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Health Care Reform Update

The following is a timeline of the effective dates of what we believe to be important provisions for employers found in the Patient Protection and Affordable Care Act (PPACA) of 2010 and the Health Care and the Education Tax Credit Reconciliation Act of 2010. It is important to note that many of these reforms and their effective dates are subject to both state and federal rules and regulations, which could alter the intended timing of implementation. In addition, group health plans and individual health insurance coverage qualifying as a "grandfathered plan" are exempt from several of the requirements so long as "grandfathered" status is maintained. (*See* pg. 6 for summary of "Grandfathered Plans.")

Changes Starting after September 23, 2010

Prohibition Against Lifetime Plan Limits or Caps	Group health plans and insurance companies providing group or individual market coverage are prohibited from setting lifetime limits on the dollar value of essential benefits for any participant or beneficiary. The Department of Health and Human Services (HHS) will issue guidance on what is considered an essential benefit. **Note**: Annual limits will be banned completely in 2014.
Prohibition Against Rescission of Coverage	Group health plans and insurance companies providing group or individual market coverage are prohibited from rescinding coverage once an enrollee is covered under a plan. Notwithstanding this general rule, group health plans and insurance companies providing group or individual market coverage may rescind coverage where a fraud or intentional misrepresentation occurs.
Elimination of Cost-Sharing for Preventive Care in Medicare and Private Plans	Preventive care will now be covered at 100%, eliminating all cost-sharing requirements imposed on insured participants. On July 14, 2010, final Interim regulations defining what medical services qualify as "preventive care" were published in the Federal Register. In addition to routine immunizations for children, adolescents, and adults; the following is a non-exhaustive list of medical services and procedures which may not be subject to any participant cost-sharing: (1) one-time screening for abdominal aortic aneurysm in men aged 65 to 75 who have ever smoked; (2) blood pressure screening for all adults over age 18; (3) breastfeeding counseling for new mothers; (4) breast cancer screening for all women over the age of 40 every 1-2 years; (5) a cervical cancer screenings for sexually active women; (6) screening for elevated cholesterol lipids for men over the age of 35; (7) screening for elevated cholesterol lipids for women over the age of 45; (8) colorectal cancer screening for all adults over the age of 50 and continuing until the age of 75; (9) diabetes screenings for adults with pre-diabetes symptoms; (10) venereal disease testing for pregnant women; (11) HIV screening for at risk individuals; (12) routine osteoporosis screening for women over the age of 60.
Adult Children Coverage	If a plan covers dependent children, it must continue to do so for unmarried and married children until the child attains age 26. For plans already in existence on March 23, 2010, the age 26 limit only applies if the child is not eligible for other coverage. This exception ends in 2014. Final interim regulations explaining the extent of coverage and eligibility of coverage were published in the Federal Register on May 13, 2010 and specifically mandate that the terms of a group health plan or individual health insurance coverage providing dependant coverage cannot vary or be restricted based on age (except for children who are 26 or older). Ohio has recently enacted similar legislation that, like its federal counterpart, extends coverage

