



Healthcare Reform in Action

National Association of Regional Councils
Austin, Texas

Date: September 28, 2010
12:15-1:15



American Affordable Health Choice Act/ Patient Protection and Affordable Care Act

Bill signed March 23, 2010

Reconciliation Bill signed March 30, 2010

*Regulations and Interim Regulations are constantly
changing and are constantly being updated*



Post Healthcare Reform Perceptions:

★ **36%** of consumers surveyed think they will be better off as a result of reform.

43% think that they will be worse off.

★ **82%** of consumers think that the cost of the reform bill will be higher than expected.

51% of surveyed adults of 18-34 year olds think that reform bill will reduce healthcare costs.

Harris Interactive for Deloitte Center for Health Solutions, June 2010



Projected Health Spending Impact:

★ **32.5** million people will gain coverage

★ Health Spending is currently at **6.1%**.

From 2013 to 2014, the report says, overall health spending will increase to **9.2%**

The report predicts some workers will pay more out of pocket as employers scale back coverage in 2018 to avoid tax on high-cost plans

Revenue Components

Spending	Revenue
Individuals subsidies, exchanges and related spending: \$464	Medicare Cuts: \$455 Medicare Fee Schedule Updates have not been on the timeline designated for above savings. Providers are fighting the reduction in payment.
Medicaid and children's coverage expansion: \$434 Medicaid Expansion for Texas is identified as a cost of \$24 billion over the next 10 years	Increased Medicare taxes: \$210
Small employer tax credits: \$40	Taxes on insurers, drug manufacturers and medical device sales: \$107
	Employer penalties: \$89
	Other tax increases: \$103
Total: \$938 billion	Total: \$964 billion



6 Month Enactment

ENHANCE

Benefits
that are
offered



EXPAND

Coverage to cover
more people

Health Plan Transition to Healthcare Six Month Compliance Timeline

Bill Signed: March 23, 2010

SideCar/Resolutions Signed: March 30, 2010

Year	Employer	Health Plan	Status Update
Six Month Enactment	Collective Bargaining Agreement and applicable to Grandfather Clause status; applies if 25% of plan participants are members of collective bargaining Applicable to GF Plans	Prohibition on Lifetime Maximum	Impacts Stop Loss Purchase regarding deductible and aggregate stop loss. Special Enrollment Procedures
	Applicable to GF Plans unless individual coverage plans	No Calendar Year Dollar Maximums on <i>Essential</i> Benefits. Defined as ambulatory patient services, emergency services, hospitalization, maternity, newborn care, mental health and substance use disorder services including behavioral health treatment, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management , pediatric services, including oral and vision care .	Currently day/visit limits may apply; usual and customary limitations may apply. HHS defined. "Relying on good faith interpretation at this time 8.5.10". Pediatric services are defined as up to age 21 years.

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Six Month Enactment	Applicable to GF Plans until 2014	Extension of pre-tax coverage up to the age twenty-six (26) for dependents/non-dependents who are not eligible for employer sponsored healthcare benefits. Regardless of marital status, full-time student status or financial support.	Eligible employer sponsored plan is currently in debate, protection of young invincible population. Pre-tax for 2010-2011 Plan Year. Special Enrollment Procedures
	Applicable to GF Plans	Prohibition of pre-existing applied for individuals under the age of nineteen (19)	Insure the Young Invincible Populations

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Six Month Enactment	Not applicable to grandfather plans but in discussion—documents are ambiguous due to definition of wellness benefits included in definition of essential benefits	<p>Preventive/Wellness no covered individual network cost share/US Preventive Services Task Force. Examples of such benefits include:</p> <p>Preventive Services: Colon cancer screenings, prenatal screenings, screenings for diabetes, cholesterol and blood pressure testing and tobacco cessation counseling</p> <p>Routine Vaccines: Immunizations</p> <p>Prevention for Children: Pediatrician visits, vision and hearing screenings, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.</p> <p>Preventive care to Women: to include biennial mammograms at age 40, pap smears at least every three years, genetic counseling for breast cancer risk, screening for osteoporosis in women age 65 and older, breastfeeding education</p> <p>Other: STD, smoking cessation, weight management, evidence based screenings such as: depression, obesity, STD infection, visual impairment, lipid disorders, phenylketonuria, cervical cancer anemia, rubella, HIV, Hep A , syphilis, autism, sickle metabolic and hearing screenings</p>	Interim Regulation, phase in program until 2014. More expensive than originally anticipated. Actuarial Assessment on Cost is 4-7%.

