - Single taxpayers with wages in excess of \$200,000 will pay an additional .9% tax on wages in excess of that threshold.
 - Married taxpayers filing jointly will pay the .9% excess for income over \$250,000.
 - The employer is not matching that increase.
- Individuals with the above incomes of \$200,000/Single and \$250,000 Family, will be subject to a 3.8% tax on their net investment income.
 - Does not include 401(K), 403(b), deferred compensation or IRA 's.
 - It does include interest, dividends, rents, gross income from a business involving passive activities and net gain from disposition of property.
- Elimination of the Part D Deduction.
 - Employers will no longer be able to deduct the portion of the expense that is offset by the subsidy.
 - This has an immediate effect on publicly traded employers because the elimination of the deduction must be reflected in the financial statements per accounting rules.

Effective dates of Changes

■ 2014

□ Exchanges:

- Each state will establish an exchange for individuals to purchase insurance.
- Each state will have a Small Business Health Options Program for small employer groups to purchase health care. (Less than 100 employees)
 - Employees can use the employers cafeteria plan to pay for it pre-tax, even if they are purchasing different plans among employees through the exchange.

□ Consistency of plan design”

- Bronze Plan: In-network coverage of 60%
- Silver: In-network coverage of 70%
- Gold: In-network coverage of 80%
- Platinum: In-network coverage of 90%
- The maximum out-of-pocket limits cannot exceed the limits for HSA's which currently are: \$5, 950 for a single and \$11,900 for a family- based upon 2010. They do increase each year.
 - Still a significant increase for many employees.
- Young Adult plan will be available to those less than 30.

Funding and Medicare Changes:

- Adjustments to Medicare advantage plans.
 - Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates.
 - Provide bonus money for MA plans that have 4 or more stars based upon the 5 star rating system.
 - Rebates will be based upon the plans quality rating.
 - If medical loss ratio is less than 85%, there is a penalty to the Federal Government.
 - If loss ratio is less than 85% for 2 years, enrollment is suspended and if it is higher than 85% for 5 years, the plan will be terminated.
- Freeze Medicare part B premiums based upon income until 2019 and reduce Medicare Part D subsidy for others with incomes over \$85,000/\$170,000
- Establish independent payment board to recommend changes to Medicare. Board cannot increase premiums but must find ways to slow growth. Rationing of care is not allowed.
- Reduce Medicare Disproportionate Share hospital payments by 75% but increase payments for hospitals with high uncompensated care.
- Reduce payments for excess readmissions by 1%
- Medicaid will cover services provided by free-standing birth centers.
- States will have the option of offering community- based attendant services to disabled Medicaid beneficiaries who would otherwise need institutional care.
- Medicaid will cover preventive care.
- Physician fee rates will increase by .05 percent over 2009 rates.
- Reduction of the Donut Hole by \$250 initially. Totally removed by 2020

Tax Changes

- 2013: Increase Medicare Part A Hospital insurance tax on wages by .09% (1.45% to 2.35%) on earnings over \$200,000 for an individual and \$250,000 for a couple filing jointly.
- Impose a 3.8% assessment on unearned income for higher income taxpayers.(Investments, rental income etc)
- Limit the amount of contributions under a Medical Flexible Spending Account to \$2,500 per year increased annually by the cost of living adjustment. (2013)
- Over the Counter medications will not be allowable under an FSA plan.(2011)
- Impose an excise tax of 2.3% on the same of any taxable medical device
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments
- Impose an excise tax on insurers of employer sponsored health plans with aggregate values that exceed \$10, 200 for individual and \$27,500 for family coverage- effective 1/1/2018.
- Distributions from H.S.A plans that are for non qualified expenses will increase from 10% to 20%, along with standard income tax levels.
- Tax on brand name prescription drug manufacturers: \$4.8 billion over 10 years- payable in 2011 for sales in 2010.
- Impose tax on private health insurers based upon net premiums written after 12/31/2010. Fees go from \$8 billion to \$14.3 billion in 2018
- Tax exempt plans could calculate the fee based upon 50 percent of premiums. (BCBSM)
- Non-profit hospitals must meet new requirements to satisfy tax exempt status
- New federal tax on fully insured and self-funded plans to fund comparative effectiveness research programs. Fee is \$2.00 for each individual covered under a specified individual or group insurance policy.
- High cost insurance excise tax on high cost “ Cadillac” plans: (Most plans will be eliminated to reduce the tax)
- \$500,000 deduction limitation on remuneration to officers, employees, directors and service providers of covered health insurance providers.
- Itemized deduction for unreimbursed medical expenses will increase form 7.5% of AGI to 10% of AGI for regular tax purposes.

Self-Funded vs. Fully Insured

- Currently fully insured plans do not have the same non discrimination rules that fully insured plans have. That would change. Fully insured would be the same as self-funded it will no longer be possible after 2014 to offer insured Executive Reimbursement plans.
- No grandfathering of self-funded plans for annual limits, lifetime limits, increased dependent coverage, policy rescissions



**Estimated Revenue Effects: Refer to Joint Committee on Taxation Handout
for Detail**

2010-1019 Some Highlights: Numbers are noted in billions

Provision	Taxes Paid in Billions
Higher Medicare Tax and tax unearned income by 3.8% for higher earners	\$210
40% excise Tax	\$32
Confirm definition of eligible medical expenses and remove OTCover the counter medications from H.S.A., FSA, HRA	\$5
Increase penalty for non qualified withdrawals from 10% to 20%+ income	\$1.4
Limit FSA to \$2,500	\$13
Annual Fee on Brand Name manufacturers and importers	\$27
2.3% excise tax on certain medical devices	\$20
Impose Tax on Health Insurers	\$60
Eliminate employer subsidy for Medicare Part D	\$4.5
Modification of section 833 of certain health organizations	\$.04
Tax on indoor tanning	\$2.7
Exclusion of unprocessed fuels from cellulosic credit	23.6



Wellness:

Finally something to bend the curve:

- Ability to increase the 20% cap on HIPAA wellness incentives to at least 30% if certain health standards are met.
- Provide grants to smaller employers to establish wellness programs, as long as they have not already had program in place.
- Establish 10 state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
 - Since the individual market may be the only market, this is very important.