

**HEALTH CARE  
INSURANCE**

**AFTER**

**HEALTH CARE  
REFORM**

**DATE:** November 9, 2016  
**TIME:** 12:00 pm - 1:00 pm  
**PLACE:** Shoreline Law  
1299 Ocean Ave., Ste. 400  
Santa Monica, CA 90401

**PRESENTER:** Craig B. Garner

**Garner Health Law**  
CORPORATION

*This Program Offers One Hour of MCLE Participatory Credit*

# Introduction



“Crazy” is a term of art; “Insane” is a term of law. Remember that, and you will save yourself a lot of trouble.

-- *Hunter S. Thompson*

# HEALTH INSURANCE IN THE UNITED STATES

- Employment has been the foundation upon which health care in the United States historically rested.
- The changing landscape created by the Affordable Care Act (ACA) now threatens to unravel this infrastructure.
- Modern American health care has introduced possible alternatives for health care insurance that are separate and apart from employer-sponsored plans.

## **GUARANTEED ISSUE AND MODIFIED COMMUNITY RATING**

- As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions (under rules referred to as guaranteed issue and modified community rating, respectively).
- These aspects of the ACA – along with tax credits for low and middle income people buying insurance on their own in new health insurance marketplaces – make it easier for people with preexisting conditions to gain insurance coverage.

## 2017 PREMIUM CHANGES

- Health insurance premiums on the ACA's marketplaces (also called exchanges) are expected to increase faster in 2017 than in previous years due to multiple factors, including substantial losses experienced by many insurers in this market and the phasing out of the ACA's reinsurance program.
- As a result of losses in this market, some insurers like UnitedHealth and Aetna have announced withdrawal from the ACA marketplaces or the individual market in some states.

## ADVERSE SELECTION

- One concern with the guaranteed availability of insurance is that consumers who are most in need of health care may be more likely to purchase insurance. This phenomenon, known as *adverse selection*, can lead to higher average premiums.
- To discourage behavior that could lead to adverse selection, the ACA makes it difficult for people to wait until they are sick to purchase insurance (*i.e.* by limiting open enrollment periods, requiring most people to have insurance coverage or pay a penalty, and providing subsidies to help with the cost of insurance).

## RISK SELECTION

- *Risk selection* is a related concern, which occurs when insurers have an incentive to avoid enrolling people who are in worse health and likely to require costly medical care. Under the ACA, insurers are no longer permitted to deny coverage or charge higher premiums on the basis of health status.
- Insurers may still try to attract healthier clients by making their products unattractive to people with expensive health conditions (e.g., in what benefits they cover or through their drug formularies). Or, certain products (e.g., ones with higher deductibles and lower premiums) may be inherently more attractive to healthier individuals.

# REINSURANCE

- The goal of the ACA's temporary reinsurance program was to stabilize individual market premiums during the early years of new market reforms (e.g. guaranteed issue). The program transferred funds to individual market insurance plans with higher-cost enrollees in order to reduce the incentive for insurers to charge higher premiums due to new market reforms.
- Reinsurance differs from risk adjustment in that reinsurance is meant to stabilize premiums by reducing the incentive for insurers to charge higher premiums due to concerns about higher-risk people enrolling early in the program, whereas risk adjustment is meant to stabilize premiums by mitigating the effects of risk selection across plans.

## more REINSURANCE

- Additionally, reinsurance payments are based on actual costs, whereas risk adjustment payments are based on expected costs. As reinsurance is based on actual rather than predicted costs, reinsurance payments will also account for low-risk individuals who may have unexpectedly high costs (such as costs incurred due to an accident or sudden onset of an illness).
- While risk adjustment payments net to zero within the individual and small group markets, reinsurance payments represent a net flow of dollars into the individual market, in effect subsidizing premiums in that market for a period of time. HHS issues reinsurance payments to plans based on need.

