What is next in Health Care Reform for 2012, 2013 and 2014.

Will your Company be Ready?

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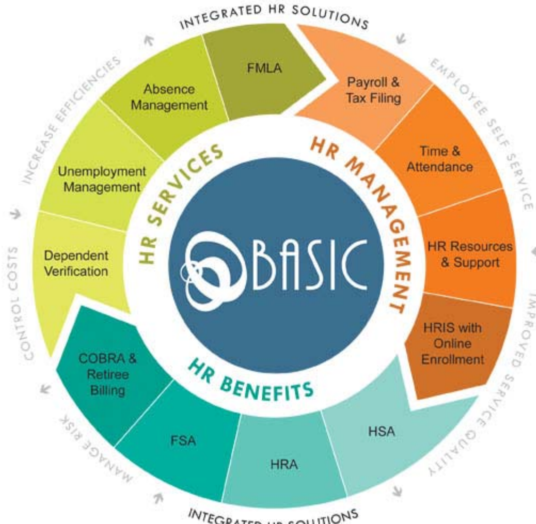

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Supreme Court Decision

- On June 28,the Supreme Court declared the individual mandate to be permissible exercise of Congress's taxing powers under the Constitution.

- The mandate was not a penalty, but a tax and was allowed under Congress's power to tax under Article 1 of the Constitution.

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Supreme Court Decision

- The Court did limit the federal government's power to terminate states' Medicaid funds.
- The Court held that the Medicaid portion of the Health Reform, which requires states to accept an enormous expansion in the number of people they cover under the program or face a cut of *all* Medicaid funds, was unconstitutional as enacted, but found that a severability clause in the law allowed it go forward without the threat of the loss of all Medicaid funds.

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Supreme Court Decision

- The Court concluded that the individual mandate is not a legal command to buy insurance, but rather a tax on the choice to forgo buying insurance.
- It does not apply to people who do not file income tax returns.
- The fact that the Patient Protection Act calls it a penalty instead of a tax was not controlling, the Court said.

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Supreme Court Decision

- The government's arguments that the Constitution's Commerce Clause or the Necessary and Proper Clause authorized Congress to enact Health Reform were rejected.
- The mandate that requires people to purchase health insurance or make a shared-responsibility payment does not regulate existing commercial activity, but instead compels individuals to become active in commerce by purchasing a product.

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Supreme Court Decision

- Congress is not permitted to regulate inactivity; otherwise, the government's logic would justify a mandatory purchase to solve any problem.
- The mandate could not be upheld under the Necessary and Proper Clause.
- To be valid under that clause, the law must be the exercise of authority under a granted power, and there is no power granted here.
- Even if the individual mandate is necessary, it is not proper.

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Important changes effective during 2012, 2013 and 2014

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Changes effective during 2012

- Prepare for mandatory Form W-2 reporting for health coverage,
- Distribute the Summary of Benefits and Coverage to enrollees for renewals, and
- Distribute Medical Loss Ratio Rebates to participants , if applicable.

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Changes Effective during 2013

- Pay "PCOR fees" by end of July 2013,
- Administer Health FSA contributions for $2,500 limit,
- Adjust pay for additional hospital insurance tax of .9 percent imposed on high income individuals ($200,000 individual, $250,000 joint),
- Advise of additional 3.8% Medicare payroll tax imposed on unearned income for high income individuals ($200,000 individual, $250,000 joint), and
- Provide written notice to employees about exchange and subsidies.

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Changes Effective during 2014

- Impose new cost sharing limits for group health plans – annual OOP limits cannot exceed HSA limits; deductibles cannot exceed $2,000 single and $4,000 family coverage (new plans),
- Impose pre-existing conditions exclusions no longer for all individuals,
- Provide waiting periods of no greater than 90 days, and
- Provide new wellness incentive rewards of up to 30 percent of health plan premiums.

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Changes Effective during 2014

- Report of minimum essential coverage for employees and EE contributions exceeding 8% of wages to IRS,
- Provides families earning up to 400% of the poverty level or, under current guidelines, about $88,000 a year with subsidies to purchase health insurance,
- Availability of state based Insurance Exchanges for individuals and small groups; expanded to large groups in 2017,
- Cover routine costs for clinical trial participants (new plans), and
- Impose Individual and employer mandates.

