

Health Care Reform:

A Critical Review

Association of Insurance Compliance Professionals

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Overview

The Patient Protection & Affordable Care Act (PPACA) (Pub.L. 111-148):

- Requires most U.S. citizens and legal residents to have health insurance;
- Creates state-based health insurance Exchanges through which individuals and small businesses can purchase coverage with premium and cost sharing credits available between 133% to 400% of the federal poverty level;
- Requires employers to pay penalties for their employees who receive tax credits for health insurance through an Exchange with exceptions for small employers;
- Imposes new regulations on health plans operating through the Exchanges and the individual and small group markets; and
- Represents a major step in the commoditization of health insurance.
 - Definition of commoditization - the process by which a product reaches a point in its development where one brand has no features that differentiate it from other brands, and consumers buy on price alone.



Overview (con't)

- On 3/20/2010 (before passage) non-partisan CBO estimated PPACA to cost over \$1 trillion but cut federal deficit by \$143 billion from 2010-2019.
 - Estimate included assumption that Congress would enact “Doc Fix” to reduce Medicare fee-for-service rates by \$332 billion from 2010-2019
 - Medicare payments to physicians have been scheduled to be cut each year since 2002, but these cuts have only been implemented once. Since 2003, Congress has taken action each year to prevent the cuts from going into effect. Medicare physician payments were scheduled to be cut by 21 percent starting April 1. Cut would be approximately 40 percent in 2011.
 - On 6/24/2010 Congress passed a 6-month freeze on enacting the Doc Fix. Passed 417-1 in the House, and unanimously in the Senate. Congress will reconsider Doc Fix after the November elections.
- On 5/11/2010 CBO estimate was revised to include an estimated additional \$115 billion in discretionary government spending.
- PPACA now projected to add to deficit from 2010-2019. Beyond 2019 – who knows....



Overview (con't)

- CBO estimates that the PPACA will reduce the number of nonelderly people who are uninsured by about 32 million.
- 23 million nonelderly residents would still be uninsured (about one-third of whom are illegal immigrants)
- The percentage of nonelderly residents with insurance would rise from 83 percent to 94 percent.



Overview (con't)

- On 5/26/2010 Doug Elmendorf, Director of the CBO, made the following points in a presentation to the Institute of Medicine in a presentation entitled “Health Costs and the Federal Budget”:
 - Rising health costs will put tremendous pressure on the federal budget during the next few decades and beyond. In CBO’s judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.
 - CBO has mis-estimated the effects of the changes in law.
 - Some observers think that subsidies will be more expensive than we project.
 - Budget conventions hide or misrepresent certain effects of the law.
 - The legislation will lead to an increase in discretionary spending, which is not included in the estimates mentioned earlier [projecting a decrease in the budget and now estimated at \$115 billion].
 - The law will be changed in the future in ways that will make deficits worse.
 - CBO estimates the effects of proposals as written and does not forecast future policy changes.
 - We have emphasized that the legislation maintains and puts into effect a number of policies that might be difficult to sustain over a long period of time. For example, the legislation reduces the growth rate of Medicare spending (per beneficiary, adjusting for overall inflation) from about 4 percent per year for the past two decades to about 2 percent per year for the next two decades.



The Bill Is Over 2,700 Pages Long But Omits the Details

The devil is in the details,
The details are in the regulations,
The regulations (mostly) don't exist!









Timeline



Healthcare Reform Timeline

- Tax credits for small businesses
- Starts to close Medicare Part D Prescription "Doughnut Hole"
- Increases investment in primary care physician training programs
- Imposes indoor tanning service tax
- Funding will be available to establish a non-profit Patient-Centered Outcomes Research Institute.

