

Health Care Reform

Bulletin

House Passes Historic Two-Part Health Care Reform Legislation; President to Sign Senate Health Care Reform Bill Into Law Now; Reconciliation Bill Making Changes to the Senate Bill Headed to the Senate for Immediate Consideration

March 22, 2010

Congress's seemingly endless march toward enacting comprehensive health care reform legislation is coming to a close with a very large and complex new law as the outcome. The new law will have significant strategic and tactical implications for employers' reward strategies and employee health plans in the years to come.

An Unusual Process

On Sunday, March 21, the U.S. House of Representatives voted 219-212 to pass a comprehensive health care reform bill (H.R. 3590), the Patient Protection and Affordable Care Act. Since the Senate passed this bill last December, President Obama plans to sign H.R. 3590 into law as soon as possible. Some provisions of the new law will begin taking effect this year while other provisions will become effective each year over the balance of this decade.

The House also voted 220-211 on March 21 to pass a second bill (H.R. 4872), the Health Care and Education Reconciliation Act of 2010. That bill now moves to the Senate for immediate consideration. If the Senate passes H.R. 4872, referred to as the "budget reconciliation bill," the bill will amend the health reform law signed by the President, making changes that were needed to obtain House approval of the Senate's health reform bill. This indirect two-bill method of modifying the Senate reform bill was designed to avoid a Republican filibuster in the Senate, where Democrats have lost the 60-vote majority needed to overcome the filibuster. Unlike other legislation, a budget reconciliation bill is not subject to filibuster and thus may pass the Senate by a simple majority vote. Republican opponents plan a series of procedural challenges to the reconciliation bill in the Senate, where a weeklong debate may ensue before a vote, which could come as early as the weekend of March 27-28.

Senate Bill + Reconciliation Bill = Final Health Reform Law

The following material provides a high-level summary, in rough chronological order, of many key employer-related provisions of the law that will emerge under the combined Senate bill (H.R. 3590)

and reconciliation bill (H.R. 4872), once both bills are signed into law. Not every employer-related provision is listed here, nor does the list include many other provisions directly affecting health care providers and the health care delivery system.

2010

Early retiree reinsurance program — Beginning 90 days after enactment, a temporary reinsurance program will be launched by the federal government to reimburse employer plans for 80% of the cost of benefits provided to retirees age 55 through 64 in excess of \$15,000 and below \$90,000. The program will end by 2014 or when the limited funding of \$5 billion is exhausted.

Medicare prescription drug “donut hole” — Beginning in 2010, with a \$250 rebate paid to Medicare Part D beneficiaries who reach the so-called donut hole this year, the law would gradually reduce the donut hole in subsequent years by phasing down the coinsurance in the coverage gap each year so that it reaches the standard 25% beneficiary cost sharing by 2020 throughout the coverage gap.

2011

Immediate reforms — Beginning with the 2011 plan year (for calendar-year plans), employer group health plans:

- Must offer coverage to adult children up to age 26 (regardless of whether they qualify as the employee’s tax dependent) who are not eligible for coverage under another employer’s health plan; the coverage would not be taxable to the employee or dependent and, beginning in 2014, the requirement that the nondependent child must not be eligible for coverage under another employer’s plan would no longer apply
- May not impose lifetime limits and could impose only “restricted” annual limits; no annual limits would be permitted beginning in 2014
- May not impose preexisting condition exclusions on children under 19; no preexisting conditions would be permitted for any participants beginning in 2014
- Must satisfy the nondiscrimination requirements of Internal Revenue Code Section 105(h), previously applicable only to self-insured plans

These changes take effect for plan years that begin following six months after enactment; thus, some non-calendar-year plans will face effective dates earlier than January 2011.

Account-based plans — Beginning in 2011, the costs of over-the-counter medicines will not be eligible for reimbursement from a health flexible spending account (FSA), health savings account (HSA) or health reimbursement arrangement (HRA) unless obtained with a prescription. Likewise, in 2011, the tax penalty on withdrawals from HSAs for reasons other than the reimbursement of qualified medical expenses will double to 20%.

