The Future of American Health Care Reform

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a different opinion

ESB-6062-0817

Agenda

Historical U.S. health care law
Recent legislative developments
Future possibilities
Steps you can take

U.S. Health Care

Early Days

- Pay as you go model
- 1920s – pre-paid services
- First employer-sponsored hospital plan was in 1929
  - Only covered members at a single hospital, so also was a precursor to HMO model

Rise of Employer-Sponsored Plans

- WWII-era shift
- Challenge to find workers
  - Federal wage caps
  - Labor force depleted by war
- Fringe benefits not included in caps
  - Became significant method of attracting new workers

Acquiring Health Care Benefits Today

- Three primary methods
  - Group (employer-sponsored)
  - Individual
  - Government
    - Medicare
    - Tricare
    - VA benefits
    - Medicaid

Taxation

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General Rule of Income Tax

Any accession to wealth is subject to income tax unless there is an Internal Revenue Code (IRC) exception.

General Rule

- Life insurance
  - Cost of up to $50,000 of term insurance may be paid on a pre-tax basis; generally premiums paid after-tax
  - Generally, life insurance benefits paid to beneficiaries are not subject to income tax

General Rule

- Disability coverage
  - Cost of disability coverage may be paid on pre-tax basis through Section 125 plan or after-tax
  - If the cost is paid for pre-tax, benefits are subject to income tax

Employer-provided Medical Benefits

- Employer receives a deduction for employer-paid cost of coverage – just like compensation (IRC Section 162)
- Employer directly paid cost of coverage is not subject to income tax for employees (IRC Section 106)
- Employees may pay employee cost of coverage on a pre-tax basis through a Section 125 Plan
- Benefits received from medical plans are not subject to income tax (IRC Section 105)
- Neither employer nor employee contributions are subject to employment tax

Savings Accounts

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Health Flexible Spending Accounts (FSAs)

- First created in 1970s
- Employers and employees can contribute
- Not portable
- No contribution limit until ACA ($2650 for 2017)
- Subject to use or lose rule
- 2005 – grace period
- 2015 – allowed $500 rollover

Health Reimbursement Arrangements (HRAs)

- HRAs first defined in early 2000s
- Defined by administrative guidance interpretation of IRC Sections 105 and 106, not by specific legislation
- Only employers may contribute
- Lots of flexibility in design
  - Contributions (no limits under the law)
  - What plans to use in conjunction with an HRA
  - What medical expenses to reimburse
  - Whether to allow portability or spend down after termination of employment

Employer's Role for HRAs and Health FSAs

- Design and sponsor plan
- Responsible for compliance
  - Plan documents
  - Designed properly
  - Administered properly, etc.
  - Employee or employer contribution amounts and timing
  - Benefits meet legal requirements
    - Only paid for qualified medical expenses which must be substantiated
  - Hire and oversight of third party admnistrator

Health Savings Accounts (HSAs)

- Passed into law in 2004
- Employers and employees may contribute tax free
- Account balance grows tax free
- Distributions are tax free if used for qualified medical expenses
- Can take a distribution for non-medical but must pay a 20% penalty
- Must offer with qualified High Deductible Health Plan
- Account owned by employee, no employer oversight once contributions are made

Section 125

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IRC Section 125

- 2003 – Flexible Spending Account debit card rules
- 2007 – proposed Section 125 plan regulations
  - Have never been finalized due to focus on health care reform, but are technically in effect

Other Laws

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ERISA - 1974

- Covers both retirement and health and welfare employer-sponsored plans
- Fiduciary rules that require the Plan Administrator, usually the employer, to make decisions about their plans in the best interest of the participants
- Claims rules regarding timeframes for claims and appeals adjudication, and requirements for explanations of benefits
- Rules for providing notices to employees about their benefits – plan documents, rules governing ability to provide required notices electronically

COBRA - 1985

- Consolidated Omnibus Budget Reconciliation Act
- Ability to continue group health plan coverage after leaving employment
- Employee generally pays full cost plus 2%
- Employer responsibilities – notices and elections, offering coverage