- No pre-existing coverage insurance exclusions for children
- Increases dependent coverage
- Eliminates lifetime caps on coverage
- Protects insurance rescission
- Bans new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31, 2010 and limits the expansion of grandfathered physician-owned hospitals

- Allows providers organized as accountable care organizations (ACOs) to share in cost savings
- Establishes a hospital value-based purchasing program
- Reduces Medicare payment for hospitals with excess readmission rates
- Establish Medicare pilot program to evaluated bundled payments
- Creates the Medicare Independence at Home demonstration program

- Prohibits health plans from denying coverage to anyone with a preexisting condition
- Expands Medicaid to 133% of the FPL
- Opens health insurance exchanges in states that have none.
- Provides Individual health care tax credits for people between 100% and 400% of the FPL
- Individual insurance mandate penalties begin
- Employers with more than 50 employees insurance penalties begin
- Limits any waiting periods for coverage to 90 days
- Reduces Medicare Disproportionate Share Hospital (DSH) payments
- Imposes fees on the health insurance industry
- Permits employers to offer employees rewards for participating in a wellness program

2010
Effective Immediately

September 2010-December 31, 2010
Effective 6 months after Implementation

2012

2014

June 2010
Effective 90 days after Implementation

- Implements temporary affordable coverage for the uninsured with pre-existing conditions
- Provides re-insurance for retiree health benefit plans

2011

- Imposes new fees on the pharmaceutical manufacturing industry
- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations
- Provides grants to small employers that establish wellness programs
- Provides 10% Medicare bonus for primary care physicians and general surgeons. (2011-2015).
- Develops a national quality improvement strategy
- Establishes a new trauma center program

2013

- Begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D "doughnut hole"
- Requires disclosure of financial relationships between health entities and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies
- Increases the Medicare tax rate on "high-income" earners by 0.9%
- Imposes an excise tax of 2.3% on medical devices

2015 and later

- Creates physician value based payment program
- Establishes Independent Payment Advisory Board
- Implements high cost "Cadillac" plan tax (2018)



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 individual penalty is phased in over time -- \$95 in 2014; \$325 in 2015; and \$695 in 2016. The penalty can increase up to three times for families and up to 2.5% of income.
- Exemptions are granted for financial hardship, religious objections, Native Americans and those without coverage for less than three months and for whom the lowest cost plan option exceeds 8% of their income.



Employer Requirements

- Penalty for Failure to Provide Insurance (effective 1/1/2014)
 - Employers with more than 50 employees who do not offer coverage and have at least one full time employee who receives a premium tax credit are assessed a fee of \$2,000 per full time employee, excluding the first 30 employees from the assessment.
 - Part time employees are aggregated by adding part time hours worked and then dividing by 120 (30 hour week). Part time employees do not count for assessment, only for determining thresholds.
- Penalty for Failure to Provide Affordable Insurance (effective 1/1/2014)
 - Employers with more than 50 employees who offer coverage and have at least one full time employee receiving a premium tax credit will pay the lesser of \$3,000 for each employee receiving a premium tax credit or \$2,000 for each full time employee (- first 30 employees).



Employer Requirements (cont'd)

- Requirement to Provide Affordable Coverage
 - To qualify as acceptable coverage, employers must pay at least 60% of the actuarial cost of the program, have annual deductibles no greater than \$2,000/ \$4,000 for individuals and families and the total cost to the employee must be less than 9.5% of their annual household income. The total cost must be under \$10,200 for individuals and \$27,500 for families to avoid “Cadillac” plan tax (discussed below).
 - Employers with over 200 employees must automatically enroll employees in an insurance plan.



