High-Level Overview

Health Reform Law: Key Provisions for Large Employers

SAGE Benefit Advisors

Changes that affect your business and the employees who depend on you.

Not to be used for implementation purposes

IMPORTANT: This document is designed to provide a general overview of the new health reform law. It does NOT attempt to cover all of the law's provisions and should NOT be used as legal advice for implementation activities. We encourage you to seek any professional advice, including legal counsel, regarding how the new requirements will affect your specific plan.

Overview

The health reform package is made up of two parts: a bill that passed the Senate on Christmas Eve, passed the House on March 21, and was signed into law by the President on March 23, and a second piece of legislation: the House's reconciliation bill, which makes changes to the original law, passed both chambers on March 25, and was signed by the President on March 30.

Many of the provisions in the law will not take effect for several years. At the earliest, provisions that affect employer-sponsored health plans will take effect six months from the date of enactment – in late September. Even then, those early provisions will not affect plans until they renew for the next plan year.

The health reform law has thousands of pages and hundreds of provisions. So it's important to remember that before many of those provisions are put in place, additional laws and regulations will need to be developed. That could be a lengthy process. Here are some highlights of the major provisions.

Individual responsibility

Starting in 2014, everyone must have coverage or pay a penalty, which will be enforced by the Internal Revenue Service. The penalties will be phased in over time:

- In 2014, an individual without insurance must pay whichever amount is greater: $95 or 1 percent of income.
- For 2016 and beyond, that penalty rises to $695 or 2.5 percent of income, whichever is greater (the $695 is indexed from 2016 on).
- Families will pay half the penalty for children, with a cap of $2,085 per family.
- There will be exemptions to this requirement, such as in cases of financial hardship and other limited circumstances.

Subsidies to buy insurance in new state exchanges will be available in the form of tax credits and cost-sharing assistance for people above Medicaid eligibility but below 400 percent of the federal poverty level. Medicaid eligibility will be increased to 133 percent of the federal poverty level.

Employer responsibility

New employer penalties and obligations

Starting in 2014, employers don't have to offer their employees health insurance coverage, but most of them with more than 50 employees will pay an assessment if they don't, or if they offer coverage that isn't affordable. Full-time and part-time employees are included when determining whether an employer has 50 employees (based on current full-time employee equivalency rules).

- Employers with 50 or more employees that do not offer "minimum essential coverage" will pay $2,000 for each employee over the first 30 employees if one of their employees gets a tax subsidy to buy insurance under an exchange.
- Employers with 50 or more employees that do offer minimum essential coverage but have at least one full-time employee receiving subsidized coverage under an exchange will pay whichever is less: $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee.

Employers must provide "free choice" vouchers to employees with incomes below 400 percent of the federal poverty level if the employee's contribution to coverage is between 8 percent and 9.8 percent of income and the employee chooses to purchase coverage in the exchange. No penalties will be imposed on employers with respect to employees who receive these vouchers.

New employer reporting requirements

- Beginning in 2011, employers will be required to disclose the value of health care benefits on an employee's annual W-2.
- Employers will be required to notify employees:
    - About the availability of the exchange – for new employees, at the time of hiring; for current employees, by March 1, 2013;
    - They may be eligible for a subsidy under the exchange if the employer's contribution to the plan is less than 60 percent of total allowed costs of the benefits;
    - If the employee purchases coverage in the exchange, he or she will lose the employer's coverage contribution.
- In 2014, Large employers will be subject to expanded 550 reporting requirements in include information on the health insurance coverage of their employees.

Group Health plan changes

Under the new law, employers/employees have the right to keep the coverage they had as of March 23, 2010 and are exempt from many reforms. These group health plans are considered "grandfathered plans." Collectively bargained plans that were ratified before the date of enactment are grandfathered until the date that the last collective bargaining agreement related to coverage ends.

Changes that impact large employers (both fully insured and self-funded plans unless otherwise noted) over the next few years:

IMMEDIATELY:

- **Federal rate review.** The Department of Health and Human Services (HHS) will establish a process for federal review of fully insured premium rate increases.

IN 90 DAYS:

- **Reinsurance for early retirees.** A temporary reinsurance program will be established for employers providing coverage to early retirees over age 55 who are not eligible for Medicare. The federal government will provide $5 billion to fund the program. Participating employers or insurers will be reimbursed 80 percent of retiree claims between $15,000 and $90,000. The program will be effective through 2013.

IN SIX MONTHS:

For new plans or plans renewed six months after the enactment date (includes "grandfathered plans"):

- **Lifetime and annual limits.** Plans may not impose lifetime limits on the dollar value of essential benefits. Annual limits will be restricted (to be determined by HHS).
- **Rescissions.** No rescissions are permitted, except in cases of fraud or intentional misrepresentation.
- **Coverage for adult children.** Children may stay on their parents' policies until age 26 if coverage isn't available through their work, regardless of their marital status. Any employer contribution toward the premium is a tax-deductible business expense for the employer and not taxable income for the member.
- **Pre-existing conditions.** Plans may no longer impose pre-existing condition exclusions for children under 19.

