

Healthcare Reform:
Analysis and Action Plan for Employers
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Grandfathered Plans, Immediate Health Reform, Exchange-Related Issues, and Essential Benefits

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Topics to be Addressed

- Healthcare Reform Under The Patient Protection Affordable Care Act (PPACA)
 - Signed by President Obama on March 23, 2010
- The House Reconciliation Bill
 - Signed by President Obama on March 30, 2010
- Slides reflect the PPACA as modified by the Reconciliation Bill

Grandfathering Provisions Group Health Plans

- Under PPACA, group health plans in effect on the date of enactment are exempt from many of the healthcare reforms
- The grandfather rule includes not only individuals enrolled on the date of enactment, but also:
 - New employees (and their families) covered under an employer's grandfathered plan
 - Family members of current employees who are covered by the grandfathered plan

Grandfathered Plans

- Grandfathered plans are permanently exempt from the following reforms under PPACA:
 - Preventive services
 - Limits on cost sharing
 - Nondiscrimination rules imposed under PPACA (i.e. the application of Code Section 105(h) to fully-insured plans)
 - Reporting requirements
 - Appeals process
 - Selection of doctors and referral requirements
 - Coverage of clinical trials
 - No discrimination against providers
 - Individual responsibility requirements
 - Coverage under a grandfathered plan satisfies the individual responsibility provisions of the Bill

Grandfathered Plans

- Under PPACA, grandfathered plans are subject to the following requirements:
 - Changes in tax rules relating to health plans
 - Uniform explanation of coverage
 - Cost reporting and rebates
 - Automatic enrollment
 - Notification of availability of the exchange and subsidies
 - Notices regarding the exchange
 - Requirement to provide employees vouchers

Grandfathered Plans

- **Under the Reconciliation Bill**, grandfathered group health plans are also subject to the following requirements:
 - Limitation on lifetime and annual limits (FPY 6 months after enactment)
 - Limitation on pre-existing condition exclusions (FPY 6 months after enactment for children and 2014 for employees)
 - Prohibition on rescissions (FPY 6 months after enactment)
 - Limitation on waiting periods (FPY 6 months after enactment)
 - Coverage of adult children (FPY 6 months after enactment however, for years before 2014, the coverage requirement applies only if the adult child is not eligible to enroll in another eligible employer plan)

Immediate Health Reform

- Immediate Health Reforms are effective for plan years beginning 6 months after the date of enrollment—meaning January 1, 2011, for the calendar year plans and as this year for plans that have a plan year beginning October 1 or later this year

Immediate Health Reform

- Annual and lifetime limits
- Plans may not impose lifetime limits, and only restricted annual limits as determined by HHS on the value of essential benefits (as defined by PPACA) for any participant or beneficiary
 - For plan years beginning on or after January 1, 2014, plans and insurers may not impose any annual limits on essential benefits
 - Bill allows for annual or lifetime limits on non-essential benefits

Immediate Health Reform

- Prohibition on Rescission
 - Plans may not rescind coverage except in cases of fraud or intentional misrepresentation
 - (Note): does not appear to prohibit employees from terminating group plans

Immediate Health Reform

- Coverage of Preventative Care
 - Plan must provide first dollar coverage (i.e. no cost sharing for certain evidence-based preventative care including well child care and certain immunizations)

Immediate Health Reform

- Coverage for Adult Children
 - Plans that cover dependent children must provide for coverage of unmarried children until age 26
 - There is no requirement to cover children of covered dependent children
 - Requirement is an applicable event if the child is not a tax dependent
 - Reconciliation Bill extend the requirement to married children and extends tax exclusion for employee-provider coverage to adult children through age 26
(Reference NE LB 551)

Immediate Health Reform

- Transparency Requirements
 - Group health plans (self-funded) and insurers will be subject to the same transparency requirements applicable to plans offered in state exchanges
 - Must provide the following to HHS:
 - Claims payment policies and data
 - Financial disclosures
 - Enrollment (and disenrollment) data
 - Information on cost-sharing and information on payments to out-of-network coverage

