

# Healthcare Reform: What Happens When

The provisions of the new healthcare reform law take effect over several years. The following is a summary of the most important provisions of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA) arranged by the year during which the provision first takes effect and impacts employers, including both those that do and do not sponsor group health plans. Look for additional articles that will examine these provisions in greater detail.

## 2010

**Dependent Coverage to Age 26.** Health plans that cover dependents will have to cover dependents on a parent's plan until their 26th birthday. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. \$\$

**Ban on Lifetime Limits and Restriction on Annual Limits.** Plans and insurers may not place lifetime dollar limits and *unreasonable annual limits* on coverage of participants and beneficiaries. These provisions apply to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. \$\$

**Pre-existing Condition Restrictions on Children.** Plans and insurers may not deny coverage of children because of preexisting conditions. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. \$\$

**Coverage Rescissions.** Insurers and plans may not rescind coverage except in cases of fraud. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

**Minimum Coverage Without Cost Sharing for Preventive Services.** Qualified health plans must provide coverage without cost sharing for preventive services, including immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women. This provision is effective for the first plan year beginning on or after September 23, 2010, but does not apply to plans in existence on March 23, 2010. \$\$ **Grandfathered**



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**Tax Credits to Small Employers.** Small employers with no more than 25 employees and average annual wages of less than \$50,000 may claim a tax credit for the cost of providing health insurance to their employees. For tax years beginning in 2010, the credit is 35 percent of the cost.

**Reinsurance Program for Employers Providing Health Insurance Coverage to Retirees over Age 55.** A reinsurance program for employers providing health insurance coverage to early retirees who are over age 55 but are not yet eligible for Medicare is available from June 21, 2010, until insurance Exchanges are available on January 1, 2014.

**Requirement to Report Medical Loss Ratio.** Health insurers and plans must annually report the percentage of premiums spent on health care effective for plan years beginning on or after March 23, 2010. Plans in the individual and small group market must maintain a medical loss ratio (MLR) of 80 percent and plans in the large group market to maintain an MLR of 85 percent.

**Nondiscrimination Testing.** The existing rules barring discrimination in favor of the highly compensated apply to insured group health plans established after March 23, 2010, effective for plan years beginning on or after September 23, 2010.

**Other Coverage Requirements.** Effective for plan years beginning on or after September 23, 2010, group health plans established on or after March 23, 2010, will: \$\$

- Have to allow plan participants to choose any participating primary care provider
- Be prohibited from requiring prior authorization or referrals for visits to an obstetrician/gynecologist
- Have to treat an obstetrician/gynecologist as a primary care provider
- Have to provide emergency care services without prior authorization and with the same cost sharing both in and out of network
- Have to provide coverage for costs of participating in a clinical trial

**Grandfather Rules.** Grandfather Rules exempt group health plans that were in existence on March 23, 2010, from many of the new insurance requirements. Regulations are expected to clarify what kind of changes could be made to a plan without losing grandfather status. The reconciliation law substantially narrowed the grandfather protections and makes the following provisions applicable to both existing and new plans:

- Dependent coverage until age 26
- Preexisting exclusions
- Lifetime maximums
- Annual maximums
- Rescission of coverage

## 2011

**Wellness Grants for Small Employer.** An amount of \$200,000,000 is authorized to be appropriated for the period of fiscal years 2011 through 2015 to fund grants to employers with fewer than 100 employees to provide their employees with access to comprehensive workplace wellness programs.

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**Exclusion of the Costs for Over-the-Counter Drugs for Reimbursement from HRAs, HSAs, FSAs, and MSAs.** Effective for taxable years beginning after December 31, 2010, the costs of over-the-counter drugs not prescribed by a doctor may no longer be reimbursed through a health reimbursement account (HRA) or health flexible spending account (FSA) and may no longer be reimbursed on a tax-free basis through a health savings account (HSA) or Archer Medical Savings Account (MSA).

**Tax on HSA and MSA Distributions Not Used for Qualified Expenses** Effective for taxable years beginning after December 31, 2010, the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses increases to 20 percent of the disbursed amount.

**Medical Loss Ratio Reimbursement.** Beginning not later than January 1, 2011, plans in the individual and small group market must maintain an MLR of 80 percent, and plans in the large group market must maintain an MLR of 85 percent. For each plan year, plans must provide a rebate to each enrollee on a pro rata basis equal to the amount of premium revenue spent on nonmedical costs that exceed the percentage limits.

**Form W-2 Reporting.** Effective for tax years beginning after December 31, 2010, employers are required to report on Form W-2 the total cost of employer-provided group health coverage that is excluded from the employee's gross income. The amount to be reported does not include amounts excluded from income through an Archer MSA, an HSA, or employee salary reductions to a flexible spending arrangement.

**CLASS Act.** The Community Living Assistance Services and Supports Act (CLASS Act) creates a national voluntary insurance program for purchasing community living assistance services and supports to provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports, establish an infrastructure that will help address community living assistance services and supports needs; and alleviate burdens on family caregivers. Employers will be encouraged to participate in the CLASS Act and adopt automatic enrollment rules that default employees into the CLASS Act, starting January 1, 2011.

**Benefits Summary Requirement.** By March 23, 2011, national standards for use in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under group health plans and group or individual health insurance coverage are to be issued.

