



## **Jumping into Health Reform**

**March 29, 2010**

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On March 23, I published a brief overview of the immediate changes we can expect from the New Health Reform law and the potential impact of the Reconciliation Bill. As we all know, the Reconciliation Bill ([H.R. 4872](#)) did go to the Senate which amended it and sent it back to the House for approval. On Thursday, March 25, 2010 the House took final action and delivered the Bill to the White House for enactment.

We have prepared our analysis from a variety of sources including parts of the actual legislation. It is very clear that the rules and regulations yet to be promulgated are absolutely essential to understanding the full impact of this important piece of legislation.

The purpose of this Memorandum is to highlight what we do know and when we can expect it to happen. We have broken our analysis into four main sections:

1. Answers to the most Frequently Asked Questions;
2. Other insurance reforms, pools, and such;
3. Changes in taxation, new taxes, and subsidies; and,
4. 2014: Implementation.

### **Answers to the Most Frequently Asked Questions So Far**

#### **NOT Protected under the Grandfather Rule:**

1. **Dependent Coverage to Age 26.** Effective Date: Plan years beginning 6 months after enactment. Eligible Dependents are unmarried individuals, who don't have access to group health benefits. It does not extend to children of dependents.

2. **Pre-existing Condition Exclusions.** Effective for plan years beginning on or after January 1, 2014. For children under the age of 19, the prohibition against pre-existing condition limitations goes into effect 6 months after enactment.
3. **Prohibition against Rescission.** Except for situations involving fraud or intentional misrepresentation, the prohibition goes into effect for plan years beginning six months after enactment.
4. **Annual Benefit Maximums.** Prohibited for plan years beginning six months after enactment (some exceptions based on benefit type are possible).
5. **Lifetime Maximums.** Prohibited for plan years beginning six months after enactment.

**The Following are Protected under the Grandfather Rule:**

6. **Preventive Services.** Must include immunizations, infant preventive care and screenings with no cost to the plan participant. This rule is effective for plan years beginning six months after enactment.
7. **Discrimination Testing.** The Health Reform law will apply a non-discrimination testing (IRC 105(h) tests) requirement to insured plans effective for plan years beginning six month after enactment.
8. **The Grandfather Rule(s).**
  - a. Health plans in existence as of March 23, 2010 or established prior to September 23, 2010, are exempt from some but not all of the new law. The exception covers existing enrollees as well as new enrollees.
  - b. Collectively bargained plans are exempt until the expiration of the bargaining agreement. If there are multiple bargained groups in one bargained plan, then the exemption lasts until the last bargaining agreement terminates.
  - c. As noted above, the Grandfather Rule does not apply to plan design elements such as 1-5 above. It also will not apply to many of the financial requirements, tax changes, and major health reform elements. For example, after 2014, employers with 50 or more full time employees may continue to offer today's plan, if it meets the Minimum Essential Coverage requirement, but they must pay a fine for other plan failures.

**Other Insurance Reforms, Pools, and Such**

1. Establishment of a temporary High Risk Pool for individuals with pre-existing medical conditions and who cannot obtain a pre-existing condition waiver. This Pool is to be established within 90 days following enactment. We will await HHS guidance on how individuals or plans may access the benefits in this Pool. The Pool ends in 2014.
2. Establishment of another temporary reinsurance plan for retiree coverage for those over age 55 and not yet eligible for Medicare. To be established 90 days after enactment.

3. Requirement for health insurers to report their claims loss ratios (incurred and paid) for plan year 2010. If they fall below 85% for large groups and 80% for small groups and individual market products (80% for Medicare Advantage plans), the insurer must rebate the savings to the policyholders beginning in 2011 (for group plans: the employer).
4. In 2010, the new laws impose additional requirements on non-profit hospitals. Failure to meet the requirements will result in a \$50,000 tax.
5. Health insurance companies must limit the deduction for executive salaries to \$500,000 each effective for 2010. Any compensation in excess of that will not be a deductible business expense.
6. The Tanning Salon Tax: 10% on amount paid for tanning services! How much time did Capitol Hill spend on this key element of Reform?
7. The \$250 Donut Hole Rebate is in effect for the 2010 Part-D plan year.
8. 2011 brings numerous changes to Medicare and Medicaid as well as an expansion of wellness incentives, among other ways, by providing grants to small employers that establish wellness programs.

