Legal Requirements with ObamaCare

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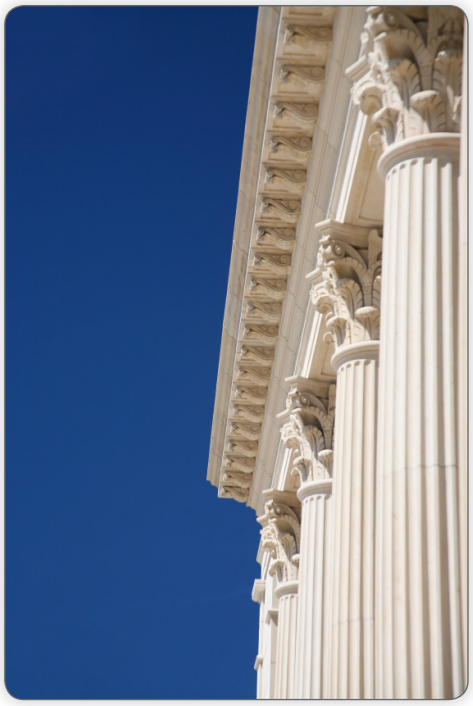
Executive Summary

Planning and decision making for the ramifications of ObamaCare requires an awareness of the new legal requirements, insurance mandates (coverage and administrative), reporting standards, and taxes imposed by the new law. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). PPACA will affect all Americans. The thrust of this paper is to identify some of the more pressing issues affecting employers and their health plans. Both insured and self-insured plans are affected. Below are some key multi-year issues most plan administrators will have to deal with.



In the past, employers may have relied completely on insurers or TPA's to handle the legal and administrative details of their health plans. Under PPACA there are critical strategic (long-term) and tactical (short-term) choices employers will have to ensure proper employee notification, qualification, participation, and compliance with new programs. The implementation process will require an understanding of the options available and a cooperative effort among employers, insurers, brokers, consultants, lawyers, and other associated plan vendors.

This paper is not intended to be a full description of the 2,700 page PPACA. Instead it highlights key issues requiring employer plan awareness and in many cases decision-making by plan administrators.

Insurance Issues

Federally Subsidized State High Risk Pools

Effective July 1, 2010 $5 billion of Federal funds were made available to support the new temporary high risk pool program. The program is funded entirely by the Federal government. Depending upon your State's acceptance of funding, the temporary $5 billion high-risk health insurance pool program can provide coverage for individuals who have been without coverage for more than six months and have a pre-existing condition.

The funding is used to cover claims and administrative costs associated with operating the State's high-risk pool. The Department of Health and Human Services (HHS) could operate the program either directly or through contracts with States or other eligible entities. States with programs already in place will have to continue their current funding levels in order to receive funding. The program terminates on January 1, 2014, or sooner, if the $5 billion earmarked for the program is exhausted before that date.

Coverage for Early Retirees

Effective June 1, 2010, the HHS established a temporary $5 billion re-insurance program to reimburse partially employers (including state and local government employers) for costs associated with health plans for retirees ages 55-64 and eligible family members. The Early Retiree Reinsurance Program (ERRP) was created under the PPACA to provide employment-based health plans. Employers will receive 80 percent of claim costs that exceed $15,000, but are less than $90,000. The program terminates on January 1, 2014, or sooner, if the $5 billion earmarked for the program is exhausted before that date.

Grandfather Clause

A grandfathered group health plan is a group or individual plan in which an individual was enrolled on March 23, 2010. A grandfathered plan can be a single employer plan, a multi-employer plan, or a multiple employer plan. It can also be an insured or a self-insured arrangement.

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with State or other Federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including.

- Coverage of recommended prevention services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

Under the PPACA, these requirements are applicable to all new plans, and existing plans that choose to make changes that would cause them to lose their grandfathered status.

New Insurance Coverage Mandates

Effective September 23, 2010, new requirements on insurance plans become effective for plan years beginning on or after six months after enactment. For most plans, this date is likely January 1, 2011.

Insurance plans may not:

- Impose lifetime limits on essential health benefits
- Rescind coverage except in instances in which an individual commits fraud
- Exclude payment for treating a pre-existing condition for any child under 19
- Impose unreasonable annual limits on essential health benefits, as defined by the law and the Secretary

All insurance plans must allow:

- "Children" to remain on their parent's health plan until age 26, if the "child" is not eligible to enroll in an employer-sponsored health plan.

All insurance plans that are not grandfathered must:

- Cover – without cost-sharing requirements – preventive services as graded "A" or "B" by the U.S. Preventive Services Task Force, certain immunizations; preventive services for infants, children, adolescents and women as provided in guidelines developed by HHS's Health Resources and Services Administration
- Implement an internal and external appeals process for coverage determinations and claims.

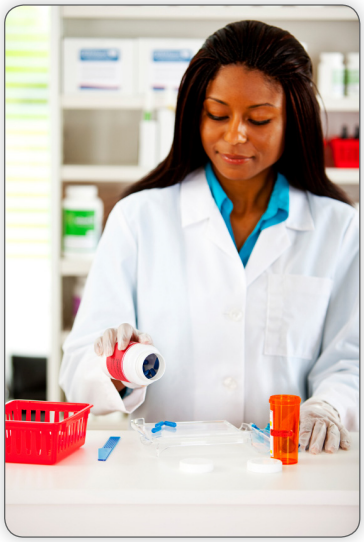
Minimum Loss Ratio Standards

Effective January 1, 2011, insurance companies must begin annual reporting on the share of premium dollars spent on medical care and health care quality activities, and provide plan enrollees rebates to fully insured policyholders if the percent of premiums spent on such activities is less than 85 percent or such higher percentage as a State may by regulation.