HIPAA - 1996

- Health Insurance Portability and Accountability Act of 1996
- Required health plans to cover pre-existing conditions if the enrollee had continuous coverage. Employers had to provide HIPAA certificates to prove participants' coverage when leaving employment (discontinued after the ACA)
- Ability to enroll in health coverage if you have special enrollment event (i.e., get married or have a baby)
- Requires certain notices to participants about privacy

MMA - 2003

- Medicare Prescription Drug, Improvement, and Modernization Act (also called the Medicare Modernization Act)
- Created HSAs
- Created Medicare Part D (Medicare Prescription Drug coverage)
  - requires employers to provide creditable coverage notices to individuals and HHS
- Retiree Drug Subsidy provided incentive to employers to continue sponsoring retiree prescription drug benefits

ACA – 2010

- Patient Protection and Affordable Care Act
- Small employer tax credit
- Coverage and tax-free reimbursement for adult children
- Initial plan design mandates
  - Pre-existing condition limits for children prohibited,
  - Lifetime limits prohibited,
  - Annual limits restricted,
  - Rescissions prohibited,
  - Must cover adult children to age 26,
  - Must cover preventive care without cost sharing, and more

ACA – 2011

- OTC drugs can only be reimbursed with a prescription
- HSA penalty for non-qualified distributions increased to 20%
- PCORI fee

ACA – 2012

- Form W-2 reporting of health coverage
- Summary of Benefits and Coverage and Uniform Glossary
- 60 day advance notice required for mid-year benefit changes

ACA – 2013

- Health FSA contributions are limited
- Employer deduction for Medicare drug subsidy is limited
- Employee Exchange (Marketplace) notice

ACA – 2014

- Exchange (Marketplace) coverage offered, along with tax credits and cost-sharing subsidies
- Individual mandate
- Plan design mandates
  - Waiting periods over 90 days prohibited,
  - Annual limits prohibited,
  - Pre-existing condition limits for adults prohibited,
  - Insured small group plans must cover essential health benefits,
  - May not discriminate against individuals in clinical trials,
  - Limits on out-of-pocket maximums, and more.

The Latest News

In the Senate

- Passed motion to proceed
- Failed to pass Better Care Reconciliation Act(BCRA)
- Failed to pass repeal-only bill from 2016, the Obamacare Repeal Reconciliation Act (ORRA)
- Failed to pass so-called “skinny repeal” bill, the Health Care Freedom Act

Why?

"What we need to do in the Senate is figure out what the lowest common denominator is — what gets us to 50 votes so that we can move forward on a health care reform legislation."

HHS Secretary Tom Price

Why is this relevant?

