



Health Care Reform: An Overview of the Law and Impact on Employers

Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA)

**A presentation to Municipal Association of South Carolina
by Sharon Cunningham**

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TOWERS WATSON 

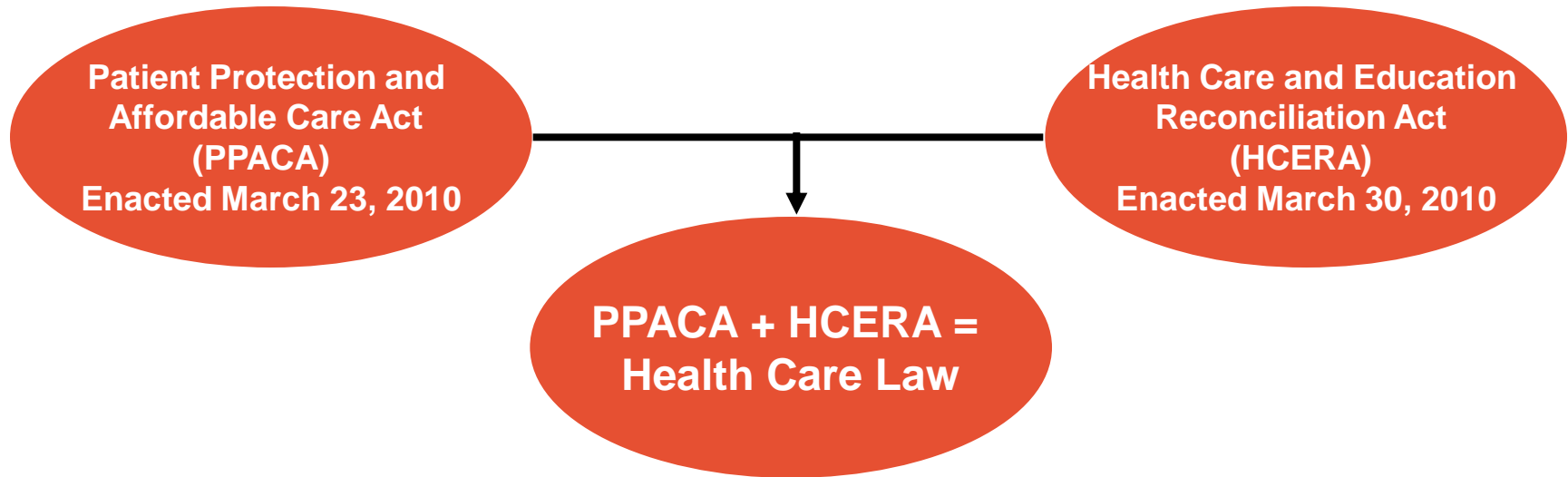
Today's discussion

- Overview of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA)
- Immediate implementation considerations for employers
- Longer-Term Impact on:
 - Employers
 - Employees/Individuals
 - Retirees
- Preparation for 2014 and beyond
- Employer considerations and next steps
- Appendices
 - A: Timeline – 2010-2018
 - B: Looking toward 2014

Overview

Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA)

Health care reform is here — and brings significant short- and long-term challenges for employers

