

Health Care Reform: What You Need to Know

Marc Boutin
**Executive Vice President &
Chief Operating Officer**

May 2010



Campaign to Put Patients First

GOAL: Engage individuals in a nationwide effort to create and implement a modern health care system, based on 5 Principles for Putting Patients First®

- Cover Everyone
- Curb Costs Responsibly
- Abolish Exclusions for Pre-existing Conditions
- Eliminate Lifetime Caps on Benefits
- Ensure Access to Long-term and End-of-life Care

Patient Protection & Affordable Care Act + 5 Principles

<i>Putting Patients First</i>[®] Principles	What's In the Act
Achieves Health Care Coverage for Everyone	Requires states to establish an exchange for the individual market and separately for the small group market by 2014.
	Authorizes \$6 billion in funding for a CO-OP program to serve individuals in one or more states and compete in the reformed individual and small group markets.
	Qualified Health Benefits Plans must cover a list of Essential Health Benefits.
	Requires the Secretary to define and update at least annually the categories of covered treatments, items, and services within benefit classes for individual plans.
	Benefits standards are a floor and do not pre-empt state mandates, however states must make payments to cover the cost of additional benefits directly to individuals or plans, not to exchanges.
	Individual mandate exempts individuals who cannot afford coverage and individuals with incomes below the tax filing threshold.
	Effective December 31, 2013.

Patient Protection & Affordable Care Act + 5 Principles

Putting Patients First[®] Principles	What's In the Act
Curbs Costs Responsibly	Requires Secretary to develop a national quality improvement strategy by January 1, 2011.
	Requires the President to convene an Interagency Working Group on Health to coordinate Federal implementation of the national quality strategy.
	Allocates \$20 million (FY 2010-2014) to the AHRQ Director to establish a Center for Quality Improvement and Patient Safety.
	Eliminates cost sharing for covered preventive services, effective 6 months after enactment.
	Narrows the size of the Part D coverage gap so that there is 25% cost-sharing for non-low income subsidy beneficiaries after the deductible until catastrophic coverage.
	Provides \$95 million annually 2010 to 2014 for quality measure development, dissemination, endorsement, and review.
	Requires the Secretary to determine quality measure gaps at least triennially, in consultation with the AHRQ Director, and provide grants for the prioritization and development of measures to fill the identified gaps.
	Creates a new Center for Medicare and Medicaid Innovation within CMS to test innovative payment and service delivery models in Medicare and Medicaid by January 1, 2011.
	Permits Secretary to grant funds to state or state-designated entities to implement multidisciplinary "Health Teams" to support implementation of the patient-centered medical home model.

Patient Protection & Affordable Care Act + 5 Principles

<i>Putting Patients First</i> [®] Principles	What's In the Act
Curbs Costs Responsibly	Requires the Secretary to establish a Medicare Shared Saving (i.e., ACO) program that promotes accountability for a patient population and coordinates services under Medicare Parts A and B starting January 1, 2012.
	Requires the Secretary to conduct a pilot program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services for chronically ill Medicare beneficiaries.
	Requires Secretary to contract (“as soon as practicable” after law enactment) with an entity to develop over 18 months standards for certifying patient decision aids .
	Establishes a grant program to develop, update, implement, and evaluate patient decision aids (educational pamphlets, videos, etc.) on improving patient understanding and decision-making of treatment options.
	Eliminates cost sharing for covered preventive services, effective 6 months after enactment.
	Expands Medicare and Medicaid coverage of preventive services to include: any clinical preventive service recommended with a grade of A or B by the USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices. Effective January 1, 2013.
	Allows the Secretary to award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

