IMPLEMENTATION OF HEALTH CARE REFORM

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Since it became effective on September 23, 2010, implementation of the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) continues apace. Despite multiple legal challenges to health care reform, federal agencies tasked with insuring timely compliance continue to write regulations that must be addressed by employers, health plans, insurers and others impacted by these massive changes to our health care delivery system. First, a refresher on some of the things still to be done:

Upcoming Health Care Reform Changes

2012:

Grandfathered [1] and Non-grandfathered Plans

- **Advance Notice of Changes in Benefits and Coverage** – Employers must distribute a uniform summary of benefits and coverage to new plan participants. If there are any material changes to a plan that are not covered in the most recent summary, participants must be provided with 60 days notice of any such changes.

- **Patient-Centered Outcomes Research Trust Fund Fee** – An annual fee of $2 ($1 for plan years ending during 2013) multiplied by the average number of covered lives under a health plan will be assessed to finance a government fund related to comparative clinical effectiveness. This fee specifically applies to both insured (fee is paid by insurer) and self insured (fee is paid by the plan sponsor – usually the employer) plans.

Non-grandfathered Plans Only

- **Quality of Care Reports** – Non-grandfathered plans are required to make annual reports available to the public regarding performance measures related to improving quality of care.

2013:

- **Additional Medicare Taxes** – The Medicare Payroll tax will be increased by 9% for individuals whose wages exceed $200,000 and for those filing a joint return whose wages exceed $250,000. A tax of 3.8% on unearned income will also be imposed.

[1] A "grandfathered" plan is a group or individual health plan that was in effect on the date of enactment of the Patient Protection and Affordable Care Act – March 23, 2010. Grandfathered plans are exempt from many, but not all, provisions of health care reform.

- **Notice of Exchanges** – Employers must notify all existing employees (and new employees at time of hire after March 1, 2013) of the existence of Exchanges, the standards for receiving tax credits and cost-sharing reductions under the Exchanges, and the penalties for purchasing a policy through an Exchange without the employer providing a free choice voucher.

- **Health Flexible Spending Account Limits** – Employee contributions to Health FSAs is limited to $2,500 salary reductions.

2014:

- **Small Business Tax Credit (Phase Two)** – A tax credit of up to 50% of a small employer's premium contribution toward employee health insurance is available to employers that pay at least half of the total premium sot for the health coverage and have fewer than 25 full-time equivalent employees who earn less than $50,000.

Grandfathered and Non-grandfathered Plans

- **The Exchanges** – Small employers (those with an average of 100 or fewer employees) may obtain coverage for employees through an Exchange. This is also available to individuals and will be extended to large employers in 2017.

- **Individual Coverage Mandate and Penalties** – Individuals are required to have health insurance. A lack if insurance will result in a tax penalty. The penalty is phased in: $95 per uninsured adult (half the fee is due for each uninsured minor) *or* 1% of household income beginning in 2014. This penalty is phased in, expanding to a $695 per person with a family total of $2085 or 2.5 % of household income in 2016. After 2016, the penalty will increase through cost of living adjustments.

- **Subsidy for Employees to Purchase Coverage through the Exchange** – An employee who is eligible for employer coverage, may be eligible for a subsidy to purchase coverage through the Exchanges. The employee's household income must be between 100% and 400% of the federal poverty level and the employer's contribution to the employer-based coverage must be less than 60% of the value of the coverage, or the employee's share of the plan costs is greater than 9.5% of the employee's household income.

- **Employer Coverage Mandate –** Employers with 50 or more full time equivalent employees are required to offer affordable health insurance coverage or pay an assessment. Employer sponsored coverage is deemed "unaffordable" if the employer's contribution to the coverage is less than 60% of the value of the coverage or the employee's share of the premium is greater than 9.5% of the employee's total household income. All employers, regardless of size, that offer coverage are required to participate in the free choice voucher program.

- **Employer Penalties for Lack of or Insufficient Coverage –** For employers that do not offer health coverage to full-time employees and one employee gets subsidized coverage through an Exchange, the penalty is $2,000 per FTE excluding the first 30. If the employer offers health coverage, but it is determined to be unaffordable and one FTE receives a premium tax

credit, then the penalty to the employer is the lesser of $3,000 for each FTE receiving a credit or $2,000 for each FTE, excluding the first 30.

- **Free Choice Vouchers** – Employers that offer coverage and contribute toward the cost of coverage must provide "free choice" vouchers to qualified employees for use in an Exchange if an employee chooses to opt out of the employer-sponsored plan.

- **Waiting Period in Excess of 90 Days Prohibited** – Plans may not impose a waiting period of longer than 90 days.