Possible new attempts at health care reform

Potential impacts of tax reform

ACA Remains Law

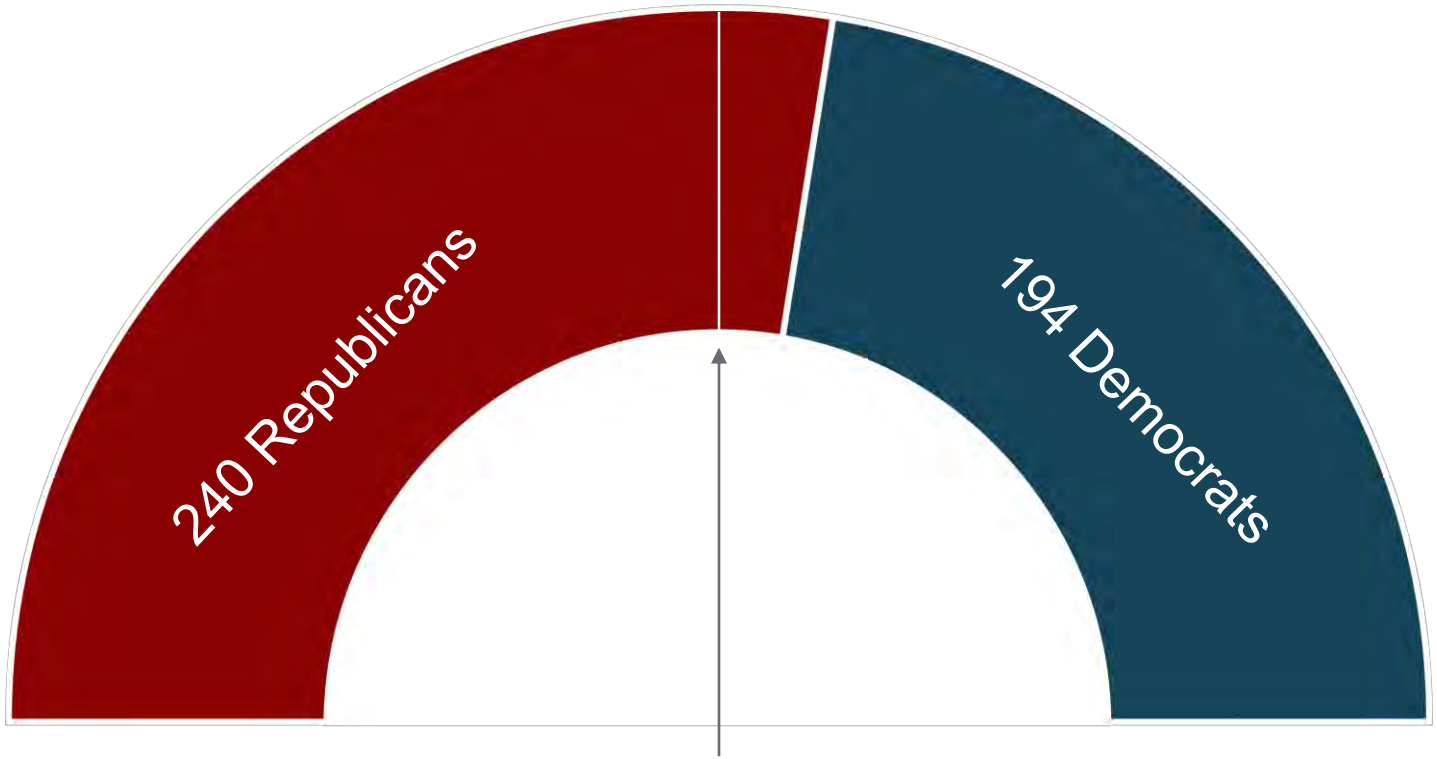
House passage of the American Health Care Act was only the first step in the effort to repeal and replace

Employers must remain compliant with current law for the time being

How Did We Get Here?