Immediate Health Reform

- Non-discrimination Rules for Insured Plans
 - Rules regarding discrimination for self-funded plans (IRC Section 105(h)), will apply to all fully insured health plans
 - While most plans do not favor highly compensated, with respect to contributions or benefits, each health plan must be scrutinized
 - Take care in identifying “health” plans, with particular attention to “Exec-U-Care” type plans

Immediate Health Reform

- Pre-existing Condition Exclusions
 - With respect to children under age 19, plans may not impose a pre-existing condition exclusion or limitation

Immediate Health Reform

- Claims Procedures
 - Plans must establish an *internal* claims appeals process that:
 - Provides notice in culturally and linguistically appropriate manner of the review process and availability of applicable health insurance ombudsman created by the State to assist claimants with appeals
 - Allow claimants to review entire claim file and present evidence
 - Allow claimants to continue receiving coverage during the appeals process

Immediate Health Reform

- Claims Procedures (cont.)
 - Plans must also establish an **external** claims appeal process that:
 - Complies with applicable State law
 - Includes consumer protections set forth in the Uniform External Review Model Act developed by the NAIC, or in the case of self-insured plans, meets similar requirements as provided by HHS

Immediate Health Reform

- Patient Protections
 - Plan enrollees are allowed to select their primary care provider, or pediatrician in the case of a child, from any available participating primary care providers
 - Precludes the need for prior authorization or increased cost sharing for emergency services, whether they are provided by in-network or out-of-network providers
 - Precludes plans from requiring authorization or referral by the plan for obstetrical or gynecological care

Immediate Health Reform

- High Risk Pools
 - Until the high risk pool established under PPACA for individuals with pre-existing conditions is terminated in 2014, a group health plan must reimburse the high risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to disenroll from group health plans

Immediate Health Reform

- Electronic Transaction Standards
 - Plans must implement certain electronic transaction standards and certify compliance to HHS
 - Timing of certification varies depending on the type of transaction
 - Standards to be established by PPACA no later than December 31, 2013, in some cases, and in others December 31, 2015

Exchange-Related Issues (cont.)

- PPACA provides funds to States to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014
- Although generally directed at individuals, the exchange-related provisions in PPACA provide that States must create SHOP exchanges to help ERs to purchase such coverage

Exchange-Related Issues (cont.)

These provisions may impact ERs in the following ways:

- Beginning in 2017, States may allow ***all ERs*** regardless of size, to offer coverage through the exchange
- For 2016, only ERs with less than 100 employees (EEs) may participate
- For years before 2016, a State may limit small ERs to those with 50 or fewer EEs

Exchange-Related Issues

- ERs who offer coverage through the exchange may permit EEs to pay for such coverage with pre-tax dollars through ERs conference plan; exchange-related coverage that is not offered by the ER may not be offered through a cafeteria plan

Essential Benefits

- The bill requires the Secretary of DHHS to establish a standard of essential benefits that would be used to determine four types of coverage packages (bronze, silver, gold and platinum) of varying actuarial values
- All individual and small group insurers would have to offer, at minimum, plans in the silver and gold values

Essential Benefits (cont.)

- The essential benefits determined by the Secretary must include coverage of the following services: 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, chronic disease management, and pediatric services, including oral and vision care

Essential Benefits (cont.)

- Each level of coverage must meet its own actuarial value of the mandatory covered services as determined by Secretary of DHHS
- Bronze level policies must equal 60% of the value of the benefits, silver 70%, gold 80% and platinum 90%
- A separate catastrophic-only policy would be available for those 30 and younger
- Plans can offer child-only coverage through the exchanges to meet the child-specific benefit provisions

Insurance Market Reforms, Vouchers, Responsibilities, Cadillac Plan Tax, and Industry Related Issues

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Overview

- Insurance Market Reforms
- Individual Responsibilities
- Employer Responsibilities
- Cadillac Plan Tax
- Industry Related Issues