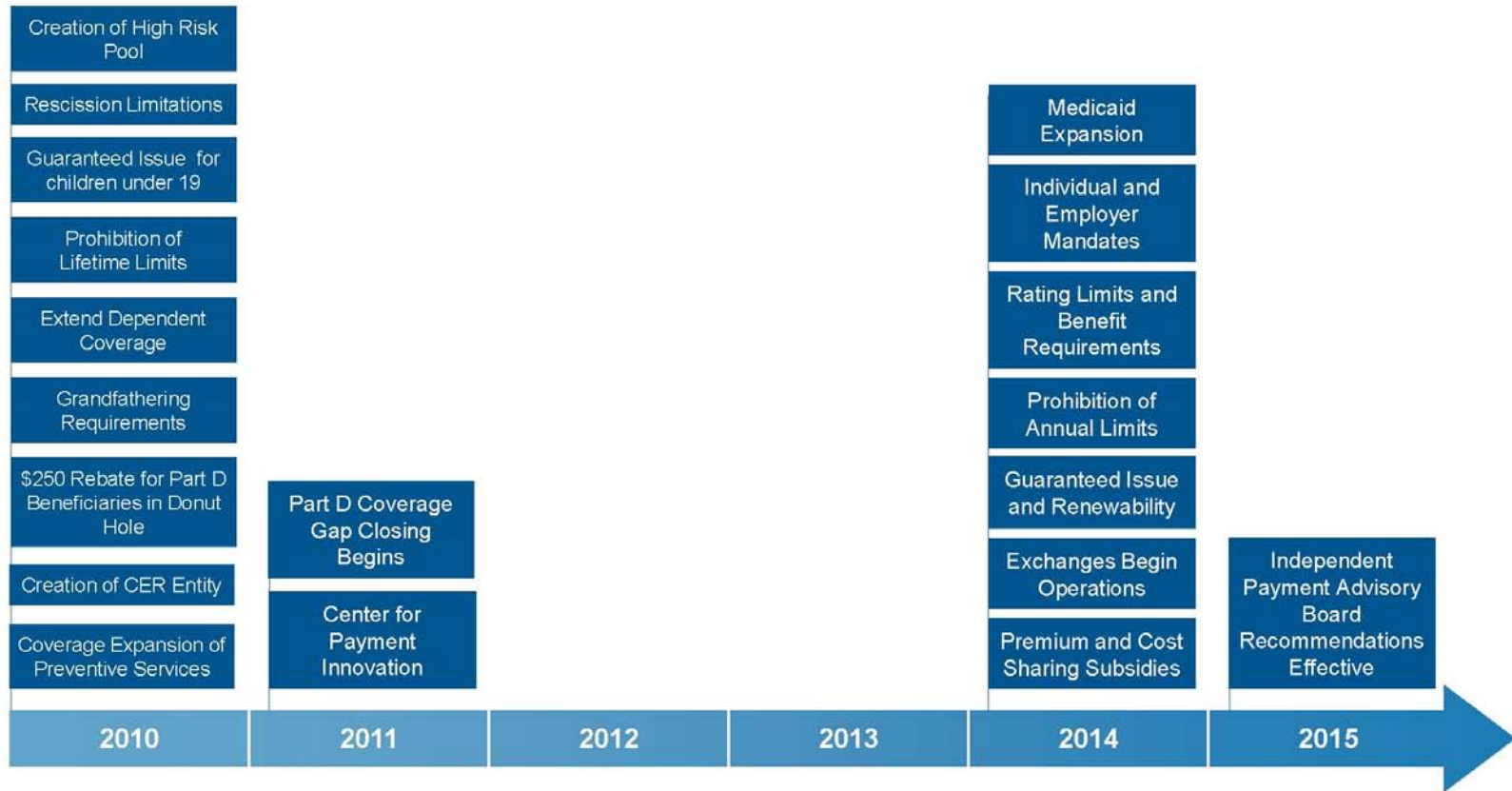
Patient Protection & Affordable Care Act + 5 Principles

<i>Putting Patients First</i>[®] Principles	What's In the Act
Guarantees Coverage Despite Pre-existing Conditions	Requires all plans to issue coverage to those seeking it, prohibits pre-existing condition exclusion, effective January 1, 2014
	Prohibits pre-existing condition exclusions for children under 19 years old, beginning 6 months after enactment
	Provides \$5 billion to establish within 90 days of enactment a temporary high-risk pool for uninsured individuals who have been denied coverage due to a pre-existing condition
	Requires guarantee issue renewability, effective January 1, 2014.
	Prohibits health plans from rescinding coverage except in the case of clear and convincing evidence of fraud, effective 6 months after enactment.
	Prohibits employers from limiting coverage eligibility based on employee salary, effective 6 months after enactment.
	Prohibits insurers from dropping or denying coverage for individuals participating in approved clinical trials.
	Requires modified community rating allowing insurers to vary premiums based only on certain criteria. Effective January 1, 2014
	Rating requirements in the large-group market apply only to fully-insured groups, not self-insured groups.

