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Hamilton Insurance Agency

Hamilton News

Health Care Reform Enacted

President Obama signed the Patient Protection and Affordable Care Act (PPACA or the Act) into law on March 23, followed by amendments to the Act in the Health Care and Education Affordability Act (the Reconciliation Bill) on March 31st. This combination of bills has far-reaching affects on the insurance industry, employers, medical care providers, physicians, hospitals, and the pharmaceutical industry.

Nearly all Americans will be required to ensure that they and their dependents are covered under at least a minimal essential health program by 2014. Changes in regulations impact what employer-sponsored plans must cover, who is covered, and how soon new employees must be eligible for coverage. There is a "play-or-pay" mandate that requires most employers to either offer an affordable plan [play] to their workforce or pay certain excise taxes [pay]. Larger employers will be required to automatically enroll new employees. All group health plans and insurers will be prohibited from denying coverage for a pre-existing condition. Insurers will be prohibited from rescinding individual or group policies except in cases of fraud. By 2014, states will create health insurance exchanges for those who are self-employed, employed at small companies, or unemployed, to reduce rates by pooling their risk.

The effective date of the changes varies widely, ranging from as early as six months after the date of enactment through 2020. Primary sources of funding for the increased costs of this plan include taxes and fees paid by prescription drug and medical device manufactures and importers, health insurers, high-income employees, coverage-providers of "Cadillac" plans, and reductions in Medicare reimbursements to hospitals, home health, skilled nursing and other providers.

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What Employers Need to Do in 2010

There are a number of employer-related changes that are effective on the first day of the plan year following September 23, 2010. For calendar year plans, these will be effective January 1, 2011, but other plans may be impacted in 2010. Initially, many of these changes were excluded for 'grandfathered' plans, but the Reconciliation Bill eliminated these exceptions. Insured and self-insured plans must do the following:

- **Coverage for children up to age 26.** Group health plans and health insurance issuers must offer dependent coverage to employees' children up to age 26 that is non-taxable to the employee. The children do not have to live with the employee or be reported as a tax dependent on the employee's return. The children can be married, but coverage does not extend to the child's spouse or children. Through 2013, employers only need to extend coverage to children not covered under another employer's plan but that requirement ends in 2014.
- **Pre-existing condition exclusion.** Group health plans must eliminate the pre-existing condition exclusion on children under the age of 19 (this exclusion extends to adults in 2014).
- **No lifetime or annual limits on the dollar value of coverage.** Group plans can no longer impose either annual or lifetime limits on the cost of providing essential health benefits, which have been defined to include ambulatory patient care, emergency services, hospitalizations, maternity and newborn care, treatment of mental health and substance abuse disorders, prescription drugs, rehabilitative services, laboratory services, preventive and wellness care, pediatric care (including oral and vision care), and disease management. The prohibition on annual and lifetime limits does not apply to non-essential benefits.
- **Adoption assistance.** Employer-provided adoption assistance benefits are increased to $13,170 per child, but this assistance ends after 2011.
- **Medicare Part D tax deduction eliminated.** If your company offers retiree medical coverage, the Act continues the non-taxable federal subsidy for Medicare Part D, but eliminates its tax deduction. Accounting recognition of this change is required in Q1 2010, even though the implementation is delayed until 2013.
- **Elimination of Medicare Part D donut hole.** There is a $250 rebate this year for seniors who fall into the coverage gap, with a phased approach to increase discounts, until the hole is closed in 2020.
- **Retiree medical subsidy.** No later than June 21st, the Secretary of Health and Human Services is required to establish a reinsurance program to reimburse employers up to 80% of the cost of providing health insurance to early retirees and their dependents. This pool will sunset in 2014 or earlier, if the $5 billion funding runs out.

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Changes for 2011 - 2013

In addition to the big changes for employers this year, the three years following will also prove to be busy as they require even more critical modifications. To simplify employer's planning, we'll show the new requirements by year and by whether they apply to new plans only or both new and grandfathered plans.

2011 (for both New and Grandfathered Plans)

- **Over-the-counter drugs ineligible for reimbursement.** Reimbursement for over-the-counter medications, except insulin, will be prohibited under flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs) unless the employee provides a prescription from a health care provider.
- **W-2 reporting of health care coverage.** Employers will be required to disclose the aggregate cost of employer-sponsored health care coverage (medical, dental and vision), calculated in a manner similar to the current COBRA premium calculation, on the employees' 2011 W-2. Salary reduction contributions to FSAs and HSAs are excluded.
- **SIMPLE cafeteria plan for small businesses.** Employers with 100 or fewer employees will be eligible to offer a simple cafeteria plan that will be deemed to comply with the IRS's nondiscrimination rules, as long as certain contribution requirements are met on behalf of each qualified employee.
- **HSA penalty increase.** Use of funds in an HSA is tax-free for qualified medical expenses, but carries a penalty for other uses. That penalty increases from 10% to 20% of the withdrawal. For Archer MSAs, the penalty increases from 15% to 20%.

