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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT and THE RECONCILIATION ACT

On Sunday, March 21st, the U. S. House of Representatives passed the "Patient Protection and Affordable Care Act" (H. R. 3590) by a vote of 219 to 212. This is the same bill that the Senate passed on December 24, 2009. The bill was signed into law by the President on March 23, 2010. **However, not every provision of the law takes place immediately.**

The House also passed the "Health Care and Education Affordability Reconciliation Act" (H. R. 4872 and also referred to as The Reconciliation Act). This Act makes changes to the Senate "Patient Protection and Affordable Care Act" (passed by the House and signed into law by the President). This Act was intended to "fix" the differences between the House and Senate versions of their proposed legislation.

H. R. 4872 was passed by both the House and the Senate on March 25, 2010. President Obama signed the final version of the Healthcare Bill on Tuesday, March 30. The passage of this bill clears the way for the beginning of Healthcare Reform.

The following is a brief summary of the provisions of the Act and the timing of when the provisions will go into effect. The details of this new legislation will take months, maybe years, to work through the regulatory process. Much of what Congress has passed will require additional regulations in order to bring clarity to this new law. **Please be assured that we will be sending additional details as they become available.**

What does this mean to me as an employer in 2010?

<u>If you have less than 25 Full-Time Employees:</u>

1. If you have less than 25 full-time employees (to be defined) and your average wage is less than $50,000, you may be eligible for a maximum tax credit retroactive to 1/1/10, of up to 50% of your premiums for up to 2 years, if you contribute at least 50% of the total premium cost.

2. If you have 10 or less full-time employees and your average employee wage is less than $25,000, you will be eligible for the maximum credit.

All fully-insured medical plans, regardless of size:

The following 9 provisions take effect on the first day of the first plan year beginning 6 months after enactment.

1. Lifetime limits on group and individual plans will be prohibited.
2. Annual limits will be allowed through 2014 only on Health and Human Services (HHS)-defined non-essential benefits (not defined as of yet). This provision applies to self-insured plans as well.
3. All group and individual plans will have to cover dependents, married or not, up to their 26th birthday unless that dependent is eligible for employer-sponsored plan. The group health plan tax exclusion is extended to those dependents. This provision applies to self-insured plans as well.
4. Rescission of health coverage will be prohibited except for fraud or intentional misrepresentation. This provision applies to self-insured plans as well.
5. Pre-existing condition limitations for children age 19 and younger will be prohibited.
6. Emergency services will be covered as in-network regardless of the provider.
7. Enrollees may designate any in-network doctor as their primary care physician. This is only applicable to those plans (such as an HMO) that required an insured to select a PCP.
8. Coverage for specific preventive services (which are not yet identified) on a first dollar basis (no deductible, no co-pay and no co-insurance).
9. Group health plans will be required to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals (which currently apply to self-insured plans).

Additionally:

1. Minimum loss ratio (MLR) requirements will be established for insurers in all markets. For a large group (defined as 101 employees or more – but individual States have the right to define large group as 51 or more employees until the year 2016) it will be 85%, and for a small group 80%. In general, the MLR is the percentage of premiums collected that must be paid out in claims. The specifics of what can be included in the "claims" category are unclear at this time.
2. Secretary of HHS will have new authority to monitor health insurance carrier premium increases to prevent unreasonable increases and publicly disclose such information.
3. A high-risk pool will be created for people who cannot obtain current individual coverage due to pre-existing conditions. Over thirty states already have such a pool. It is unclear how the two plans will coordinate. This pool will expire on 12/31/2013 when the Exchanges become operational and pre-existing condition limitations are totally removed.
4. A 10% excise tax will be imposed on indoor tanning services.

What does this mean to me as an employer in 2011?

All fully-insured medical plans, regardless of size:

1. All employers must include on the W-2s issued for the 2011 tax year, the aggregate cost of employer-sponsored health benefits.
2. The penalty tax on distributions from a Health Savings Account (HSA) that are not used for qualified medical expenses increases from 10% to 20%.
3. Over-the-counter drugs will no longer be reimbursable under HSAs, FSAs, HRAs or Archer MSAs, unless prescribed by a doctor, with the exception of insulin. (This provision becomes effective January 1, 2011 regardless of plan year.)
4. Small employers will be allowed to adopt new "simple cafeteria plans".
5. A federal grant program for small employers providing wellness programs to their employees takes effect.

