Wells Fargo Insurance Services

Legislative Alert

Summary of Federal Health Care Reform Law

Status Report, March 30, 2010

The Patient Protection and Affordable Care Act (H.R. 3590) was signed into law by President Obama on March 23, 2010. The companion bill, the Health Care and Education Reconciliation Act (H.R. 4872), was signed into law on March 30, 2010. Together, these two bills constitute the new "Federal Health Care Reform Law."

Important notes

- **Fully-insured vs. self-insured group health plans.** Except as otherwise noted below, all of the items below for group health plans apply to both fully-insured and self-insured group health plans.
- **Grandfathered plans.** Group health plans existing on March 23, 2010, are "grandfathered" under the Patient Protection and Affordable Care Act. Grandfathered plans are deemed to offer "minimum essential benefits," have special effective date rules for certain health reform changes, and are completely exempt from certain other changes (as noted in the chart below). A grandfathered plan is allowed to enroll new employees (and their families), and family members of currently covered employees. Otherwise, the scope of this exception is unclear.
- **Non-grandfathered plans.** Plans that are not in existence prior to March 23, 2010.
- **Collectively-bargained plans.** For group health plans maintained under one or more collective bargaining agreements ratified before March 23, 2010, the provisions of the Patient Protection and Affordable Care Act may be postponed until the termination date of the last collective bargaining agreement relating to the plan, with the exception of coverage requirements described below (see grandfathered plans below).

Topic	Provisions of Federal Health Care Reform Law	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Government subsidies for small employers	The government provides a 35 percent tax credit to small employers (up to 25 employees) with average annual wages of less than $50,000 that purchase health insurance for employees	2010	2010	Apply for tax credit, if applicable
Government subsidies for early retirement plans (temporary)	For employers with early retirement medical plans, the government will temporarily reimburse employers for 80 percent of the cost of medical benefits (between $15,000 and $90,000) for retirees age 55 to 64 and their dependents until $5 billion in funding is exhausted; subsidy must be applied only to plan expenses	When the program is established by the federal government (which must occur by June 20, 2010); the program ends on December 31, 2013	When the program is established by the federal government (which must occur by June 20, 2010); the program ends on December 31, 2013	Apply for reimbursement, if applicable
Encouraging disenrollment of high risk enrollees	Plans found by the Secretary of Health and Human Services (HHS) to have encouraged a covered individual with a pre-existing condition to disenroll, according to criteria to be established by the Secretary, may be required to reimburse the high risk pool to be established under the law for any medical expenses incurred by that individual under the program.	Immediately, subject to release of criteria by Secretary of HHS	Immediately, subject to release of criteria by Secretary of HHS	Monitor government developments
Lifetime limits on plan benefits	Group plans may not place lifetime limits on essential health benefits	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation
Annual limits on plan benefits	Group plans may not place "restrictive" annual limits on essential health benefits as defined by the Secretary of HHS, with all annual limits on essential health benefits phased out by 2014	Requirement for government-approved limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Requirement for government-approved limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Amend plan documentation
Rescinding coverage	Plans cannot rescind coverage of an enrollee, except in cases of enrollee fraud or material misrepresentation	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation
Pre-existing condition limits on plan benefits	Group plans may not impose a pre-existing condition exclusion with respect to children under age 19, with pre-existing condition exclusions eliminated for all participants by 2014	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation

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Adult child coverage	• All group health plans must extend eligibility to married or unmarried children of the covered employee until the child turns 26 years of age, if the child is not eligible for coverage under another employer-sponsored group health plan (lack of other coverage requirement eliminated in 2014) • Coverage does not need to extend to children of an adult child (i.e., grandchildren of the employee) • Healthcare benefits for adult children are excludible from taxable income through the end of the calendar year in which the adult child turns age 26 • State laws extending coverage for overage dependents past the age of 26 are still enforceable	• Effective for plan years beginning after September 23, 2010, if the adult child is not eligible to enroll in another employer-sponsored health plan • Effective with first plan year beginning in 2014, coverage must be extended to all children up to the age of 26	First plan year beginning after September 23, 2010	Amend plan documentation
Preventive care coverage	Employer plans must provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force; recommended immunizations; preventive care for infants, children, and adolescents; and preventive care and screenings for women	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation
Appeals procedures	All group plans must have both internal and external claims review procedures that are expanded beyond current requirements; states must provide assistance to claimants making an appeal	Not applicable, except that state government assistance is effective with 2010 fiscal year	First plan year beginning after September 23, 2010, except state government assistance which is effective with 2010 fiscal year	Amend plan documentation
Nondiscrimination requirements	Insured health plans will now be required to comply with IRS Section 105(h)(2) nondiscrimination rules	Not applicable	First plan year beginning after September 23, 2010	Conduct testing, if applicable
Access to certain healthcare providers	Certain plans must meet certain requirements for designating a primary care provider, including pediatricians for children, access to emergency services, and direct access to participating OB-GYNs	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation

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Disclosure of data on plans	In "plain language," plans must disclose specified data to the Secretary of HHS, the relevant state insurance commissioner, and the public, including: • claims payment policies and practices; • periodic financial disclosures; • data on enrollment, disenrollment, number of claims denied, and rating practices; • information on cost-sharing and payments with respect to any out-of-network coverage; • information on enrollee and participant rights under the Health Care Law; and • other information as determined appropriate by the Secretary of HHS	Not applicable	First plan year beginning after September 23, 2010, but some uncertainty remains	Monitor government data disclosure requirements
Over-the-counter drugs	Except for insulin, over-the-counter drugs without a prescription are not reimbursable from a health care flexible spending accounting (FSA) or health reimbursement account (HRA), and are not a tax-free reimbursement from a health savings account (HSA).	2011	2011	Amend plan documentation
Medicare Part D	Provides a $250 rebate to Medicare Part D participants who reached the "donut hole" in 2010, with a rebate payable at the end of the first quarter in 2011; includes a phase-down of the coinsurance rate from 100 percent to 25 percent by 2020	January 1, 2011	January 1, 2011	If offering coverage to retirees, notify them of changes to Medicare Part D benefit
Health savings accounts (HSAs)	Penalty on non-medical HSA distribution is raised from 10 percent to 20 percent	January 1, 2011	January 1, 2011	Amend plan documentation, and notify HSA participants of new excise tax

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Medicare Parts B and D	Freezes the threshold for imposing higher premiums for Medicare Part B coverage for 2011 through 2019; individuals also pay a greater share of the cost of Medicare Part D coverage if they have income above $85,000 ($170,000 if filing jointly)	2011	2011	None
Simple cafeteria plans for small employers	Code § 125 cafeteria plans maintained by small employers (with an average of 100 or fewer employees during either of the two preceding years) are deemed to be nondiscriminatory if all employees with at least 1,000 hours of service in the preceding year are eligible to participate; certain nondiscrimination standards are met; and employer contribution are either: • a uniform percentage (at least two percent) of employee compensation, or • not less than six percent of employee compensation (or, if less, two times the employee contribution amount)	2011	2011	Consider adopting a simple cafeteria plan, if applicable
Medical loss ratio for insurance policies	Insurance carriers must provide a rebate to consumers if the amount spent on clinical services and quality is less than 85 percent of the premium cost (80 percent for plans in the individual and small group markets)	2011	2011	None
Employer tax reporting to employees	The value of the employee's health coverage must be disclosed on Form W-2	For 2011 tax year	For 2011 tax year	Develop reporting mechanism
Tax on insured and self-insured group health plans	Establishes a tax of $2 times the average number of lives covered ($1 times the average number of lives covered for plan years ending in 2013)	Plan years ending after September 30, 2012	Plan years ending after September 30, 2012	Monitor government payment procedures