Insurance Market Reforms (fully-insured and self-insured) Post January 1, 2014

- No pre-existing condition exclusions or limitations are permitted
- No discrimination based on health status (same rules that currently exist under HIPAA, are included in PPACA)
 - *Note:* PPACA raises the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20% of the COBRA cost to 30% of the COBRA cost, with leeway to increase percentage to 50%

Insurance Market Reforms (fully-insured and self-insured) Post January 1, 2014

- No discrimination against a provider who is acting within the scope of his/her license is permitted (Does not force a plan to contract with every willing provider)

Insurance Market Reforms (fully-insured and self-insured) Post January 1, 2014

- Certain cost sharing requirements must be satisfied so that out-of-pocket (OOP) expenses do not exceed that applicable to HSA related coverage, and deductibles do not exceed \$2,000 for single and \$4,000 for family coverage (indexed). Please note that the regulations are still being clarified if this will be applicable to all employers or only small employers.

Insurance Market Reforms (fully-insured and self-insured) Post January 1, 2014

- Plans may not impose a waiting period in excess of 90 days
- A plan may not deny qualifying individuals participation in certain clinical trials or deny the coverage of routine patient costs for items and services furnished in connection with the clinical trial

Individual Responsibility

- Effective January 1, 2014
 - Individuals who do not enroll in qualifying coverage, qualifying ER-sponsored coverage, must pay an excise tax of the greater of:
 - \$95.00 in 2014, \$325.00 in 2015, and \$695.00 in 2016 and thereafter, or
 - A percentage of income equal to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter
 - Families will pay half the amount for children up to a cap of \$2,250 for the entire family
 - After 2016, dollar amounts will increase by the annual cost of living adjustment

Vouchers

- ERs that offer minimum essential coverage and make a contribution must offer “free choice vouchers” to qualified EEs for the purchase of qualified health plans through exchanges
 - The free choice voucher must be equal to the contribution that the ER would have made to its own plan
 - EEs qualify if their household income does not exceed 400% of the federal poverty level and required contribution under the ER’s plan would be between 8% and 9.8% of their income
 - Free choice vouchers are excludable from EE’s incomes (to the extent used for health care) and deductible by the ER
 - Voucher recipients are not eligible for tax credits through the exchange

Employer Responsibility

- Effective January 1, 2014
 - Increased ER reporting obligations
 - Confirmation that they offer (or do not offer) minimum essential coverage to their full-time EEs and their dependents
 - Length of any applicable waiting period
 - Lowest-cost option in each enrollment category under the plan
 - ER's share of the total allowed costs of benefits provided under the plan
 - Total number and names of full-time EEs receiving health coverage

Employer Responsibility (cont.)

- There is generally no requirement for ERs to offer the same coverage that insurers offering coverage in the exchange must offer
- In fact, there is generally no requirement for ERs to offer any coverage; however, ERs with 50 or more full-time EEs are subject to certain penalties as follows, related to coverage that they offer or fail to offer to full-time EEs

Employer Responsibility: Small Business Incentive

- Beginning in 2010, the law provides tax credits for qualified small ER contributions to purchase coverage for EEs
- The maximum credit is 35% of premium paid in 2010 by eligible small businesses, and 25% of premium paid by eligible ERs that are tax-exempt organizations
- In 2014, the maximum credit jumps to 50% of premiums paid by eligible small ERs and 35% of premiums paid by eligible ERs that are tax-exempt organizations
- This applies to small ERs with fewer than 25 FTEs and average annual wages of less than \$50,000 that purchase health insurance for their EEs
- The maximum credit will be available to ERs with 10 or fewer EEs and average annual wages of less than \$25,000

Employer Responsibility: Small Business Incentive

- The credit would phase out entirely for ERs of more than 25 EEs whose average annual salaries exceeded \$40,000.
- **Example:** For the 2010 tax year, a qualified ER has 9 FTE with average annual wages of \$23,000 per FTE. The ER pays \$72,000 in healthcare premiums for those EEs (which does not exceed the average premium for the small group market in the ER's State), and otherwise meets the requirements for the credit. The credit for 2010 equals \$25,000 (35% X \$72,000).