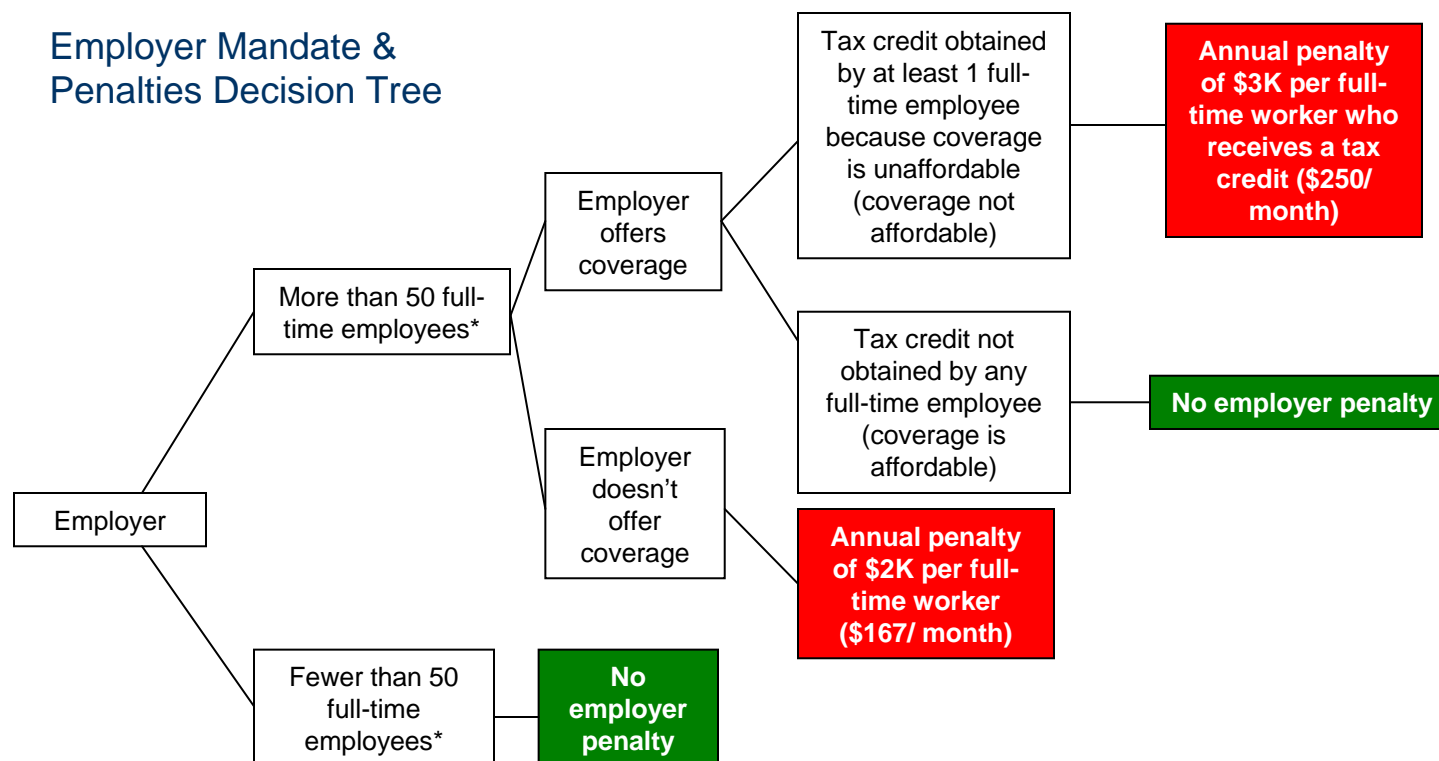
Employer Requirements (cont'd)

- Free Choice Vouchers (effective 1/1/2014)
 - Employers that offer coverage to their employees must provide a free choice voucher to employees with incomes less than 400% of the federal poverty level whose share of the premium is between 8% and 9.8% of their household income.
 - The voucher amount is equal to what the employer would have paid to provide the coverage to the employee under the employer's plan and will be used to offset premium cost through the Exchange.
 - Employees can keep any remaining amount after applying the voucher.
 - No employer penalty when providing free choice voucher.



Employer Requirements (cont'd)

Employer Mandate & Penalties Decision Tree



*Including full-time equivalents



Changes for Insurers & Group Plans

- For Plan Year 2010 and beyond, all plans are required to report premium dollars spent on clinical services, quality and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. This is the Medical Loss Ratio (MLR).
 - Rules not yet promulgated defining MLR.
- Plans must use community rating in individual and small group markets and Exchanges.