2011 (for New Plans only)

- **No cost sharing for required preventive care.** Not only does PPACA require new insured and self-insured group plans to provide certain preventive care services, the plans may not impose any "cost sharing requirements" including copayments, coinsurance or deductibles.
- **Nondiscrimination for eligibility based on salary.** Group plans cannot limit eligibility or continued coverage based on total hourly or salaried earnings of full-time employees in favor of more highly-paid employees.
- **Appeals process.** Insured and self-insured group health plans must have written internal and external appeals processes that provide an impartial review, offer participants access to their records, and give them an opportunity to give a presentation on appeal.
- **Section 105 nondiscrimination rules.** These apply to insured plans, where they previously only applied to self-insured plans.
- **Selection of physician.** If the plan requires the designation of a primary care physician, participants must be allowed to select any PCP that will accept them and may not require referral or authorization to seek care from an OB/GYN.

2012 (for both New and Grandfathered Plans)

- **Comparative effectiveness fee.** Effective for plan years ending after September 30, 2012, employers must pay a fee per covered life to fund comparative effectiveness research. The fee is $1 per covered life in 2013 and it increases to $2 each in subsequent years. It applies to accident or health policies that are covered by HIPAA, including self-insured plans.

2013 (for both New and Grandfathered Plans)

- **Limit on FSA contributions.** Annual salary reduction contributions to health FSAs will be limited to $2,500 per year, indexed for inflation.
- **Uniform explanation of coverage.** New and existing plans must distribute an annual uniform explanation of coverage that complies with to-be-issued regulations. The requirements include that it can be no longer than four (4) pages, must be in at least 12-point font, and use "culturally and linguistically appropriate manner." It must include common benefits scenarios such as when emergency care is warranted, and state whether the plan covers essential health benefits and meets minimum cost-sharing requirements. (This will be in addition to the more detailed Summary Plan Description currently required.)
- **Wellness incentives.** New rules for employer-based wellness programs take effect, including certain reporting requirements.
- **Medicare Part D tax deduction.** While this had to be recognized on an accounting basis in Q1 2010, it's actual effective date is 2013.
- **Medicare tax increase.** Individuals with Adjusted Gross Income (AGI) of $200k and joint filers with an AGI of $250k will pay an additional 0.9% in Medicare payroll taxes, beginning in 2013.
- **Additional nondiscrimination rules (does not apply to grandfathered plans).** New plans cannot discriminate on the basis of health status, including medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

2010 *(continued)*

- **Rescission limitations.** Group health coverage for enrollees cannot be terminated, except in very limited cases (fraud or intentional misrepresentation of material fact) and not without prior notice.
- **Temporary high-risk pool coverage for those with pre-existing conditions.** A national high-risk pool will be created to permit adults with pre-existing conditions to obtain subsidized coverage with certain cost sharing caps. The pool will be eliminated in 2014 when insurers will be prohibited from excluding persons with pre-existing conditions.
- **Tax credit for small business health coverage.** As of January 1, 2010, an employer that has fewer than 25 full-time equivalent employees, average pay of less than $50,000, and pays at least 50% of the cost of health coverage will be eligible for tax credit for a portion of the cost of medical coverage.
- **Whistleblower prohibition and protection.** PPACA prohibits an employer from retaliating against employees who exercise their rights under the new law and offers employee protections if it occurs.