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Distribute uniform explanation of coverage document	Employers will be required to distribute to enrolled employees a summary of benefits with an explanation of coverage (in addition to a summary plan description) that accurately describes the benefits and coverage levels offered under the employer's plans according to uniform standards; employers also must notify enrollees if they intend to make any material modifications not reflected in the most recent summary within 60 days prior to the effective date of the modifications; each compliance failure can result in a $1,000 penalty	March 23, 2012 (possibly sooner)	March 23, 2012 (possibly sooner)	Prepare benefits summaries that comply with the standards established by HHS and distribute summaries to new and existing employees
Health care flexible spending account plans	Employee pre-tax contributions to a health care FSA are limited to $2,500 per year	2013	2013	Amend plan documentation, if applicable
Medicare payroll tax increase	Employees pay 2.35 percent (not 1.45 percent) on earnings greater than $200,000 ($250,000 if filing jointly); increase is not matched by employers and employers only withhold an additional 0.90 percent on wages above $200,000; taxpayers with an income of at least $200,000 ($250,000 if filing jointly) will also pay a 3.8 percent tax on investment income	2013	2013	Develop payroll tax mechanism
Automatic enrollment	Large employers (those with more than 200 full-time employees) that offer coverage must automatically enroll all new full-time employees in the employer's health plan; employees may opt out of coverage	Uncertain; most likely 2014	Uncertain; most likely 2014	Amend plan documentation, if applicable
Itemized deduction for medical expenses	Threshold for tax deduction is 10 percent (not 7.5 percent) of adjusted gross income; threshold remains at 7.5 percent until 2017, if the taxpayer or spouse is age 65 or older	2013	2013	None

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Administrative simplification	Health insurance administrators must comply with the following:			Monitor government developments
	• Adopt a single set of operating rules for eligibility verification and claims status;	2013	2013	
	• Enable electronic funds transfers and healthcare payments; and	2014	2014	
	• Maintain information on health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization.	2016	2016	
	A penalty of $1 per covered life will be assessed for noncompliance	2014	2014	
Employer notice to employees	Notice must be provided to existing employees and new hires of the existence of an insurance exchange, and of the consequences if the employee waives coverage under the employer plan in favor of obtaining coverage through the exchange	March 1, 2013	March 1, 2013	Develop reporting mechanism
Individual mandate	U.S. citizens and legal residents are required to have "minimum essential benefits" consisting of at least bronze-level coverage (see "Insurance exchanges," below) or, if applicable, catastrophic coverage The tax penalty for noncompliance is $695 per year (up to a maximum of $2,085 per family); lower penalties apply during the phase-in period (2014 through 2016); exceptions will be made for financial hardship, religious objections, Native Americans, those without coverage for less than three continuous months, whenever the lowest cost plan option costs more than 8 percent of income, or whenever the individual's income is below the tax filing threshold (e.g., $9,350 for individuals and $18,700 for couples in 2009, if under age 65)	2014	2014	None

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Insurance exchanges	Individuals (U.S. citizens and legal immigrants) and small employers (having an average of 100 or fewer employees in the previous calendar year) may purchase insurance from state-run exchanges beginning in 2014; if the state agrees, large employers (having an average of at least 101 employees in the previous calendar year) may also purchase from the exchange beginning in 2017 Five tiers of coverage are offered through the exchange: • Bronze – provides minimum essential benefits, covers at least 60 percent of actuarial value of covered benefits, with out-of-pocket limit equal to current limits on HSAs ($5,950 for individuals and $11,900 for families, in 2010); • Silver – provides minimum essential benefits, covers at least 70 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Gold – provides minimum essential benefits, covers at least 80 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Platinum – provides minimum essential benefits, covers at least 90 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Catastrophic – similar to high-deductible health plan, except available only to individuals up to age 30 in the individual market (not through an exchange) Reduced out-of-pocket limits apply to individuals with incomes up to 400 percent of the federal poverty level	2014	2014	Monitor government developments