Medicare Part D drug discounts — Beginning in 2011, drug manufacturers will be required to provide a 50% discount to Medicare Part D beneficiaries on brand-name drugs and biologics in the donut hole coverage gap.

Medicare Advantage plans — Beginning in 2011, and phased in over three years, the law will change payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments (115% of FFS) for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Additional changes will reward or penalize Medicare Advantage plans based on financial and quality performance.

Means testing Part D premiums — Beginning in 2011, Medicare Part D premiums will be set higher than the standard level for those with incomes above \$85,000 for individuals and \$170,000 for couples.

Form W-2 reporting — Beginning with the Form W-2 form covering the year 2011, employers will be required to disclose the value of each employee's health coverage on the employee's annual Form W-2 that is filed with the IRS.

New fees on pharmaceutical manufacturers — Beginning in 2011, the law will impose new annual fees on pharmaceutical manufacturers, expected to be passed on to employers and other payers, under the following schedule:

- \$2.5 billion in 2011
- \$2.8 billion in 2012-2013
- \$3.0 billion in 2014-2016
- \$4.0 billion in 2017
- \$4.1 billion in 2018
- \$2.8 billion in 2019 and later

2013

Change in employer tax treatment of the Medicare Part D RDS — Beginning in 2013, an employer's tax deduction will be reduced to the extent the employer's drug expenses are reimbursed under the Medicare Part D retiree drug subsidy (RDS) program. Although this change in tax law does not take effect until 2013, employers participating in the RDS program will be required to recognize the full accounting impact of the 2013 tax law change in the financial statements for the accounting period in which the President signs the legislation into law.

Broaden Medicare Hospital Insurance (HI) tax base — Beginning in 2013, taxpayers with earned income above \$200,000 (single return) or \$250,000 (joint return) will be subject to an additional 0.9% tax (i.e., rising from 1.45% to 2.35%) on wages in excess of those amounts. Employers will not be required to match the payment of this incremental increase, which is applicable only to the

employee. Separately, taxpayers with total taxable income above \$200,000 (single return) or \$250,000 (joint return) from any source will be subject to a 3.8% tax on the lesser of:

- Their net investment income (e.g., interest, dividends)
- The amount, if any, by which their modified adjusted gross income exceeds the dollar thresholds

Net investment income excludes distributions from qualified plans.

Limit on health FSA — Beginning in 2013, contributions via pretax salary reduction to a health FSA will be capped at \$2,500 per year, indexed to the CPI.

Tax on medical device manufacturers — Beginning in 2013, the law will impose an excise tax of 2.3%, expected to be passed through to employer plans and other payers, on the sale of medical devices, with certain exceptions.

Itemized deductions for unreimbursed medical expenses — Beginning in 2013, individual taxpayers seeking to claim an itemized income tax deduction for medical expenses will be able to deduct only the portion of such expenses in excess of 10% of their adjusted gross income, up from the current level of 7.5% of income, deferred to 2017 for those age 65 and over.

2014

Employer “pay or play” responsibility — Beginning in 2014, if an employer with more than 50 full-time equivalent employees (counting full and part timers) chooses to:

- *Offer coverage*, but has at least one full-time employee (working ≥ 30 hours/week) who receives subsidized health coverage in an Exchange, the employer would pay the *lesser* of (i) \$3,000 multiplied by the number of full-time employees who receive subsidized coverage in an Exchange or (ii) \$2,000 multiplied by the number of full-time employees
- *Not offer coverage* to employees, the employer would pay \$2,000 multiplied by the number of full-time employees, if at least one full-time employee obtains subsidized health coverage in an Exchange

No penalty would be payable with respect to employees who have not completed an employer’s waiting period of up to 90 days. Employers also will be permitted to subtract the first 30 full-time employees from the payment calculation when determining the employer’s number of full-time employees.

