

CLIENT BULLETIN

House Passes Senate Health Reform Bill; Additional Changes Coming - Summary

March 24, 2010



This discussion highlights changes in the new federal health reform law as of March 24, 2010, with a focus on issues affecting employer health plans. (An individual mandate also applies.) Hub International has detailed information available, including effective date discussions. We will provide more details when final reform is signed into law.

Employer “Mandate” -- Starting in 2014, most employers with over 50 employees must provide qualified group health plan coverage or pay a per-employee penalty tax. Employers with fewer than 50 employees usually are exempt. The minimum plan will have four options available: bronze, silver, gold, and platinum. Specific benefit design is to be determined by federal regulators. The employer must pay “most” of the premium, likely 60% or more. Waiting periods cannot exceed ninety days. Many employers will offer the minimum plan, avoiding the penalty tax. The law allows maintenance of existing coverage, but that provision’s meaning is unclear.

Plans will not be able to impose preexisting condition exclusions, or consider health status or history of individuals in setting premiums. Plans also cannot place dollar limits on annual or lifetime benefits. (A \$1 to \$2 million lifetime cap has been typical.) Health insurance carriers generally may only determine small group plan premiums using location, age, tobacco use, and family size. (Carriers have been basing premiums on the employees’ medical conditions.) Insured policies will be guaranteed issue (applicants are not turned away), and renewal is guaranteed. Plans cannot have eligibility rules based on hourly versus salaried workers, or favor higher-paid persons over other employees.

Effect on Consumer-Driven Health Plans-- The minimum health plan structure -- with low deductibles and out-of-pocket maximums -- *may* prevent an employer from offering a high deductible health plan alongside a Health Savings Account (HSA). However, some rules in the new law indicate these programs may continue.

Automatic Enrollment -- Employers with over 200 employees and which offer a group health plan must automatically enroll employees in a plan option. Employees may opt out and select no plan coverage.

Dependent Coverage Expansion -- Coverage must be provided to an employee’s adult child until at least age 26. No coverage is required for the child of a child.

Wellness Plan Design – Plan sponsors can offer a reward, up to 30% of total premium cost, in exchange for the individual satisfying certain conditions (such as weight loss) in order to qualify. The plan must operate as a wellness program within certain guidelines, offering a different way to earn the reward for people excused by a doctor’s statement.

Disclosure Rules – Insurance carriers and all group health plan sponsors must provide a four-page, detailed summary of benefits and coverage, distributed at enrollment and with the traditional SPD. If there is a “material modification” to plan terms, the plan must notify participants 60 days *prior* to the change’s effective date.

Reporting Care Management Provisions -- Employers must report on plan benefits and provisions that improve the health of persons covered by the plan. (They may address outcomes through quality reporting, effective case management, care coordination, chronic disease management, and care compliance initiatives.)

Form 5500 Changes -- Employers must report additional information to the federal government on Form 5500, so the government can make sure plans are in compliance and so they can conduct studies.

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Reinsurance for Early Retiree Plans -- Prior to January 1, 2014, a temporary federal reinsurance program will reimburse employer plans some portion of the cost of providing cost-effective health insurance to early retirees (age 55 and over) and dependents.

Employer-Provided Vouchers – Employers must provide special vouchers to certain lower-paid workers who do not qualify for a tax credit. The voucher amount will equal the employer’s contribution toward premium costs. A voucher is required if the employer’s plan is not “affordable,” meaning the employee’s cost exceeds 8% to 9.8% of his income (which must be 400% or less than federal poverty level).

Individual Mandate -- An individual must be covered under an insurance policy or pay a penalty tax (either a flat dollar amount or a percentage of income). An individual will be able to purchase coverage either through an employer’s plan or in a new Insurance Exchange (using a tax credit from the government or a voucher from his employer if the plan is unaffordable for that person).

Revenue Provisions

- **Cadillac Health Plan Tax** – Under the new law, plans with a value over certain amounts will be subject to a 40% excise tax.
- **Changes to Account-Type Plans** – Health Flexible Spending Accounts must cap annual benefit maximums at \$2,500. No over-the-counter medicines can be reimbursable by these Accounts (nor by HSAs and HRAs).
- **Medicare Part D** – Employer deductions for a Part D subsidy are eliminated.
- **Research Tax** – Plans must pay a \$2 per covered person fee to fund research.
- **Fees** – Pharmaceutical, medical device, health insurer, and TPA industries must pay new annual taxes or fees
- **Medicare Taxes** – High income persons must pay a surtax of .9% as an additional Medicare tax on earned income over \$200,000 (\$250,000 for couples). High income persons also must pay an additional 3.8% Medicare tax on their net investment income.

The information contained herein is intended to provide general information and does not constitute legal advice. You should not act or rely on any information contained herein without seeking the advice of an attorney.