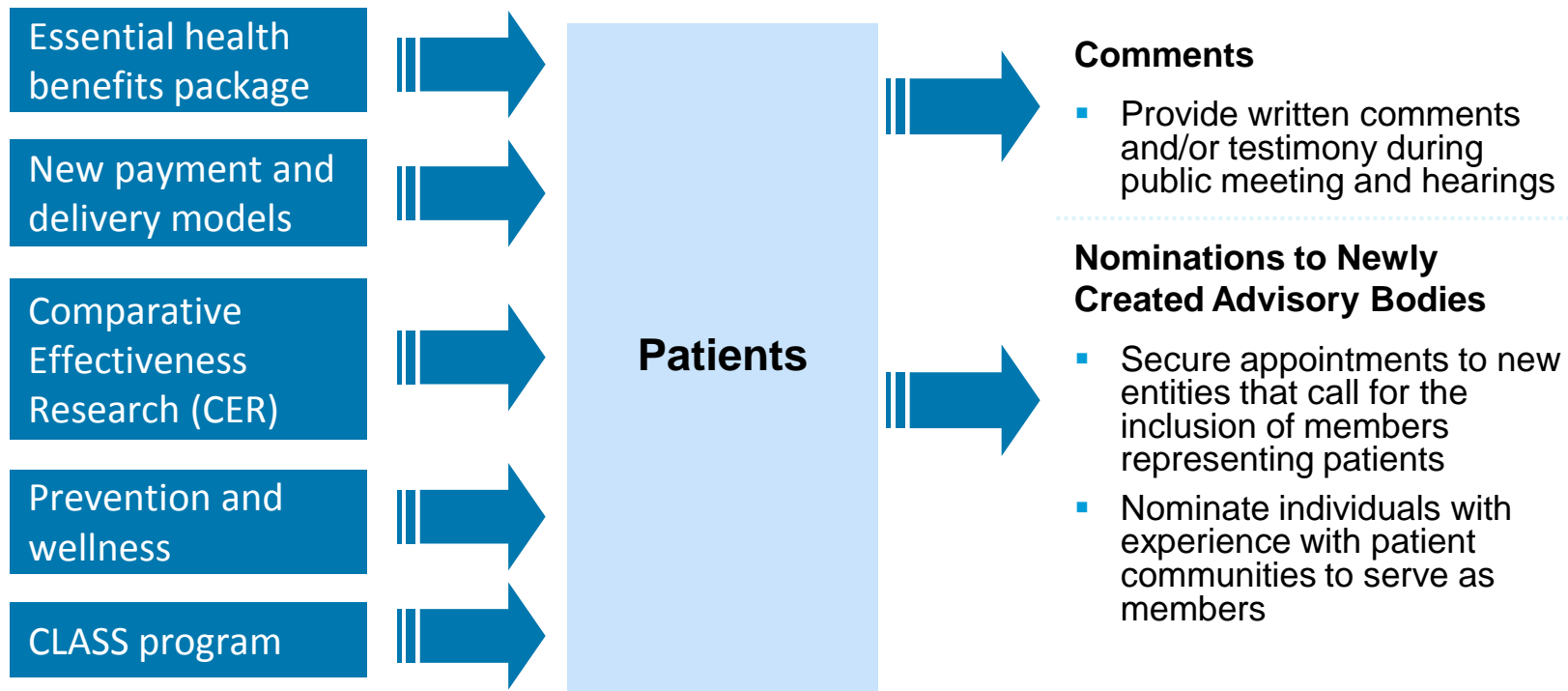
Patient Protection & Affordable Care Act + 5 Principles

<p><i>Putting Patients First</i>® Principles</p>	<p>What's In the Act</p>
<p>Eliminates Lifetime Caps on Health Insurance</p>	<p>Prohibits all plans from establishing lifetime and or annual limits on the dollar value of coverage beginning in 2014.</p>
	<p>Prior to 2014, plans cannot have lifetime limits and may only apply annual limits on the dollar value of coverage as approved by the Secretary.</p>
<p>Ensures Access to Quality Long-Term and End-of-Life Care</p>	<p>Establishes Community Living Assistance Services and Supports (CLASS) program - a voluntary, opt-out, national insurance program. Financed by enrollee premiums.</p>
	<p>Provides a lifetime cash benefit for enrollees who have paid premiums for five years and meet disability criteria.</p>
	<p>Establishes an Elder Justice Coordinating Council to recommend to the Secretary possible actions aimed at preventing the abuse, neglect and exploitation of elders. Also establishes an Advisory Board on Elder Abuse, Neglect, and Exploitation to make multi-disciplinary strategic plans to make improvements in the long-term care of elders and to make recommendations to the Coordinating Council.</p>
	<p>Directs the Secretary to carry-out activities to improve the long-term care delivery system.</p>

Timeline for Implementation



Patients' Opportunity for Impact on Systemic Issues



Regulation Process: Opportunities for Input

Federal Rulemaking Process

Request for Comments:

Agencies invite public comment to aid in the development of regulations

Subject to review by:

- Agency
- Department
- OMB

Proposed Rule:

Agencies issue Notice of Proposed Rulemaking Notice (NPRM)

Subject to review by:

- Agency
- Department
- OMB

Public Comment Period:

NPRM must be published in Federal Register, triggering a 60-day comment period

Final Rule:

Published in the Federal Register

Subject to review by:

- Agency
- Department
- OMB

The NHC's Priorities

Essential Health Benefits

Health care reform creates 10 categories of essential benefits that all plans must cover:

- HHS Secretary is required to define and update the categories of covered treatments, items, and services in a transparent process that allows for public comment