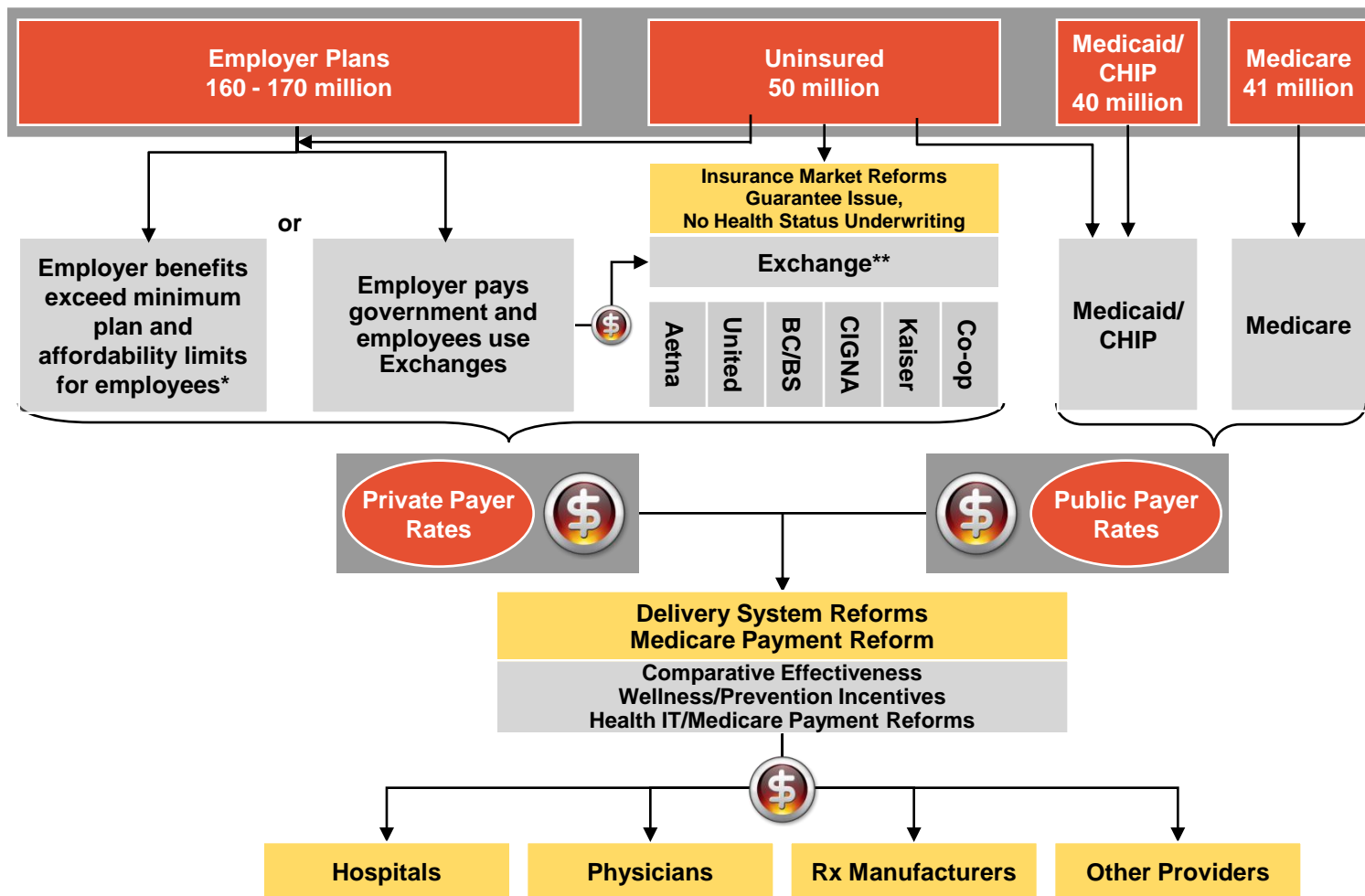


- Health care reform has significant implications for employers, employees/individuals, insurers, health care providers and others
- Impact starts immediately for employers
 - Major changes continue for years to come
- Employers face short-term and long-term challenges
 - *Short-term* challenges include understanding the new law and its implications and implementing immediate provisions
 - *Long-term* challenges include managing compensation and benefit strategy in a new environment

Building blocks of PPACA and HCERA

| Key Element | Provisions |
|------------------------------------|--|
| Individual mandate | <ul style="list-style-type: none"> • All individuals are required to enroll in basic health coverage or pay penalty • Limited exemptions |
| Health insurance market reform | <ul style="list-style-type: none"> • Guaranteed issue, renewal, no rescissions, premium rating restrictions, other consumer protections • Health Benefit Exchanges and standard benefit designs |
| Premium and cost-sharing subsidies | <ul style="list-style-type: none"> • Federal premium subsidies for individuals earning up to 400% of the federal poverty level (FPL) • Cost-sharing subsidies to reduce out-of-pocket expenses • Available only for coverage obtained through Exchanges, not through employer-sponsored plans |
| Health Benefit Exchanges | <ul style="list-style-type: none"> • Established by States, structure the market • Initially, for individual and small group coverage – Large groups may participate at later date |
| Employer mandates | <ul style="list-style-type: none"> • Offer employees who work 30 hours per week coverage meeting minimum requirement or pay penalties • Automatically enroll new employees in coverage and continue enrollment of current employees • Provide vouchers to help certain low-income employees purchase coverage through Exchange • Comply with new benefit mandates and reporting requirements |
| New and expanded public plans | <ul style="list-style-type: none"> • New, private, nonprofit Health Insurance Cooperatives and federally-administered multistate options through Exchanges • Medicaid eligibility expanded up to 133% of FPL |
| Revenue raisers | <ul style="list-style-type: none"> • 40% nondeductible employer excise tax on high-cost group health coverage • Increased and expanded Medicare (HI) taxes on earned and unearned income • Eliminate favorable employer tax treatment of Part D retiree drug subsidy • Changes for account-based plans |

The new health care insurance market



■ Source: U.S. Census Bureau. Does not depict 15 million now with individual insurance expected to move to Exchange or other sources.

* Employees may decline employer's plan in favor of Exchange-based coverage, but they may obtain federal premium subsidies for Exchange-based coverage only if employer coverage does not meet minimum requirements or, is 'unaffordable'.

** Low- and middle-income premium and out-of-pocket cost subsidies available up to 400% of federal poverty level.

Immediate implementation considerations

For Employers

Grandfathered plans

- Group health plans in existence when PPACA was enacted (March 23, 2010)
- Certain design and reporting mandates waived
- Family members and new employees may join plan without loss of plan's grandfathered status
- What actions (if any) might cause loss of grandfathered status remains to be determined
- No grandfathering for
 - Covering adult children to age 26
 - Restrictions on lifetime and annual dollar limits
 - Prohibition against rescissions
 - 90-day limit on waiting periods (2014)
 - Uniform coverage document requirements
 - Prohibitions on preexisting condition exclusions

At a glance — Health care reforms requiring immediate attention

| Key provisions effective 2010 and 2011 | | |
|--|--|---|
| Provisions | Overview | Effective date |
| Benefit mandates and consumer protections | <ul style="list-style-type: none"> • Cover adult children to age 26 • No lifetime and restricted annual dollar limits • No rescissions • No preexisting condition exclusion for enrollees under age 19 • Preventive health services without cost sharing* | Plan years beginning 6 months after enactment |
| Early retiree health reinsurance program | <ul style="list-style-type: none"> • Reimburse 80% of early retiree costs between \$15,000 and \$90,000 | HHS Secretary to establish by June 21, 2010 |
| Tax provisions | <ul style="list-style-type: none"> • No OTC medicines or drugs through FSAs, HRAs or HSAs, unless prescribed • Higher penalty if HSA distributions not used for qualified medical expenses • W-2 reporting of value of employee health coverage | Taxable years beginning after December 31, 2010 |
| Medicare Part D changes | <ul style="list-style-type: none"> • Accounting for RDS and other Part D changes • Begin to close the donut hole | 2010 and beyond |
| Community Living Assistance Services and Supports (CLASS) Act | <ul style="list-style-type: none"> • Voluntary federal disability/long-term care program funded through individual contribution • Employers may facilitate enrollment, withhold payments for employees | January 1, 2011 |