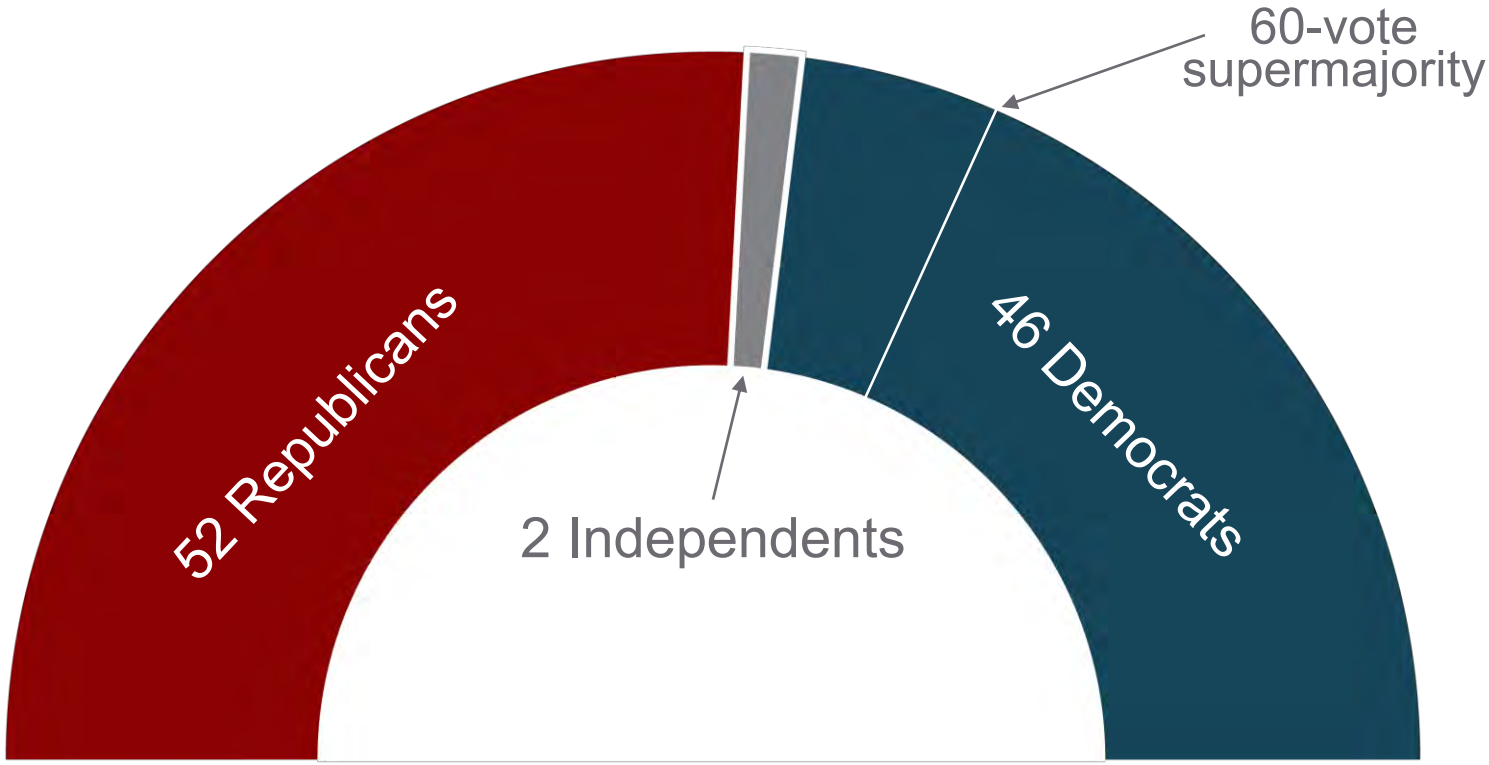
The 115th Congress

House



Simple majority (218) to pass a bill

Senate



Simple majority (51) to pass a budget

Super majority (60) to prevent filibuster

Repeal Options

Bipartisan repeal

Budget reconciliation

A Limitation

Budget measures: items that address taxing or spending

The House

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American Health Care Act (AHCA)

- Budget resolution passed by both House and Senate
- Bill introduced, then pulled from consideration
- AHCA passed a vote in the House after amendments

Meadows-MacArthur Amendment

- Set higher ratios for premiums charged to older enrollees;
- States may specify their own list of services that are required to be covered;
- In some states, would allow increased premiums based on health status; resulting in potentially higher premiums for sicker people

Upton Amendment

- $8 billion over five years to help cover insurance costs for those with pre-existing conditions
- Helped develop support among moderate Republicans

Impact on Coverage

- First House bill: 24 million more uninsured
- Second House bill: 23 million more uninsured
- Senate bill: 22 million more uninsured

The Senate

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Senate Approach

- Formed working group to write a health care bill
- Small group represents diverse views across GOP

Better Care Reconciliation Act of 2017 (BCRA)

- Similar to AHCA
- Cruz Amendment
- Byrd Rule

What Was Proposed?