Employer free-choice vouchers — Beginning in 2014, employers that offer and subsidize minimum essential coverage for their employees will be required to offer certain employees the option of either enrolling in the employer’s plan or receiving a tax-free voucher from the employer.

An employee would be eligible for a voucher if:

- The employee’s premium share for the employer plan was between 8% and 9.8% of the employee’s household income (above that level, an employee will be eligible for federal subsidies)

- The employee's household income did not exceed 400% of the federal poverty level

The 8% and 9.8% levels would be indexed after 2014 to reflect the rate of premium growth over the rate of income growth.

The amount of the voucher will be equal to the employer's largest cost-sharing contribution to any of the options under the employer's health plan. Furthermore, the amount of the voucher will be adjusted for age and based on the amount the employer would pay for employee self-only coverage — unless the employee elects family coverage (in which case the voucher amount will be the amount the employer would pay for family coverage).

An employee may keep the amount of the voucher in excess of the cost of any Exchange-based coverage the employee obtains and will be taxed on the excess portion. An employee will not be taxed on the portion of a voucher used to pay premiums in an Exchange.

Wellness incentives — Beginning in 2014, the HIPAA-related limit on total financial incentives will increase from 20% to 30% of plan costs (rewards and penalties) for participation in a wellness program that is part of an employer group health plan. The legislation gives regulators the discretion to allow an increase in incentives of up to 50% of the cost of coverage if it is determined to be appropriate.

Employer health coverage reporting — Beginning in 2014, employers will be required to report annually to the government on:

- Whether they offer minimum essential coverage to their full-time employees and their dependents
- The length of any applicable waiting period
- The lowest-cost option in each enrollment category under the plan
- The employer's share of the total allowed costs of benefits provided under the plan
- The total number and names of full-time employees receiving health coverage

Automatic enrollment and ongoing employee notice requirement — Amendments to the Fair Labor Standards Act will require employers:

- With more than 200 full-time employees to automatically enroll full-time employees in health coverage; employees will have the opportunity to opt out of coverage
- To provide new employees with a notice regarding the health insurance Exchanges, whether the employer's plan meets minimum coverage requirements and how to access information regarding premium subsidies that may be available for Exchange-based coverage; current employees must receive the notice no later than March 31, 2013

The effective date of the automatic enrollment requirement on employers is unclear but appears to be dependent on regulations to be issued by the Secretary of Labor.

New fees on health insurers— Beginning in 2014, the law will impose new annual fees on health insurers allocated according to their market share of net written premiums (and expected to be passed through to policyholders) under the following schedule:

- \$8 billion in 2014
- \$11.3 billion in 2015-2016
- \$13.9 billion in 2017
- \$14.3 billion in 2018
- Indexed to the rate of premium growth in subsequent years

Only 50% of nonprofit insurers' net premiums will be taken into account in allocating the fees, with exemptions available for certain nonprofit plans and VEBAs not established by an employer.

Individual health coverage mandate— Beginning in 2014, individuals (with limited exceptions) who do not enroll in “minimum essential coverage” would pay a penalty based on the greater of a flat dollar amount or a percentage of income. Minimum essential coverage includes Medicare, Medicaid, employer plans and Exchange-based health coverage. The annual flat dollar penalty would equal \$95 in 2014, \$325 in 2015, \$695 in 2016 and indexed thereafter. The percentage of income would equal 1.0% in 2014, 2.0% in 2015 and 2.5% for 2016 and subsequent years. The penalty would be 50% of these amounts for those under age 18 who do not maintain health coverage. Individuals with income below the tax-filing threshold will not pay the assessment (e.g., a married couple with income below \$18,700).

Insurance market reforms— Beginning in 2014, insurers in the individual and small-group markets will be required to offer coverage to those up to age 65 via new state-based health insurance Exchanges. This coverage will be offered on a guaranteed available and renewable basis with no health status underwriting, no preexisting condition exclusions and limits on permissible premium rating bands.