*Grandfathered plans (group health plans in existence when PPACA was enacted) are not subject to requirement

Health care reforms requiring immediate attention — Insured and self-insured group health plans

| Provisions effective for plan years beginning 6 months after enactment | |
|--|--|
| Provision | Description |
| Cover adult children to age 26 | <ul style="list-style-type: none"> • If plan offers dependent coverage, it must cover an adult child to age 26 regardless of whether child (1) is the employee's tax dependent, (2) resides with the employee or (3) is married • Coverage is tax-free for employer and adult child • Before 2014, grandfathered plan not required to cover adult child who is eligible for an employer plan (other than plan of parent's employer) • Plan is not required to cover children of such dependents • Plan may not deny or restrict coverage based on child's financial dependence on employee (or any other person), residency with employee (or any other person), student status, employment status or combination of these factors • Terms of plan cannot vary based on age (except for children 26 and older) |
| No lifetime dollar limits | <ul style="list-style-type: none"> • No lifetime dollar limits on essential benefits |
| Restricted annual dollar limits | <ul style="list-style-type: none"> • Before 2014, plan may impose only restricted annual dollar limits on essential benefits • HHS Secretary to define restricted limits |

Health care reforms requiring immediate attention — Insured and self-insured group health plans (continued)

| Provisions effective for plan years beginning 6 months after enactment | |
|--|---|
| Provision | Description |
| No rescissions | <ul style="list-style-type: none"> Plans cannot revoke coverage after an individual enrolled <ul style="list-style-type: none"> Exceptions for fraud and intentional misrepresentation |
| Cover preventive services* | <ul style="list-style-type: none"> Plans are to cover preventive services without cost-sharing requirements <ul style="list-style-type: none"> Evidence-based health care services rated A or B by U.S. Preventive Services Task Force Immunizations recommended by CDCP** Advisory Council Preventive care and screenings for infants, children and adolescents under Health Resources and Services Administration guidelines Preventive care and screenings for women under Health Resources and Services Administration guidelines |
| Prohibition on salary discrimination* | <ul style="list-style-type: none"> Extend Internal Revenue Code section 105(h) to insured plans Self-insured plans already subject to requirement |

* Grandfathered plans (group health plans in existence when PPACA was enacted) are not subject to requirement

**CDCP: Center for Disease Control and Prevention

Health care reforms requiring immediate attention — Insured and self-insured group health plans (continued)

| Provisions effective for plan years beginning 6 months after enactment | |
|--|--|
| Provision | Description |
| Grievance and appeals procedures* | <ul style="list-style-type: none"> • New rules for internal and external appeals procedures • Allow individuals to review their file, present evidence and testimony and continue receiving coverage pending outcome |
| Patient protections* | <ul style="list-style-type: none"> • Cover emergency services without prior authorization and without increased out-of-network cost-sharing • Special rules for direct access to pediatricians and OB/GYN care |

* Grandfathered plans (group health plans in existence when PPACA was enacted) are not subject to requirement

Health care reforms requiring immediate attention

| Provision | Description |
|--|---|
| Uniform explanation of coverage documents | <ul style="list-style-type: none">● In addition to SPD:<ul style="list-style-type: none">● 4-page required disclosure with specific requirements● Notice of material changes to be provided 60 days <i>before</i> they become effective● HHS Secretary to issue standards for disclosure within 12 months of enactment<ul style="list-style-type: none">— Employer distribution begins within two years of enactment |
| Medical loss ratios for <i>insured</i> plan | <ul style="list-style-type: none">● Insurance issuers required reporting on medical loss ratio<ul style="list-style-type: none">● Reporting effective for plan years beginning after enactment● Rebates if ratio does not meet statutory requirements<ul style="list-style-type: none">● Rebates to begin not later than January 1, 2011<ul style="list-style-type: none">— 85% in group market— 80% in individual market |

Health care reforms requiring immediate attention — Early retiree health reinsurance program

- HHS Secretary to establish program; began on June 1, 2010
- Federal program would reimburse 80% of eligible claims
 - Exceeding \$15,000 but not \$90,000
 - Incurred by non-Medicare retirees age 55-64 and their spouses and dependents
- Payments may
 - Not be used as general revenues for employer
 - Reduce health premium or benefit costs for employer
 - Reduce premiums, contributions, cost-sharing for retirees
- Plans must meet minimum requirements, apply for participation
 - Applications processed in order received; application to be available by end of June
 - Secretary may limit participation in program to comply with funding limit
- Program is limited
 - \$5 billion in funding
 - Sunsets January 1, 2014 (or when funds run out)

