



March 30, 2010

Health Reform – What It Means to Employers

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act together represent a significant legislative milestone. Six of the last 11 presidents have offered proposals to address the problem of the uninsured. While three modern presidents have overseen dramatic expansions of government-involved health coverage, including Medicare, State Children's Health Insurance Program, and Medicare Part D (prescription drug coverage for Medicare participants).

Given the complexity of the reform legislation, we cannot expect this to be the end of the health care reform debate. There are many legal challenges arising at the state level concerning aspects of the laws. Further, Health and Human Services, Treasury, and the Labor departments have been given authority to interpret many provisions, while each state has been charged with creating and implementing certain statutory specifics. This means the legislative framework of these acts will continue to be fleshed out and the impact on our businesses will shift and unfold over time.

In the meantime, we would like to assure you that we will continue to stay abreast these changes and communicate their impact on you. We have provided an Impact Timeline that highlights key aspects related to employer plans for your reference. We want you to be knowledgeable so you can prepare operationally and financially for the changing landscape.

There are several resources that you may find helpful as you continue to educate yourselves on these sweeping changes. The Kaiser Family Foundation (<http://www.kff.org>) has several comparison charts that are very helpful and reader friendly. The National Association of Health Underwriters (<http://nahu.org>) has published summaries that outline the insurance reform and benefits plan design changes expected over the next several years.

Employers, employees, insurers, governmental entities and benefits consultants are all in this together! We must search for and adapt to the new opportunities these laws provide us. To that end, look for us to have an ongoing dialogue with you as changes to the benefits industry and your plans occur in response to the health care reform legislation.

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IMPACT TIMELINE

2010

- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and, prior to 2014, plans may only impose annual limits on coverage as determined by the Health and Human Services Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide, at a minimum, coverage without cost-sharing for preventive services, certain recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Require individual and group health plans to provide coverage of emergency services at in-network level, regardless of provider.
- Allow enrollees of group health and individual plans to designate any network doctor as the primary care physician, including OB/GYNs or pediatricians.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees.
- Require all employers to include on W-2s the aggregate cost of employer sponsored health benefits with certain exclusions applicable.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014.)

2011

- Small employers (generally those with 100 or fewer employees) will be allowed to adopt new “simple cafeteria plans.”
- Provide grants for up to five years to small employers that establish wellness programs.
- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.
- Increase the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.



2013

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Limit the amount of contributions to a health FSA for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.
- Require employers to provide notice to their employees informing them of the existence of an Exchange.

2014

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. 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.
- Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.



- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan. (Employer sponsored plans offered outside of the exchange do not have to provide essential benefits coverage.)
- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

2018

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018.)