ACA provisions that would be repealed

Mandates

Would have immediately repealed individual and employer mandate penalties

OTC Reimbursement

Would have repealed requirement to have a prescription to receive FSA/HSA reimbursement of over-the counter items

Health FSA Limits

Would have repealed contribution limits so employers may return to setting their own

Other Tax Repeals

Health insurers

Prescription drugs

Medical devices

And more

Cost-Sharing Subsidies

Would have repealed subsidies to assist with out-of-pocket expenses under Public Exchange (Marketplace) coverage

Medicaid Expansion

Would have phased out federal funding for ACA Medicaid expansion

ACA provisions that would stay

Cadillac Tax

Delay (but not repeal) the Excise Tax on High Cost Plans (Cadillac Tax) from 2020 to 2026

Employee Exclusion

Would have left untouched the provision that makes employer-provided health coverage not subject to income or employment tax

IRS Reporting

Would continue Forms 1094/1095 reporting until 2020, then migrate to Form W-2 reporting and verification of plan eligibility

Market Reforms

Would have maintained ACA plan design mandates

- States could define their own essential health benefits
- Exception for lower-premium catastrophic plans

Changes to ACA provisions

HSA Expansion

Increased contributions

Catch-up by spouse

Establishing the HSA

Reduced excise tax

Use HSA funds to pay premiums

Individual Tax Credits

Advanceable, refundable individual tax credit to purchase insurance

Available to income-qualified individuals without access to government or employer coverage

Continuous Coverage

30% premium surcharge for 12 months following 63 day lapse in coverage under AHCA

No surcharge in Senate plan; six month waiting period

Age-Based Premiums

Permits states to set their own ratios for the amounts insurers can charge older compared to younger individuals

Stability Funds

Provided funding for states to pursue various market stabilization activities

What could happen next?

Public Exchanges (Marketplaces)

Will the last insurers withdraw for next year?

Will the administration enact provisions to entice them to stay?

Cost Subsidies

Will Republicans continue to contest payments to insurers in the Public Exchanges (Marketplaces)?

Will Congress pay the subsidies due to insurers under the ACA?

Apply Trump's Executive Order?

Will the agencies repeal burdensome regulations?

Or will they seek to help the ACA fail?

Implement Open ACA Provisions?

Will the administration finally implement ACA provisions currently without regulations?

- Nondiscrimination by insured plans
- Quality reporting
- Transparency disclosures

Future Legislation?

Health care reform or tax reform?

Repeal only?

Bipartisan legislation or another pass at budget reconciliation?

If Not Now, When?

Best chance for the President to promote his agenda: 1st 100 days

Second best chance: 1st 15 months

Becomes much more difficult after that as Congress starts running for reelection

Who gets the blame if the system fails?

Republicans will point to ACA as Democrat-established

Democrats will point to Republican failure to replace it with better

What This Means for Employers

Sources of Tension

Most of the tension with the AHCA is related to the Public Exchanges (Marketplaces) and Medicaid

Such parts of the ACA have little impact on employers

Connection to the Employer Mandate

Employer Mandate penalties are not triggered unless a full-time employee enrolls in Public Exchange (Marketplace) coverage and qualifies for a tax credit

Continue ACA Compliance Efforts

The ACA remains the law so compliance needs to continue

Key provisions:

- Employer mandate
- Form 1094/1095 reporting

Support for Employer Coverage

As a general rule, Republicans are very supportive of employers providing coverage to employees

Unclear how that will play out in enforcement efforts

Cost Management

- Consumer driven plans with HSAs or HRAs
- Value based benefit design for members with specific conditions or disease (e.g. diabetes)
- Wellness programs
- Health promotion
- Telemedicine

Cost Management

- Increased cost-sharing through higher deductibles
- Narrow network of providers
- Specialty drug management
  - Prior authorization
  - Step therapy
  - Limited networks
  - Preferred treatment within disease categories
- Provider reimbursement changes (ACOs, bundled payments, etc.)
- Price and quality transparency tools

What does this mean for my district?

Agenda

What employers should be doing now:

- Common questions
- Potential pitfalls

Common Questions

Common Questions

Is it true that President Trump's Executive Order directed the IRS NOT to go after any employers not offering coverage nor individuals for failing to prove they had coverage?