Employer Responsibility

- Effective January 1, 2014 – play or pay mandate:
 - ERs with 50 or more full-time “applicable” EEs are subject to the following penalties:
 - Applicable ERs who fail to offer any full-time EE health coverage must pay a penalty with respect to each full-time EE in any month in which any EE receives a federal subsidy for the exchange
 - The penalty is determined on a monthly basis and is the product of the total number of full-time EEs of the ER (over 30) for that month and 1/12 of \$2,000
 - » For example, a business with 51 EEs that does not offer coverage is subject to tax equal to 21 times the applicable payment amount

Employer Responsibility (cont.)

- Effective January 1, 2014 – play or pay mandate:
 - Part-time EEs are taken into account solely for the purpose of determining if an ER has at least 50 EEs
 - The number of full-time EEs otherwise determined is increased by dividing the aggregate number of hours of service of EEs who are not full-time EEs by 120

Employer Responsibility (cont.)

- Effective January 1, 2014 – play or pay mandate:
 - Applicable ERs who impose a waiting period of more than 90 days must pay a penalty (\$600) for each full-time EE to whom the extended waiting period applies
 - Even when coverage is extended, applicable ERs who offer coverage for any month to a full-time EE who is certified as having enrolled in the exchange and received a tax subsidy is subject to a penalty equal to the product of the total number of such EEs who have received a tax subsidy and 1/12 of \$3,000 (capped at 1/12 of \$750 times the total number of full-time EEs during such month)
 - Note: EEs offered ER coverage are not eligible for a credit unless their required premium exceeds 9.5% of household income or the plan's share of allowed costs is less than 60%

Cadillac Plan Tax

- Beginning 2018, PPACA (as modified by the Reconciliation Bill) imposes a 40% excise tax on:
 - “Coverage providers” for the sum of months in which the aggregate value of employer sponsored health coverage for the EE exceeds:
 - 1/12 of \$10,200 for single coverage and \$27,500 for family coverage
 - The higher family threshold applies to both single and family coverage offered under a multi-employer plan

Cadillac Plan Tax (cont.)

- These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018
- The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter
- An ER may make an adjustment to reduce the cost of plans when calculating the tax if the ER's age and gender demographics are not representative of a national average
- The PPACA transition rule for high cost States does not apply

Cadillac Plan Tax (cont.)

- The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g. law enforcement professionals, EMT's, longshoremen, construction workers, and miners) and those employed to install electrical or telecommunication lines is increased to \$11,850 for individual coverage and \$30,950 for family coverage

Cadillac Plan Tax (cont.)

- Determined by the employer and assessed against “coverage providers”
- “Coverage providers” are defined to include the following:
 - In the case of fully insured plans, the health insurer
 - In the case of HSA or medical savings account (MSA) contributions, the ER is making the contributions
 - In the case of self-insured plan or flexible spending account (FSA), the person that administers the plan (e.g. ,the TPA)

Cadillac Plan Tax (cont.)

- In many cases, ER-sponsored coverage will include both fully insured and self-insured contributions (it may also include HSA contributions)
 - The coverage providers applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage providers coverage to the total value of ER-sponsored coverage

Cadillac Plan Tax (cont.)

- The coverage subject to the excise tax rule includes:
 - The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the ER, even if paid for with after-tax dollars by the EE (except vision only insurance, long-term care insurance, and after-tax funded hospital indemnity and/or specified disease coverage)
 - Both non-elective and salary reduction contributions to a health FSA
 - ER contributions (presumably including salary reductions) to a HSA

Industry Related Issues: Minimum Loss Ratios (MLR) for Fully Insured Plans

- Starting January 1, 2011, creates a minimum loss ratio requirement that applies to all fully insured plans including grandfathered plans. The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below)
- This allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets

Industry Related Issues: (MLR) for Fully Insured Plans

- The amendment creates a premium rebate to individuals for plans that fail to meet the minimum MLR
- The legislation also gives the Secretary of DHHS, in conjunction with the States, new authority to monitor health insurance carrier premium increases beginning in 2010 to prevent unreasonable increases and publicly disclose such information
- Carriers that have a pattern of unreasonable increases may be barred from participating in the exchange