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Changes Effective During 2012

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Reporting Cost of Health Coverage on Form W-2

- An employer must report on an employee's Form W-2 the aggregate cost of the employee's health insurance coverage sponsored by the employer, excluding the amount of any salary reduction contribution to a flexible spending arrangement.
- "Aggregate cost" is determined under "rules similar to" the COBRA rules for applicable employer-sponsored coverage (including employee and employer contributions), including the special rules governing self-insured plans.
- Reporting is optional for 2011 and required for 2012 for employers who issued 250 or more Form W-2 in 2011.

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Reporting Cost of Health Coverage on Form W-2

- The new Form W-2 reporting requirement applies only to "applicable employer-sponsored coverage,"
- This term generally includes any employer-provided coverage under an insured or self-insured health plan, but is subject to numerous exceptions, including exceptions for:
  - accident-only insurance;
  - disability income insurance;
  - long-term care coverage;
  - coverage only for a specified disease;
  - hospital indemnity or other fixed indemnity insurance;
  - stand-alone dental, or vision coverage.
  - HRAs;
  - Certain health flex plans; and
  - Certain EAPs, on-site clinics and wellness plans

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Summary of Benefits and Coverage

- A four-page "summary of benefits and coverage" ("SBC")is required to be provided to applicants and enrollees before enrollment or re-enrollment.
- This summary must accurately describe the "benefits and coverage under the applicable plan or coverage."
- This requirement applies in addition to ERISA's SPD and SMM requirements.

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Summary of Benefits and Coverage

- HHS was required to issue guidance (referred to as "standards") addressing the four-page summary requirement by March 23, 2011 (i.e., 12 months after the enactment date) –was not issued until August 2011.
- Once developed, the standards will be periodically reviewed and updated.
- First SBC must distributed by the first open enrollment occurring after September 23, 2012 or for those who enter the plan any other time, the plan or policy year beginning after September 23, 2012.

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Summary of Benefits and Coverage

- **Who Must Be Furnished With Four-Page Summaries?**
  - Generally, the four-page summaries must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment).
  - Four-Page Summaries vs. SPDs and SMMs. Welfare plan SPDs and SMMs must be provided only to participants covered under the plan (and not to beneficiaries).
  - In contrast, the four-page summaries required under health care reform must be provided to applicants, policyholders, and enrollees—a set of recipients that appears to be broader than participants, and may include beneficiaries.
  - Can be provided by paper or electronically.

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Summary of Benefits and Coverage

- **Appearance:**
  - The summaries must be presented in a uniform format and cannot be longer than four pages.
  - In addition, the four-page summaries cannot include print that is smaller than 12-point font.
- **Language:**
  - The four-page summaries must be presented in a "culturally and linguistically appropriate manner.

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Summary of Benefits and Coverage

- **Content:**
  - A four-page summary must include the following information:
    - Uniform definitions of standard insurance and medical terms so that applicants, policyholders, and enrollees can compare health insurance coverage and understand the terms of coverage, or exceptions to such coverage;
    - A description of the group health plan's coverage, including cost sharing, for each of the "essential health benefits" and any other benefits that may be required;
    - Exceptions, reductions, and limitations on coverage;
    - Cost-sharing provisions, including deductible, co-insurance, and co-payment obligations;
    - Renewability and continuation of coverage provisions;
    - A "coverage facts label" that includes examples illustrating common benefits scenarios (e.g., pregnancy, serious or chronic medical conditions, and related cost-sharing);

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Summary of Benefits and Coverage

- **Content:**
  - A four-page summary must include the following information:
    - A statement of whether the plan or coverage provides "minimum essential coverage," beginning January 1, 2014;
    - A statement that the outline is a summary of the plan (or policy or certificate) and that the coverage document itself should be consulted to determine the governing contractual provisions;
    - The telephone number to call for additional questions and the Internet web address where a copy of the group certificate of coverage (or individual coverage policy) or SPD can be reviewed and obtained;
    - If a provider network is used, an Internet address (or similar contact information) for obtaining a list of network providers; and
    - For plans that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage.