The NHC's Priorities

Delivery Reform

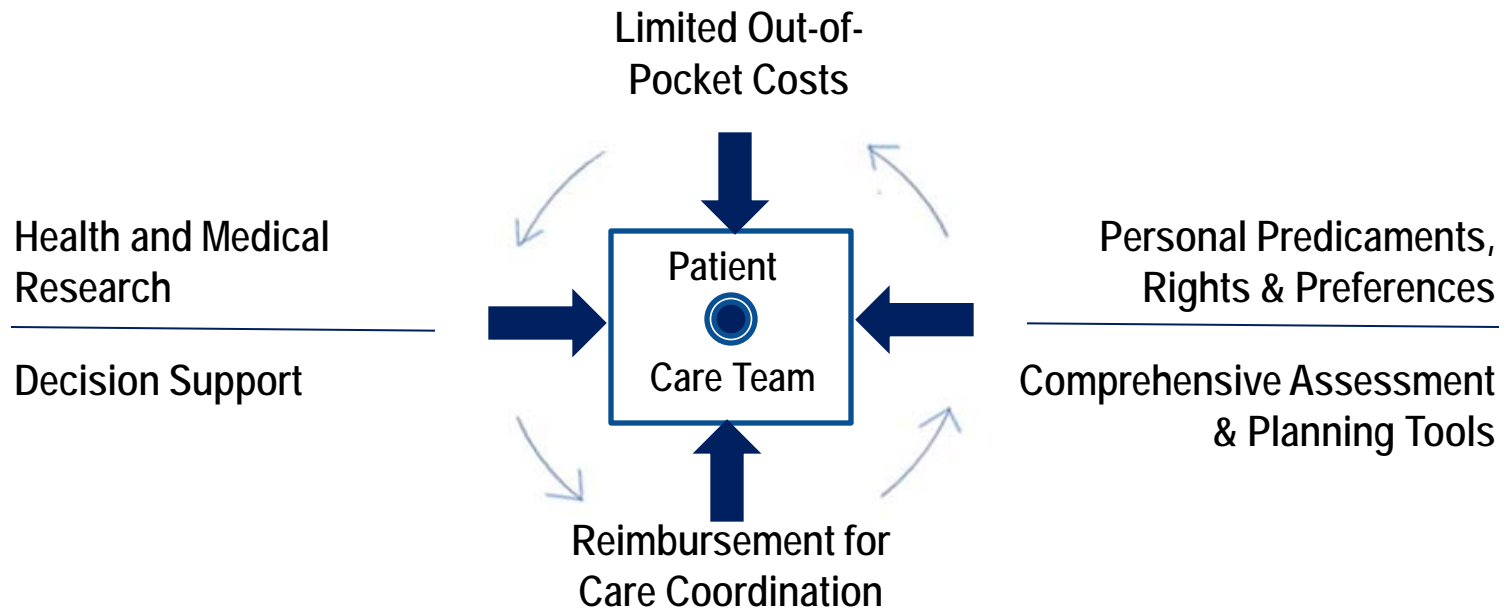
Two new entities will be created to promote new payment and delivery models that improve care and lower costs

- Center for Medicare and Medicaid Payment Innovation
 - » Required to use open door forums or other mechanisms to seek stakeholder input

- Independent Payment Advisory Board
 - » Membership in the 15-member board must include representatives of consumers
 - » Consumer Advisory Council created to advise Board on impact of payment policies on consumers

Health Care Delivery System Reform

Getting the right care at the right time to the right patient for the right price – Institute of Medicine



The NHC's Priorities

Comparative Effectiveness Research

Patient-Centered Outcomes Research Institute will be established to conduct CER

- Patients or their representatives will be appointed to the Board of Governors (3 seats) and Expert Advisory Panels
- Nominations to the Methodology Committee will be solicited from the public
- Numerous opportunities will exist for the public to comment on the research agenda and conduct of research

Areas of Focus: Prevention and Wellness

Prevention and Wellness

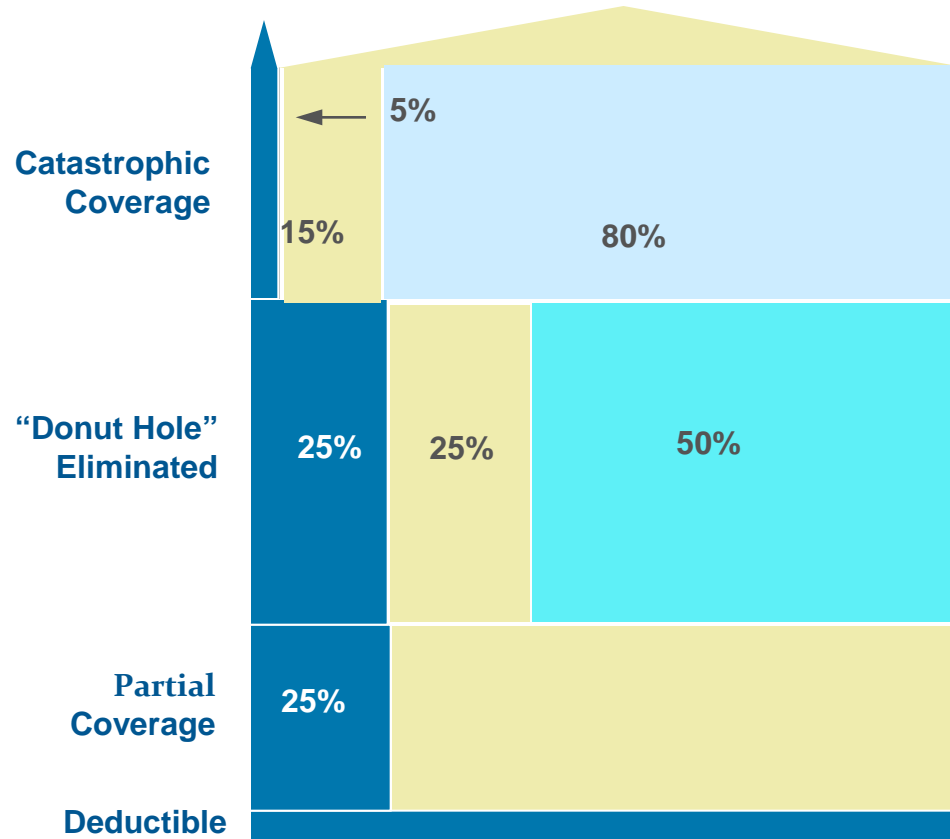
Provisions

- Eliminates cost sharing for preventive services covered in the essential benefits package
- Expands Medicare and Medicaid coverage of preventive services to include: any clinical preventive service recommended with a grade of A or B by the USPSTF, immunizations recommended by the Advisory Committee on Immunization Practices
- Establishes National Prevention, Health Promotion, and Public Health Council (NPHPPHC)