Common Questions

IRS Office of Chief Counsel

Letters 2017-0010 and 2017- 0013

No waivers available to large employers under IRC 4980H

Common Questions

IRS Office of Chief Counsel

Letters 2017-0011 and 2017-0017

Individuals must maintain minimum essential coverage for each month, qualify for a coverage exemption, or pay a penalty when filing their federal income tax return

Common Questions

Do employers still have to comply with the IRC 6055 and 6056 information reporting requirements?

Common Questions

Mail to employees by January 31, 2018

File on paper by February 28, 2018

E-file with IRS by Monday, April 2, 2018

Draft B Form Instructions

2017

Instructions for Forms 1094-B and 1095-B

Department of the Treasury
Internal Revenue Service

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Forms 1094-B, Transmittal of Health Coverage Information Returns, and 1095-B, Health Coverage, and the instructions, such as legislation enacted after they were published, go to IRS.gov/Form1094B and IRS.gov/Form1095B.

What's New

Filing requirements. Health insurance issuers and carriers are encouraged (but not required) to report coverage in catastrophic health plans enrolled in through the Marketplace for months in 2017.

Additional Information

For information related to the Affordable Care Act, visit IRS.gov/ACA.

For the final regulations relating to Form 1095-B reporting, see T.D. 9660, 2014-13 I.R.B. at IRS.gov/IRB/2014-13_IRB/AR08.html.

For additional guidance and proposed regulatory changes relating to Form 1095-B reporting, including clarifications regarding the reporting requirements for providers of minimum essential coverage and the requirement to solicit the TIN of each covered individual for purposes of the reporting of health coverage information, see Proposed Regulations section 1.6055-1(h) and Regulations section 301.6724-1.

For additional information related to reporting by Providers of Minimum Essential Coverage, go to IRS.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage.

For information related to filing Forms 1094-B and 1095-B electronically, visit IRS.gov/For-Tax-Pros/Software-Developers/Information-Returns/Affordable-Care-Act-Information-Return-Air-Program.

General Instructions for Forms 1094-B and 1095-B

Purpose of Form

Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore aren't liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. Minimum essential coverage is described in more detail under *Who Must File*, later. Additional information about minimum essential coverage and the individual shared responsibility provision is at IRS.gov/Affordable-Care-Act/Individuals-And-Families/Individual-Shared-Responsibility-Provision.

TIP *Minimum essential coverage doesn't include coverage consisting solely of excepted benefits. Excepted benefits include vision and dental coverage not part of a comprehensive health insurance plan, workers' compensation coverage, and coverage limited to a specified disease or illness.*

Who Must File

Every person that provides minimum essential coverage to an individual during a calendar year must file an information return reporting the coverage. Filers will use Form 1094-B (transmittal) to submit Forms 1095-B (returns).

Employers (including government employers) subject to the employer shared responsibility provisions sponsoring self-insured group health plans generally will report information about the coverage in Part III of Form 1095-C instead of on Form 1095-B. However, employers that offer employer-sponsored self-insured health coverage to non-employees who enroll in the coverage may use Form 1095-B, rather than Form 1095-C, Part III, to report coverage for those individuals and other family members. In general, employers with 50 or more full-time employees (including full-time equivalent employees) during the prior calendar year are subject to the employer shared responsibility provisions. See the Instructions for Forms 1094-C and 1095-C for more information about who must file Forms 1094-C and 1095-C and for more information about reporting coverage for non-employees. Small employers that aren't subject to the employer shared responsibility provisions sponsoring self-insured group health plans will use Forms 1094-B and 1095-B to report information about covered individuals.

Insured coverage. Health insurance issuers and carriers must file Form 1095-B for most health insurance coverage, including individual market coverage and insured coverage sponsored by employers. However, health insurance issuers and carriers don't report coverage under the Children's Health Insurance Program (CHIP), Medicaid, Medicare (including Medicare Advantage), or the Basic Health Program provided through health insurance companies. These types of coverage are reported by the government sponsors of those programs.