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Summary of Benefits and Coverage

- **When Must the SBC be Distributed?**
  - **From Plan or Insurer to Participants and Beneficiaries:**
    - A group health plan and insurer to provide an SBC to a participant or beneficiary with respect to each "benefit package" offered for which the participant or beneficiary is eligible.
    - **At Open Enrollment (Renewal**) The SBC must be included with open enrollment materials.
    - If the plan or insurer requires participants or beneficiaries to renew in order to maintain coverage for a succeeding plan year, a new SBC must be provided no later than the date the renewal materials are distributed.
    - If renewal is automatic, the proposed rules provide that the SBC must be furnished no later than 30 days prior to the first day of the new plan year, but there is a seven day rule if the policy is not yet issued.

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Summary of Benefits and Coverage

- **When Must the SBC be Distributed?**
  - **From Plan or Insurer to Participants and Beneficiaries:**
    - **At Initial Enrollment** -The SBC for each benefit package offered for which the participant or beneficiary is eligible must be provided as part of any written application materials that are distributed by the plan or insurer for enrollment.
    - If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries.
    - **At Special Enrollment** - The plan or insurer must also provide the SBC to special enrollees (employees and dependents with the right to enroll in coverage midyear upon specified circumstances) within 90 days of enrollment.
    - **Upon Request** - The plan or insurer provide the SBC to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request.

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Summary of Benefits and Coverage

- **When Must the SBC be Distributed?**
  - **From Insurer to Plan**
  - In the case of an insured plan, the proposed regulations address when an insurer would be required to provide an SBC to the group health plan (i.e., the employer/plan sponsor sponsor):
    - Upon an application or request for information by the plan about the health coverage (e.g., for a group health plan not currently insured by the insurer), the SBC must be provided as soon as practicable following the request, but in no event later than seven days following the request.
    - If there is a change to the information in the SBC before the coverage is offered, or before the first day of coverage, the insurer must update and provide a current SBC to the plan no later than the date of the offer (or no later than the first day of coverage, as applicable).
    - If written application for renewal is required, the SBC must be provided no later than the date the materials are distributed.
    - If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year, but there is a seven day rule if the policy is not yet issued.
    - Upon request from the group health plan, the SBC must be provided as soon as practicable but no later than seven days following the request.

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Summary of Benefits and Coverage

- **Updating the SBC: Notice of Material Modifications**
  - A group health plan or insurer must provide notice of a material modification if it makes a material modification in any of the terms of the plan that is not reflected in the most recently provided SBC.
  - Only material modification that would affect the content of the SBC would require plans and insurers to provide this notice.
  - In these circumstances, the notice must be provided no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs other than in connection with a renewal (i.e., mid-plan year).

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Summary of Benefits and Coverage

- **Penalty for failure to provide new summary or SMM:**
  - A penalty of not more than $1,000 may apply for each willful failure to provide the required plan summary or advance summary of a material modification.
  - Each participant who fails to receive a required summary (or summary of material modification) is counted separately in determining the amount of the penalty, so it appears that a willful failure to timely provide 5 participants with a summary could result in a fine of up to $5,000.

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Medical Loss Ratio Rebates

- Insurers are required to make the first round of rebates by August 2012 based on their 2011 MLR.
- Insurers must generally provide rebates for individuals covered by group health plans to the policyholder—typically the employer sponsoring the plan.
- Who receives the rebate depends on the plan provisions and who paid the premiums.

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Changes Effective During 2013

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Health Flexible Spending Accounts

- The $2,500 limit on annual salary reduction contributions to health FSAs offered under cafeteria plans, effective for plan years beginning after December 31, 2012.
- All health FSAs offered under cafeteria plans must comply.
- The limit does not apply to Dependent Care FSAs, HRAs or HSAs.

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Health Flexible Spending Accounts

- The $2,500 amount is indexed for inflation for taxable years beginning after December 31, 2013.
- The $2,500 limit is reduced for short plan years.
- By its terms, the $2,500 limit applies to health FSA salary reduction contributions and not to other employer contributions.
- Plans do not have to be amended until the end of the 2014 plan year.

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Additional Medicare Tax

- The employee portion of the hospital insurance tax part of FICA, currently amounting to 1.45% of covered wages, is increased by 0.9% on wages that exceed a threshold amount for tax years beginning after 12/31/2012.
- The additional tax is imposed on the combined wages of both the taxpayer and the taxpayer's spouse, in the case of a joint return.
- The threshold amount is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case.