Health care reforms requiring immediate attention — Tax provisions

- Over-the-counter medicines and drugs
 - Effective January 1, 2011
 - No reimbursement through health FSAs, HRAs, HSAs, unless prescribed
- W-2 reporting
 - Effective for taxable years beginning after December 31, 2010
 - Aggregate value of coverage, excluding health FSA and HSA
 - Individualized calculation depending on combination of coverage chosen
 - Valued by COBRA premium
- HSA penalty
 - Effective for distributions made after December 31, 2010
 - Penalty for distributions not used for qualified medical expenses if individual is younger than 65
 - Penalty increased from 10% to 20% of distribution

Requiring immediate attention — Retiree-only plans

- Retiree-only plans may be able to avoid certain mandates based on long-standing exemption for such plans under ERISA and IRC
 - Provisions impacted by retiree-only plan exemption include:
 - Lifetime/annual benefit limits; coverage for adult children to age 26; rescissions of coverage; limits on waiting periods; prohibition against preexisting conditions exclusions
- Employers should review applicability of this exemption with legal counsel

Longer-Term Impact

On employers

At a glance - Longer-Term key elements having direct implications for employers

| Key Element | Key Provisions effective 2014 and Beyond |
|---|--|
| Employer responsibility requirements | <ul style="list-style-type: none"> • Play-or-pay • Employer free-choice vouchers • Automatic enrollment • New disclosures to government and participants |
| Tax provisions | <ul style="list-style-type: none"> • High-cost plan excise tax • W-2 reporting • Comparative effectiveness fee on employer plans • Account-based plan changes |
| Employer plan design requirements | <ul style="list-style-type: none"> • No excessive waiting periods • No preexisting condition exclusions • No lifetime/annual limits on essential benefits • No exclusion for participants in clinical trials* • Preventive care requirements* |

* Grandfathered plans (group health plans in existence when PPACA was enacted) are not subject to requirement

Direct implications for employers — Play-or-pay

Play-or-pay mandate based on plan sponsorship

| No employer plan | Employer offers minimum essential coverage |
|---|---|
| <ul style="list-style-type: none"> • \$2,000 x all full-time employees (FTEs) <ul style="list-style-type: none"> • Triggered if any employee receives subsidized coverage through Exchange | <ul style="list-style-type: none"> • Employee contributions to coverage exceed 9.5% of household income • Pay lesser of <ul style="list-style-type: none"> • \$3,000 for each subsidized FTE in Exchange • \$2,000 x all FTEs |

- Effective in 2014
- Penalties nondeductible by employer
- Full-time employees defined at 30 hours per week
- Exclude first 30 employees if calculating penalty where no employer plan or cap for employers that offer coverage
- Employer with 50 or more *full-time equivalent* employees determined by counting *all* employees
 - Special rules for seasonal employees

Direct implications for employers — Free-choice vouchers

- Effective in 2014
- Required if employer offers and contributes toward coverage
- **If** full-time (FT) or part-time (PT) employee:
 - Has household income up to 400% FPL
 - Would be required to pay from 8% to 9.8%* (indexed) of household income toward premiums for employer-coverage
 - Does not participate in employer plan
- **Then** employer must offer voucher to employee (FT or PT)
 - Based on plan to which employer pays largest percentage of cost
 - Adjusted for age
 - Based on employee-only coverage unless employee elects family coverage in the Exchange
 - Voucher payment deducted by employer
- Amount used by employee to purchase coverage through Exchange is tax-free
 - Employee can keep excess as taxable cash
 - No federal subsidies in Exchange for those taking employer voucher

* Need legislated technical correction to lower 9.8% to 9.5% to align with subsidy eligibility

Direct implications for employers — Automatic enrollment

- Effective date unclear; likely 2014
- Applies if employer has more than 200 full-time employees
- Enroll new full-time employees
 - Subject to permitted waiting period
- Continue enrollment for current employees
- Employees may opt-out of coverage
- Employee notice will be required
- Implementation will require DOL to develop regulations under Fair Labor Standards Act

Direct implications for employers — High-cost plan excise tax

- Thresholds effective 2018
 - Basic:
 - \$10,200 individual
 - \$27,500 family
 - Retirees, high-risk professions
 - \$11,850 individual
 - \$30,950 family
 - Additional adjustments
 - Age/gender demographics of plan
 - Higher-than-expected U.S. health care cost increases prior to 2018
 - Indexed
 - CPI-U plus 1% for 2019
 - CPI-U only, beginning in 2020

