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What's Next in Healthcare Reform for 2012, 2013 and 2014

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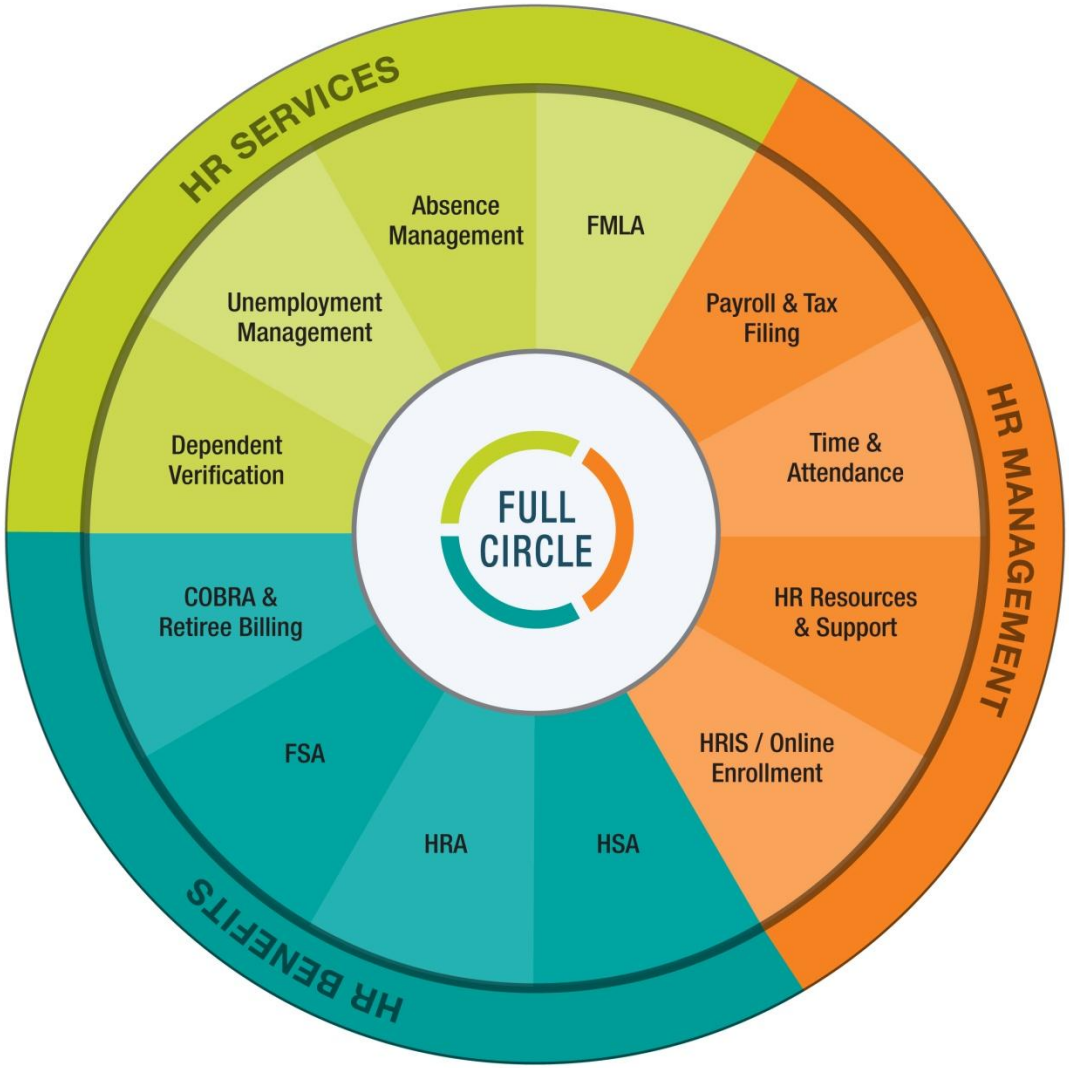

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Supreme Court Decision

- 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.

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.

Important Changes Effective During 2012, 2013, 2014

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.

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.

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),
- Prohibit pre-existing conditions exclusions from being imposed 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.

Changes Effective During 2014

- Report of minimum essential coverage to IRS-applies to large employers and other employers if the required contribution of any employee exceeds 8% of the wages,
- Provides families earning up to 400% of the poverty level or, under current guidelines, about $92,200 a year (family of 4) 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.

Changes Effective During 2012

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.

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

Summary of Benefits & 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 requirement applies in addition to ERISA's SPD and SMM requirements.
- 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.

Summary of Benefits & 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.

Summary of Benefits & 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.