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Additional Medicare Tax

- So, in 2013, a single individual with wages of $230,000 will owe HI tax at a rate of 1.45% on the first $200,000 of wages, and HI tax at a rate of 2.35% on the remaining $30,000 of wages for the year.
- Employers will be responsible for collecting and remitting the additional tax on wages that exceed $200,000.
- An individual will be responsible for the additional tax if the amount withheld from his or her your wages is insufficient.
- The employer portion of the HI tax remains unchanged (at 1.45%).
- If an individual is self-employed, the additional 0.9% tax applies to self-employment income that exceeds the dollar amounts above (reduced, though, by any wages subject to FICA tax).
- If self-employed, an individual won't be able to deduct any portion of the additional tax.

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Medicare Tax on Unearned Income

- The new tax is equal to 3.8% of the lesser of:
  - Net investment income (generally, net income from interest, dividends, annuities, royalties and rents, and capital gains, as well as income from a business that is considered a passive activity or a business that trades financial instruments or commodities), or
  - Modified adjusted gross income (basically, your adjusted gross income increased by any foreign earned income exclusion) that exceeds $200,000 ($250,000 if married filing a joint federal income tax return, $125,000 if married filing a separate return).

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Medicare Tax on Unearned Income

- An individual is only subject to the additional 3.8% tax if his or her adjusted gross income exceeds the dollar thresholds
- Interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence that are excluded from gross income are not considered net investment income for purposes of the additional tax.
- Qualified retirement plan and IRA distributions are also not considered investment income.

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Notice of Exchange

- Employers are required provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.
- This disclosure requirement is generally effective for employers in a state beginning on March 1, 2013.
- Employees hired on or after the effective date must be provided the Notice of Exchange at the time of hiring.
- Employees employed on the effective date must be provided the Notice of Exchange no later than the effective date (i.e., no later than March 1, 2013).

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Notice of Exchange

- With this notice, employees must be informed of the following:
  - The existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.
  - They may be eligible for a premium tax credit or a cost-sharing reduction (under PPACA § 1402) through the Exchange if the employer plan's share of the total cost of benefits under the plan is less than 60%.
  - If they purchase a qualified health plan through the Exchange, then they may lose any employer contribution toward the cost of employer-provided coverage; and all or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes.

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Comparative Effectiveness Research Fees

- Health care reform created a new nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research.
- This entity will be funded in part by fees (sometimes referred to as "PCOR fees" or "CER fees") paid by certain health insurers and applicable sponsors of self-insured health plans.
- These fees do not apply to plans that provide "excepted benefits."

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Comparative Effectiveness Research Fees

- Fees are payable in connection with policy/plan years ending after September 30, 2012, but stop applying for policy/plan years ending after September 30, 2019.
- While insurers will file reports and pay the fees for insured policies, self-insured plan sponsors must do file reports and pay these fees.
- Plan sponsors and insurers will file IRS Form 720 to report the fees and make annual payments.
- This return must be filed each year by July 31 of the calendar year immediately following the last day of the policy year (for insured plans) or the plan year (for self-insured plans)

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Comparative Effectiveness Research Fees

- These fees will be calculated as the average number of covered lives under a policy or plan multiplied by $1 for plan years ending after October 1, 2012.
- The multiplier increases to $2 for the next plan year, then may rise with health care inflation through plan years ending before Oct. 1, 2019, when the fees are slated to end.
- To determine the average number of covered lives, plan sponsors generally can use any reasonable method in the first plan year and will choose from several proposed approaches in later years.

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Changes Effective During 2014

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Employer Mandate

- Certain large employers may be subject to penalty taxes for failing to offer health care coverage for all full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage under which the plan's share of the total allowed cost of benefits is less than 60%.
- The penalty tax is due if any full-time employee is certified to the employer as having purchased health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

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Employer Mandate

- An employer is large if it employed an average of at least 50 full-time employees on business days during the preceding calendar year.
- In determining the number of full-time employees, an employer must add up the total number of hours worked in a month by part-time employees, divide by 120, and add that number to the number of full-time employees.
- A "full-time employee" for any month is an employee who is employed for an average of at least 30 hours of service per week.