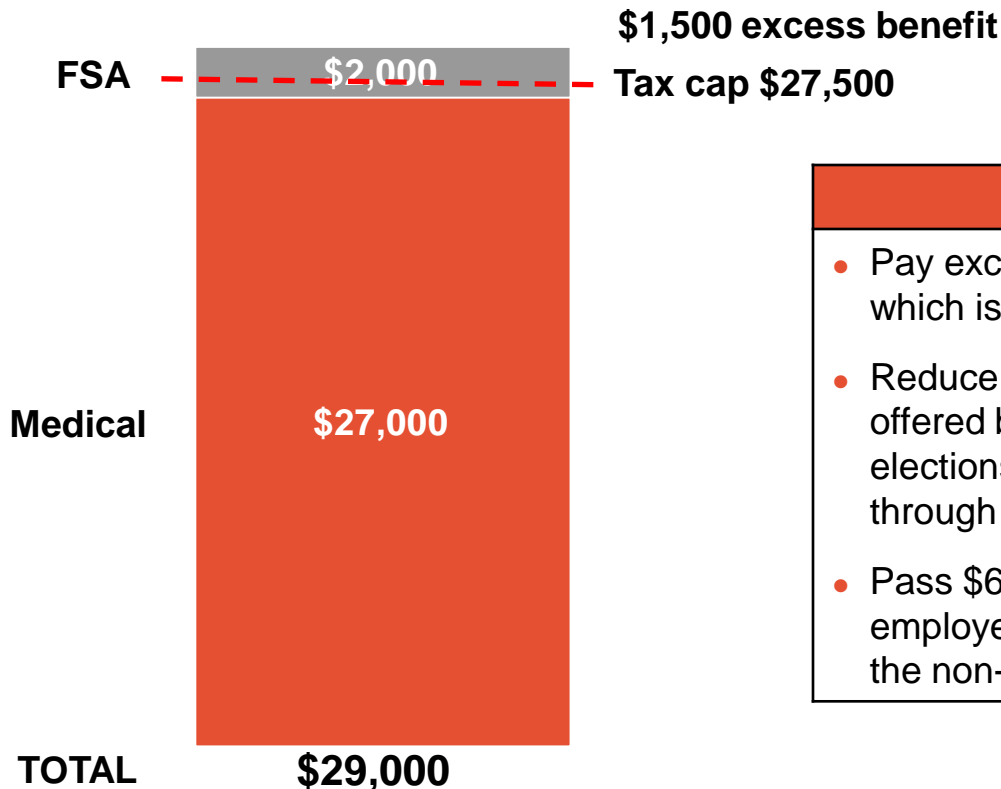
Direct implications for employers — High-cost plan excise tax (continued)

- Aggregate premium for health benefits
 - 40% of amount with respect to an employee's or retiree's coverage above threshold
 - Medical (e.g., PPO, HMO, HDHP), FSA, HRA, HSA contributions (other than other after-tax employee contribution), EAP, on-site primary care medical clinics
 - NOT applicable to separate vision, dental*, certain other limited-scope benefits
 - Determine plan value based on 100% of COBRA premium
 - For purposes of calculating plan value, it does not matter whether the employer or employee/retiree paid the cost of coverage
 - May elect to treat pre-65 retirees together with post-65 retirees
- Imposed on insurers (insured plans), employers (self-insured plans)
 - Employers calculate, apportion, report taxable amounts
 - Plans with insured and self-insured options will need to allocate tax due among options

* Legislative language raises possibility that only insured vision and dental plans exempted

Direct implications for employers — High-cost plan excise tax (continued)

2018 Family Coverage



Employer Options

- Pay excise tax of \$600 ($\$1,500 \times 40\%$), which is non-deductible
- Reduce overall value of health benefits offered by \$1,500, e.g., reduce FSA elections, reduce medical plan value through design changes
- Pass \$600 cost of excise tax along to employee — potentially adjusted to reflect the non-deductible nature

*Illustration based on standard thresholds in PPACA. Under special rules threshold amounts are increased for retirees and for high-risk jobs, and have potential to be adjusted based on higher-than-expected cost increases in U.S. health care system and age and gender demographics in plan.

Direct implications for employers — Tax issues

| Provision | Description |
|----------------------------------|--|
| W-2 reporting | <ul style="list-style-type: none"> • Effective for 2011 • Aggregate value of coverage, excluding health FSA and HSA • Individualized calculation based on employee's chosen coverage • Value based on COBRA premium, less any after-tax employee contribution |
| Account-based plans | <ul style="list-style-type: none"> • Salary-reduction contributions to health FSAs <ul style="list-style-type: none"> • Capped at \$2,500 beginning in 2013 • Indexed to inflation beginning in 2014 • No reimbursement for OTC medicines or drugs through health FSAs, HRAs, HSAs unless prescribed, beginning in 2011 • Penalty for improper HSA distributions increased from 10% to 20% beginning in 2011 |
| Comparative effectiveness | <ul style="list-style-type: none"> • Fee on insured and self-insured plans • FY2013: \$1 per covered life • FY2014-2019: \$2 per covered life, indexed to inflation • Scheduled to sunset after FY2019 |

Direct implications for employers — Additional elements

| Key Element | Provisions |
|---------------------------------|---|
| Plan design requirements | <ul style="list-style-type: none"> • Immediate and longer-term requirements for plans, such as <ul style="list-style-type: none"> • Restrictions on lifetime and annual dollar limits • Prohibitions against preexisting condition exclusions • Extended coverage for adult children to age 26 • No waiting periods longer than 90 days • Coverage for those participating in clinical trials, unless grandfathered |
| HIPAA wellness programs | <ul style="list-style-type: none"> • HIPAA limit on financial incentives for participation in wellness programs increased <ul style="list-style-type: none"> • Effective in 2014 • 20% to 30%, based on employee's tier of coverage • If family members permitted to fully participate, incentive limit can take into account more than employee's share • Departments of HHS, Labor, Treasury may increase limit to 50%, if appropriate • HIPAA wellness regulations codified |