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Employer "play or pay" mandate	Employers with more than 50 full-time employees during 121 days or more in the preceding calendar year (employed an average of at least 30 hours per week) can "play" by offering a "minimum essential benefits" package to full-time employees and their dependents; part-time workers are converted to full-time equivalents (by adding all hours worked by part-timers during the month and dividing by 120) solely for the purposes of determining whether the employer has more than 50 full-time employees; seasonal employees are excluded from the calculation Note: Exclude the first 30 employees from the assessments described below Employers with more than 50 full-time employees that do not offer coverage or that offer coverage that is at least the "minimum essential benefits" coverage must pay an "assessment" of $2,000 times the number of full-time employees of the employer if at least one full-time employee receives government-subsidized coverage through an insurance exchange If the employer offers "minimum essential benefits" coverage, but a full-time employee receives government-subsidized coverage through an insurance exchange anyway, the employer must pay an "assessable payment" equal to the lesser of $3,000 for each employee receiving a subsidy or $2,000 for each full-time employee; there is no assessment if the employee's share of the cost of coverage is between 8.0 percent and 9.5 percent of income Note that all non-grandfathered plans will have to offer at least bronze level coverage (i.e., minimum coverage of 60 percent coinsurance with HSA out-of-pocket maximums), which will satisfy the "minimum essential benefits" requirement, and grandfathered plans are deemed to satisfy the "minimum essential benefits" requirement. Thus, employers that just provide any other group health plan coverage will be subject to the "assessments" described above.	2014	2014	Evaluate "play or pay" strategy; monitor government developments

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Medicaid eligibility	Eligibility is expanded to all individuals under age 65 with incomes up to 133 percent of the federal poverty level	2014	2014	None
Government subsidies for individuals	A government subsidy is available to U.S. citizens and legal immigrants with incomes up to 400 percent of the federal poverty level to purchase coverage through an insurance exchange; this is not available if coverage is available from an employer plan, unless the plan has an actuarial value of less than 60 percent of covered benefits or the employee's contributions exceed 9.5 percent of household income	2014	2014	None
Employer free-choice vouchers	Employers with more than 50 full-time employees that offer the "minimum essential benefits" package to employees must give eligible employees the option of receiving a voucher from the employer to purchase coverage from an insurance exchange (which is tax-free up to the purchase price of coverage purchased); the voucher amount offsets any "play or pay" penalty The employee is eligible for a voucher if his or her share of the cost of the employer plan is between 8.0 percent and 9.5 percent of household income, and the employee's household income does not exceed 400 percent of the federal poverty level, and the employee does not participate in the employer plan The dollar amount of the voucher equals the employer's largest contribution for any employee-only coverage (or family coverage, if elected by the employee) under the employer plan, and is adjusted for age and category of enrollment; no voucher is required if the employee makes no contribution to the plan	2014	2014	Monitor government developments; determine how many employees who waive coverage and do not have coverage elsewhere are eligible for vouchers
Waiting periods	Waiting periods in excess of 90 days are prohibited	First plan year beginning in 2014	First plan year beginning in 2014	Amend plan documentation, if applicable
Approved clinical trials	Group plans cannot deny qualified individuals' participation in certain clinical trials, including coverage for routine patient costs that would typically be covered outside the clinical trials	Not applicable	First plan year beginning in 2014	Amend plan documentation

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Employer reporting to government	Employers must report to the government whether they offer minimum essential coverage to full-time employees and dependents; the length of the waiting period; the lowest-cost option for coverage; the employer's share of coverage costs; and the total number and names of employees receiving coverage from the employer's plan	2014	2014	Monitor government reporting mechanism
Wellness programs	Financial incentives for wellness programs – employers may offer financial incentives to employees of up to 30 percent (not just 20 percent) of the cost of coverage to participate in a wellness program that satisfies the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination requirements; the government can increase the limit to 50 percent if deemed appropriate	2014	2014	Amend plan documentation, if applicable; monitor government developments
Excise tax on high-cost plans	A 40 percent excise tax is imposed on insurers (for insured coverage) and employers (for self-insured coverage) to the extent that the aggregate annual value of an employee's health coverage (including medical, prescription, HRA, health care FSA, and employer HSA contributions) exceeds $10,200 ($27,500 for more than employee-only coverage) Threshold values are indexed to changes in the consumer price index; the threshold is raised by $1,650 ($3,450 for family coverage) for retirees age 55 to 64, for persons in certain high-risk professions (including law enforcement, fire protection, and others), certain utility workers. The threshold is also adjusted to reflect higher healthcare costs attributable to age or gender in the workforce. The employer is responsible for calculating the value of excess coverage using COBRA rules, and making reports to insurers and the government.	2018	2018	Evaluate whether group health plan would be subject to excise tax

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