CLASS Act, Fair Labor Standards Act, Health Benefits, and Reporting Issues

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Overview

- CLASS Act
- Amendments to Fair Labor Standards Act
- Cafeteria Plans & Related Issues
- New Reporting Requirements

CLASS Act

CLASS Act

- Community Living Assistance Services and Support Act ("CLASS Act")
- New national voluntary insurance program to purchase community living assistance services and support
 - CLASS Independence Benefit Plan
- Essentially form of long-term care insurance

CLASS Act Benefits

- Premiums based on actuarial analysis of 75-year cost of the program
- CLASS Act establishes rules for premiums, vesting, and benefit levels
- Plan must provide minimum cash benefit that averages \$50/day
- No lifetime or aggregate limit

Employers & CLASS Act

- Employers may elect to participate in the CLASS Independence Benefit Plan
- Treasury and HHS will establish rules to automatically enroll employees
 - Employees may opt-out
- Automatic enrollment will result in payroll deductions for monthly premium payments

Taxes & CLASS Act

- Treated for federal income tax purposes in same manner as qualified long-term care insurance contract for qualified long-term care services
- Implementation: HHS must designate a benefit plan as the CLASS Independence Benefit Plan no later than October 1, 2012

Amendments to Fair Labor Standards Act of 1938 (FLSA)

Amended FLSA § 7

- PPACA requires reasonable break times for nursing mothers
- Must be provided for 1 year after birth
- Employer must provide place for nursing
 - Not bathroom
 - Reasonably shielded from view
 - Free from intrusions
- Not required to compensate during breaks

New FLSA § 18C

- Provides protections for employees:
 - Against discharge
 - Against other discrimination: compensation, terms, conditions, or other privileges of employment
- Applicable to:
 - Employee receiving certain tax credits
 - Employee receiving subsidy
 - Employee providing information to government

Cafeteria Plans & Related Issues

PPACA Changes to FSAs

- Pre-PPACA
 - No statutory limit on amount employee can elect to contribute to FSA
 - “Qualified medical expenses” include over-the-counter drugs (e.g., aspirin)
- Post-PPACA
 - \$2,500 annual limit on FSA contribution (indexed)
 - “Qualified medical expenses” do not include over-the-counter drugs
- Effective: Tax years beginning after December 31, 2012

Qualified Medical Expenses

- New uniform definition of “qualified medical expenses” for:
 - Health Savings Accounts (“HSAs”)
 - Archer Medical Savings Accounts (“Archer MSAs”)
 - Health FSAs
 - Health Reimbursement Arrangements (“HRAs”)
- “Qualified medical expenses” include amounts paid for a medicine or drug only if such medicine or drug is a prescribed drug or insulin

Qualified Medical Expenses

- Effects of change in definition
 - Types of reimbursable expenses
 - Potential tax implications
 - Plan amendments required
- Effective: Tax years beginning after December 31, 2010

New “Simple Cafeteria Plans”

- New “Simple Cafeteria Plans for Small Businesses” created
- Purpose: treat “eligible employers” as satisfying nondiscrimination rules
- Eligible employer: employed average of 100 or fewer employees during either of the 2 preceding years

Contribution Requirement

- Key concept: “qualified employee”
- Contribution requirement:
 - Employer must contribute to plan a specified statutory amount for each qualified employee
 - Must make contribution regardless of whether the qualified employee contributes

Eligibility and Participation

- Certain exclusions may apply
- Must be able to elect any plan benefit
- Effective: January 1, 2011

Reporting Issues

Changes to W-2 Reporting

- PPACA requires reporting of employer-sponsored health coverage
- Aggregate cost of applicable employer-sponsored coverage must be reported on form W-2

W-2 Reporting

- Exception: Health FSAs
 - Amount of salary reductions to health FSA not reported on W-2
- Effective date:
 - W-2 reporting applies to taxable years beginning after December 31, 2010