Changes for Insurers (cont'd)

Early Effective Date Changes (effective 9/23/2010):

- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage.
- Prohibit rescissions except in the case of fraud.
- Cover preventable care without cost sharing.
- Prohibit individual and group health plans from placing annual limits on the dollar value of coverage.
 - *Starting 9/23/10, the annual limits must be at least \$750,000. The minimum annual limit will increase to \$1.25 million after 9/23/11, and to \$2 million after 9/23/12. No limit after 9/23/13.*



Changes for Insurers & Group Plans (cont'd)

Early Effective Date Changes cont'd (effective 9/23/2010):

- Provide dependant coverage for children up to age 26 for all individual and group policies.
- Allow enrollees to choose, rather than be assigned, a participating primary care physician.
- Plans need to institute new internal and external appeals standards.



Changes for Insurers & Group Plans (cont'd)

Later Effective Date Changes (effective 1/1/2014):

- Prohibit pre-existing conditions exclusions for adults and for children under 19. (effective 1/1/2014 for adults and 9/23/2010 for children).
- Limit any waiting periods for coverage to 90 days.



Changes for Insurers & Group Plans (cont'd)

- Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless employer contributions are offered that off-set deductible amounts above these limits.
- Require all new policies, including those offered through the Exchanges and those offered outside the Exchanges, to comply with the four benefit categories.



Changes for Insurers & Group Plans (cont'd)

Plans in existence on 3/23/2010 are not subject to certain provisions of the PPACA (so called Grandfathered Plans). There is no requirement for insurers to maintain grandfathered plans.

HHS estimates that, by 2013, up to 80% of small groups (under 100 employees), 64% of large groups (over 100 employees), and almost all individual market participants will have relinquished their grandfather status.

133 million participants in large group plans, 43 million in small group plans and 17 million in individual market.

Provision	Applicable to Grandfathered Plan?
Ban on Annual/Lifetime Limits	Yes
Ban on Pre-Existing Condition Exclusions	Yes
Extended Coverage of Adult Children	Yes
Ban on Discriminating in Favor of Highly Compensated Individuals	No
Appeals Process Standards	No
Ban on Over the Counter Medication Reimbursement	Yes
Automatic Enrollment of Full-Time Employees by Large Employers	Yes
Advance Notice of Material Modifications	Yes
Penalties for Encouraging Employee Disenrollment	Yes
Premium Rebates for Plans with Low Medical-Loss Ratios	Yes
Temporary Reinsurance Program for Early Retirees	Yes
Ban on Cost-Sharing Requirements for Certain Preventative Health Services	No
Ban on Prior Authorization Requirements for Emergency Services	No
Limits on Ability to Rescind Coverage	Yes
Cost-Sharing Obligations for Out-of-Network Emergency Services	No
Participant Choice of Primary Care Physician/Pediatrician/Gynecologist	No
W-2 Health Coverage Cost Reporting Obligation	Yes



Review of Grandfather Regulations

- Interim regulations released on June 14, 2010. Compared to their policies in effect on March 23, 2010, grandfathered plans:
 - **Cannot Significantly Cut or Reduce Benefits.** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
 - **Cannot Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
 - **Cannot Significantly Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status.
 - **Cannot Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-to-5% so this formula would allow deductibles to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
 - **Cannot Significantly Lower Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
 - **Cannot Add or Tighten an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
 - **Cannot Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.



Operation of Health Insurance Exchanges

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges.
- Exchanges are administered by a government agency or non-profit organization through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Beginning in 2017, states can open the SHOP Exchanges to businesses with more than 100 employees.
- If a state fails to set-up the Exchanges by 1/1/2014 HHS will establish and operate the Exchange.
- Insurers may be required to participate in the Exchanges – waiting for further rule making.