	for adult children in all plans that provide coverage for dependant children. Unlike the federal law, however, the limiting age for coverage is 28 and the child must be (1) unmarried; (2) not employed by an employer that offers any health benefit plan which the child is eligible for coverage, and (3) not eligible for coverage under Medicare or Medicaid.
Pre-existing Condition Exclusions, Part I	Insurance Plans cannot exclude pre-existing conditions for children under age 19. This includes both employees, who may themselves be under 19 years of age, and dependents of employees under age 19. Currently, it is not clear whether the prohibition expires on the individual's 19th birthday, or whether it applies until the end of the plan year in which the individual turns age 19. It is anticipated that forthcoming regulations with provide further guidance. This is the first stage of the elimination of pre-existing condition exclusion. In 2014, all pre-existing condition exclusions will be abolished.
Small Business Tax Credit, Phase I	Small employers are eligible for new tax credits to offset their premium costs in 2010. Under Phase I of the Small Employer Tax Credit, employers with no more than 25 employees and average annual wages of less than $50,000 can qualify for a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% off the total premium cost (or 50 % of a benchmark premium to be determined by the Secretary of HHS). When determining total number of employees and wages, the following categories of individuals are excluded: (1) self employed individuals, including sole proprietors and partners in a partnership; (2) individuals owning more than 2% of a subchapter S corporation; (3) Individuals owning more than 5% of a corporation; and (4) certain family members and dependants of these individuals. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance. Notably, the full credit (*i.e.*, 35%) is available only to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as an employer's size and average wage increase.
Temporary National High Risk Pool	Individuals with pre-existing conditions will be eligible for subsidized coverage through a national high risk pool. People who have been uninsured for at least six months and who have a preexisting condition will be eligible for subsidized coverage through a temporary national high-risk pool, to be established by the Secretary of HHS. High risk pools will not impose pre-existing condition exclusions and plans will be reviewed to cover on average no less than 65% of medical costs and places caps on out-of pocket expenses. The Secretary is to receive $5 billion to carry out the program.
"Doughnut Hole" Rebate	Under the Medicare Part D benefit, the "doughnut hole" starts when the retail cost of a Medicare beneficiary's medications reaches $2,830 and continues until the beneficiary has spent $4,550 (which would be reached when the covered cost of medications reaches $6,430). In this gap the Medicare Beneficiary must pay 100% of the cost of his or her medication. Pursuant to Health Care reform, Medicare beneficiaries who reach the coverage gap, or "doughnut hole," in prescription drug coverage are eligible to receive $250 rebates. The coverage gap is phased out completely by 2020.
Employer Retiree Health Benefits Reinsurance	Effective June 1, 2010 the Patient Protection and Affordable Care Act established a temporary program to reimburse employment-based plans for a portion of the costs they incur providing health coverage to early retirees. Under this program, a plan sponsor may be reimbursed for 80% of the qualifying retiree health benefit costs incurred by its retiree health plan. Qualifying costs are limited to those that exceed $15,000 and do not exceed $90,000.
Limits on Share of Private Premiums Insurers Spend on Non-Medical Costs	New limits will be set for the percent of premiums that insurers can spend on non-medical costs. Beginning in 2010, health plans are required to report the proportion of premiums spent on items other than medical care. Beginning in 2011, health plans that spend less than 85% on medical care will be required to offer rebates to enrollees.

Changes Starting on January 1, 2011

Increased Tax on Non-Medical Distributions for Health Saving Accounts (HSA)	The current tax on spending distributions from HSAs that are not used for qualified medical expenses is increased from 10% to 20%.
Reporting of Employer Benefits on IRS Form W-2	Employers are required to report the value of health care benefits, including medical, dental, vision and supplemental coverage, on employees' W-2 tax statements.
SIMPLE Cafeteria Plans for Small Businesses	A cafeteria plan is an employer sponsored plan under which employees have the option of selecting benefits or cash. Employees can choose which tax free benefits fit their needs or elect to receive taxable cash payments in lieu of unselected benefits. For example, under a cafeteria plan, employees are able to pay their share of premiums for employer provided health insurance on a pre-tax basis through salary reductions. A cafeteria plan may not discriminate in favor of highly compensated participants or other key employees. In the past, these non-discrimination rules have discouraged the use of cafeteria plans by small businesses as smaller businesses tend to have a higher ratio of highly compensated and key employees to other employees. The healthcare reform package eases the administrative burden to small businesses b y providing eligible small employers a safe harbor from the nondiscrimination requirements for cafeteria plans as well as from the nondiscrimination requirements for specified qualified benefits offered under a cafeteria plan, including group term life insurance, benefits under a self-insured medical expense reimbursement plan, and benefits under a dependent care assistance program.
Over-the-Counter Drug Costs Reimbursement Restrictions in HRA, HAS, and FSA	Over-the-counter drugs not prescribed by a doctor cannot be reimbursed through a Health Reimbursement Account or Flexible Savings Account and such drugs cannot be reimbursed on a tax-free basis through a Heath Savings Account.
Discounts to Medicare Part D Enrollees in the "Doughnut Hole"	Beneficiaries are eligible for 50% discounts on all brand-name drugs in the doughnut hole. Additional discounts on brand-name and generic drugs are phased in, completely closing the "doughnut hole" for all Part D enrollees by 2020.