Potential Points of Engagement

- US Preventive Services Task Force (USPSTF) recommendations will carry greater weight in CMS coverage decision making process
 - Nominations solicited annually. Members of USPSTF are generally primary care clinicians.
 - USPSTF also encourages public input through public comment periods
- NPHPPHC must obtain input from relevant stakeholders, as well as establish processes for continual public input
 - Advisory Group to Council consists of 25 non-Federal members appointed by the President and to include diverse group of licensed health professionals

Areas of Focus: Medicare Part D by 2020



Beneficiary Cost-Share
 Plan
 Manufacturer Discount
 Government Payment

Areas of Focus: Cures Action Network (CAN)

Cures Acceleration Network

Provisions

Establishes Cures Acceleration Network under NIH to accelerate the development of high-need cures

Potential Points of Engagement

NIH will award contracts or grants to promote innovation and accelerate development

- Eligible entities include disease advocacy and patient advocacy organizations

Areas of Focus: Quality Measurement

Quality Measurement

Provisions

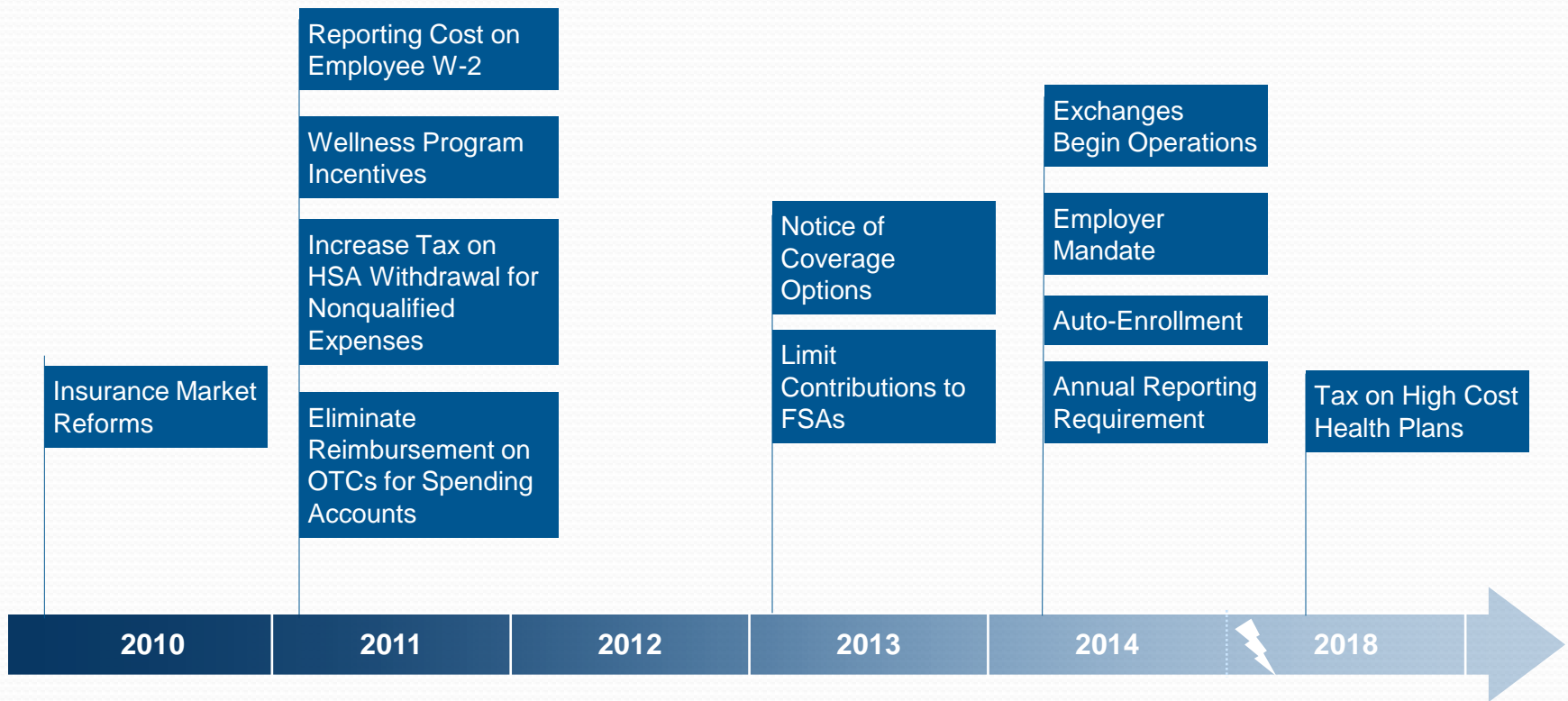
Provides for \$95 million annually for quality measure development during 2010-2014