# RISK CORRIDORS

- The ACA's temporary risk corridor program was intended to promote accurate premiums in the early years of the exchanges by discouraging insurers from setting premiums high in response to uncertainty about who will enroll and what they will cost.
- The program worked by cushioning insurers participating in exchanges and marketplaces from extreme gains and losses.

## ENROLLMENT DEADLINES

- November 1, 2016: Open enrollment starts for coverage starting on January 1, 2017.
- December 15, 2016: Last day to enroll in or change plans for coverage starting on January 1, 2017.
- January 31, 2017: Last day to enroll in or change a 2017 health plan.
- Exceptions for special enrollment periods (qualifying life events).

# Glossary of Key Terms



When dealing with the insane, the best method is to pretend to be sane.

-- *Hermann Hesse*

## FROM THE U.S. DEPARTMENT OF LABOR

- **Allowed Amount:** Maximum amount on which payment is based for covered health services.
- **Balance Billing:** When a provider bills you for the difference between the provider's charge and the **allowed amount**.
- **Co-Insurance:** Your share of the costs of a covered health care service, calculated as a percent of the **allowed amount** (in addition to any deductible amount).
- **Co-Payment:** A fixed amount paid for a covered health care service.

## more FROM THE U.S. DEPARTMENT OF LABOR

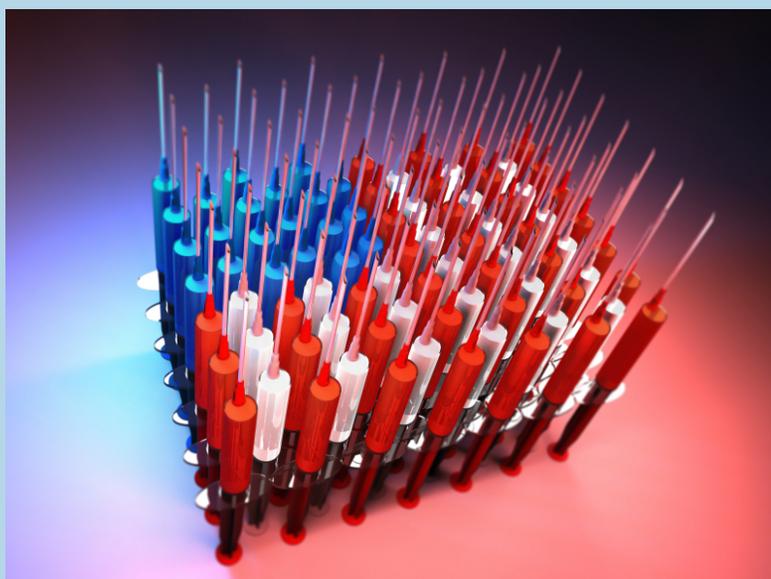
- **Health Insurance:** A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.
- **Home Health Care:** Health care services a person receives at home.
- **Hospice Services:** Services to provide comfort and support for persons in the last stages of terminal illness and their families.
- **Hospitalization:** Care in a hospital that requires admission as an inpatient (typically requires an overnight stay, subject to observation rules).

## more FROM THE U.S. DEPARTMENT OF LABOR

- **Medically Necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms.
- **Preauthorization:** A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
- **Premium:** The amount that must be paid for your health insurance or plan.
- **Skilled Nursing Care:** Services from licensed nurses in your own home or in a nursing home.

## more FROM THE U.S. DEPARTMENT OF LABOR

- **Usual, Customary and Reasonable:** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.
- **Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require a visit to an emergency department.



# ESSENTIAL HEALTH BENEFITS

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Nothing recedes like progress.  
-- *Edward Estlin (e.e.) Cummings*

# ESSENTIAL HEALTH BENEFITS

*Every qualified health plan must include the following services:*

- Ambulatory patient services (outpatient care)
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment

## more ESSENTIAL HEALTH BENEFITS

- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help with injuries, disabilities or chronic conditions)
- Laboratory services
- Preventive and wellness services
- Pediatric services (including pediatric oral and vision care)

## BIRTH CONTROL COVERAGE

- Plans must cover contraceptive methods and counseling for all women.
- Plans must cover these services without charging a copayment or coinsurance when provided by an in-network provider (even if deductible has not been met).
- FDA-approved contraceptive methods prescribed by a woman's doctor are covered.
- Exceptions may apply for religious employers and non-profit religious organizations.