For new plans or plans renewed six months after the law's enactment date (does not include "grandfathered plans"):

- **Preventive services.** New policies must cover the full cost of preventive care as recommended by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care for women.
- **Appeals.** New minimum requirements for internal and external claims appeals processes.
- **Patient protections.** Plans that require or provide for a primary care provider (PCP) designation must allow each member to designate any in-network PCP, or pediatrician for children, accepting new patients. Plans may no longer require an authorization or referral to an Ob-Gyn. Prior authorization or increased cost-sharing for emergency services is also prohibited.
- **Nondiscrimination rules.** Nondiscrimination rules that apply to self-funded health plans are expanded to group fully insured health plans. Plans cannot base an employee's eligibility or continued eligibility on hourly or annual salary.

IN 2011:

- **Medical loss ratio (MLR).** An insurer must publicly report on its MLR and spend at least 80 percent of small group premiums on medical services or provide rebate payments to enrollees.
- **Spending accounts.** Health savings accounts (HSAs) and flexible spending accounts (FSAs) may no longer be used to purchase over-the-counter drugs unless prescribed by a doctor. Increases tax for nonqualified HSA withdrawals from 10 percent to 20 percent, and for Archer MSA withdrawals from 15 percent to 20 percent.
- **HHS studies.** HHS is required to study the group health plan markets to compare employer characteristics and determine whether the new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure. HHS and the Department of Labor must also collect information on self-funded plans. These studies could lead to additional employer reporting requirements.
- **Uniform explanation of coverage.** Within 12 months of the law's enactment, HHS, in consultation with the National Association of Insurance Commissioners, will develop uniform standards and definitions for summaries of benefits and coverage explanations. Within 24 months of enactment, group health plans must provide enrollees and applicants with coverage documents that meet these standards.

IN 2012:

- **Comparative effectiveness fee.** A new fee is imposed on group health plans to fund comparative effectiveness research ($1 per participant through 2013; $2 per participant through 2019).
- **Release of Medicare claims data.** The private sector may purchase standardized data extracts of Medicare Part A, B and D claims data to combine with their own claims data to evaluate provider performance measures on quality, efficiency, and the effectiveness of care.

IN 2013:

- **FSA contributions.** Contributions to flexible spending accounts are limited to $2,500 a year.

IN 2014:

- **Pre-existing conditions.** Group health plans can no longer impose pre-existing condition exclusions for any person of any age.
- **Annual limits.** Annual limits on essential health benefits are prohibited.
- **Guaranteed issue.** Health insurers must accept every employer who applies for coverage.
- **Clinical trials.** Coverage of routine patient care costs is mandated for participation in approved clinical trials (does not apply to grandfathered plans).
- **Exchanges.** State health insurance exchanges are up and running for small businesses and individuals to buy insurance. States can allow large employers to participate beginning in 2017. (Note: the federal definition of a large employer is an employer with 101 or more employees. States can modify the definition to 51 or more employees until January 1, 2016).
- **Cost-sharing limits.** Cost sharing imposed under group health plans is limited to current health savings account amounts (does not apply to grandfathered plans).
- **Waiting periods.** Waiting periods cannot exceed 90 days.
- **Wellness.** Expands health plan wellness incentives up to 30 percent of total coverage costs (up to 50 percent with HHS approval).
- **Essential benefits.** Essential benefit plan is created, which mandates the level of benefits that must be included in plans offered in the exchange, as well as in the individual and small group markets outside the exchange. (Self-funded plans and grandfathered plans are exempt from this requirement).
- **Reinsurance.** A temporary reinsurance program will be established for the individual market and funded by individual and group health plan assessments ($25 billion in 2014-2016).

IN 2018:

- **Taxes.** A new excise tax goes into effect for high-value, “Cadillac” health plans: 40 percent for amounts over $10,200 for individuals and $27,500 for family plans, paid by insurance companies and plan administrators.

Medicare and Medicaid-related provisions

- **Retiree drug subsidy.** Beginning in 2013, employers may no longer deduct the retiree drug subsidy when offering qualified coverage under Medicare Part D.
- **Part D donut hole.** Provides a $250 rebate for Part D enrollees who enter the “donut hole” coverage gap (2010 only) Beginning in 2011, there will be a 50 percent brand discount on drugs in the gap. The donut hole is eliminated by 2020.
- **Medicaid.** Beginning in 2014, states are required to provide premium assistance and wraparound benefits to any Medicaid beneficiary who is offered employer-sponsored coverage, if it is cost-effective to do so.

Other

- **Administrative simplification.** The law also requires HHS to adopt a single set of operating rules for electronic transactions to create uniformity (e.g., health claims or equivalent encounter information, eligibility and claims status, enrollment and disenrollment, premium payments, and referral certification and authorization). Group health plans will have to certify compliance with these standards.
- **CLASS Act.** Creates a new government-run voluntary long-term care insurance program (CLASS Program). Employers must automatically enroll employees and facilitate payroll deductions. Employees may choose not to participate.

Revenue-raising provisions

- Starting July 1, 2010, impose a 10 percent tax on tanning services.
- Beginning in 2011, the pharmaceutical industry will pay annual industry fees. The fee will be phased in and will hold steady at $2.8 billion a year after 2019.
- Beginning in 2013, manufacturers of medical devices will pay a 2.3 percent excise tax on sales of medical devices.
- Beginning in 2013, the Medicare payroll tax rate will increase by 0.9 percent for individuals who make more than $200,000 and couples that make more than $250,000.
- A new 3.8 percent tax will be added on income from interest, dividends, annuities, royalties and rents for those at the same income threshold.
- Beginning in 2014, a non-deductible premium tax will be imposed on insurers ($8 billion in 2014, 11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. After that, it will increase in an amount proportional to overall premium growth).