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The Supreme Court Upheld the Affordable Care Act—Now What?

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Agenda

- Overview of the Act
- Arguments on Appeal and Supreme Court Findings
- The Devil in the Details
- Impact of the Act
  - Health Care Providers
  - Health Plans
- Employers, Penalties and the Health Care Exchange
- Individuals
- Question and Answer

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PPACA—What is It?

Expansion of health insurance coverage

- Individual mandate
- Employer requirement to offer coverage
- Medicaid expansion for all non-Medicare eligible individuals with incomes at or below 133% federal poverty level
- Premium and cost sharing subsidies to individuals
- Premium subsidies to employers
- Tax changes

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PPACA—What is It (continued)

- Creation of Health Insurance Exchanges
- Essential benefit package design
- Changes to private insurance design
- Cost Containment Measures
- Quality Improvement/Health System Performance
- Prevention/Wellness
- Long-term Care Changes
- Investments in Medicare, workforce, underserved areas, populations, and conditions

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Arguments to Supreme Court

- Is penalty a tax, making review unripe?
  - Anti-Injunction Act
- Constitutionality
  - Individual Mandate
  - Medicaid Expansion
- Severability

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Individual Mandate

- Constitutional
  - Commerce Clause? No
  - "Necessary and Proper"? No
  - Tax? Yes

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Medicaid Expansion

- Constitutional?
  - Not as mandate
  - Congress' spending power doesn't encompass conditioning continued receipt of funds on participation

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The Details: Individual Mandate

- Citizens and legal residents required to have coverage or face penalty

- Penalty amount to be phased in over 3 years
  - Exemptions granted for financial hardship, religious objections, Native Americans, people lacking coverage for less than 3 months, undocumented immigrants, incarcerated persons, those for whom lowest plan available exceeds 8% of income, and those with incomes below tax filing threshold

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The Details: Employers

- Employers with 50 or more full-time employees required to offer coverage by penalizing employers if their employees receive a tax credit
- Employers with more than 200 employees required to automatically enroll employees (employee can opt out)

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The Details: Medicaid expansion

- States that choose to participate have Medicaid coverage expanded to all non-Medicare eligible individuals under 65 with incomes of up to 133% of the federal poverty line and provide essential benefit package
- Federal funding for increased coverage
- Increase in Medicaid payment to 100% of Medicare for primary care physicians

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The Details: Premium and Cost Sharing Subsidies for Individuals

- Eligibility—limited to those who meet income limits and those whose employer's plan is not actuarially valued at at least 60% or for whom employee contribution exceeds 9.5% of income
- Credits—given to individuals between 100% and 400% of poverty level to limit percentage of income they must contribute to their insurance
- Cost-sharing—subsidies for eligible individuals to increase actuarial value of plan at specified income levels
  - Premium and subsidies not to be used for abortion services if not necessary to save life or in case of rape or incest; insurers that offer such services must segregate funds appropriately

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The Details: Premium Subsidies to Employers

- Small business tax credit for employers with fewer than 25 employees and average wages of less than $50K annually who purchase insurance
  - Credit phased in
- Reinsurance—temporary program for employers who provide coverage to retirees over 55 who are not eligible for Medicare

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The Details: Tax Changes

- Individual penalty (tax) for those who do not obtain coverage
- Exclude non-prescribed OTC drugs from HRA or FSA and no tax-free reimbursement under HSA
- Increased tax on distributions from HSA that aren't qualified
- Limit contributions to FSA
- Increased threshold for itemized deductions for unreimbursed medical expenses
- Increase Medicare tax rate for individuals earning over $200K ($250 for married filing jointly) and tax on unearned income
- Excise tax on rich plans (on issuer)
- Eliminate tax deduction for employers who receive Medicare Part D retiree drug subsidy
- New fees on pharmaceutical manufacturers and health insurers
- Excise tax on sale of medical device
- Tax on amount paid for indoor tanning

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The Details: Health Insurance Exchanges