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Employer Mandate

- Large employers who do not offer "minimum essential coverage" and have at least one full-time employee who receives premium tax credits would be assessed a fee of $2,000 for every full-time employee beyond the first 30 employees.
- "Minimum essential coverage" means coverage under any of the following:
  - a government-sponsored program, including coverage under Medicare Part A, Medicaid, the CHIP program, and TRICARE;
  - an "eligible employer-sponsored plan;"
  - a health plan offered in the individual market;
  - a grandfathered health plan; or
  - other health benefits coverage (such as a State health benefits risk pool) as HHS recognizes.

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Employer Mandate

- Beginning in 2014, an applicable large employer will pay a penalty tax (i.e., make an assessable payment) for any month that—
  - (1) the employer offers to its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan for that month; and
  - (2) at least one full-time employee of the employer has been certified to the employer as having enrolled for that month in a QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.

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Employer Mandate

- If an employee is offered affordable minimum essential coverage under an employer-sponsored plan, then the individual generally is ineligible for a premium tax credit and cost-sharing reductions for health insurance purchased through an Exchange.
- But employees covered by an employer-sponsored plan will be eligible for the premium tax credit if the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of those costs (that is, the plan does not provide "minimum value"), or the premium exceeds 9.5% of the employee's household income.

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Employer Mandate

- The penalty tax (assessable payment) is equal to $250 (1/12 of $3,000, adjusted for inflation after 2014) times the number of full-time employees for any month who receive premium tax credits or cost-sharing assistance (this number is not reduced by 30).
- This penalty tax (assessable payment) is capped at an overall limitation equal to the "applicable payment amount" (1/12 of $2,000, adjusted for inflation after 2014) times the employer's total number of full-time employees, reduced by 30.

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Employer Mandate

- **Notice to Employer of Premium Assistance:**
  - The penalty tax is triggered, in part, by the employer receiving a certification that one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction.
  - The employee may be eligible because the employer does not provide minimal essential coverage through an employer-sponsored plan.
  - Or the employee may not be eligible because the coverage the employer offers either is not affordable, or the plan's share of the total allowed cost of benefits is less than 60% .
  - The employer must also receive notification of the appeals process established for employers notified of potential liability for penalty taxes.

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Employer Mandate

- **Reporting of Health Insurance Coverage:**
  - Certain employers are required to report to the IRS whether they offer their full-time employees and their employees' dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan and to provide certain other information.
  - Reporting employers must also provide a related written statement to their full-time employees.

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Employer Mandate

- **Reporting of Health Insurance Coverage:**
  - The employer's return, which must in the form be set out by the IRS, must contain the following information—
    - the employer's name, date, and employer identification number (EIN);
    - a certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan (as defined in Code § 5000A(f)(2));
    - the number of full-time employees the employer has for each month during the calendar year;
    - the name, address, and taxpayer identification number (TIN) of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan sponsored by the employer during the calendar year; and
    - any other information required by the IRS.

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Employer Mandate

- **Reporting of Health Insurance Coverage:**
  - Employers that offer the opportunity to enroll in "minimum essential coverage" must also report—
    - the months during the calendar year for which coverage under the plan was available;
    - the monthly premium for the lowest cost option in each of the enrollment categories under the plan;
    - the employer's share of the total allowed costs of benefits provided under the plan;
    - in the case of an employer that is an applicable large employer, the length of any waiting period with respect to such coverage; and
    - in the case of an employer that is an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option.

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Employer Mandate

- **Notice Requirements:**
  - Employers required to submit a report of health insurance coverage to the IRS must also furnish a written statement to each of their full-time employees whose name was required to be included in the report.
  - This statement must include—
    - the name, address, and contact information of the reporting employer; and
    - the information required to be shown on the return with respect to the individual.
  - The written statement must be furnished to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.

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Waiting Periods

- A plan must not apply a waiting period that exceeds 90 days.
- This prohibition applies to group health plans and insurers but not to certain "excepted benefits."
- Grandfathered health plans must also comply with the waiting period requirements.

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Pre-existing Conditions

- A plan may not impose any pre-existing condition exclusion.
- This will be the case whether or not an individual has prior creditable coverage and whether or not the individual is a late enrollee.
- The prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition.
- A PCE also includes any limitation or exclusion based on information relating to an individual's health status, "such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period."