Health Benefit Exchanges— Beginning in 2014, states will be required to establish an insurance Exchange to facilitate the offering and purchase of approved, qualified health plans offered to those up to age 65.

Federal premium subsidies for low- and middle-income individuals— Beginning in 2014, premium subsidies and reduced cost sharing will be provided on a sliding scale to individuals earning up to 400% of the federal poverty level (FPL) who enroll in options offered through the Exchanges, where coverage will be available up to age 65. Employees offered minimum acceptable coverage by an employer (e.g., generally at least 60% actuarial value) would be eligible for the government's premium subsidies only for Exchange-based coverage and only if the employee's required contribution for the employer plan exceeded 9.5% of the employee's household income. If the required contribution equaled between 8% and 9.8% of household income, the employer would be required to offer such employees a free-choice voucher to be used on Exchange-based coverage. The FPL for 2010 is \$22,050 for a family of four.

Medicaid eligibility expansion — Beginning in 2014, national Medicaid eligibility will be expanded to those with incomes up to 133% of the federal poverty level (e.g., \$29,000 for a family of four, based on 2009 poverty levels). The federal government will pay the cost associated with these newly eligible Medicaid beneficiaries generally at the following levels:

- 100% for 2014 - 2016
- 95% for in 2017
- 94% for 2018
- 93% for 2019
- 90% for 2020 and later years

States will be required to pay the difference in the cost of those in this newly eligible class of Medicaid beneficiaries. This income-based expansion of Medicaid will not extend to those over age 65 or to those who are entitled to or enrolled in Medicare Part A, or to those enrolled in Medicare Part B.

2018

Excise tax on high-cost health plans — Beginning in 2018, a nondeductible 40% excise tax will apply to the cost of employee health coverage that exceeds a threshold of \$10,200 for single coverage and \$27,500 for family coverage. The tax will be collected from employers (on self-insured coverage) and from insurers (on insured coverage). For retirees and those in designated high-risk professions, the thresholds will be \$11,850 for single coverage and \$30,950 for family coverage. Separate dental and vision coverage is excluded from this determination. However, the cost of coverage for an employee or a family is generally aggregated, such as the cost of a preferred provider organization (PPO) plus an HRA or FSA, or the cost of a high-deductible health plan (HDHP) plus HSA contributions made by an employer or via employee salary reduction. Higher threshold amounts could also apply to employers whose health care costs are higher due to the age or gender of their workers. If health costs increase more rapidly than projected by 2018, an additional adjustment to the thresholds will also be permitted, using the federal employees' health benefit plan Blue Cross Blue Shield standard option as an index.

What's *Not* in the New Law

Employers offering medical benefits to retired former employees will be relieved to hear that the so-called retiree medical vesting provision is not included in the final legislation. This worrisome vesting provision was part of H.R. 3962, the health reform bill that passed the House back in November 2009. However, this vesting provision was not included in either the Senate health reform bill (H.R. 3590) or the reconciliation bill (H.R. 4872).

What's Next?

After the President signs H.R. 3590 into law this week, action will focus on the Senate, which will debate and vote on the reconciliation bill, H.R. 4872. If Senate Democrats succeed in passing the reconciliation bill — perhaps in a week's time — then the President will sign that bill into law, too, thus completing the long journey to the enactment of comprehensive health care reform legislation. For employers, however, the work is just beginning. We expect that most large employers to group their “must address” issues into three categories:

- Immediate: Options for responding to the accounting recognition of the change in tax treatment of the RDS payment and actions related to the federal reinsurance payments for retiree medical coverage
- 2011 compliance and incremental changes: Plan and implement the provisions effective in 2011 and make other incremental program changes as appropriate
- Strategic changes: Changes in the overall program for active, disabled and retired employees to reflect the revised future state

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