Operation of Health Insurance Exchanges (cont'd)

Exchanges will:

- be funded by assessments or user fees on participating insurers;
- certify whether health plans are qualified to be offered in the Exchange, including examining their premium increases - \$250 million allocated for grants to states for premium increase reviews;
- require of plans and make public disclosure of the following information in plain language: claims payment policies and practices; periodic financial disclosures; data on enrollment, denied claims, and rating practices; information on cost sharing and payments for out-of-network coverage; and enrollee and participant rights;
- require qualified health plans to make available timely information about the amount of cost sharing for specific items or services;



Operation of Health Insurance Exchanges (cont'd)

Exchanges will (cont'd):

- operate a toll-free telephone assistance hotline;
- maintain an Internet website where enrollees can obtain standardized comparative information about the health plans;
- assign a rating to each health plan in the Exchange based on the relative quality and price of their benefits;
- use a uniform enrollment form and a standardized format for presenting health benefits plan options;
- inform people about the eligibility requirements for the Medicaid, CHIP or other State or local public programs and coordinate enrollment procedures with them; and
- make available an electronic calculator to determine the actual cost of coverage after any premium tax credit and any cost-sharing reduction has been applied.



Operation of Health Insurance Exchanges (cont'd)

- Public Plan Option
 - Office of Personnel Management is required to contract with insurers to offer at least two multi-state plans in each Exchange.
 - At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.



Operation of Health Insurance Exchanges (cont'd)

- Consumer Operated and Oriented Plan (CO-OP)
 - Creates the CO-OP program to foster the creation of non-profit, member run health insurance companies in all 50 states to offer qualified health plans.
 - \$6 billion has been set aside to finance the program and award loans and grants to established co-ops by 7/1/2013.



Operation of Health Insurance Exchanges (cont'd)

- Insurer's rating flexibility is restricted in the Exchanges.
 - Rating variation based on age is limited to a 3 to 1 ratio and tobacco use is limited to 1.5 to 1 ratio in the individual and small group markets and the Exchange.
 - Exchanges are required to offer four benefit categories plus a separate catastrophic plan available only to those individuals who are under 30 years old.
- Plans must include essential health benefits:
 1. ambulatory patient services
 2. emergency services
 3. hospitalization
 4. maternity and newborn care
 5. mental health and substance use disorder services (including behavioral health treatment)
 6. prescription drugs
 7. rehabilitative and habilitative services and devices
 8. laboratory services
 9. preventive and wellness services and chronic disease management
 10. pediatric services (including oral and vision care).



Operation of Health Insurance Exchanges (cont'd)

- Bronze Plan represents the minimum credible coverage and provides essential health benefits. It covers 60% of the benefit cost of the plan with an out-of-pocket limit equal to the HSA amount (currently \$5,950 for individuals and \$11,900 for families in 2010).
- Silver Plan provides the same benefits but covers 70% of the benefit cost with the same HSA out-of-pocket limits.
- Gold Plan provides the same benefits but covers 80% of the benefit cost with the same HSA out-of-pocket limits.
- Platinum Plan provides the same benefits but covers 90% of the benefit cost with the same HSA out-of-pocket limits.
- Insurers participating in the Exchanges must offer at least Silver and Gold plans.



Subsidies in Health Insurance Exchanges

- Premium tax credits to lower total cost of insurance. Credits are refundable and advanceable – calculated on second lowest cost Silver plan:

Income Level	Premium as a % of Income
Up to 133% of FPL	2% of income
133-150% of FPL	3-4% of income
150-200% of FPL	4-6.3% of income
200-250% of FPL	6.3-8.05% of income
250-300% of FPL	8.05-9.5% of income
300-400% of FPL	9.5% of income

- 2009 Federal Poverty Level (FPL) = \$10,830 for an individual, \$22,050 for a family of 4.



Subsidies in Health Insurance Exchanges (cont'd)

- Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:

Income Level	Actuarial Value
100-150% of FPL	94%
150-200% of FPL	87%
200-250% of FPL	73%
250-400% of FPL	70%



Subsidies in Health Insurance Exchanges (cont'd)

- The out-of-pocket limits are reduced for those with incomes up to 400% of the federal poverty level to the following levels:

Income Level	Reduction in Out-of-Pocket Liability
100 - 200% FPL	One-third of the HSA Limits (\$1,983 individual and \$3,967 family)
200 - 300% FPL	One-half of the HSA Limits (\$2,975 individual and \$5,950 family)
300 - 400% FPL	Two-thirds of the HSA Limits (\$3,987 individual and \$7,973 family)

- The out-of-pocket reductions are applied within the actuarial limits of the plans and will not increase the actuarial value of the plan.
- Current HSA limits are \$5,950 single / \$11,900 family.