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Guaranteed Availability of Coverage

- Health insurance issuers offering coverage in the group market are subject to certain guaranteed-availability and guaranteed-renewability requirements.
- For plan years beginning before January 1, 2014, only health insurance issuers that actively market coverage in the small group market are subject to the guaranteed-availability rules.
- Specifically, health insurance issuers that actively market coverage in the small group market must—
  - accept every small employer that applies for coverage and make all products that they actively market in the small group market available to all small employers; and
  - accept for enrollment every eligible individual who applies for coverage when first eligible.

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Guaranteed Availability of Coverage

- As of plan years beginning on or after January 1, 2014, each health insurance issuer that offers health insurance coverage in the individual or group market (regardless of whether the coverage is offered in the large or small group market) is required to accept every employer and individual in the state that applies for such coverage.
- Enrollment may, however, be restricted to open or special enrollment periods.
- For plan years beginning before January 1, 2014, insurers are permitted to impose employer contribution and minimum participation requirements (to the extent consistent with applicable state law), within certain limitations.

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Guaranteed Availability of Coverage

- **Guaranteed-Renewability Rules Applicable to All Insurance**
  - Group insurance issuers in the small and large group market as well as in the individual market are required to renew coverage at the option of the plan sponsor—subject only to specified exceptions and restrictions (e.g., nonpayment of premiums, fraud, violation of certain employer contribution or group participation requirements).
- **Special Rule for Grandfathered Health Coverage**
  - Insurance coverage that qualifies as a grandfathered health plan is not required to comply with the guaranteed-availability and guaranteed-renewability rules.

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Fair Health Insurance Premiums (Individual & Small Group Market)

- Premiums charged by insurers in the individual & small group market may vary with respect to a particular plan or coverage only by:
  - whether the plan or coverage covers an individual or family,
  - the rating area, as established under state standards,
  - age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and
  - tobacco use, except the rate may not vary by a factor of more than 1.5 to 1.

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Fair Health Insurance Premiums (Individual & Small Group Market)

- Insurers are also subject to the guaranteed issue requirements, along with the rating limitations.
- The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to offer large group coverage through the state exchange (beginning on or after 2017).
- Insurance coverage that qualifies as a grandfathered health plan is not required to comply with health care reform's fair health insurance premium requirement.

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Wellness Programs

- A new set of rules governing wellness programs.
- Rules are similar to those set forth in current HIPAA current regulations (Participation and standard based programs), but with refinements.
- HIPAA wellness program incentive limit will increase from 20% to 30% of total cost of coverage.
- The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.

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Cost Sharing Requirements

- Health care reform requires that "cost-sharing" be limited.
- Cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure which is a qualified medical expense with respect to essential health benefits covered under the plan.
- Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for noncovered services.

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Cost Sharing Requirements

- **Overall Cost-Sharing Limitation (Out-of-Pocket Maximum**
  - For plan years beginning in 2014, a plan must not impose cost-sharing in excess of the maximum out-of pocket amount in effect for high deductible health plans for 2014.
  - For 2010 and 2011, the HDHP maximum out-of-pocket expense limit (that is, the sum of the plan's annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $5,950 for self-only coverage and $11,900 for family coverage.
  - For 2015 and later years, the maximum is subject to increase.

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Cost Sharing Requirements

- **Limit on Annual Deductible:**
  - For nongrandfathered plans, the annual deductible must not exceed :
    - $2,000, in the case of a plan covering a single individual, or
    - $4,000 in the case of any other plan.
  - The above figures will be indexed and may increase for years after 2014.
  - The maximum deductible amounts may be increased by the maximum amount of reimbursement reasonably available to a participant under a "flexible spending arrangement."

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Comprehensive Health Coverage Requirement

- Health insurance issuers offering coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits package."
- This requirement does not apply to excepted benefits.
- Insurance coverage and health plans that qualify as grandfathered health plans are not required to comply with comprehensive health coverage requirement.

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Comprehensive Health Coverage Requirement

- To provide the essential health benefits package, a plan must—
  - provide essential health benefits,
  - limit cost-sharing, and
  - provide either bronze, silver, gold, or platinum level coverage (that is, benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the full actuarial benefits provided under the plan), as or a catastrophic plan (also known as "young invincibles" coverage).

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Comprehensive Health Coverage Requirement

- What precisely constitutes "essential health benefits" is to be defined by regulations, but they include minimum benefits in ten general categories and the items and services covered within those categories—
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care.