# ALMOST ESSENTIAL HEALTH BENEFITS

- Emergency room visits (as opposed to emergency services)
- Ambulance services
- Diabetes care management
- Kidney dialysis
- Physical therapy
- Durable medical equipment
- Prosthetics
- Infertility treatment
- Organ and tissue transplantation

## MHPAEA

- The 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became effective January 2010.
- MHPAEA prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits.
- MHPAEA applies to health plans provided by employers with more than 50 employees and individual plans purchased through a Health Care Exchange.

## more MHPAEA

- Does not apply to Medicare or Medicaid.
- A qualified health plan must include at least ten essential health benefits.
- California mandates “chemical dependency services” must be consistent with MHPAEA, including inpatient detoxification, outpatient evaluation and treatment for chemical dependency, transitional residential recovery services or chemical dependency treatment.

# HEALTH INSURANCE SUBSIDIES

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The truth is rarely pure and  
never simple.

-- *Oscar Wilde*



## FINANCIAL ASSISTANCE

- To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the ACA includes provisions to lower premiums and out-of-pocket costs for people with low and modest incomes.
- The ACA also gives states the option to bolster public coverage by expanding their Medicaid programs to cover people with incomes under 138% of the Federal Poverty Level (FPL).

## PREMIUM TAX CREDIT

- Reduces marketplace enrollees' monthly payments for insurance plans purchased through the marketplace.
- Marketplace metals include bronze, silver, gold and platinum.
- Can be applied to any of the metal levels, but cannot be applied toward the purchase of catastrophic coverage (to qualify for a catastrophic plan, an individual must either be under 30 years of age or eligible for a "hardship exemption").

# ELIGIBILITY FOR PREMIUM TAX CREDIT

*In order to receive the premium tax credit for coverage, an enrollee must meet the following criteria:*

- Have a household income from one to four times the Federal Poverty Level (FPL).
- Not have access to affordable coverage through an employer (including a family member's employer).
- Not eligible for coverage through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other forms of public assistance.
- Have U.S. citizenship or proof of legal residency.
- If married, must file taxes jointly in order to qualify.

## more ELIGIBILITY FOR PREMIUM TAX CREDIT

- Employer coverage is considered affordable if the employee's contribution is less than 9.5 percent of his or her household income (for the employee's coverage only, not including the cost of adding family members).
- The employer's coverage must also meet the "minimum value" standard, meaning that the plan has an actuarial value of at least 60 percent (equivalent to a bronze plan).
- If the employer's plan fails to meet one or both of these requirements, the employee (and family) may be eligible for subsidized coverage if they meet the aforementioned criteria.

## GETTING YOUR PREMIUM TAX CREDIT

- To receive the premium tax credit, an individual or family must purchase insurance coverage through the marketplace.
- When applying for coverage, enrollees will receive a subsidy determination, letting them know whether they are eligible for a premium tax credit and the amount they may receive.
- The person or family then has the option to receive the tax credit in advance or wait until they do their taxes the following year.

