



NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS



NEW NATIONAL HEALTH INSURANCE LAW

What It Means For You and Your Clients

TIMELINE (Revised 4/13/10)

Following is a list of reforms based on effective dates.

2010

- States and Federal officials review premium increases (self-insured plans excluded)
- Establishes federal grant program for small employers providing wellness programs
- Provide income exclusion for specified Indian tribe health benefits provided after 3/23/10
- Temporary high-risk pool and high-cost union retiree reinsurance (\$5 B each for 3.5 years) (6/23/10)
- Impose 10% tax on indoor UV tanning (7/1/10)
- Medicare cuts to inpatient psych hospitals (7/1/10)
- Prohibits lifetime and annual benefit spending limits (plan years beginning 9/23/10)
- Prohibits non-group plans from canceling coverage (rescissions) (plan years beginning 9/23/10)
- Requires plans to cover, at no charge, most preventive care (plan years beginning 9/23/10)
- Allows dependents to stay on parents' policies through age 26 (plan years beginning 9/23/10)
- Provides limited protections to children with pre-existing conditions (plan years beginning 9/23/10)
- Hospitals in "Frontier States" (ND, MT, WY, SD, UT) receive higher Medicare payments (FY11)
- Hospitals in "low-cost" areas receive higher Medicare payments for 2 yrs (\$400 million, FY11)
- FDA authorized to approve "follow-on" biologics
- Increase brand name pharmaceutical Medicaid rebate (from 15.1% to 23.1%)
- Medicare payments to physicians in primarily rural areas increase (2 years)
- Tax credits provided to certain small employers for health care-related expenses
- Increase adoption tax incentives for 2 years

2011

- Medicare Advantage cuts begin
- No longer allowed to use FSA, HSA, HRA, Archer MSA distributions for over-the counter medicines
- Small employers (under 100 lives) allowed to adopt new "Simple Cafeteria Plans"
- Medicare cuts to home health begin
- Wealthier seniors (\$85k/\$170k) begin paying higher Part D premiums (not indexed for inflation in Parts B/D)
- Medicare reimbursement cuts when seniors use diagnostic imaging like MRIs, CT scans, etc.
- Medicare cuts begin to ambulance services, ASCs, diagnostic labs, and durable medical equipment
- Impose new annual tax (based on annual sales) on brand name pharmaceutical companies
- DOL begins annual studies on self-insured plans using Form 5500 data
- Americans begin paying premiums for federal long-term care insurance (CLASS Act)
- Employers must enroll workers in CLASS Act, unless employee opts out
- Health plans required to spend a minimum of 80% of premiums on medical claims
- Physicians in "Frontier States" (ND, MT, WY, SD, UT) receive higher Medicare payments
- Prohibition on Medicare payments to new physician-owned hospitals
- Penalties for non-qualified HSA and Archer MSA distributions double (to 20%)
- Seniors prohibited from purchasing power wheelchairs unless they first rent for 13 months
- Brand name drug companies begin providing 50% discount in the Part D "donut hole"
- 10% Medicare bonus payment for primary care and general surgery (5 years)
- Employers required to report value of health benefits on W-2

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- Steps towards health insurance administrative simplification (reduced paperwork, etc) begins (5 yr process)
- Additional funding for community health centers (5 years)
- Seniors who hit Part D “donut hole” in 2010 receive \$250 check (3/15/11)
- New Medicare cuts to long-term care hospitals begin (7/1/11)
- Additional Medicare cuts to hospitals and cuts to nursing homes and inpatient rehab facilities begin (FY12)
- New tax (\$2 per enrollee) on all private health insurance policies (including self-insured plans) to pay for comparative effectiveness research (plan years beginning FY12)

2012

- Medicare cuts to dialysis treatment begins
- Require information reporting on payments to corporations
- Medicare to reduce spending by using an HMO-like coordinated care model (Accountable Care Organizations)
- Medicare Advantage plans with a 4 or 5 star rating receive a quality bonus payment
- New Medicare cuts to inpatient psych hospitals (7/1/12)
- Hospital pay-for-quality program begins (FY13)
- Medicare cuts to hospitals with high readmission rates begin (FY13)
- Medicare cuts to hospice begin (FY13)

2013

- Increase Medicare wage tax by 0.9% and impose a new 3.8% tax on investment income including annuities for those earning over \$200k/\$250k (not indexed to inflation)
- Impose \$2,500 annual cap on FSA contributions (indexed to CPI)
- Generally increases (7.5% to 10%) threshold at which medical expenses, as a % of income, can be deductible
- Eliminate deduction for Part D retiree drug subsidy employers receive
- Impose 2.3% excise tax on medical devices
- Medicare cuts to hospitals who treat low-income seniors begin
- Post-acute pay for quality reporting begins
- CO-OP Program: Secretary awards loans and grants for establishing nonprofit health insurers
- \$500,000 deduction cap on compensation paid to insurance company employees and officers
- Part D “donut hole” reduction begins, reaching a 25% reduction by 2020

2014

- Individuals without government-approved coverage are subject to a tax of the greater of \$695 or 2.5% of income
- Employers who fail to offer “affordable” coverage would pay a \$3,000 penalty for every employee that receives a subsidy through the Exchange
- Employers who do not offer insurance must pay a tax penalty of \$2,000 for every fulltime employee
- More Medicare cuts to home health begin
- States must have established Exchanges
- Employers with more than 200 employees can auto-enroll employees in health coverage, with opt-out
- All non-grandfathered and Exchange health plans required to meet federally-mandated levels of coverage
- States must cover parents /childless adults up to 138% of poverty on Medicaid, receive increased FMAP
- Tax credits available for Exchange-based coverage, amount varies by income up to 400% of poverty
- Insurers cannot impose any coverage restrictions on pre-existing conditions (guaranteed issue/renewability)
- Modified community rating: individual or family coverage; geography; 3:1 ratio for age; 1.5 :1 for smoking
- Insurers must offer coverage to anyone wanting a policy and every policy has to be renewed
- Limits out-of-pocket cost-sharing (tied to limits in HSAs, currently \$5,950/\$11,900 indexed to COLA)
- Insurance plans must include government-defined “essential benefits “ and coverage levels
- OPM must offer at least two multi-state plans in every state
- Employers can offer some employees free choice vouchers for health insurance in the Exchange
- Government board (IPAB) begins submitting proposals to cut Medicare
- Impose tax on nearly all private health insurance plans (\$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, \$14.3 billion in 2018, and indexed to medical cost growth thereafter); based upon firm’s market share starting in 2013
- Medicare payment cuts for hospital-acquired infections begin (FY15)



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2901 Telestar Court | Falls Church, VA 22042-1205 | 703/770-8100 | www.naifa.org

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2016

- States can form interstate insurance compacts if the coverage with HHS approval (2016)

2017

- Physician pay-for-quality program begins for all physicians
- States may allow large employers and multi-employer health plans to purchase coverage in the Exchange.
- States may apply to the Secretary for a limited waiver from certain federal requirements

2018

- Impose “Cadillac tax on “high cost” plans, 40% tax on the benefit value above a certain threshold: (\$10,200 individual coverage, \$27,500 family or self-only union multiemployer coverage)

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