- State-based organizations through which individuals and small businesses can purchase qualified coverage
- At least 2 multi-state plans must be offered in each Exchange (one must be non-profit and one must not cover abortions except to extent allowed)
- Create co-op program to foster creation of non-profit member run insurance companies
- Create 4 benefit tiers and catastrophic plan for each Exchange
- Increased transparency on health plans

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The Details: Private Insurance

- Temporary high risk pool for individuals with pre-existing conditions and financing for cost of program
- Health plan rebates for amounts not spent on care
- Condition continued participation in exchanges on legitimacy of premium increases
- Standard for financial and administrative transactions
- Dependent coverage for children up to age 26
- No lifetime or annual limits, no pre-existing condition exclusions, no rescission unless fraud
- Limit deductibles
- Limit waiting periods for coverage

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The Details: Medicare

- Bonuses for well-performing Medicare Advantage plans
- Accountable care organizations
- Advisory Board to slow growth in expenditures while preserving quality
- Reduced payments to hospitals for hospital acquired conditions and readmissions

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The Details: Quality

- Medical malpractice reform demonstrations
- Medicare payment bundling demonstrations
- Medical home demonstrations
- 10% bonus to primary care physicians
- Increased transparency with health care system—disclosure of relationships

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The Details: Prevention/Wellness

- Coverage of preventive services (removal of cost-sharing for Medicare-Medicaid)
- Development of evidence-based and community-based prevention and wellness initiatives
- Grants for employers that offer wellness programs
- Allow employers to offer rewards, including premium discounts and enhanced benefits of up to 30% of cost of coverage for participation in wellness and meeting health-related standards
- Chain restaurant and vending machine disclosures of nutritional content

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Implications of Act for Health Care Providers

- Expansion of health care coverage
  - 32 million Americans previously not covered by insurance will be with no lifetime or annual limits on care
- Reduced paperwork and administrative simplification Consumer protections to protect delivery of (and payment for) care
- Enhanced Medicare benefits
- State resources for certain chronic health problems
- Providers encouraged to drive improvements

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Changes in Healthcare Delivery Models and Rewards

- Pay for Performance
  - Evidence-based utilization protocols
  - Coordination of care
  - Avoidance of adverse outcomes
  - Active management of chronic illness
  - Value of care in comparison to peers

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Delivery Models (continued)—Accountable Care Organizations

- Mechanism for shared governance
- Receives payments from Medicare and distributes among providers
- Responsible for quality, cost, overall care
- Cost savings awarded to ACO (provided quality standards are met) to be shared among providers

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Imminent Guidance on Non-Discrimination Rules Expected

- Non-discrimination rules (Code Section 105(h)) applicable to self-insured plans were extended under health care reform to include fully insured plans.

- Generally, a plan must benefit at least 70% of all employees, or must benefit 80% of all employees who are eligible to benefit under plan if 70% or more of all employees are eligible, with certain exclusions (part time employees, under age 25, less than 3 years of service and collectively bargained employees).

- Employees of entities with common ownership are aggregated for purposes of this rule.

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Imminent Guidance on Non-Discrimination Rules Expected

- Failure to satisfy test for self-insured plan results in loss of tax benefit for highly compensated employees.
- Failure to satisfy test for fully-insured plan results in civil penalty of $100 per day per individual.
- Lost of confusion over application of current rules under Section 105(h) to self-insured plans. IRS delayed extension of rules to fully-insured plans until regulations issued. Notice 2011-1.
- Rules still currently applicable to self-insured plans.

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New Reporting Obligations Beginning 2013

- Employers that file less than 250 Form W-2 for the previous year must report value of the aggregate cost of employer-sponsored health benefits on W-2s for 2012 and thereafter

- Employers that filed less than 250 Form W-2s in 2011, and each year thereafter, remain exempt from this requirement until further guidance issued. IRS Notice 2011-28; 2012-9.

- Communication with employees is key: The value reported on the W-2 is NOT taxable income.

- Aggregate cost is total cost (employer contribution and employee contribution).

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Medicare Tax Changes Beginning 2013

- Tax on Employment Income.

  For employment income in excess of $250,000, if married, or $200,000, if single:

  - W-2 employee's share of Medicare withholding tax will increase from 1.45% to 2.35%.
  - Medicare tax on self-employment income will increase from 2.9% to 3.8%.