Subsidies in Health Insurance Exchanges (cont'd)

Following is an example of how the Exchange subsidies will work for a family of four with a household income of 250% of FPL (\$58,562 in 2014):

- Average Silver plan (70%) annual plan premium: \$14,245
- Cap on premiums as a % of income: 8.05%
- Adjusted family premium payment: \$4,714 (\$393 month) (gov. subsidy of \$9,531 or 67% of premium)
- Cost sharing subsidy would raise actuarial value to 73% (plan would pay a higher share of covered benefits)
- Annual out of pocket limit: \$6,250 (50% of HSA limit – est. \$12,500)

Source: <http://healthreform.kff.org/SubsidyCalculator.aspx>



Subsidies in Health Insurance Exchanges (cont'd)

- CBO estimates that approx. 24 million people will purchase coverage through an Exchange and be eligible for subsidies.
 - An additional 5 million people will buy coverage in the exchange but will not be eligible for subsidies.
- CBO estimates that 5 million people will leave individual market to purchase through an exchange and that 8-9 million people will no longer get coverage through their employer. CBO estimates that 6-7 million people will be added to employer coverage.
- Premium and cost sharing subsidies are estimated to cost \$350 billion from 2014-2019.
- Given the limited cost to employers for dropping coverage and the generous subsidies, these costs may be drastically underestimated. (avg. household income in 2008 was \$68,424; 2/3 of households had income under \$75,000).



Tax Changes

- Insurers are required to pay an annual fee based on market share:
 - \$8,000,000,000 in 2014
 - \$11,300,000,000 in 2015 to 2016
 - \$13,900,000,000 in 2017
 - \$14,300,000,000 in 2018

Non-profit plans only count 50% of premium.

After 2014, the fee is based on the previous year's fee times the rate of premium growth.

- In 2008, health insurance industry was 86th in profit margin and earned about \$18 billion in profits.



Tax Changes (cont'd)

- For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee.
- Limited deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers. (effective 1/1/2009)
- Impose a 10% tax on the amount paid for indoor tanning services.
- Impose an excise tax of 2.3% on the sale of any taxable medical device. (effective for sales after 12/31/2012)
- Require all businesses to issue a 1099 to any entity from whom they purchased more than \$600 of products or services in a year. (effective 1/1/2012)
 - Expected to raise \$17 billion in taxes over 10 years.



Tax Changes (cont'd)

- Impose an excise tax on insurers of employee-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage indexed to the CPI-U for years beginning in 2020 (the so-called Cadillac tax). (effective 1/1/2018)
 - Taxes equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy which, in the case of a self-insured plan, is the plan administrator or in some cases the employer.
- Increases the Medicare Part A tax rate on wages from 1.45% to 2.35% on earnings over \$200,000 for individuals and \$250,000 for couples and imposes a 3.8% tax on unearned income for higher income taxpayers. (thresholds are not indexed - effective 1/1/2013)



Tax Changes (cont'd)

- Small business tax credits provide a tax credit to employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees.
 - Phase 1:
 - For tax years 2010 through 2013, provides a tax credit of up to 35% of the employer's contribution if the employer contributes at least 50% of the total premium.
 - Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - Phase 2:
 - For tax years 2014 and later, eligible small businesses that purchase coverage through an Exchange receive a tax credit of up to 50% of the employer's contribution if the employer contributes at least 50% of the total premium.
 - Full credit is available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - Credit will be available for two years.
- Shareholders of 2% or more of an S Corp or 5% of a C Corp are excluded for purposes of calculating and determining the credit. Family members are also excluded.