Fully insured small group and individual coverage insurers have an 80 percent requirement or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

Limited Use of Over-the-Counter (OTC) Medications

Effective January 1, 2011 PPACA prohibits taxpayers from using their Flexible Spending Accounts (FSA), Health Reimbursement Accounts (HRA), and Health Savings Accounts (HSA) to purchase OTC medicines without a prescription.



Summary Plan Descriptions

Effective March 23, 2011, the Secretary will to release standards for use by health plans to give enrollees a summary of the plan's benefits (including an assessment of whether the plan provides benefits that meet the minimum essential coverage requirements established in the Act). Plans must use these standards when disclosing this information no later than one year after the standards' release.

Electronic Eligibility

Effective July 1, 2011 the Secretary will adopt standard operating rules to determine electronically eligibility for a health plan and health claim status transactions.

Reporting Requirements and Tax & Penalty Issues

Insurers and plan vendors will likely increase their product and service pricing of insurance plans and coverages. Many of the new taxes start in 2013 and 2014. The more immediate benefit impacts were briefed through 2011. These out-year taxes are briefed here because they may impact employer strategic cost planning.

Increase in Prescription Drug Taxes

On January 1, 2011, the law levies a new tax on brand-name pharmaceutical companies and importers, which will be based on the market share of each company's branded prescription drugs sales.

Reduced FSA Tax Free Cap

On January 1, 2013 the law places a $2,500 cap on the amount of money American taxpayers can contribute tax-free annually to a FSA

Increase in Medicare Payroll Tax

On January 1, 2013 the law places a 0.9 percentage point increase in the Medicare payroll tax and a new 3.8 percent tax on unearned, non-active business income. The tax applies to individual taxpayers earning more than $200,000 ($250,000 for taxpayers filing jointly).

Reduced Individual Medical Expense Deduction

On January 1, 2013, the law increases the threshold for the deduction of medical expenses (from 7.5 percent to 10 percent of adjusted gross income).

Elimination of Employer Deduction for Medicare Part-D

On January 1, 2013 the law eliminates the deduction for employers who maintain prescription drug plans for their Medicare Part D-eligible retirees

Increased Tax on Medical Devices

On January 1, 2013, the law imposes a new 2.3 percent excise tax on medical devices manufacturers. Devices exempted from this tax include eyeglasses, hearing aids, contact lenses, and other devices as determined by the Secretary to be of a type generally purchased by the general public and retained for individual use.

Limit on Deductibility of Insurance Executive Compensation

On January 1, 2013 the law imposes a new $500,000 deduction cap on insurance company employee and officer compensation for services performed after December 31, 2009.

Increased Plan Taxes for Research

On January 1, 2013 the law imposes a new tax on insured and self-insured health plans, levied to fund the Patient-Centered Outcomes Research Institute (comparative effectiveness research center). The statute makes the tax effective for plan years ending after September 30, 2012. The tax is likely to go into effect for most plans after January 1, 2013.

Individual Mandate Penalty

Effective January 1, 2014, most individuals must maintain insurance coverage for themselves and their dependents or pay a new penalty. The penalty amount based on household income is one percent in 2014, two percent in 2015, and 2.5 percent in 2016 and later years. The annual flat-dollar penalty is phased-in ($95 in 2014, $325 in 2015, $695 in 2016, and adjusted for inflation thereafter), and the penalty is assessed for each taxpayer and any dependents.

Employer Mandate Penalty

Effective January 1, 2014, most employers with 50 or more full-time equivalent employees, with at least one full-time employee (30 hours/week) who purchases insurance subsidized with a tax credit through the Exchange, would have to pay a monetary penalty. The penalty is calculated according to a formula based on whether or not the employer offers health coverage.

Plan Mandates

Effective January 1, 2014, all plans except grandfathered plans must:

- Accept all applicants for coverage
- Comply with new Federal rating rules that allow policy prices for individual and small group plans to vary only according to an applicant's age (on a 3-to-1 ratio), family structure, geographic location, and tobacco use (on a 1.5-to-1 ratio)
- Comply with annual cost-sharing limits

Single Risk Pool Pricing

Effective January 1, 2014, individual and small group insured plans are required to be lumped into a single risk pool.

- Individual Market – A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
- Small Group Market - A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
- Merger of Individual & Small Group - A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

Conclusion

This is a high-level overview of the key legal issues with ObamaCare. There are insurance requirements, benefit mandates, and new reporting standards throughout the periods listed and beyond. This white paper only begins to touch on some of the most important and impactful legal changes. Employers will want to consult with their broker/agent and legal counsel to assure compliance. An annual compliance audit may be needed to assure a plan is meeting the legal and regulatory requirements.

About Ebix Health

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to better manage their benefits and better manage their lives. With our Brokerworks™ solutions, we're giving brokers the technology tools and resources they need to increase agency efficiencies, improve customer service, and drive new client acquisition. For more information, contact adam.com or 800.755.2326..

About the Author

Ron Bachman is president and CEO of Healthcare Visions, a thought leadership firm dedicated to advancing ideas and policy initiatives that are transforming the U.S. healthcare market. Bachman is a Senior Fellow of the Center for Health Transformation (CHT), the Georgia Public Policy Foundation (GPPF), the National Center for Policy Analysis (NCPA), and the Wye River Group on Health. He is an actuary with extensive experience in healthcare strategy for payers, providers and employers. Bachman is a retired partner from Pricewaterhouse Coopers where he consulted to a broad range of clients including: employers, HMOs, hospitals, physicians, indemnity carriers, BlueCross BlueShield plans, as well as State and Federal Agency clients.