Minimum Essential Coverage Reporting

- Every person who provides minimum essential coverage must file a return
- Must also provide a written statement to the individual receiving coverage
 - January 31 deadline (statement for prior year)
- Applies to calendar years after 2013

Uniform Summary of Benefits and Coverage Explanations

- PPACA requires use of uniform explanations of coverage documents and standardized definitions
- HHS to develop standards for compliance
- Deadline: May 23, 2011

Summary of Benefits Requirements

- Uniform format
- 4 pages maximum
- At least 12-point font
- Culturally and linguistically appropriate manner
- Understandable by average plan enrollee
- Contact information
- Consult plan document
- Uniform definitions
- Description of coverage
- Exceptions, limits, and reductions on coverage
- Cost-sharing
- Renewability
- Coverage facts label
- Minimum essential coverage

Use of Summary of Benefits

- Applies to: health insurance issuers, group health plans, and self-insured group health plans
- By March 23, 2012, must provide Summary of Benefits to:
 - applicant at time of application
 - enrollee prior to time of enrollment or re-enrollment
 - policyholder or certificate holder at time of issuance of policy or delivery of certificate

Material Modifications

- ERISA definition
- If terms of plan or coverage involved is not reflected in the most recently provided Summary of Benefits, plan must provide notice of modification to enrollees at least 60 days **prior to** date modification **will become** effective

Penalty – Material Modification

- Willful failure to provide information:
 - Fine up to \$1,000 per failure
 - Failure with respect to each enrollee is a separate offense
- Example:
 - 200 Employees
 - No material modification notice provided
 - Fine: $200 \times \$1,000 = \$200,000$

Tax, "Fee," and Rebate Provisions: When, How Much, and What To Do?

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Provisions Affecting

- Individuals
- Insured and Self-Insured Coverage
- Employers
- Health Insurance Providers
- Pharmaceutical Companies
- Reporting and Compliance

Medicare Hospital Insurance

- New 0.9% tax
- Wages and Self-Employment Earnings over \$200,000 (individual)/\$250,000 (joint)
- Does ***not*** apply to employer – However, ***employer must withhold*** employee share
- Self-employed – no deduction for this tax
- Starts January 1, 2013

HI Tax Impact

Single Return		Joint Return	
Earnings	Additional Tax	Earnings	Additional Tax
\$250,000	\$450	\$250,000	\$0
\$500,000	\$2,700	\$500,000	\$2,250
\$1 Million	\$7,200	\$1 Million	\$6,750

Expected Revenue: \$86.8 Billion

Unearned Income Medicare Tax

- New 3.8% tax on passive income: interest, dividends, capital gains, annuity payments, royalties, and rent
- Does ***not*** apply to active participation rents, royalties or nontaxable income: tax-exempt interest, Roth IRA distributions
- Applies to passive income ***over*** \$200,000 (individual) and \$250,000 (joint)
- Starts January 1, 2013

Unearned Income Tax Impact

<u>Single Return</u>		<u>Joint Return</u>	
Passive Earnings	Additional Tax	Passive Earnings	Additional Tax
\$250,000	\$1,900	\$250,000	\$0
\$500,000	\$11,400	\$500,000	\$9,500
\$1 Million	\$30,400	\$1 Million	\$28,500

Expected Revenue: \$123.4 Billion

NOTE: Some taxpayers will be subject to both the Medicare HI Tax **and** the Unearned Income Medicare Tax

Insured and Self-Insured Coverage Fees

- New \$2 per covered individual fee imposed
- Funds "comparative effectiveness research"
- Applies to individual and group health insurance policies (insurance company pays) **and** to self-insured plans (employer pays) (Mixed Plans?)
- Starts: Policy/plan years ending after September 30, 2012
- Ends: September 30, 2019
- Expected Revenue: \$2.6 Billion

Medicare Part D (Retiree Prescription) Deduction Partially Repealed

- Currently employers can receive a deduction ***and*** a rebate ("double dip") for a portion of the same expense of providing a retiree prescription benefit
- Starting January 1, 2013, the deduction for the amount rebated is eliminated
- Expected Revenue: \$4.5 Billion