# COST SHARING SUBSIDIES

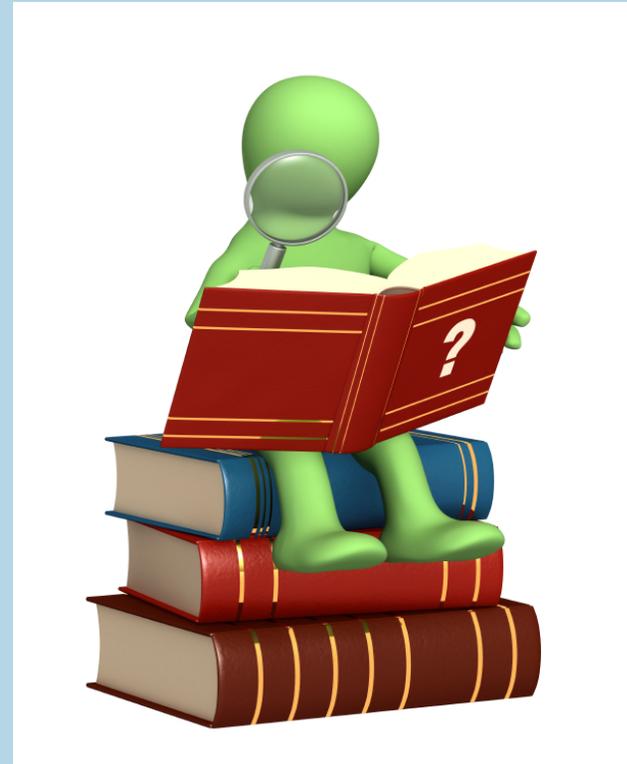
- Cost-sharing subsidies work by reducing a person or family's out-of-pocket cost when they use health care services, such as deductibles, copayments, and coinsurance.
- Unlike the premium tax credit (which can be applied toward any metal level of coverage), cost-sharing subsidies can only be applied toward a silver plan. In essence, the cost-sharing subsidy increases the actuarial value (protectiveness) of a silver plan, in some cases making it similar to a gold or platinum plan.
- The cost-sharing subsidies are available only to the lowest-income marketplace enrollees who meet all of the other criteria for receiving the premium tax credit.

# COVERED CALIFORNIA

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If you have ten thousand  
regulations you destroy all  
respect for the law.

-- *Winston Churchill*



# FOR SMALL BUSINESSES

The screenshot shows the 'SMALL BUSINESS' section of the Covered California website. The navigation bar includes 'INDIVIDUALS AND FAMILIES', 'SMALL BUSINESS', 'Español', and a search bar. The main content area features a banner with the text 'COVERED CALIFORNIA FOR SMALL BUSINESS' and 'We can help your business.' with a 'Learn More' link. To the right, there are four menu items: 'Health and Dental Plans', 'Tax Credits', 'How to Apply', and 'Employer Resources'.

**HEALTH INSURANCE AFTER  
HEALTH CARE REFORM**

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Key Benefits (2016)	Blue Shield Platinum (90%)	Blue Shield Gold (80%)	Blue Shield Silver (70%)	Blue Shield Bronze (60%)
<b>Individual Deductible</b>	\$0	\$0	\$1500 (medical) \$250 (pharmacy) \$0 (dental)	\$6000 (medical) \$500 (pharmacy) \$0 (dental)
<b>Family Deductible</b>	\$0	\$0	\$3000 (medical) \$500 (pharmacy) \$0 (dental)	\$12000 (medical) \$1000 (pharmacy) \$0 (dental)
<b>Lab Testing Co-Pay</b>	\$20	\$35	\$35	\$40
<b>X-Ray Co-Pay</b>	\$40	\$50	\$65	100%
<b>Emergency Dept. Co-Pay</b>	\$150	\$250	\$250	100%
<b>Inpatient Physician Fee</b>	\$40	\$55	20%	100%
<b>Inpatient Hospital Fee</b>	\$250/day (up to 5 days)	\$600/day (up to 5 days)	20%	100%
<b>Imaging (MRI, CT, etc.)</b>	\$150	\$250	\$250	100%
<b>Mental Health Outpatient</b>	\$20	\$35	\$45	\$70 (deductible waived first 3 visits)
<b>Mental Health Inpatient</b>	\$250/day (up to 5 days)	\$600/day (up to 5 days)	20%	100%
<b>Substance Use Outpatient</b>	\$20	\$35	\$45	\$70 (deductible waived first 3 visits)
<b>Substance Use Inpatient</b>	\$250/day (up to 5 days)	\$600/day (up to 5 days)	20%	100%

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## HOW TO APPLY

- Call 844-332-8384.
- Email [shop@covered.ca.gov](mailto:shop@covered.ca.gov).
- Contact a certified insurance agent (sometimes known as “navigators”).
- To qualify as a small business, you need at least one W-2 employee who is not your business partner or spouse.