Potential Points of Engagement

Multi-stakeholder group will be convened to provide input on the selection of quality measures and national priorities

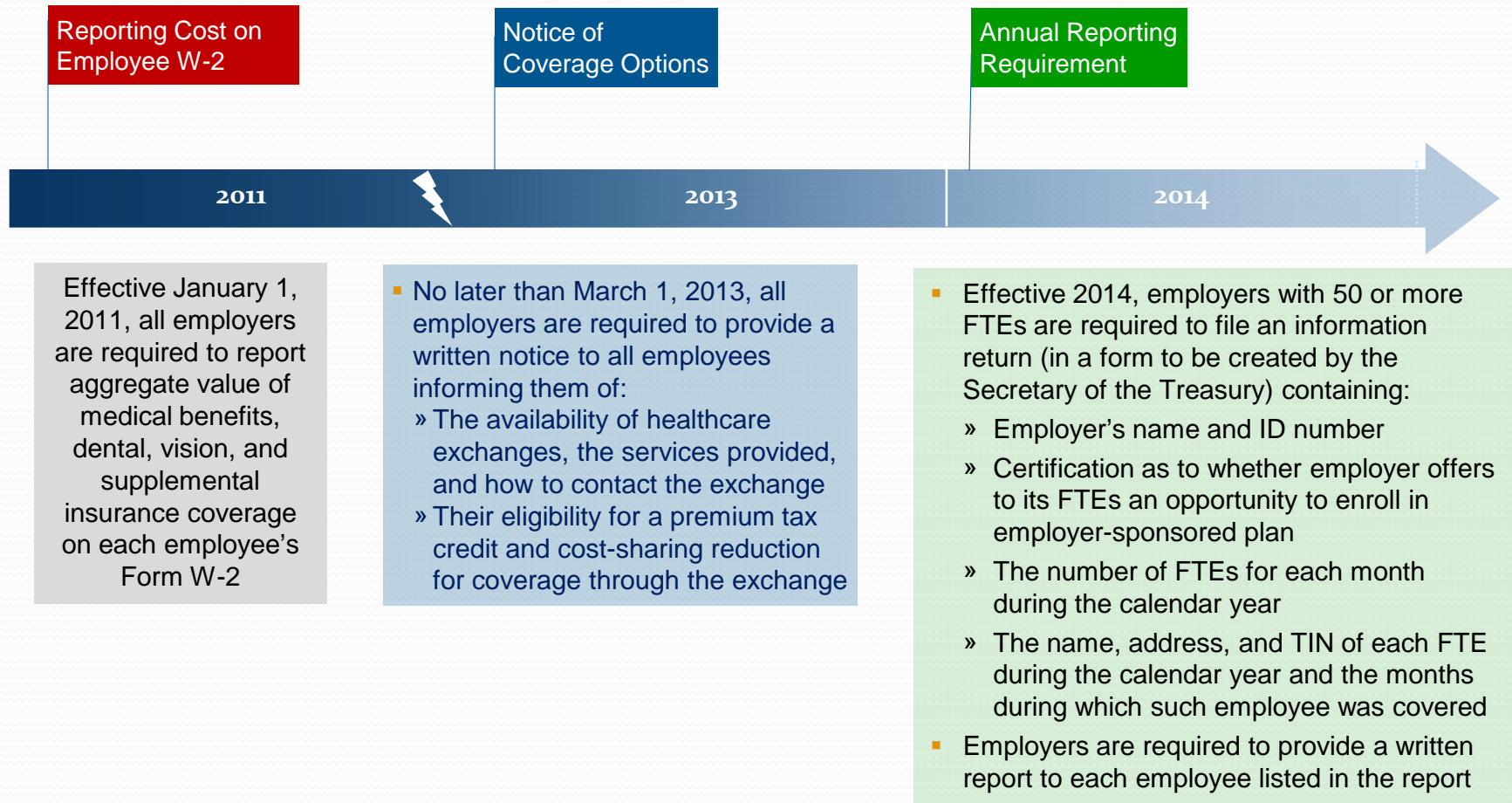
- National Quality Forum likely to play a role in convening this group

Requirements on Employers



FSA = Flexible spending arrangement
HSA = Health savings accounts
OTC= Over-the-counter (medication)

New Employer Reporting Requirements



Provisions Beginning in 2010

Insurance Market Reform Provisions	Applies to Grandfathered Plans
Prohibits pre-existing condition exclusions for children under 19 years old	✓
Prohibits health plans from rescinding coverage except in the case of fraud.	✓
Prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage.	✓
Prior to 2014, allows plans to only impose annual limits on the dollar value of coverage as determined by the Secretary.	✓
Requires coverage of dependents up to age 26. Definition of dependent is left to the discretion of the Secretary.	✓
Eliminates cost-sharing for covered preventive services. Services include those with a USPSTF A or B rating; immunizations recommended by ACIP, children's services in the HRSA guidelines, and women's preventive services in the HRSA guidelines.	
Prohibits limitations on waiting periods	✓
Prohibits employers from limiting coverage eligibility based on employee salary	✓