**Simple Cafeteria Plans for Small Employers.** Effective beginning after December 31, 2010, Internal Revenue Code Sec. 125 is amended to provide for simple cafeteria plans for small businesses that include a safe harbor from nondiscrimination requirements for employers that employed an average of 100 or fewer employees during either of the 2 preceding years. If an employer qualifies as a small employer, it retains the status until it employs an average of 200 or more employees during the preceding year.

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## 2012

**Benefits Summary Requirement.** By March 23, 2012, a summary of benefits and coverage explanation that meets the national standards for providing a summary of benefits and coverage must be provided to applicants at the time of application, to the enrollee prior to the time of enrollment or reenrollment, and to a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

**Quality of Care Reporting.** No later than March 23, 2012, requirements for use by group health plans and health insurance issuers offering group or individual health insurance coverage to report benefits and healthcare provider reimbursement structures that improve health outcomes through the implementation of activities are to be issued. Examples of activities to be reported include quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives; activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate healthcare professional; activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and wellness and health promotion activities. Plans and insurers must annually report whether the benefits under the plan or coverage satisfy these elements.

## 2013

**Health Insurance Administration Simplification.** Rules establishing a single set of operating rules for eligibility verification and claims status must be adopted July 1, 2011, and take effect January 1, 2013. Rules for electronic funds transfer and healthcare payment and remittance rules must be adopted by July 1, 2012, and take effect January 1, 2014. Rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization rules are to be adopted by July 1, 2014, and take effect January 1, 2016. Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. The penalty takes effect April 1, 2014.

**Medicare Tax.** Effective January 1, 2013, the Medicare Part A (hospital insurance) tax rate on wages goes up by 0.9 percent (from 1.45 percent to 2.3 percent) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly. There is also a 3.8 percent Medicare tax assessment on investment income from interest, dividends, royalties, rents, gross income from a trade or business, and net gain from disposition of property for individuals earning over \$200,000 and families earning over \$250,000. \$\$

**FSA Contribution Limit.** Effective January 1, 2013, contributions to an FSA for medical expenses are limited to \$2,500 per year increased annually by the cost-of-living adjustment.

**Elimination of Tax Deduction for Part D Subsidy Payment.** Effective January 1, 2013, the tax deduction for employers that receive Medicare Part D retiree drug subsidy payments is eliminated.

**Requirement on Employers to Inform Employees of Coverage Options.** Employers are to provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice informing the employee of the existence of an Exchange, including a description of the services provided by such an Exchange, and how the employee may contact

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the Exchange to request assistance; if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, the employee may be eligible for a premium tax credit under Section 36B of the Internal Revenue Code of 1986 and a cost-sharing reduction under Section 1402 of the PPACA if the employee purchases a qualified health plan through the Exchange; and if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

## 2014

**Individual Mandate.** U.S. citizens and legal residents will be required to have qualifying health coverage beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family) or 2.5 percent of household income, phased in from 2014–2016. There will be exceptions given for financial hardship and religious objections.

**Employer Play or Pay—The Employer Mandate.** Effective in 2014, employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium assistance tax credit, must pay a fee of \$2,000 per full-time employee. The first 30 employees are not counted for assessing the fee. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Employers that offer coverage will be required to provide a voucher to employees with incomes below 400 percent of the poverty level if their share of the premium cost is between 8 percent and 9.8 percent of income to enable them to enroll in a plan in an Exchange and will not be subject to the above penalty. \$\$

**Large Employer Automatic Enrollment Requirement.** Effective in 2014, large employers with more than 200 full-time employees that offer coverage will be required to automatically enroll employees in the employer's lowest cost plan if the employee does not sign up for employer coverage or does not opt out of coverage. Any automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of any coverage.

**Insurance Exchanges for Individuals and Small Businesses.** By 2014, state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or nonprofit organization, are to be operating so that individuals and small businesses with up to 100 employees can purchase qualified coverage.

**Guaranteed Issue, Renewability, and Rating Variation Requirements** Effective January 1, 2014, insurers will be required to guarantee issue and renewability and allow rating variation based only on age (limited to 3-to-1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5-to-1 ratio) in the individual and the small group market and the Exchanges. \$\$

**Annual Limits.** Effective for plan years beginning on or after January 1, 2014, plans and insurers may no longer impose annual dollar limits on coverage. \$\$

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**Limit on Waiting Periods.** Effective for plan years beginning on or after January 1, 2014, insurers and plans must limit any waiting periods for coverage to 90 days. \$\$

**Wellness Incentives.** Effective for plan years beginning on or after January 1, 2014, employers may offer employees rewards of up to 30 percent (increasing to 50 percent, if appropriate) of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

**Preexisting Condition Exclusions.** The application of preexisting condition exclusions for plan years beginning on or after January 1, 2014, is prohibited. \$\$

**Comprehensive Health Insurance Coverage.** Effective for plan years beginning on or after January 1, 2014, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package that includes at least the following general categories and the items and services covered within the categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

**Limits on Cost Sharing and Deductibles.** Effective for plan years beginning on or after January 1, 2014, a group health plan may not provide any annual cost sharing in excess of those that apply to HSAs.

## 2018

**Excise Tax on Cadillac Plans.** Effective January 1, 2018, an excise tax is imposed on insurers of employer-sponsored health plans with total values that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

Source: Business and Legal Reports (BLR.com)