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Six Month Enactment	Not applicable to grandfather plans	<p>Standard Appeal Process (TAT)/maintain data 6 years, stating 24 hour Turnaround Time .</p> <p>I Rules set process for claims appeals:</p> <p>For plan years beginning on or after September 23, (1) must give claimants up to four months to request an external review after an adverse claim or benefit decision. (2) A preliminary review of that request must be conducted within five business days of its receipt (3) Plan must issue a written notification of its decision to the claimant within one business day of completing the preliminary review (4) If the preliminary review finds an external review is needed, the request must be referred to an independent review organization accredited by URAC or similar nationally recognized accrediting organization, which as 45 days to render a final coverage decision. (5) Self-insured plans must contract with at least three accredited review organizations (6) Claimant can request an expedited review for a medical condition that could seriously jeopardize life, health or the ability to regain maximum function IRO must complete an expedited review within 72 hours</p>	<p>Interim Regulations; Individual's eligibility Benefit eligibility Pre-existing exclusion Injury exclusion Network exclusion Experimental, investigational, or not medically necessary Other benefit limitations. Independent Review Organizations certified by TDI to review the utilization reviewer's decision that health care services are not medically necessary or appropriate or that health care services are experimental or investigational. ERO (External Review Organizations, Admin fee \$65.00 plus \$235 hourly review charge.</p>

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Six Month Enactment		Prior-notification for OB-GYN and Emergent Care Prohibited	
	Definitions in Book regarding Emergent and/or Immediate Care— Specialty Physician Benefit	Emergency Care visits (network and non-network) paid at same benefit percentage	

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Six Month Enactment		Prohibits rescission except in case of fraud	Coverage may only be cancelled with prior notice, and clarifies that consistent with current law, a plan may request or require an individual to undergo genetic testing. Current discussion in regards to COBRA and retro terminations due to no payment.
	Not applicable to Grandfather Plans	Prohibition of discrimination based on salary	
	Cost Projections, Claim Utilization, Manual Rates, Tiered Rate Structure ie., employee +1, employee +2 or composite rating	Plans begin transparency protocol	

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June 2010		Premium Review Begins (excluding self-insured) Requires health plans to report the proportion of premium/contribution dollars on clinical services, quality and other costs	
		<ul style="list-style-type: none">• Retiree age 55• Reinsurance Program 80% of eligible claims per retiree between \$15,000-\$90,000	

Patient Protection and Affordable Care Act

Grandfathered Plans

- ▶ Grandfather Status Eligibility **is declined** if Employer/Plan:
 - Eliminates all or substantial benefits
 - Changes to plan structure (such as switching from a health reimbursement arrangement to major medical coverage)
 - Changes in provider network
 - Increases a percentage cost share requirement (such as benefit percentage)
 - Increase copayments
 - Employer decreases contribution rate
 - Increase in Deductible
 - Insurance Company change
 - Changes to prescription drug formulary, and if so, magnitude of changes would be made
 - Any other substantial changes to eligible benefits

Federal Health Care Reform

- Healthcare Reform Mandates **not applicable** to Grandfathered plans
 - Discrimination on health status
 - Coverage for eligible services within clinical trials
 - Fair health insurance premiums
 - Guaranteed availability of coverage
 - Guaranteed renewability of coverage
 - Prohibition on discrimination on highly compensated individuals
 - No discrimination against highly compensated employees
 - Ensuring quality of care
 - Appeals Process
 - Emergency Services
 - Patient protections
 - **Non-Essential** Wellness Benefits (ambiguous language)

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Year	Employer	Health Plan	Status Update
2011		<ul style="list-style-type: none"> • Higher penalty for Health Savings Accounts • 10% to 20% cash out penalty 	
			Part D discounts on brand-name and generic drugs in doughnut hole for retirees in Prescription Drug Plan
			Medicare Advantage reimbursements for 2011 are frozen at 2010 levels —Medicare Advantage reimbursements will decrease over several years
		Standard Format Guidelines (must comply 24 months of enactment)	Not released yet
		Over the Counter Medications paid under Section 125 must have prescription	

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2012	2011 Employer W-2 reporting benefit coverage		
		<ul style="list-style-type: none"> • \$1.00 PPPM for comparative effectiveness research 2012-2019 - \$2.00 indexed • Sunset in 2019 	
	Not applicable to GF Plans	Plans to begin reporting on quality and health outcomes	
	Note Tax Exempt requirement of 50% of excess	Requires health plans to provide rebates to consumers for the amount of the premium/contribution that has a Medical Loss Ratio less than 85% for plans in large group market and 80% in individual/small group market (50% for tax exempt; 100% for others)	Facts published by Price, Waterhouse, Coopers found that 87% of all premium dollars collected are being spent on care. The other 13% is not pure profit. $\frac{3}{4}$ of increase in healthcare costs were driven by provider costs, administrative costs and 25% of paid claims in reserve , disease management , electronic transactions

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2012		Employer notice to employees about Health Insurance Exchange	7.29.10 \$1,000,000.00 in grant money for States to use for exchange development
2013		Limits contributions to employee health FSA's to \$2,500 per year	Retiree Part D Drug Subsidy (RDS) is taxable starting in 2013 (most government entities are not taxable)
2014	STATE EXCHANGE Benefit Plans <i>(for employers with 50 or more employees)</i>		
			Medicaid Expansion/Legal Suites have been submitted Texas is identified as a cost of \$24 billion over the next 10 years.
		Prohibited waiting periods in excess of 90 days	