Changes Starting on March 23, 2012

New Explanation of Coverage Document	The plan administrator (self-insured plans) or the insurance carrier (fully-insured plans) must give a coverage summary to all applicants and enrollees, at initial enrollment and open enrollment. This is in addition to the Summary Plan Description (SPD). HHS will provide standards by March 23, 2011. The document can be no more than four pages long and address covered benefits, exclusions, cost sharing and continuation. A $1,000 penalty applies for each failure to provide.

Changes for Plan Years Starting on or after January 1, 2013

Health FSA Limit	Beginning January 1, 2013, the Act imposes a limit of $2,500 per taxable year on employee salary reductions for coverage under a cafeteria plan Flexible Spending Arrangement ("FSA"). Current law does not impose a limit on salary reductions into an FSA, but many employers impose a limit on annual contributions ($5,000 is a common limitation).
Medicare Retiree Drug Subsidy (RDS) Tax Deduction	Employers offering retiree drug coverage have long been able to receive a 28% subsidy on the costs through a tax deduction. That will end as of this effective date.

Medicare Payroll Tax	Beginning in 2013, the Act imposes an additional 0.9% Medicare Hospital Insurance Tax ("HI tax") on all earned income in excess of $200,000 for individuals, and $250,000 for joint filers. Thus, the HI tax rate increases from the current 1.45% to 2.35% on earnings above those income thresholds. The increased tax applies only to the wage earner or self-employed person and does not increase the employer's portion of the HI tax. However, the employer will have withholding responsibility. It should also be noted that, unlike the wage cap on Social Security wages, neither the $200,000 nor the $250,000 threshold for additional HI tax is indexed for inflation. In addition, self-employed persons cannot deduct any portion of the additional tax. A new tax of 3.8% on unearned income, such as dividends and interest, is also added.
Health Care Choice Compacts	The Secretary of HHS in consultation with the National Association of Insurance Commissioners will issue regulations by July 13, 2013, for the creation of health care choice compacts under which two or more states may enter into an agreement to allow for purchase of qualified health plans across state lines beginning in 2016.

Changes for Plan Years Starting on or after January 1, 2014

Health Insurance Exchange	Each state is required to establish an American Health Benefit Exchange and Small Business Health Options Program (SHOP) Exchange by 2014 for individuals and small employers with 50 to 100 employees; after 2017, states have the option of opening the small business exchange to employers with more than 100 employees. States can opt to provide a single exchange to employers with more than 100 employees. States can opt to provide a single exchange for individuals and small employers. Groups of states can form regional exchanges or states can form more than one in-state exchange, but the exchanges must serve a geographically distinct area. While the individual and small-group markets will not be replaced by the exchanges, the same market rules will apply inside and outside the exchanges. Premium subsidies, that can be obtained through the Federal government, can only be used for plans purchased through the exchanges.
Employer Mandate 200+ Employees	Employers with 200 or more full-time employees must automatically enroll all new hires into one of the employer's health benefit plans. All employers must provide Adequate notice and employees who are automatically enrolled must be given an opportunity to opt out of coverage.
Employer Mandate 50+ Employees	Employers with 50 or more employees are required to offer coverage to their employees or pay a fine of $2,000 per full- time employee, if even one employee obtains a federal subsidy to buy health insurance from one of the new state-based health insurance exchanges. The first 30 employees are exempt from the calculation of the penalty. The mandate also requires an employer who does provide coverage to pay either of the following: an "assessment" of $3,000 for each employee who qualifies for subsidized coverage from an exchange either because the employer pays less than 60% of the full actuarial value of the coverage provided or because the employee's cost is greater than 9.8% of their adjusted gross income; or $2,000 per full-time employee, whichever is less.
Pre-existing Condition Exclusions, Part II	Group health plans and insurance companies providing group or individual market coverage Plans are prohibited from excluding anyone due to a pre-existing condition.
Cost-Sharing	Out-of-pocket expenses and deductibles cannot exceed those applicable with the HSA-eligible high-deductible health plans.
Reduced Waiting Periods	All waiting periods for coverage will be limited to 90 days.

Individual Mandate	Individuals who do not enroll in qualifying coverage are subject to an excise tax. They generally pay the greater of a flat dollar amount (2014: $95, 2015: $325, 2016 and beyond: $695) or a percentage of income (2014: one percent, 2015: two percent, 2016 and beyond: 2.5 percent). There is a hardship exemption for those with incomes below a certain level.
Small Business Tax Credit, Phase II	The 35% tax credit that goes into effect in 2010 for businesses with fewer than 25 employees and average wages of less than $50,000 increases to up to 50%.
Annual Plan Limits	Group health plans and insurance carriers may not impose any annual limit.