Additionally:

1. A new public long-term care program is created and requires all employers to enroll employees, unless the employee elects to opt out.

What does this mean to me as an employer in 2012?

All group plans, fully-insured or self-insured:

1. Will have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees including: when they apply for coverage, when they enroll or re-enroll in coverage, when the policy is delivered and identify when any material modification is made to the terms of their coverage.
2. The summary and explanation can be provided electronically or in written form, and there is a $1,000 per enrollee fine for willful failure to provide the required information.

What does this mean to me as an employer in 2013?

All group plans, fully-insured or self-insured:

1. An additional 0.9% Medicare Hospital Insurance tax on self-employed individuals and employees with earnings and wages during the year of $200,000 for individuals and $250,000 for joint filers.
2. Self-employed individuals are not permitted to deduct any portion of the additional tax.

Additionally:

1. A new 3.8% Medicare contribution on certain unearned income from individuals with Adjusted Gross Income (AGI) over $200,000 for individuals or $250,000 for joint filers.

2. The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI to 10% of AGI for regular tax purposes.

3. New annual fees will be imposed on medical device manufacturers and importers. The tax does not apply to eyeglasses, contact lenses, hearing aids and any other device deemed by the Secretary of HHS to be of the type available for regular retail purposes.

What does this mean to me as an employer in 2014?

All group plans, fully-insured or self-insured:

1. Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable.

2. Exclusions based on pre-existing conditions would be prohibited in all markets.

3. Full prohibition on any annual limits or lifetime limits in all group or individual plans.

4. All individual health insurance policies and all fully-insured group policies with 100 lives or less (and larger groups purchasing their coverage through the exchanges) must abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco usage (1.5:1), family composition and geographic regions to be defined by the states. Experience rating based on actual costs would be prohibited (not sure yet how this will impact self-insured plans).

5. Wellness discounts are allowed for group plans under specific circumstances.

6. Redefines small group coverage as 1-100 employees.

7. Employers don't have to offer health insurance coverage, **but** if they employ more than 50 FTEs, they must pay a fine per employee per year for each employee they **don't** cover. The coverage can't be just any coverage and must meet the "essential benefits" requirements in order to be compliant.

8. Catastrophic-only policies will be allowed for those individuals age 30 and younger.

9. **For the construction industry only**, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than $250,000.

10. An employer with more than 50 Full Time Employees is required to have no longer than a 90 day waiting period before an employee can enroll in health care coverage. If their waiting period is longer than that, they will pay a $600 fine for each employee subject to the longer waiting period.

11. Flexible Spending Account contributions for medical expenses are limited to $2,500 per year with the cap indexed for inflation.

12. Employers of 200 or more employees will be required to auto-enroll all new employees into any available employer-sponsored health insurance plan.

13. All health plans must provide coverage documentation to both covered individuals and the IRS.

14. If the employer does not offer coverage – penalty of $2,000 per full-time employee minus the first 30 full-time employees if one employee is eiligible for an exchange subsidy.

15. If the employer does offer coverage but coverage is unaffordable (greater than 9.5% of family income) the employee can opt out. Employer is penalized $3,000 for each opt-out (subsidy-eligible) employee up to a maximum of $2,000 times every full-time employee.

16. Opt-out voucher – "Employee free choice voucher" – Workers paying between 8% and 9.5% of income for coverage may opt out and take their employer's contribution in the form of a voucher.

Additionally:

1. All American citizens and legal residents will be required to purchase qualified health insurance coverage. Some exceptions apply and subsidies will be available for certain situations.

2. Penalties will apply for those who do not comply.

3. Each state will be required to create an Exchange to facilitate the sale of qualified benefit plans to individuals and small employers.

What does this mean to me as an employer in 2018?

For all fully-insured or self-insured medical plans:

1. A 40% excise tax on "Cadillac plans" with values exceeding certain dollar amounts. Certain high-cost states would receive transition relief. This excise tax would be charged to the insurance carrier, or to the self-insured plan.

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