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Comprehensive Health Coverage Requirement

- **Comply With Cost-Sharing Limits**
  - The four prescribed coverage levels vary based on the percentage of full actuarial value of benefits the plan is designed to provide, as follows:
    - Bronze: designed to provide benefits actuarially equivalent to 60% of full value;
    - Silver: designed to provide benefits actuarially equivalent to 70% of full value;
    - Gold: designed to provide benefits actuarially equivalent to 80% of full value; and
    - Platinum: designed to provide benefits actuarially equivalent to 90% of full value.

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Individual Mandate

- U.S. citizens and legal residents are required to have qualifying health coverage.
- Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.
- The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.

Individual Mandate

- Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.
- Exemptions will be granted for:
  - financial hardship, religious objections,
  - American Indians,
  - those without coverage for less than three months,
  - Undocumented immigrants,
  - incarcerated individuals,
  - those for whom the lowest cost plan option exceeds 8% of an individual's income, and
  - those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

Exchanges and Qualified Health Plans (QHPs)

- By January 1, 2014, each state must establish an American Health Benefit Exchange (Exchange).
- An Exchange must be a governmental agency or nonprofit entity established by a State.
- The purpose of an Exchange is to facilitate the purchase of qualified health plans (QHPs) and to provide for a Small Business Health Options Program (SHOP Exchange) to assist small employers in enrolling their employees in QHPs in the small group market.
- Beginning in 2017, states may allow all employers of any size to offer coverage through an Exchange.
- Before 2017, only small employers (employers with 100 employees or fewer) may participate.

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Exchanges and Qualified Health Plans (QHPs)

- **Health plans offered outside the Exchange:**
  - A health insurer is not prevented from offering a health plan outside of the Exchange.
  - An individual is not prevented from enrolling in a health plan offered outside of an Exchange.
  - An employer is not prevented from selecting a health plan outside of an Exchange.

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Exchanges and Qualified Health Plans (QHPs)

- **Individuals and Employers Eligible for the Exchange:**
  - Beginning in 2014, individuals may enroll in a plan through the Exchange of the state where they reside.
  - Only lawful residents may obtain coverage in an Exchange. Unauthorized aliens will be prohibited from obtaining coverage through an Exchange.
  - Beginning in 2014, small employers can offer coverage to their employees through an Exchange.
  - A "small employer" is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

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Exchanges and Qualified Health Plans (QHPs)

- Qualified Health Plans (QHPs):
  - An Exchange will be required to make qualified health plans (QHPs) available to qualified individuals and qualified employers.
  - An Exchange cannot make available any health plan that is not a QHP.
  - A qualified health plan (QHP) is an Exchange-certified "health plan" that offers an "essential health benefits package."

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Exchanges and Qualified Health Plans (QHPs)

- **Small Business Health Option (SHOP Exchange)**
  - The Exchange that each state is to establish by 2014 must create a Small Business Health Options Program ("SHOP Exchange") to assist qualified employers in the state who are small employers to enroll their employees in QHPs offered in the small group market.
  - Before 2016, states have the option to define "small employers" essentially as either those with (1) 100 or fewer employees, or (2) 50 or fewer employees.
  - Beginning in 2016, small employers will be defined as those with 100 or fewer employees.

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Exchanges and Qualified Health Plans (QHPs)

- **Individual Credits or Subsidies:**
  - Tax credits or subsidies are provided to purchase health insurance through the exchange on a sliding scale to individuals and families with incomes up to 400% of the federal poverty level.
  - Households in the lowest income group would spend approximately 2% to 4% of their income on premiums.
  - The health plans would cover 94% of the cost of benefits.
  - Households in the highest eligible group would pay 9.5% of their income on premiums, with health plans paying 70% of the cost of the benefits.
  - Subsidies would increase at the same rate as the increase in premium contributions from the prior year.

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Coverage for Individuals Participating in Approved Clinical Trials

- Group health plans providing coverage to a qualified individual may not deny the individual participation in an approved clinical trial, deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against the individual based on participation in the trial.
- A group health plan may not:
  - deny any qualified individual the right to participate in a clinical trial as described below;
  - deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial; and
  - may not discriminate against any qualified individual who participates in a clinical trial.

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Questions?

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