### Changes in Taxation

1. For plan years beginning 2011, the cost of over-the-counter drugs no longer will be reimbursable under HRAs, health FSAs, HSAs or Archer Medical Savings Accounts (Archer MSA).
2. In 2011, distributions from an HSA or Archer MSA which are not used for qualified medical expenses will be taxed at 20% of the disbursement.
3. In 2013, the new law increases the threshold for the 1040 Schedule A itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to a 10% threshold. This new threshold will apply to all individuals.
4. In 2013, the Medicare Part A payroll tax rate on wages increases by 9/10% from 1.45% to 2.35% on earnings over \$200,000 per individual taxpayers and \$250,000 for married couples filing jointly. Employers must also pay the additional 0.9% on wages paid in excess of \$200,000. In addition, these tax payers will pay an additional 3.8% of income on unearned income.
5. In 2013, the new law will limit the Health Flexible Spending Account maximum to \$2,500.
6. In 2013, the new law imposes a tax of 2.3% on the sale of medical devices.
7. For employers who provide retiree drug benefits and who receive a non-taxable Part-D prescription drug subsidy under the HHS RDS program, the subsidy will become taxable. This provision was to become taxable for tax years beginning on January 1, 2011. It is our understanding that the Reconciliation Bill postpones the tax to 2013.

8. Beginning in 2014, the new law imposes a tax on all U.S. citizens and legal residents who do not maintain minimum amount of health insurance coverage (Minimum Essential Coverage). The tax is the lesser of a flat fee and a percentage of income. The Reconciliation Bill exempts individuals from the tax if their income is below a threshold level, lowers the 2014 tax \$495 to \$325 in 2015 and from \$750 to \$695 in 2016. It also raises the percent of income from 0.5% to 1.0% in 2014, 1.0% to 2.0% in 2015, and 2.0% to 2.5% in 2016.
9. The new law also will provide tax credits to employers with 25 or fewer employees with average annual wages up to an average annual wage of \$50,000 (sliding scale) for health plan coverage in force in 2010 and later.
10. In 2014, the law provides a tax credit (subsidy) to low income individuals to purchase coverage through the exchange. The subsidies would only be available to legal U.S. residents and U.S. citizens who purchase individual coverage through the exchanges or do not have access to affordable employer-sponsored coverage.

An employee with employer plan coverage that meets the Minimum Essential Coverage standards may not opt out of that coverage for subsidized coverage in the Exchange unless their income is 400% of FPL or below and their employer plan coverage is deemed unaffordable (exceeds 9.8% of their family income) or is not valued at 60% of the actuarial value of the essential benefits package.

However, beginning in 2014, employers must give a voucher to use in the individual market or the Exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the Exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the Exchange to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in the Exchange without being taxed on the excess amount.

11. In 2018, the Reconciliation Bill requires a 40% excise tax payable by the insurer or the employer in the case of self-funded plans, to the value of coverage that exceeds \$10,200 for single coverage and \$27,500 for family coverage (exclusive of standalone dental and vision benefits). The final Bill also creates higher thresholds:
  - a. Higher thresholds for retirees and works in high-risk professions (\$11,850 and \$30,950) and for multiemployer plans (\$30,950);
  - b. Thresholds adjusted for age and gender; and,
  - c. Thresholds indexed to:
    - CPI plus 1% in 2018-2019
    - CPI in 2020 and later years
12. Finally, in 2014, the new law imposes fees and taxes on health care providers. It also provides tax incentives to the formation of non-profit health delivery systems such as the co-ops, which we discuss below.

## 2014: Implementation

### 1. Reforms:

- a. Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- b. Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges.
- c. Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
  - 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).
- d. Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- e. Limit waiting periods for coverage not more than 90 days.
- f. Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- g. Require the Office of Personnel Management 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.
- h. Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- i. Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)

- j. Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- k. Require qualified health plans to meet new operating standards and reporting requirements.

## 2. Employer Requirements:

### a. 50 or more employees:

- Average of 50 or more employees and has one full time employee on premium assistance fails to offer Minimum Essential Coverage to full timers (30 hours) will pay:
  - \$750 annual fine for each F/T employee employed but no employer health plan
  - If coverage is offered by the employer and one full-time employee is on premium assistance, but it doesn't meet the "Minimum Essential Coverage" the employee becomes eligible for the premium assistance credit if their income is between 100%-400% of FPL
- Minimum Essential Coverage Defined:
  - 60% benefit
  - Employee contribution less than 9.8% of wage
  - Maximum waiting period: 60 days
- Premium Assistance "Credit" Defined: Employers offering a plan that doesn't meet the "Minimum Essential Coverage" test will pay the lesser of \$3,000 per employee receiving assistance or \$750 for each employee employed.
- Size of the Employer:
  - Employers that employ at least 50 employees for more than 120 days (if employ seasonal employees) are subject to the Shared Responsibility Rules
  - Employers with fewer than 50 employees are not required to pay fees for employees who receive a tax credit for health insurance through a state exchange

### a. 200 or more employees:

- Must enroll new employees automatically, with the opportunity to opt out;
- Provide notice regarding the Exchange;
- Include aggregate cost of coverage on W-2; and,
- Qualified employees (low income) get vouchers.

### In Summary

There are still other provisions for us to talk about. We will do so as they become more well defined. Throughout both laws, there are references to the duties of regulators at both the state and federal levels to create guidelines. This Memorandum must be broad in certain parts by necessity. Needless to say, we will expand upon those areas which become the subject of further guidance as that occurs. There also is misinformation. On critical matters, be sure to seek the advice of professionals.

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