Action Items

STATE EXCHANGE BENEFIT PLANS

ACTUARIAL EQUIVALENCY 2014

PLATINUM	GOLD	SILVER	BRONZE
Deductible \$1000	Deductible \$1250	Deductible \$1500	Deductible \$1750
Out of Pocket Maximum \$5,000			
90% Network	80% Network	70% Network	60% Network
70% OON	60% OON	50% OON	40% OON

- Out of pocket accumulation
- Maximum allowable amount

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2014	Employer mandate penalties begins for employers with 50 or more employees		<ul style="list-style-type: none"> • Requires individual to purchase health coverage beginning in 2014, phasing in penalties • 2014 penalty is the lower of \$95 per individual per year or 1% of total incomes • 2015 penalty is the lower of \$395 per individual per year or 2.0% of total income • 2016 penalty is the lower of \$695 per individual, up to maximum of three times that for families, per year or 2.5% of household income • Exemptions exist for financial hardship if lowest plan offered exceeds 8.0% of individual income
		Prohibition on exclusions based on pre-existing conditions for all enrollees	
		40% Excise Tax on high-cost plans; Excise Tax 40% \$10,000 individuals, \$27,500 families, \$11,850 for retirees and \$30,950 for employees in high-risk professions, such as police and fire	

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2014	<ul style="list-style-type: none"> • Employer <i>Free Rider</i> Penalty - applies to employers with 50 or more employees, including public sector employers; must aggregate hours of part-time employees to create total number of employees with subtraction of first 30 workers when paying assessment • If employer does not offer coverage (and one employee receives a tax credit in the Exchange) Penalty is \$2,000 times the total # of full-time employees (2080 hours) • If employer does offer coverage but coverage is unaffordable or value less than 60% of plan costs (and one employee receives a tax credit in the Exchange). Penalty is \$3,000 times # of full-time employees getting tax credit in Exchange 		<ul style="list-style-type: none"> • <i>Free-choice Vouchers</i> - vouchers offered if employees with incomes less than 400% of the Federal Poverty Level if contributions for employer plan or 8-9.8% of employees household income (8.5.10 defined as employer payroll) and employee does not enroll in employer plan • Vouchers are equal to amount employer would have provided toward employee's coverage • Employers pay vouchers to exchange; if coverage through Exchange is less than voucher amount, Exchange pays different to employee

Low Income- Free Choice Vouchers

Family Size	100% of Federal Poverty Level (FPL)	133% FPL	200% FPL	300% FPL	400% FPL
1	\$10,830	\$14,440	\$21,660	\$32,490	\$43,320
2	\$14,570	\$19,427	\$29,140	\$43,710	\$58,280
3	\$18,310	\$24,413	\$36,620	\$54,930	\$73,240
4	\$22,050	\$29,400	\$44,100	\$66,150	\$88,200
5	\$25,790	\$34,387	\$51,580	\$77,370	\$103,160
6	\$29,530	\$39,373	\$59,060	\$88,590	\$118,120

All figures represent annual household income

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2014	<ul style="list-style-type: none"> ▪ Eligible small businesses purchasing coverage through the state Exchange tax credit of up to 50% of the employers contribution is provided, if the employers contributes at least 50% of the total premium/contribution amount ▪ Credits will be available for two years, full credit will be available to employers with 10 or fewer employees and average annual wages less than \$25,000 ▪ Tax exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of their contribution toward employee health insurance premiums/contributions 		
		Prohibition based on health status	
		Guaranteed availability and renewability	27

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2015		Plans to certify compliance with HIPAA <i>EDI standards</i>	
2017		States may allow employers with more than 100 employees to purchase coverage in the Exchange	
2018		40% Excise tax on high-cost plans: ✓ Medical FSAs ✓ HRAs ✓ HSAs—excludes dental and vision	Concern if this will be implemented noted on 8.5.10
2020			Close Medicare Doughnut hole

Department of Health and Human Services

➤ Mail

- Office of Consumer Information and Insurance Oversight
- Department of Health and Human Services
- Attention: OCIIO-9991-IFC
- PO Box 8016
- Baltimore, MD 21244-1850

➤ Electronic Submission: <http://www.regulations.gov>

➤ Overnight Mail

- Department of Health and Human Services
- Attention: OCIIO-9991-IFC
- Mail Stop C4-26-05
- 7500 Security Boulevard
- Baltimore, MD 21244-1850



Political Subdivision Purchasing Cooperative (PEBA)

www.buypeba.org

*Texas is in Discussion with Other States for Political
Subdivision Purchasing Strength*

Resources



Flex, Section 125



Prohibition on Lifetime Max



Grandfathered Plans



No cost Preventive Benefits



Benefit Appeal Timelines



HIPAA opt-out Provisions



Thank You!

Brett Bowers, MBA

Marketing Manager, TML IEBP

(512) 719-6500

brett.bowers@tmliebp.org

www.tmliebp.org – Healthcare Reform Pamphlet

www.buypeba.org- Healthcare Reform Resources



Have a Great Day!