Provisions Beginning in 2011

Provision	Details	Impact
Reporting Cost on Employee W-2	<ul style="list-style-type: none"> Requires employers to report aggregate value of medical benefits, dental, vision, and supplemental insurance coverage on each employee's Form W-2* 	<ul style="list-style-type: none"> New reporting requirement
Wellness Program Incentives	<ul style="list-style-type: none"> Allows employers to reduce premiums by up to 30 percent to reward employee participation in wellness programs <ul style="list-style-type: none"> » The Secretary may increase the available reward to up to 50 percent if deemed appropriate 	<ul style="list-style-type: none"> Option to offer premium discounts linked to wellness
Increase Tax on HSA Withdrawal for Non Qualified Expenses	<ul style="list-style-type: none"> Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10% to 20%* The additional tax for Archer Medical Savings Account withdrawals not used for qualified medical expenses would increase from 15% to 20%* 	<ul style="list-style-type: none"> Could impact employees
Eliminate Reimbursement on OTCs for Spending Accounts	<ul style="list-style-type: none"> Eliminates reimbursement for over-the-counter medications from HSAs, FSAs, or HRAs beginning in 2011 	<ul style="list-style-type: none"> Program changes required

*Beginning January 1, 2011

HSA – Health savings account; FSA – Flexible spending account, HRA – Health reimbursement arrangement

Provisions Beginning in 2013

Provision	Details	Impact
Notice of Coverage Options	<ul style="list-style-type: none"> ■ No later than March 1, 2013, requires employers to provide a written notice to all employees informing employees: <ul style="list-style-type: none"> » That healthcare exchanges are available, the services provided by the exchange, and how to contact the exchange » If the employer pays less than 60% of the costs of benefits, the employee may be eligible for a premium tax credit and cost-sharing reduction for coverage through the exchange » If the employee purchases coverage through the exchange, all or a portion of the contribution that would otherwise be paid by the employer for health benefits is excluded from the employee's federal tax income liability. 	<ul style="list-style-type: none"> ■ New reporting requirement
Limit FSA contributions	<ul style="list-style-type: none"> ■ Limits tax-deductible contributions to health flexible spending arrangements to \$2,500 per employee, per year beginning in 2013 	<ul style="list-style-type: none"> ■ Need to cap employee contributions

Provisions Beginning in 2014

Provision	Details	Impact
Establishing State Exchanges	<ul style="list-style-type: none">▪ Requires each state to establish an exchange for individual market and separately for small group market by 2014▪ Allows states to form regional or interstate exchanges, subject to approval by Secretary	<ul style="list-style-type: none">▪ Creates new options for purchasing individual coverage
Employer Eligibility	<ul style="list-style-type: none">▪ Requires states to allow small businesses with up to 100 employees to purchase coverage through the small employer exchange<ul style="list-style-type: none">» States may allow employers with more than 100 employees into the state exchange in 2017» For plan years before January 1, 2016, a state may limit the small group market to 50 employees	<ul style="list-style-type: none">▪ Exchange coverage may offer more options to employees

Employer Coverage Mandate & Auto-Enrollment Requirements - 2014

Provision	Details	Impact
Employer Mandate	<ul style="list-style-type: none"> ■ Sets penalties, effective December 31, 2013, as follows: <ul style="list-style-type: none"> » For employers that offer coverage, fee will be lesser of \$3,000/employee receiving tax credit or \$2,000/full-time worker » For employers that do not offer coverage, fee will be \$2,000/full-time worker » For purposes of calculating total penalty, number of full-time employees is reduced by 30 	<ul style="list-style-type: none"> ■ Could face new fees if low-wage workers receive tax credits via the exchange
Auto-Enrollment	<ul style="list-style-type: none"> ■ Requires employers with 200 employees or more to auto-enroll employees in employer coverage, but allows employees to opt out if they can show proof of other coverage 	<ul style="list-style-type: none"> ■ New procedural requirement

Annual Reporting of Employee Benefits - 2014

Provision	Details	Impact
Annual Reporting Requirement	<ul style="list-style-type: none">▪ Effective 2014, requires employers of 50 or more FTEs to file an information return (in a form to be established by the Secretary of the Treasury) containing:<ul style="list-style-type: none">» Employer's name and ID number» Certification as to whether employer offers to its FTEs an opportunity to enroll in employer-sponsored plan» The number of FTEs for each month during the calendar year» The name, address, and TIN of each FTE during the calendar year and the months during which such employee was covered▪ Requires employer to provide a written report to each employee listed in the report▪ Report due to employee by January 31 of the year following the year for which the return is required to be submitted	<ul style="list-style-type: none">▪ New reporting requirement