Impact

On employees/individuals

At a glance – Key elements having direct implications for employees/individuals

| Key Element | Provisions |
|---|--|
| Individual mandate | <ul style="list-style-type: none"> • All individuals required to enroll in basic health coverage or pay penalty • Limited exemptions |
| Health Benefit Exchanges | <ul style="list-style-type: none"> • Established by States to structure market for individuals and employers • Initially for individuals and small groups; then expand to large employers |
| Health insurance market reform | <ul style="list-style-type: none"> • Guaranteed issue, renewal, no revoking coverage for enrollees, premium rating restriction, other consumer protections • Standard benefit designs and insurance Exchanges |
| Premium and cost-sharing subsidies | <ul style="list-style-type: none"> • Federal premium subsidies for individuals earning up to 400% of the federal poverty level (FPL) • Cost-sharing subsidies to reduce out-of-pocket expenses • Available only for coverage obtained through Exchanges, not through employer-sponsored plans |
| New and expanded public programs | <ul style="list-style-type: none"> • Medicaid expanded in all States to 133% of federal poverty level • Private, nonprofit Health Insurance Cooperatives and federally-administered multistate options through Exchanges |
| Medicare Hospital Insurance (HI) tax | <ul style="list-style-type: none"> • Increased tax on wages in excess of \$200,000 for individual taxpayers and \$250,000 for joint-filers; employee wages only • New 3.8% tax on certain unearned income for individual taxpayers with income over \$200,000 and \$250,000 for joint-filers |
| Account plan limitations | <ul style="list-style-type: none"> • Limits pre-tax health FSA contributions to \$2,500 per year, indexed for inflation • Increases penalty to 20% for HSA funds used for non-qualified medical expenses prior to age 65 • Prohibits OTC medicine reimbursement in health accounts (e.g., FSA/HRA/HSA), unless prescribed |

Impact

On retirees

At a glance - Key elements having direct implications for retiree plans

| Key Element | Provisions |
|--|--|
| High-cost plan excise tax cap | <ul style="list-style-type: none"> • Applies to retiree plans, but higher thresholds available • Pre-65 and post-65 coverage may be combined for this purpose, even if different COBRA rates normally applied |
| Reinsurance for employer-provided retiree health coverage | <ul style="list-style-type: none"> • Temporary reinsurance program to reimburse employers for part of pre-65 retiree health coverage • 80% of cost per enrollee in excess of \$15,000 and below \$90,000 |
| Elimination of tax advantage for RDS | <ul style="list-style-type: none"> • Business income tax deduction reduced by 28% Part D retiree drug subsidy payments received by employer • Immediate accounting recognition that may have significant P&L impact |
| Medicare Part D donut hole and drug discount | <ul style="list-style-type: none"> • One-time \$250 rebate for seniors hitting donut hole in 2010 • Narrows the donut hole over time to achieve 25% cost-sharing throughout by 2020 • 50% discount off negotiated price for brand-name drugs covered under Part D for drug costs incurred during donut hole |
| Other Part D changes | <ul style="list-style-type: none"> • Medicare Advantage payments reduced through new benchmarking program • Higher Part D prescription drug premiums for higher-income seniors |

Preparation for 2014 and beyond

Implementation approach

| IDENTIFY | DECIDE | IMPLEMENT |
|---|--|---|
| <p>Know the law and the key questions, issues and data</p> | <p>Analyze options and make decisions</p> | <p>Develop and execute implementation plan</p> |
| <ul style="list-style-type: none"> • Understand law, effective dates and compliance requirements • Understand tactical and strategic issues • Collect data • Find opportunities, costs and risks in all plans • Identify issues for different segments of employees • Identify issues for different segments of pre-65 and post-65 retirees | <ul style="list-style-type: none"> • Conduct financial, qualitative and other analyses • Conduct employee and retiree impact analysis • Evaluate options <ul style="list-style-type: none"> • Design • Financial management • Delivery • Change management • Strategy • Make decisions | <ul style="list-style-type: none"> • Formulate multi-year plan for implementation, change management and communication • Secure resources, suppliers, commitments and budgets • Implement tactics in 2010 to meet 2011 requirements • Incorporate health care reform into 2011 – 2018 annual benefit planning process |
| <p>Create an implementation plan and governance process</p> | | |

Considerations and next steps

- New strategies must begin now
 - Immediate provisions and grandfathering considerations
- Stay ahead of the curve
 - Begin or continue data collection for modeling cost implications and alternatives
- Anticipate communications planning and change management opportunities

Appendix A

Timeline - 2010-2018

2010

- Accounting
 - Accounting recognition required for financial impact of various PPACA provisions on postretirement medical (RDS, high-cost excise tax, lifetime maximums, etc.)
- Retiree reinsurance
 - Early-retiree reinsurance program for employer plans to begin within 90 days after enactment; i.e., by June 21, 2010
- Medicare Part D
 - “Donut hole” begins to close in stages, with completion by 2020
- Adoption assistance
 - Employer-provided adoption assistance benefits under IRC section 137 are increased to \$13,170 per child; exclusion sunsets after 2011

2011

- For calendar-year group health plans, including those in existence upon enactment of the PPACA, compliance with the following four items is required on January 1, 2011:
 - Adult child coverage
 - Must offer coverage to adult children up to age 26
 - Lifetime/annual maximums
 - Must remove lifetime dollar limits and impose only “restricted” annual limits
 - Preexisting conditions
 - Must remove preexisting condition exclusions on children under age 19
 - Rescission
 - Group health plan coverage for enrollees may not be terminated, except for certain limited reasons (e.g., fraud or misrepresentation); no rescission without prior notice.
- Since the four changes above are effective for plan years that begin following six months after enactment (i.e., September 23, 2010 or later), plan years that begin in the fourth quarter of 2010 will face effective dates earlier than January 2011. Note that “retiree-only” plans that meet certain conditions under ERISA and the IRC may be excused from compliance with the group health plan mandates listed above