Summary of Benefits & Coverage

Each SBC must include:

- uniform definitions (see Uniform Glossary of Terms below) as well as an internet address leading to a uniform glossary and information such as a phone number, on how to obtain a paper copy of the uniform glossary;
- a description of the plan's coverage for each category of benefits, including exceptions, reductions and limitations;
- cost-sharing provisions such as coinsurance, copays and deductibles;
- renewability and continuation of coverage information;
- coverage examples (see SBC ‘Coverage Examples' below);
- an internet address for obtaining a list of the network providers;
- an internet address for additional information about any prescription drug coverage;
- a statement that the SBC is only a summary and an explanation of the document, such as the plan document or certificate of insurance, which should be consulted for more information;
- contact information for questions or for obtaining a copy of the plan document, certificate of insurance, insurance policy or certificate of insurance, whichever is applicable; and
- for coverage beginning on or after Jan. 1, 2014, a statement as to whether the plan provides minimum essential coverage and pays at least 60 percent of the total cost of the benefit.

When Must the SBC be Distributed?

- **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.

- **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.

Summary of Benefits & 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.

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.

Changes Effective During 2013

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.

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.

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.

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.

Medicare Tax on Unearned Income

- Additional Medicare contribution tax will be imposed on the unearned income of individuals, estates and trusts, reduced by the deductions properly allocable to such income.
- Individuals pays a tax equal to 3.8% of the lesser of not investment or the excess of modified adjusted gross income over the threshold amount.
- 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.

Medicare Tax on Unearned Income

Net investment income is the sum of:

- gross income from interest, dividends, annuities, royalties, and rents (other than income derived from any trade or business to which the tax does not apply);
- other gross income derived from any business to which the tax applies; and
- net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply.

- Net investment income does not include distributions from a qualified retirement plan or amounts subject to SECA tax.
- The tax applies to a trade or business only if it is a passive activity with respect to the taxpayer or it consists of trading financial instruments or commodities
- It does not apply to other trades or businesses.

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).

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.

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.”

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).

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.

Changes Effective During 2014

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.

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.

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.

Employer Mandate

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.”

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.

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.

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). -applies prior to 2014

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.

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.

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.

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.

Cost Sharing Requirements

- Health care reform requires that “cost-sharing” be limited.
- This requirement applies to all group health plans (including self-insured plans)
- 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.

Overall Cost-Sharing Limitation (Out-of-Pocket Maximum:

- 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 2013, 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 $6,250 for self-only coverage and $12,500 for family coverage.

- For 2015 and later years, the maximum is subject to increase.

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.”

Comprehensive Health Coverage Requirements

- 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.

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).

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.

Comprehensive Health Coverage Requirement

Comply With Cost-Sharing Limits:

- The limits on cost-sharing are described in the previous slides.
- HHS has indicated that the cost-sharing features (such as deductibles, co-payments, and co-insurance) of the essential health benefits package will be addressed in separate rules and will determine the actuarial value of the plan, which are expressed as a "metal value" (e.g., bronze, silver, gold, and platinum).

Meet Coverage Level Requirements:

- To satisfy the requirement that they offer the "essential health benefits package," insurers in the individual or small group market must either provide a level of coverage that meets the definition of bronze, silver, gold or platinum level coverage, or may instead offer a catastrophic plan.

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).

Establishment of the Exchanges

- By January 1, 2014, each state must establish an American Health Benefit Exchange (“Exchange”).

- If a state does not establish an Exchange, then the federal government will establish a federally facilitated Exchange.

- The Exchanges will perform a variety of functions required by health care reform, including certifying QHPs, determining eligibility for enrollments in QHPs, and for insurance affordability programs (e.g., premium tax credits), and responding to customer requests for assistance.

Establishment of the Exchanges

- HHS is required to determine by January 1, 2013 whether each state's Exchange will be fully operational by January 1, 2014.
- This is important because of assessing whether the Exchange will be able to start the initial open enrollment period on October 1, 2013. HHS may conditionally approve a state-based Exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013.
- In states that don't obtain HHS approval by January 1, 2013, or in states that decide not to establish an Exchange, a federally facilitated Exchange would be implemented by HHS for 2014.
- A state that does not obtain initial approval by January 1, 2013 can seek approval for a subsequent year, but it must do so at least 12 months prior to the Exchange's first effective date and must work with HHS to plan the transition from the federally facilitated Exchange that will have been put in place for 2014 to the then-approved state Exchange.

Establishment of the Exchanges

The following are functions that be provided by Exchange, and that HHS will require for approval:

- certifying, recertifying, and decertifying QHPs;
- assigning relative quality and price ratings to each QHP offered through the Exchange;
- providing standardized consumer information on QHPs;
- creating an electronic calculator that allows consumers to assess the cost of coverage after application of any advanced premium tax credits and cost-sharing reductions;
- operating a website and toll-free call center providing comparative information on QHPs and allowing eligible individuals to apply for and purchase coverage;
- determining eligibility for the Exchange, tax credits and cost-sharing reductions, public health coverage programs (such as Medicaid and CHIP), and facilitating enrollment of eligible individuals in such programs;
- determining exemptions from the individual mandate and granting approvals relating to hardship or other exemptions; and
- establishing a Navigator program.

Establishment of the Exchanges

- In states without a state-based Exchange, HHS will establish a federally facilitated Exchange (FFE) and perform all Exchange functions including plan management functions and consumer-assistance functions.

- A state may, however, choose to establish a state partnership FFE which permits the state to administer plan management functions and/or consumer-assistance functions.