- **Coverage of Adult Children to Age 26** – All plans that provide coverage to dependent children must make that coverage available to adult children (regardless of marital status) through age 26 even if the adult child is otherwise eligible for coverage through his or her employer.

- **Pre-existing Condition Exclusions Limited -** Plans may not impose pre-existing condition limitations on any participants.

- **Annual Dollar Limits on Prohibited -** Plans may not impose any annual dollar limits on essential benefits.

- **Wellness Programs Incentives Increased** – The maximum incentive cap for wellness programs is increased from 20% to 30%, with the possibility of raising the cap as high as 50%.

- **Additional Employer Reporting to IRS** – Employers are required to provide annual reports to the IRS to demonstrate minimum essential coverage.

- **Auto-Enrollment for Certain Employers** – Employers that have more than 200 full time employees and offer health coverage, must automatically enroll full time employees in the coverage unless the employee opts out.

Non-grandfathered Plans Only

- **Limits on Cost-Sharing and Deductibles** – Plans must limit participant annual cost-sharing to the limits established for other high deductible health plans. Plans must further limit deductibles to $2,000 for individual coverage and $4,000 for family coverage.

- **Coverage of Clinical Trial Expenses** – Plans must cover costs for participation in certain clinical trials.

2018:

- **Cadillac Tax on High Cost Plans** – An excise tax of 40% will be imposed on high cost employer-sponsored coverage.

Implementation Initiatives

A variety of other implementation initiatives have been announced. For example, the IRS has issued additional proposed regulations concerning the post-2013 health insurance premium tax credit. *See* proposed IRS Regulation 1.36B-1 through 1.36B-5. Other proposed regulations address various topics, including:

UNIFORM DISCLOSURE REGULATIONS

On August 17, 2011, The IRS, Department of Labor, and the Department of Health and Human Services issued proposed regulations regarding the uniform disclosures of plan benefits and coverage that group health plans and health insurance issuers offering group health insurance coverage must make to plan participants and beneficiaries. These regulations are intended to become effective on March 23, 2011.

The new uniform disclosure rules (IRS Reg. 54.9815-2715 and Labor Reg. 2590.715-2715) describe the information that must be included in the required summary of benefits and coverage (SBC). They also specify when this information must be provided by the group health insurance issuers to group health plans and by group health insurance issuers and group health plans to plan participants and beneficiaries. The SBC must include:

- Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- A description of the coverage, including cost sharing, for each category of benefits identified by IRS guidance, and the exceptions, reductions, and limitations to the coverage;
- The cost sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;
- The renewability and continuation of coverage provisions;
- With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage meets minimal essential coverage requirements and whether the plan's or the coverage's share of the total allowed costs of benefits provided under the plan or coverage meet applicable requirements;
- A statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;
- Contact information for questions and obtaining copies of the plan document or the insurance policy, certificate or contract of insurance, and relevant internet addresses for network providers; and,
- Coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions).

Failure to comply with these requirements may result in the imposition of an excise tax of up to $100.00 per day per individual for each day the plan fails to comply.

AFFORDABLE INSURANCE EXCHANGES

The Department of Health and Human Services has issued proposed regulations detailing the standards and processes for enrolling in qualified health plans and insurance affordability programs through the Affordable Insurance Exchanges established under the Patient Protection and Affordable Care Act of 2010. *See* 45 CFR parts 153, 155, and 156 (7/11/2011).

The exchanges, which will become operational by January 1, 2014, are intended to provide competitive market places for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The new proposed Regulations are directed at eligibility determinations for Exchange Participation and Insurance Affordability Programs. Among other things, the proposals for exchange eligibility are intended to minimize the burden on states and individuals by relying on electronic data sources to verify applicant information wherever possible. Exchanges will be required to use information technology standards that will make the system easily accessible to consumers while encouraging innovation and competition.

Small Business Heath Options Program (SHOP)

The Department of Health and Human Services has also proposed regulations outlining basic standards for employer participation in the initial Small Business Health Options Program. *See* 45 CFR parts 155 Subpart D and 157; 76 Federal Register 51202 (8/17/2011). In addition to standards for employer participation, these regulations describe employer obligations for offering their employees qualified health plans, including employer requirements for disseminating information to their employees about selecting and enrolling in qualifying health plans. For this purpose, employers may need to interact with insurance exchanges to verify employee eligibility for qualifying coverage in an eligible employer-sponsored plan. Since the systems are new, HHS is soliciting comments on these ideas and on the timing of the interactions between employers and Exchanges and how these interactions might be structured.