2011

- Nondiscrimination
 - New insured group health plans must meet tax law nondiscrimination requirements previously applicable only to self-insured plans; however, it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply
- Preventive benefits
 - New group health plans must provide preventive care without cost sharing, and cover certain child preventive care services as recommended by government; it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply
- Provider selection
 - Must permit participants to select primary care providers (PCPs) or pediatricians from any available PCPs; no prior authorization or increased cost sharing for out-of-network ER or emergency services as compared to in-network; no prior authorization or referral to OB-GYN; it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply

2011

- Plan disclosures
 - Group health plans must disclose to Health and Human Services (HHS) and to the public: claim payment policies and practices; financial disclosures; data on enrollment and disenrollment, claims denied, rating practices; cost-sharing and out-of-network coverage; enrollee and participant rights; it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply
- Wellness reporting
 - New government data collection on employer wellness programs may not require information on the presence of lawful firearms; may not base premiums, discounts, rebates or rewards on the basis of lawful firearm or ammunition ownership; it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply
- Appeals
 - Must implement an effective internal appeals process with participant rights; self-insured plans must implement an external review process; insured plans must satisfy state law external review requirements or federal standards if no state rule exists; it appears that plans in existence on the enactment date of the PPACA are grandfathered, i.e., need not comply

2011

- Nonprescription medicine
 - Over-the-counter medicines are ineligible for reimbursement in flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) or health spending accounts (HSAs) without a prescription
- IRS Form W-2
 - Employers must begin Form W-2 disclosure of the total value of each employee's employer-subsidized health coverage, except health FSA and HSA, i.e., on the Form W-2 issued in January 2012 for the preceding year
- HSA penalty
 - HSA tax penalty on nonmedical withdrawals will double to 20%
- Medicare Part D brand-name drugs
 - Drug manufacturers must provide a 50% discount on brand-name drugs in the Part D donut hole
- Medicare Advantage
 - Three-year phased reduction begins in Medicare Advantage plan capitation payments

2011

- Medicare Part D income-based premiums
 - Higher Part D premiums begin for beneficiaries with incomes above \$85,000 and \$170,000 for couples
- Fees on pharmaceuticals
 - Fees on pharmaceutical manufacturers begin (\$28B through 2019); likely passed on to employers and other payers
 - \$2.5 billion in 2011
 - \$2.8 billion in 2012-2013
 - \$3.0 billion in 2014-2016
 - \$4.0 billion in 2017
 - \$4.1 billion in 2018
 - \$2.8 billion in 2019 and later
- CLASS
 - Government launches Community Living Assistance Services and Supports (CLASS) benefit; federal voluntary insurance program to provide community living assistance services to individuals with functional limitations; no employer contribution required; employers may choose to offer workplace enrollment (including automatic default enrollment) and payroll withholding of employee contributions; however, employer involvement appears voluntary

2011

- Annual report on self-insured plans
 - By March 23, 2011, Department of Labor to begin delivering an annual report to Congress on self-insured group health plans; determine if adverse selection will cause small/midsize employers (i.e., less than 100 employees) to self-insure; if self-insured plans offer less costly coverage due to efficiency or due to claim denial patterns and limited benefit packages, examine potential for conflict of interest between self-insured enrollees and employer's financial condition; collect information from employers; HHS to submit separate but parallel study of insured and self-insured markets to Congress by March 23, 2011
- Tort reform
 - Grants totaling up to \$50 million over five years become available for state demonstration projects on alternatives to tort litigation; emphasizing patient safety, disclosure of errors, early resolution of disputes; patients may opt out of these alternatives; determine effectiveness of alternatives

2012

- New plan summary
 - Plan administrators must begin distributing new summary of health plan coverage to all applicants/enrollees at initial enrollment and annually in addition to the summary plan description (SPD); will contain uniform elements set by HHS including covered benefits, exclusions, cost sharing and continuation; plan must begin to notify enrollees of material changes at least 60 days in advance of changes
- Quality of care
 - Plans must begin disclosing to HHS and enrollees plan benefits that improve health, case management, disease management and wellness; HHS to develop annual reporting standards
- Comparative effectiveness tax
 - Employers pay annual comparative effectiveness research fee of \$1 per plan participant in 2012, rising to \$2 in 2013 through 2019; effective for plan years ending after September 30, 2012

2013

- Medicare Part D
 - Employers' income tax deduction is reduced by the amount of retiree drug subsidy (RDS) payments received under Medicare Part D
- Health FSA
 - Health FSA pretax salary reductions capped at \$2,500 per year, indexed to the CPI
- Medicare payroll tax
 - Medicare Hospital Insurance (HI) tax rate rises from 1.45% to 2.35% on employees' earned income above \$200,000 (single return) or \$250,000 (joint return); affects only employee-paid portion of payroll tax (no employer match payment required on 0.9% increment)

2013

- Medicare investment tax
 - For taxpayers with income above \$200,000 (single return) or \$250,000 (joint return), new 3.8% Medicare HI tax on net investment income or (if less) on amount by which modified adjusted gross income exceeds those dollar thresholds; excludes distributions from qualified plans
- Tax on device makers
 - New 2.3% excise tax begins on medical device manufacturers; expected to be passed through to employer plans and other payers
- Personal medical deduction
 - Taxpayers' unreimbursed medical expenses in excess of 10% of AGI are deductible, up from 7.5%; change deferred to 2017 for those age 65 and over
- Health insurer compensation
 - Corporate deduction for an employee's compensation paid by a health insurer is limited to \$500,000 per year; also applies to deferred compensation for services performed after 2009