## WHAT YOU WILL NEED TO APPLY

- Employer name, as reported to the California Employment Development Department.
- Federal Employer Identification Number (FEIN) and state Employer Identification Number (SEIN).
- A copy of local business license.
- A DE-9C reconciled by the employer.
- The total number of employees.

## more WHAT YOU WILL NEED TO APPLY

- The total number of full-time employees.
- The total number of part-time employees working 20 to 29 hours per week (if offering part-time employees coverage).
- Employee roster, including addresses, hire dates, dates of birth and Social Security numbers or tax identification numbers.
- Dependent information (if offering dependents coverage), including the dependents' dates of birth to determine age.

# FOR INDIVIDUALS AND FAMILIES

The screenshot shows the Covered California website interface. At the top left is the Covered California logo. To its right are two tabs: "INDIVIDUALS AND FAMILIES" (selected) and "SMALL BUSINESS". Further right are links for "Account Sign In" and "Español", followed by a search bar. Below this is a navigation bar with "Need Coverage", "Shop and Compare", "Members", and "Get Help". The main content area features a banner with a woman and child, the text "Health insurance that's right for you.", and a link to "Learn more about Covered California and how to enroll." To the right of the banner are four action buttons: "See if You Qualify for Financial Help", "Apply for Coverage", "Medi-Cal Information", and "Free Local Help to Enroll".

## HEALTH INSURANCE AFTER HEALTH CARE REFORM

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## LOS ANGELES COUNTY (NORTHEAST) 2017 RATE CHANGES

- Overall county area rate change is **+16.4%** (weighted average).
- Statewide rate change (weighted average) is **+13.2%**
- Lowest-price Bronze plan (unweighted average) is **-4.1%**.
- Lowest-price Silver plan (unweighted average) is **+3.3%**.
- Weighted rate change if consumers switch to lowest-price plan available in the same metal tier is **-1.3%**.

<b>Carriers</b>	<b>Percentage of Enrollment</b>	<b>Weighted Average Increase (consumers staying in plan)</b>
<b>Anthem EPO</b>	10%	27%
<b>Anthem HMO</b>	2%	4.6%
<b>Blue Shield PPO</b>	46%	21.1%
<b>Health Net HMO</b>	26%	12.1%
<b>Kaiser Permanente HMO</b>	12%	5.7%
<b>L.A. Care HMO</b>	3%	3.7%
<b>Molina Healthcare HMO (coinsurance)</b>	1%	-3.7%

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## REGIONAL OBSERVATIONS

- 175,111 individuals renewed their coverage or signed up for coverage during the third open-enrollment period.
- 90 percent are receiving financial assistance to pay their premiums. Generally, the amount of financial assistance available to consumers in this region will increase in 2017.
- All consumers in this region will have 5 insurance companies from which to choose, and some will have as many as 6.

## more REGIONAL OBSERVATIONS

- Blue Shield is now offering a new HMO plan in most ZIP codes within this region, at three levels of coverage: Silver, Gold and Platinum.
- Consumers in this region may benefit from shopping around for lower-cost insurance company options that offer a lower premium in the same metal tier.

# PATIENT CENTERED BENEFIT DESIGN

- Covered California is leading the way by using a Patient Centered Benefit Design.
- Consumers can shop across different health insurance companies knowing that the benefits are the same, depending on metal tier, no matter which company they choose.
- Consumers get an apples-to-apples comparison about co-pays, deductibles and other costs.
- Choice of coverage level based on a metal tier system to select best plan.

## SPECIAL ENROLLMENT

- Losing health coverage
- Income changes so much
- Turning 26 years old
- Moving
- Having a child or adopting a child
- Getting married
- Becoming a citizen.