In addition, health insurance issuers and carriers aren't required to file Form 1095-B to report coverage in individual market qualified health plans that individuals enroll in through Health Insurance Marketplaces. This coverage generally is reported by Marketplaces on Form 1095-A. However, health insurance issuers are required to file Form 1095-B to report on coverage for employees obtained through the Small Business Health Options Program (SHOP). For coverage in 2017 (filing in 2018), health insurance issuers and carriers are encouraged (but not required) to report coverage in catastrophic health plans enrolled in through the Marketplace.

Eligible Employer-Sponsored Plans

Eligible employer-sponsored plans are minimum essential coverage and include:

1. Group health insurance coverage for employees under:
   a. A governmental plan, such as the Federal Employees Health Benefits program.
   b. An insured plan or coverage offered in the small or large group market within a state.
   c. A grandfathered health plan offered in a group market.
2. A self-insured group health plan for employees.

As noted earlier, minimum essential coverage doesn't include coverage consisting solely of excepted benefits. Excepted benefits include vision and dental coverage not part of a comprehensive health insurance plan, workers' compensation coverage, and coverage limited to a specified disease or illness.

Health insurance issuers or carriers will file Form 1095-B for all insured employer coverage. Plan sponsors are responsible for reporting self-insured employer coverage. Plan sponsors that are employers subject to the employer shared responsibility provisions generally must report the coverage on Form 1095-C and other plan sponsors (such as employers not subject to the employer shared responsibility provisions and sponsors of multiemployer plans) report the coverage on Form 1095-B.

Plan sponsors of self-insured employer coverage include:

- Each participating employer (for its own covered individuals) in a plan or arrangement established or maintained by more than one employer;
- The association, committee, joint board of trustees, or similar group of representatives who establish or maintain a multiemployer plan;
- The employee organization for a plan or arrangement maintained solely by an employee organization; and
- Each participating employer (for its own employees) for a plan or arrangement maintained by a Multiple Employer Welfare Arrangement.

A government employer may designate another government entity to report coverage of its employees. Generally, a designated government entity will file Form 1095-B on behalf of a government employer that sponsors or maintains a self-insured group health plan for its employees only if that government employer isn't subject to the employer shared responsibility provisions, which would require reporting on Form 1095-C. The Instructions for Forms 1094-C and 1095-C contain further information on reporting options for government entities.

Government-Sponsored Programs

The following government-sponsored programs are minimum essential coverage.

1. Medicare Part A.
2. Medicaid, except for the following programs:
   a. Optional coverage of family planning services.
   b. Optional coverage of tuberculosis-related services.
   c. Coverage of pregnancy-related services.
   d. Coverage of medical emergency services.
   e. Coverage of medically needy individuals.
   f. Coverage under a section 1115 demonstration waiver program.
3. The Children's Health Insurance Program (CHIP).
4. The TRICARE program, except for the following options:
   a. Coverage on a space-available basis in a military treatment facility for individuals who aren't eligible for TRICARE coverage for private sector care.
   b. Coverage for a line of duty-related injury, illness, or disease for individuals who have left active duty.
5. Coverage administered by the Department of Veterans Affairs that is:
   a. Coverage consisting of the medical benefits package for eligible veterans.
   b. CHAMPVA.
   c. Comprehensive health care for children suffering from spina bifida who are the children of Vietnam veterans and veterans of covered service in Korea.
6. Coverage for Peace Corps volunteers.
7. The Nonappropriated Fund Health Benefits Program of the Department of Defense.

In general, the government agency sponsoring the program will file Form 1095-B. The state agency that administers a Medicaid or CHIP program will file Form 1095-B for coverage under those programs. However, Medicaid and CHIP agencies in U.S. possessions or territories (American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands) aren't required to report Medicaid or CHIP coverage on Form 1095-B.