Excise Tax on High-Cost Health Care Plans - 2018

Provision	Details	Impact
Tax on High Cost Health Plans	<ul style="list-style-type: none">■ Imposes an excise tax on employer health insurance plans that offer policies with generous levels of coverage<ul style="list-style-type: none">» The tax would be levied on group health insurance plans as well as plan administrators for self-insured companies■ Tax is equal to 40% of the plan's value that exceeds \$10,200 for an individual and \$27,000 for family coverage, beginning in 2018<ul style="list-style-type: none">» For example, if a given plan is worth \$15,000 for an individual in 2018, the difference between the plan cost (\$15,000) and the threshold amount (\$10,200) is \$4,800» The insurer would pay a tax equal to 40 percent of the difference, or \$1,920■ Threshold will increase beginning in 2019 by the cost-of-living adjustment plus 1%■ Imposes a penalty for employers that under-report excise tax liability to insurers<ul style="list-style-type: none">» The penalty is equal to the difference between the actual and reported liability amount, plus interest from the date the tax was due to the date paid by the employer	<ul style="list-style-type: none">■ May want to reduce coverage below taxable thresholds beginning in 2018

Employer Mandate Penalties – 2014

- Employers with fewer than 50 employees are exempt from the mandate
- Employer with an average of 50 or more full-time employees (FTEs*) during the preceding calendar year that
 - » does not offer coverage for all its full-time employees and their dependents;
 - » offers minimum essential coverage that is unaffordable (i.e., the employee's required contribution to the cost of premiums is more than 9.5% of the employee's household); or
 - » offers minimum essential coverage that is unacceptable (i.e., a plan under which the plan's share of the total allowed cost of benefits is less than 60%)

Employer is required to pay a penalty if any FTE purchases health insurance through an exchange with the aid of either the premium tax credit or cost-sharing subsidy

*FTEs are defined as those who work for any month an average of 30 hours per week

Employer Mandate Penalties By Who Does/Does Not Offer Coverage – 2014

If at least one employee purchases health insurance through an exchange with a subsidy, the employer must pay:	
For a 50+ employer that <u>does not</u> offer coverage	<ul style="list-style-type: none">▪ A penalty (non-deductible) each month equal to the number of full-time employees over a 30-employee threshold during the month multiplied by one-twelfth of \$2,000 (the amount will be indexed to premium cost growth)▪ For example, an employer with 50 FTEs that does not offer coverage for an entire year and that employs one or more employees who buys coverage through an exchange with the help of a subsidy will owe the IRS: (50-30) times \$2000, or \$40,000
For a 50+ employer that <u>does</u> offer coverage	<ul style="list-style-type: none">▪ The lesser of:<ul style="list-style-type: none">» \$2,000 per year times the number of FTEs minus 30, or» \$3,000 per year for each FTE who buys coverage through an exchange with a subsidy because the employer-offered coverage is unaffordable or unacceptable▪ For example, an employer with 50 FTEs that offers coverage that is unaffordable for 10 employees who then buy coverage through an exchange with a subsidy will owe the IRS \$30,000: the lesser of [(50-30) times \$2000] and [10 times \$3000]

Employer Mandate – Additional Details

- Non-profit organizations are not exempt from the employer mandate
- An employer is not required to pay a penalty for any employees enrolled in Medicaid
- There is no mandate to cover part-time employees or penalty for not offering them coverage
- The Secretary of HHS and the Secretary of Labor will issue regulations and guidance on details of implementation and interstitial issues, such as how to treat employees with more than one 30 hour per week job

Personal Health Accounts

Effective Date	Provision	Details	Impact
2011	Eliminate Reimbursement on OTCs for Spending Accounts	<ul style="list-style-type: none"> Eliminates reimbursement for over-the-counter medications from HSAs, FSAs, or HRAs beginning in 2011 	<ul style="list-style-type: none"> Program changes required
2011	Increase Tax on HSA Withdrawal for Non Qualified Expenses	<ul style="list-style-type: none"> Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10% to 20% The additional tax for Archer Medical Savings Account withdrawals not used for qualified medical expenses would increase from 15% to 20% 	<ul style="list-style-type: none"> Could impact employees
2013	Limit FSA contributions	<ul style="list-style-type: none"> Limits tax-deductible contributions to health flexible spending arrangements to \$2,500 per employee, per year beginning in 2013 	<ul style="list-style-type: none"> Need to cap employee contributions

FSA – Flexible spending account
HSA – Health spending account

HRA – Health reimbursement arrangement
OTC – Over the counter

Other Health Provisions Affecting Employers

Effective Date	Provision	Details	Impact
2011	Wellness Program Incentives	<ul style="list-style-type: none"> Allows employers to reduce premiums by up to 30 percent to reward employee participation in wellness programs <ul style="list-style-type: none"> » The Secretary may increase the available reward to up to 50 percent if deemed appropriate 	<ul style="list-style-type: none"> Option to offer premium discounts linked to wellness
2014	Auto-Enrollment	<ul style="list-style-type: none"> Requires employers with 200 employees or more to auto-enroll employees in employer coverage, but allows employees to opt out if they can show proof of other coverage 	<ul style="list-style-type: none"> New procedural requirement
2014	State Exchanges and Employer Eligibility	<ul style="list-style-type: none"> States required to establish an exchange for individual market and for small group market (up to 100 in size) <ul style="list-style-type: none"> » Beginning in 2017, states may allow employers with more than 100 employees into the state exchange 	<ul style="list-style-type: none"> Exchange coverage may offer more options to employees



Marc Boutin
Executive Vice President &
Chief Operating Officer

mboutin@nhcouncil.org
May 2010