# FREQUENTLY ASKED QUESTIONS

*For individuals and families, some FAQs on the Covered California website include:*

- What can I do if I created an online account but forgot my password?
- What can I do if I forgot my user name?
- Should I include my first premium payment with the application?
- What if I do not have all the information I need to answer the questions?

## more FREQUENTLY ASKED QUESTIONS

- What if I choose not to get health insurance?
- How much does it cost to buy insurance through Covered California?
- Does Covered California offer dental coverage? Vision?
- Is Covered California an insurance company?

# HIPAA AND HITECH



The secret of being a bore . . . is to tell everything.

-- *Voltaire*

# PROTECTIONS UNDER HIPAA

- In direct opposition to the fundamental tenet for which it now stands, the introduction of the 1996 Health Insurance Portability and Accountability Act (“HIPAA”) did not originally include privacy legislation, but was modified in November 1999 to address patient concerns.
- Some 52,000 public comments and another year later, the U.S. Department of Health and Human Services (“HHS”) issued final regulations known as the HIPAA Privacy Rule.
- HHS again modified the Privacy Rule in March 2002, and after 11,000 more public comments, issued its directive in August 2002.

## more PROTECTIONS UNDER HIPAA

- HIPAA's Security Rule governing "e-PHI" (2003)
- Enforcement Rule (2006)
- Breach Notification Rule as well as HITECH (the Health Information Technology for Economic and Clinical Health Act) Enforcement Rule (2009)
- Updated Administrative Simplification Rule (2013)

## more PROTECTIONS UNDER HIPAA

- Psychotherapy notes receive special protections under the HIPAA Privacy Rule.
- Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient's information to the patient's family, friends, or other persons is in the best interests of the patient.

## THERAPIST NOTES

- Federal law refers to psychotherapy notes as excluded from access (45 CFR Section 164.524).
- But California does not set aside psychotherapy notes. California law wants to provide access to such health care records by patients. There are limits to this disclosure, however (Health and Safety Code Section 123115 (b)).
- Providers should make a determination if there would be a "substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient."

# PENALTIES

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Reason has always existed, but  
not always in a reasonable form.

-- *Karl Marx*



## **PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE**

- Did the employer have at least 50 full-time equivalent employees in the previous year?
- If employer has 25 full-time employees with average annual wages of about \$50,000 or less, and covers at least 50% of full-time employees' premium costs, the employer may be eligible for a health insurance tax credit to purchase coverage through the SHOP Marketplace.
- Federal tax credits are only available to small businesses that purchase health insurance through Covered California for Small Business. The maximum available tax credit is 50 percent of insurance premium expenses and is available for a total of two consecutive years.

## more PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE

- Does the employer offer health insurance coverage to at least 95% of its full-time workers and their dependent children? Did at least one full-time employee receive a premium tax credit or cost-sharing subsidy in the marketplace? *If no, penalty does not apply.*
- If yes, employer must pay penalty (\$2,260/12) for each month the employer fails to offer coverage x the number of full-time employees (subtracting up to 30).

## more PENALTIES FOR EMPLOYERS NOT OFFERING COVERAGE

- Does insurance pay for at least 60% of the covered care expenses? *If no, penalty may apply.*
- Did at least one full-time employee receive a premium tax credit to help pay for coverage on the marketplace?
- Employer must pay a penalty for not offering coverage that is affordable and provides minimum value.
- Do any employees have to pay more than 9.69% of their household income for employer coverage? *If no, penalty does not apply.*

## EMPLOYER PAYMENT PLANS

- What happens if the employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance (either through a qualified health plan in the marketplace or outside the marketplace)?
- This is an employer payment plans. An employer payment plan generally does not include an arrangement under which an employee may have an after-tax amount applied toward health coverage or take that amount in cash compensation.

## more EMPLOYER PAYMENT PLANS

- These employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing.
- Consequently, such an arrangement fails to satisfy the market reforms and may be subject to a \$100/day excise tax per applicable employee (which is \$36,500 per year, per employee).