- Tax on Investment Income.

  Medicare tax imposed at 3.8% on net investment income for taxpayers with modified adjusted gross income over $250,000, if married, or $200,000, if single.

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Medicare Tax Changes Beginning 2013

Investment Income:

- Interest
- Dividends
- Annuities
- Royalties
- Rents
- Passive activity income
- Income from trading in financial instruments and commodities
- Gain from the sale of an interest that produces such income

Does not include amounts otherwise excluded from income.

Reduced by deductions allocable to such income.

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Key Changes to Group Health Plans

- Must extend dependent coverage of children until child exceeds age 26. Employers continue to have significant implementation issues.

- May not impose a pre-existing condition exclusion on individuals under Age 19. Applies to all individuals for plan years beginning on or after January 1, 2014.

- May not impose lifetime or annual limits on the dollar value of “essential health benefits” for any participant or beneficiary (limited ability to do so prior to plan years beginning before January 1, 2014).

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Additional Issues of Note for Employers

- Flexible Spending Accounts limited to $2,500 effective January 1, 2013.
- Aggregate permissible wellness rewards increase to 30% of total premium cost (possibly up to 50%).
- Transitional Reinsurance Program Fees, possibly significant, effective January 1, 2014.
- Automatic enrollment requirement for employers with more than 200 employees indefinitely delayed.
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Penalties Imposed on Employers - 2014

- Imposed only on “Applicable Large Employers.”
  - At least 50 full-time equivalent employees during the preceding calendar year. Includes all entities under common ownership.
  - A full-time employee works 30 or more hours per week.
  - Part time employees are aggregated together on pro-rata basis to equal full-time equivalent employees.

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Penalties Imposed on Employers Failure to Offer Coverage - 2014

If an Applicable Large Employer does not offer minimum essential coverage to all of its full-time employees and their dependents, it may be subject to an excise tax:

The tax is: # of actual full-time employees (minus 30) and multiplied by 1/12th of $2,000 for each month that such coverage is not offered.

Example: 60 actual full-time employees and the employer does not offer coverage for 6 months. 60 – 30 = 30 x $2,000 x 6/12 = $30,000 tax.

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Premium Credit to Obtain Coverage through a Health Insurance Exchange

An Individual is eligible to receive a premium credit if:

- Household income is between 100% and 400% of the federal poverty level;
- The individual is not enrolled in the employer's group health plan; and
- The individual's required premium cost for his or her employer group health plan exceeds 9.5% of the individual's household income or the employer plan's share of covered health expenses is less than 60%.
- Detailed regulations issued in May, 2012.

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Penalties Imposed on Employers
Failure to Offer Affordable Coverage

If the employer's sponsored group health plan meets either of the following criteria:

1. The employee's required premium cost exceeds 9.5% of the employee's household income; or

2. The employer plan's share of covered expenses is less than 60%.

Then an excise tax is imposed on the employer equal to the number of full-time employees who receive a premium credit x 1/12 of $3,000 for each month during the year that such coverage is "unaffordable."

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Penalties on Individuals for Failure to Maintain Coverage

Failure to maintain minimum essential coverage results in the greater of two penalty calculations – the Flat Dollar Amount or the Percentage of Income test (not to exceed the cost of the national average premium for a plan that provides 60% of the actuarial value of benefits covered).

The Flat Dollar Amount is a fixed amount ($95 per person in 2014, $695 per person in 2016) x 1/12th for each month that coverage is not maintained. Per person penalty is reduced by 50% for each person under age 18.

The Flat Dollar Amount may not exceed 300% of the annual flat dollar amount.

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Penalties on Individuals for Failure to Maintain Coverage

Percentage of Income Test:

1. The applicable percentage is 1% in 2014, and rising to 2.5% in 2016;

2. The applicable percentage is multiplied by "household income" in excess of the threshold amount required to file a federal income tax return ($9,500 for a single person, and $19,000 for married persons filing jointly in 2012).

"Household income" is adjusted gross income, plus tax exempt interest and foreign earned income for all persons in the household.

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Questions?

Thank You.

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