Changes Starting on January 1, 2018

Cadillac Plan Tax	A 40% excise tax will be applied to the value of a health plan that exceeds a statutory threshold. For most health plans, the threshold in the law will be established at $10,200 for single coverage and $27,500 for family coverage. The threshold for the new excise tax will be adjusted annually for general inflation beginning in 2019. The Act, as amended, also provides for adjusted premium thresholds for Retirees and "high-risk" professions. For retired individuals over age 55 and for plans that cover employees engaged in high-risk professions, the annual premium threshold is increased by $1,650 ($11,850) for individual coverage and $3,450 ($30,950) for family coverage. These amounts will also be indexed for inflation beginning in 2019, as noted above. High-risk professions include: • law enforcement officers; • firefighters; • rescue squad or ambulance crews • longshoreman, and • individuals engaged in construction, mining, agriculture, factory or fishing industries.

Changes Starting on January 1, 2020

Medicare Reform	“Doughnut hole” coverage gap in Medicare prescription benefit is fully phased out. Seniors continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage (*i.e.*, $6,430).

Special Rules for "Grandfathered Plans"

Under the Patient Protection Affordable Care Act (PPCA), group health plans and health and health insurance coverage that were in existence on March 23, 2010 (the enactment date of the Act) are excused from some of the health care reform requirements.

To qualify as a "grandfathered plan" group health plans or individual health insurance coverage must have had at least one participant on the day the PPCA was enacted. To remain a "grandfathered plan," the plan or coverage must have continuously covered someone (although not necessarily the same individual) since March 23, 2010.

Grandfathered Plans Are Excused From Some, But Not All, PPCA Mandates

Although "grandfathered plans" are excused from many of the healthcare reform mandates, they are not excused from all of them.

The following is a list of mandates that apply to "grandfathered plans":

1. Pre-existing conditions exclusion
2. Reduced waiting periods for coverage (not to exceed 90 days)
3. Prohibition on annual/lifetime limits
4. Prohibition on recession
5. Dependant coverage for children under the age of 26. Note: Prior to 2014, coverage need not be provided if the child is eligible for other employer-sponsored coverage.
6. Explanation of Coverage Document

What Will Cause A Plan To Lose Its Grandfathered Status?

In order to maintain "Grandfathered plan" status group health plans and individual insurance coverage must comply with several regulatory mandates. For example, group health plans and individual insurance coverage must not engage in any conduct for the purpose of removing or adding participants to a "grandfathered plan." A Group health plan or individual insurance coverage will lose "grandfathered" status if it engages in a business transaction (*e.g.*, a merger, acquisition, or other restructuring) for the purpose of covering new individuals under a "grandfathered plan." In addition, a plan will lose its "grandfathered" status if a plan transfers employees to another plan unless there is a bona fide employment-based reason for the transfer. However, employees may voluntarily change from one "grandfathered plan" to another without endangering the "grandfathered" status of either plan.

The regulations also contain several other instances that will cause a "grandfathered plan" to lose its "grandfathered" status. Some of these include:

1. Changing the insurance contract or policy under an employer plan.
2. The elimination of all or substantially all benefits to diagnose or treat a particular condition.
3. Any increase in percentage cost-sharing. In addition, increase in fixed-amount cost-sharing can cause a group health plan to lose its "grandfathered" status if it increases beyond that of inflation.

Notwithstanding the above, if a group health plan or individual insurance coverage enacts changes that would cause a plan to lose "grandfathered" status were adopted after March 23, 2010, but before June 14, 2010, (the date the regulations were made publically available), they will not cause a plan to lose "grandfathered" status if the plan modified or revokes the changes as of the first day of the first plan year beginning on or after September 23, 2010.

Finally, according to the preamble to the regulations, the agencies will take into account good faith efforts to comply with a reasonable interpretation of the statutory requirements and may disregard changes to plan terms that "only modestly exceed" the changes that are not permitted and that accumulate before June 14, 2010 (the date the regulations were made publically available).

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