## HIGH COST EMPLOYER-SPONSORED PLANS

- Applies to taxable years beginning after December 31, 2019 (delayed from 2017).
- Under this provision, if the aggregate cost of applicable employer-sponsored coverage provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40 percent excise tax.

## TAX PENALTY FOR REMAINING UNINSURED

- This shared responsibility payment is required to be part of the health insurance system – buying health coverage for individuals and families rather than relying on others to pay for health care.
- Those who do not buy health insurance in 2016 may be subject to the penalty, which is \$695 per person in a household or 2.5 percent of their income, whichever is greater.

# MISCELLANEOUS CHANGES



The evolution of sense is, in a sense, the evolution of nonsense. -- *Vladimir Nabokov*

# MEDICARE

Picture a law written by James Joyce and edited by E.E. Cummings. Such is the Medicare statute, which has been described as 'among the most completely impenetrable texts within human experience.' . . .

The Court clarifies, however, that by making this analogy, it is referring not to Joyce's early work, such as *Dubliners* or *A Portrait of the Artist as a Young Man*, but his later period, specifically *Finnegan's Wake*.

- - *Chief Judge Royce Lamberth (U.S.D.C., D.C.)*

# EXPATRIATE HEALTH PLANS

- The Expatriate Health Coverage Clarification Act of 2014 (EHCCA): Most ACA provisions do not apply to expatriate health plans covering individuals traveling to or from the United States.
- Exceptions include: (1) an expatriate health plan shall be treated as minimum essential coverage; (2) the employer shared responsibility provisions continue to apply; (3) the health care reporting provisions continue to apply but with certain modifications relating to the use of electronic media for required statements to enrollees; and (4) the excise tax provisions continue to apply with respect to coverage of certain qualified expatriates who are assigned (rather than transferred) to work in the United States.

## MEDICAL DEVICE EXCISE TAX

- On Dec. 5, 2012, the IRS and the Department of the Treasury issued final regulations on the new 2.3-percent medical device excise tax that manufacturers and importers will pay on their sales of certain medical devices starting in 2013.
- The Consolidated Appropriations Act, 2016 (Pub. L. 114-113), signed into law on Dec. 18, 2015, includes a two year moratorium on the medical device excise tax. Thus, the medical device excise tax does not apply to the sale of a taxable medical device by the manufacturer, producer, or importer of the device during the period beginning on Jan. 1, 2016, and ending on Dec. 31, 2017.

## MEDICAL SAVINGS ACCOUNT: SELF-ONLY COVERAGE

*For taxable years beginning in 2017, the term "high deductible health plan" as defined in the Internal Revenue Service Code means, for self-only coverage:*

- A health plan that has an annual deductible that is not less than \$2,250 and not more than \$3,350.
- Under which the annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed \$4,500.

## MEDICAL SAVINGS ACCOUNT: FAMILY COVERAGE

*For taxable years beginning in 2017, the term "high deductible health plan" means, for family coverage:*

- A health plan that has an annual deductible that is not less than \$4,500 and not more than \$6,750.
- Under which the annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed \$8,250.

## CAFETERIA PLANS

*For taxable years beginning in 2017, the dollar limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements is \$2,600.*

## **PERIODIC PAYMENTS RECEIVED UNDER QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS OR UNDER CERTAIN LIFE INSURANCE CONTRACTS**

*For calendar year 2017, the stated dollar amount of the per diem limitation regarding periodic payments received under a qualified long-term care insurance contract or periodic payments received under a life insurance contract that are treated as paid by reason of the death of a chronically ill individual is \$360.*

## **Craig B. Garner** Garner Health Law Corporation

- Craig is an attorney and health care consultant, specializing in issues pertaining to modern American health care and the ways it should be managed in its current climate of reform.
- Craig's law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. Craig is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act.
- Between 2002 and 2011, Craig was the Chief Executive Officer of Coast Plaza Hospital in Norwalk, California. Craig is also a Fellow Designate with the American College of Healthcare Executive.
- Additional information can be found at [www.garnerhealth.com](http://www.garnerhealth.com).

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**THANK YOU**

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