Temporary Early Retiree Medical Incentive

- Available for plans benefitting retirees age 55 and older but not yet Medicare eligible
- Apply to HHS for participation
- "Semi-Catastrophic" Reimbursement: HHS to reimburse 80% of documented claims over \$15,000 but less than \$90,000 per retiree per year
- Temporary: June 21, 2010 to December 31, 2013
- Apply Early: \$5 Billion available

Health Insurance Company "Fees"

- Applies to "health insurance" **not** accident, disability, indemnity, long-term care, or Medicare Supplement insurance
- Does **not** apply to extent plan is self-insured
- Fees to be determined annually by IRS and allocated based on "market share"
- "Fees" are nondeductible – it's a tax
- Expected Revenue: \$112 Billion
- Expect "Pass-Through"
- Starts: January 1, 2014

Pharmaceutical Company "Fees"

- Annual fees range from \$2.5 Billion (2011) to \$4.1 Billion (2018) and \$2.8 Billion thereafter
- Allocated based on branded drug sales to Medicare, VA, and DOD
- Expect "Pass-Through"
- Starts: January 1, 2011

1099 Reporting

- Must report payments to taxable corporations
- Includes amounts paid for property **or** services

Starts: January 1, 2012

Expected Revenue: \$17.1 Billion

Possible Actions

- Increase Tax-Exempt Bond Income
- Roth Conversion
- Apply for Early Retiree Medical Incentive
- Increase Self-Insurance to Reduce Health Insurance "Fees"

Important Information

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Questions and Answers

Implementation Timeline for Healthcare Reform

Implementation Timeline for Healthcare Reform

2010 Insurance Market Reforms

- New limits on pre-existing condition exclusions
- Ban on annual/lifetime limits
- Carrier rebates take effect if health insurer providers do not meet the MLR requirements
- Dependent coverage increase to age 26
- Provides coverage of preventative health services
- Establish Patient-Centered Outcomes Research Institute
- Group and Individual Plans must provide first dollar coverage for preventative services
- Employers provide reinsurance for early retirees

2011 Insurance Market Reforms

- Standardize the definition of qualified medical expenses for HSA, FSA, HRA
- Increase tax on HSA and MSA to 20% for non-qualified medical expenses
- Only prescribed drugs will be reimbursable through HSA or MSA, health reimbursement arrangement, or FSA
- \$4.8 Billion fee on pharmaceutical manufacturing industry
- Imposes a tax on medical device manufacturers

2011 Employers

- Small employers that establish wellness programs would be eligible for grants for up to 5 years
- Employers must disclose the value of the benefit provided for each employees coverage on W-2s
- Create simple Cafeteria Plan to help small businesses provide tax-free benefits

2013

Revenue Generating Provisions

- Cap contribution to FSA at \$2,500 per year
- Imposes a hospital insurance tax of 0.9% on high income individuals (\$200,000 individual and \$250,000 couples)

2014 Employer Mandates

- Generally, employers with more than 50 employees must offer coverage
- A temporary reinsurance program will be created for employers providing coverage to retirees over age 55 who are not eligible for Medicare
- Employers with more than 200 employees would be required to automatically enroll employees into health insurance plans offered by the employer
- Employees may opt out of coverage

2014

Subsidies for Employers

- Employers permitted to offer employees rewards of up to 30% of the cost of participating in a wellness program
- Phase II of the Small Business Tax Credit would provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost
- Premium credits and cost-sharing subsidies would be available to low-income individuals and families

2014

Health Insurance Reforms

- Insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS
- Allow states the option of merging the individual and small group markets
- Most insurers are prohibited from denying coverage for a pre-existing medical coverage
- New limits on pre-existing condition exclusions for group health plans

2014

- Individual Mandate

- Requires individuals to obtain insurance or pay a penalty, unless affordable coverage is not available

- Benefits Mandates

- Exchanges would be established; all new plans would be required to comply with one of four benefit categories
- All qualified health benefit plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, would be required to offer at least the essential health benefits package

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