2014

- Pay or play
 - Employer “pay or play” responsibility begins; offer minimum essential coverage to full-time employees or make nondeductible payments to government
- Annual maximums
 - Group health plans must remove all annual dollar limits on all participants
- Out-of-pocket limit
 - Group health plans must limit cost sharing and deductibles to levels that don’t exceed those applicable to an HSA-eligible high-deductible health plan (HDHP)
- Preexisting conditions
 - Group health plans must remove all preexisting condition exclusions on all participants
- Waiting periods
 - Group health plans must remove waiting periods longer than 90 days
- Wellness incentives
 - Permitted wellness incentives in group health plans increase from 20% to 30% of plan costs; up to 50% if determined to be appropriate

2014

- Free-choice vouchers
 - Employer must offer free-choice vouchers to certain low- and moderate-income employees who are not eligible for government premium subsidies if employee plan contributions are too costly relative to total household income; no pay-or-play penalty applies to employers with respect to those employees who receive a voucher
- Clinical trials
 - Employer plans must cover clinical trials for life-threatening diseases; overcomes plan restrictions on out-of-network providers; plans in existence at the enactment of the PPACA are grandfathered
- Employer reporting
 - Employer government reporting begins on employee health coverage to enforce individual and pay-or-play mandates

2014

- Auto enrollment
 - Automatic employee enrollment in group health plans begins (employers with more than 200 employees); effective date unclear; regulations to be issued by the Secretary of Labor
- Health insurer fees
 - New fees on health insurers begin (\$74B through 2019); likely passed on to employers and other payers
 - \$8 billion in 2014
 - \$11.3 billion in 2015-2016
 - \$13.9 billion in 2017
 - \$14.3 billion in 2018
 - Indexed to premium growth after 2018
- Individual mandate
 - Individual health coverage mandate begins with certain exceptions; increasing tax penalties for noncompliance equal to greater of flat dollar amount (e.g., \$95 in 2014) or percent of income (e.g., 1.0% in 2014)
- Insurance market reform
 - Insurers in individual and group market must offer “qualified health plans” up to age 65; no health status underwriting or preexisting condition exclusions; premiums within rate bands

2014

- Health Insurance Exchanges
 - States must establish Health Benefit Exchanges; marketplace for private sector insurers to offer “qualified health plans”; administer federal premium subsidies for low-/moderate-income individuals without employer or other coverage
- Premium subsidies
 - Federal premium subsidies begin for low-/middle-income individuals with household income up to 400% of the federal poverty level (FPL); available only for Exchange-based coverage; unavailable to those offered affordable minimum coverage by employer; in 2010, \$88,200 is 400% of FPL for family of four
- Medicaid
 - Medicaid eligibility expands nationally to those with household income up to 133% of FPL; in 2010, \$29,325 is 133% of FPL for family of four; income-based expansion of Medicaid does not extend to those over age 65
- Provider nondiscrimination
 - While a group health plan is not required to contract with any willing provider, a plan may not discriminate against a provider that is acting within the scope of its license
- Small-employer cafeteria plan
 - Small employers (less than or equal to 100 employees) may offer all full-time employees an option to pay or reimburse premiums for Exchange-based coverage under an IRC Section 125 cafeteria plan

2018

- High-cost plan excise tax
 - Nondeductible 40% excise tax begins on employers' high-cost health plans; excise tax applies to excess coverage value above threshold of \$10,200 single coverage and \$27,500 family coverage; threshold higher for retirees and certain high-risk professions (\$11,850 single coverage, \$30,950 family coverage); dental and vision coverage excluded, but other health coverage aggregated including PPO, HMO, HDHP, HSA, FSA, HRA, etc.

Appendix B

Looking toward 2014

Obtaining coverage in 2014

- Individual mandate: obtain minimum essential coverage or pay penalty
 - 2014: greater of \$95 or 1% of income
 - 2015: greater of \$325 or 2% of income
 - 2016: greater of \$695 or 2.5% of income
 - Family cap: 3 times the flat-dollar penalty
- Minimum essential coverage:
 - Grandfathered group or individual coverage
 - Employer-sponsored coverage
 - Government programs (Medicare, Medicaid, CHIP)
 - Coverage in individual market
 - Tricare and VA coverage
 - Certain other coverage as permitted by HHS Secretary

Coverage through Exchange

- Four benefit tiers with different actuarial values (AV)
 - Bronze plan: 60% AV
 - Silver plan: 70% AV
 - Gold plan: 80% AV
 - Platinum plan: 90% AV
- Catastrophic “young invincible” policy available to those:
 - Younger than 30 at beginning of plan year
 - Without access to other affordable coverage
- Individual eligibility to participate in Exchange
 - U.S. citizens and legal residents
 - Reside in state in which exchange operates
 - Not incarcerated
- Employer eligibility to participate in Exchange
 - Initially small employers (≤ 100 employees; States may lower to ≤ 50 employees)
 - States may open Exchanges to large groups beginning in 2017

Premium and cost-sharing subsidies

- Premium subsidies for those with income up to 400% federal poverty level
 - Sliding scale: Individual to pay 2% - 9.5% of income toward premiums
- Only for coverage through insurance Exchange – not employer plans
- Cost-sharing subsidies also available

| Current Poverty Guidelines | | |
|----------------------------|----------|-----------------|
| Family size | 2010 FPL | 400% FPL (2010) |
| 1 | \$10,830 | \$43,320 |
| 2 | \$14,570 | \$58,280 |
| 3 | \$18,310 | \$73,240 |
| 4 | \$22,050 | \$88,200 |