Required 2014+

The big year in changes for health care reform is 2014… That's the year that the following are required:

- **Individual coverage mandate.** As of the beginning of the year, most individuals who are not enrolled in qualifying coverage must pay an excise tax. Most employer-sponsored coverage will qualify and the tax is based on the greater of a flat dollar amount or percentage of income.
- **Employers must "Play or Pay."** Employers with 50 or more full-time equivalent employees that do not offer minimum essential coverage (MEC) to their full-time employees and have at least one employee enroll in and receive a subsidy for the exchange are subject to a "free rider penalty." The penalty is paid monthly and is equal to 1/12 of $2,000 per FTE employee, excluding the first 30 employees. The 50 employee minimum defines full-time as 30 or more hours per week, and includes the aggregate hours worked by part-timers in determining the threshold.
  Employers that do offer MEC, but have at least one full-time employee obtain federally subsidized coverage through the exchange other than with a free choice voucher will pay the lesser of 1/12 of $3,000 for those employees receiving the subsidy or 1/12 of $2,000 per full-time employee.
- **Employer reporting.** Employers must report to the Treasury Department on an annual basis regarding coverage offered, waiting periods, and details on employees covered.
- **State-operated health insurance exchanges.** Individuals and small businesses of up to 100 employees will be allowed to purchase qualified coverage through exchanges that pool risk in an attempt to lower premiums.
- **Notification of availability of exchanges and subsidies.** Employers must notify employees of the exchanges, how they work and that premium subsidies are available for certain employees.
- **Premium subsidies.** Refundable tax credits will be provided to individuals who do not have access to coverage through an employer-sponsored health plan, Medicaid, or other acceptable coverage and whose household income is below 400% of the federal poverty level (FPL).
- **Free choice vouchers.** Employers that offer MEC must offer vouchers for the purchase of qualified coverage through an exchange. The value of the voucher will be equal to the company's contribution to its own plan. Employee participation is limited to those whose household income does not exceed 400% of the FPL and have a required contribution to the employer plan between 8 and 9.8% of income.
- **Automatic enrollment for large employers.** Employers with 200+ employees will need to automatically enroll full-time employees, with an option for them to opt out of coverage.
- **Certain changes continue.** The pre-existing condition ban is extended to adults, grandfathered plans must now remove annual coverage maximums, health FSA contributions are limited to $2,500 per plan year, and the temporary high-risk pool is eliminated. Wellness programs are now able to offer greater premium discount incentives.
- **Expanded Medicaid coverage.** Coverage in Medicaid expands nationally to those under the age of 65 with income of less than 133% of the federal poverty level.
- **Waiting periods limited.** Group health plans must not have eligibility waiting periods of longer than 90 days.
- **Medicare tax on unearned income.** Individuals subjected to the Medicare tax increase in 2013 will also face a 3.8% tax on income from interest, dividends, capital gains annuities, and trusts and estates.
- **New plans face added requirements.** A number of plan design requirements are added, including no out-of-pocket fees for preventive care and mandatory participation in clinical trials for life-threatening diseases.
- **Cadillac plan tax.** Delayed until 2018, the excise tax applies to coverage exceeding $10,200 for individuals and $27,500 for families.

What is a "Grandfathered" Plan Anyway?

Under PPACA, group health plans in effect on the date of enactment are exempt from many of the health care reforms. The rule is not limited to the individuals enrolled on the date of enactment, but rather to the plans in effect on that date. Grandfathered (GF) plans can accept new employees and their dependents or new family members of current employees.

GF Plans Exempt From:

- ✓ Requirement to offer preventive services
- ✓ Limits on cost sharing
- ✓ Nondiscrimination rules imposed on fully-insured plans
- ✓ Reporting requirements
- ✓ Appeals process
- ✓ Selection of doctors and referral requirements
- ✓ Coverage of clinical trials
- ✓ Individual responsibility requirements (coverage in a GF plan satisfies this)

GF Plans Still Subject to:

- ✓ Prohibition on lifetime or annual limits *
- ✓ Rescission of benefits limitations *
- ✓ Expanded dependent coverage *
- ✓ Waiting period limits *
- ✓ Pre-existing condition exclusions *
- ✓ Changes in tax rules relating to health plans
- ✓ Uniform explanation of coverage
- ✓ Requirement to provide employees vouchers
- ✓ Automatic enrollment for larger employers
- ✓ Cost reporting and rebates
- ✓ Required notices regarding the availability of and other facets of the exchange and subsidies

* Grandfathered group health plans were initially exempted from these requirements, until passage of the Reconciliation Bill removed that exception.

DID YOU KNOW?

The Health Care Reform bill included an amendment to the Fair Labor Standards Act (FLSA) that requires employers to provide nursing mothers "reasonable break time" to express breast milk for up to one year after the birth of their child. This is the first federal break requirement in the FLSA, but at least 17 states already require some type of break time for expressing milk. The FLSA changes define this as an unpaid break and only employers with less than 50 employees that can demonstrate an undue hardship to compliance are exempt. If an employer faces conflicting state and federal regulations, they are required to comply with the regulations that most benefit the employee.

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