When coverage under the Nonappropriated Fund Health Benefits Program of the Department of Defense or TRICARE is reported on Form 1095-B, Part I, line 8, filers should use code C (government-sponsored program).

Coverage designated as minimum essential coverage. The Department of Health and Human Services has

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Changes for 2017

- No more transition relief
- No special code for waivers
- Safe harbor for incorrect Line 15 contribution info

Changes for 2017

Affordability thresholds:

Calendar Year	Affordability Percentage
2015	9.56%
2016	9.66%
2017	9.69%
2018	9.56%

Source: Rev. Proc. 2014-37, Rev. Proc. 2014-62, Rev. Proc. 2016-24, and Rev. Proc. 2017-36

Changes for 2017

- COBRA
  - Offer of coverage due to termination ***not*** reported as an offer on line 14
  - On Form 1095-C, use code 1H (no offer) on line 14 for any month post-employment coverage applies, and code 2A (not an employee) on line 16

Changes for 2017

- COBRA
  - During the month of termination, see instructions
  - On Form 1095-C, use 2B on line 16 only if offer coverage offer ended before the last day of the month solely because the employee terminated employment during the month

Changes for 2017

- COBRA
  - Reduction in hours
  - On Form 1095-C, use applicable 1 series code on line 14
  - This means offer code may change part way through reporting period

Changes for 2017

- Non-COBRA
  - Offer of coverage effective after termination ***not*** reported as an offer on line 14
  - On Form 1095-C, use code 1H (no offer) on line 14 for any month of post-employment coverage applies, and code 2A (not an employee) on line 16

Changes for 2017

- Process for correcting authoritative transmittals
  - File a standalone, fully complete Form 1094-C
  - Enter an "X" in the CORRECTED checkbox
  - Do not attach any other documents

Common Questions

Does a large employer have to make a formal offer of coverage every year?

Common Questions

- Type of offer (adequate? affordable? dependents?)
- Time period during which offer was effective
- Notice to employee that offer was available

Common Questions

- Review plan documents and privacy policies
- Do not use or disclose PHI for employment-related actions or any other purpose
- Third party vendors are likely business associates

Potential Pitfalls

Potential Pitfalls

"Parity" Requirements

Mental Health

Substance Abuse

Potential Pitfalls

Annual or Lifetime Limits

Financial/Quantitative Treatment Limitations

Nonquantitative Treatment Limitations

Potential Pitfalls

Enforcement Priority for DOL

Service provider designs plan, but employers ultimately liable

Active area for litigation

Potential Pitfalls

Group Health Plan Mandates

Integrated HRAs

Stand-alone HRAs

Potential Pitfalls

Spouses and Dependents –

For plan years after Jan 1, 2017, do not reimburse expenses for family members who are not enrolled in the employer's group health plan

Potential Pitfalls

HRA Funding

-Exclusively by Employer

-Not with Salary Reductions

-Not under a Section 125 Plan

Potential Pitfalls

HRA Funding

Mandatory contribution of accrued vacation or sick pay to HRA on termination okay

Potential Pitfalls

Health FSA – plan design check

Unless limited scope (dental/vision only), limit participation to those employees who are eligible for medical

Potential Pitfalls

- Health FSA – plan design check
  - Employer contributions capped at $500, if employee contributes $500 or less
  - Matching contributions: dollar for dollar up to $2,600 salary reduction limit

Potential Pitfalls

- Health FSA – plan design check
  - Credit based Section 125 Plans: if more than $500 in employer-provided credits may be directed into the Health FSA, give choice to cash out 100% of the credits as taxable compensation

Final Thoughts

More Questions than Answers

A lot of this is speculative

Unclear exactly what will happen next

- Often hard to predict because Trump presidency has not been following the normal rules

What We Do Know

ACA remains the law

Repealing it is not as easy as it first appeared

Stay Informed

Find a trusted source of news

Get regular updates

We're here to help

Thank you!

American Fidelity Administrative Services

www.HCReducation.com

Contact us: 877-302-5073 or HCR@americanfidelity.com

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