- In either case, states will continue performing their traditional regulatory role for insurers and health plans—an insurer that offers QHPs through an FFE must meet both applicable state requirements and QHP certification standards.

Establishment of the Exchanges

- In General: - 15 states plus the District of Columbia have established state-based exchanges.
- Of those, three have done so via executive order: Rhode Island, New York, and Kentucky.
- The majority of states with established exchanges have appointed Boards, hired staff, and solicited subcontractors to begin planning and building exchange infrastructure.
- These states are also tackling a growing number of policy decisions such as defining their contracting relationship with qualified health plans, the size of their small-business exchange, and their exchange's financing structure.

Establishment of the Exchanges

Illinois:

- looking to partner with the federal government for a year, then branch off to their own exchange.
- They have issued a call looking for an IT company to come in and create, operate and maintain their digital exchange platform.

Wisconsin:

- Governor Scott Walker issued a statement declaring that he will not implement any part of the federal health law.
- On January 18, 2012 Governor Scott Walker announced he will return $37.6 million in Early Innovator Grant program funding to the federal government.

Establishment of the Exchanges

Indiana:

- Current governor will let successor decide.
- No action taken.

Michigan:

- Governor decided to apply for a state-federal partnership health insurance exchange after failing to persuade Republican legislators in the House to pass a Senate-approved bill that would allow the state to run its own exchange,

What is a Private Exchange?

- There are two types of private exchanges: one kind that allows a consumer to choose from a variety of types of health coverage from one company, and the kind that gives a choice of plans from several companies.

- Shoppers may be using their own money or spending a set amount from their employer.

- A health plan might host the exchange on its website, or an independent company may host the exchange and deal with collecting premiums.

What is Private Exchange

- Use of defined contribution model for employer premium payment.
- Role of broker and employer in the use of this exchange.
- Purchase of both individual and group products.
- Eligibility for credits and subsidies under Health Care Reform?
- Avoid Pay or Play Penalty?
- The impact of COBRA, ERISA and HIPAA.

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.

Exchanges and Qualified Health Plans

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."

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.

- Purchasing employer-provided health coverage for employees through a SHOP, however, will entitle certain qualified employers to obtain a small business health care tax credit
- Eligible employers are those defined by the state as a ”small employer.”

Exchanges and Qualified Health Plans (QHPs)

Individual Credits or Subsidies:

- Beginning in 2014, individuals who purchase health insurance coverage through one of the new health insurance exchanges will be eligible for financial assistance if their income is no more than 400% of the federal poverty line.
- Two forms of financial assistance will be provided.
  - A premium assistance tax credit will be provided monthly to lower the amount of premium the individual or family must pay for their coverage.
  - Cost sharing assistance will limit the plan's maximum out-of-pocket costs, and for some people will also reduce other cost sharing amounts (i.e., deductibles, coinsurance or copayments) that would otherwise be charged to them by their insurance plan.

Exchanges and Qualified Health Plans (QHPs)

Individual Credits or Subsidies:

- **Premium Assistance.**
  - The premium assistance tax credit is calculated to limit the amount that an individual or family must pay for health insurance coverage in the exchange as a percentage of income.
  - A sliding scale is used to determine the amount of the tax credit.
  - For those at the lowest incomes (less than 133% of the poverty level) the tax credit amount is based on limiting the individual's premium contribution to no more than 2% of income.
  - For those between 300% and 400% of the poverty line, the tax credit is amount is based on a limiting the contribution amount to 9.5% of income.

Exchanges and Qualified Health Plans (QHPs)

Individual Credits or Subsidies:

- **Cost sharing assistance.**
  - People who qualify for the premium assistance tax credit will also be eligible for cost sharing assistance if they enroll in a silver plan.
  - This assistance will further reduce the limit on the out of pocket maximum that can apply to their coverage, with the amount of the reduction depending on income.
  - For those with incomes between 100% and 200% of poverty, a 2/3 reduction applies.
  - For others, the reduction in the limit is either ½ or 1/3, depending on income

Exchanges and Qualified Health Plans (QHPs)

Employer Credits or Subsidies:

- For tax years beginning in 2014 and later, the maximum small business health care tax credit available to eligible small employers increases to 50% of nonelective contributions, but the requirements for the contribution arrangement are different from those applicable to earlier tax years.

- The nonelective contributions for 2014 and later tax years must be made on behalf of employees who enroll in a qualified health plan offered to employees by the employer through an Exchange.

Exchanges and Qualified Health Plans (QHPs)

Employer Credits or Subsidies:

- In order to qualify to receive a small business health care tax credit in any tax year, an employer must be either an eligible small employer or a tax-exempt eligible small employer, as defined in Code 45R.

Definition of Eligible Small Employer:

- There are three requirements that an employer must satisfy to be an "eligible small employer." With respect to any tax year—
- the employer must have no more than 25 full-time equivalent (FTE) employees for the tax year;
- the employer's FTEs must have average annual wages that do not exceed $50,000 (for 2010 through 2013); and
- • the employer must have a contribution arrangement in effect that meets the requirements of Code 45R(d)(4).

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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