

# Health Care Reform at a Glance

	Provision	Effective Date	Implications for Large Employers
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## Employer Mandate

1	<b>Play <u>or</u> Pay Penalty for not offering coverage if at Least One Employee gets Subsidy in Exchange</b>	\$2,000 times the number of full time employee (FTE), indexed. (Excludes first 30 FTEs.) FTE defined as 30 or more hours per week. No PTE coverage requirement. No minimum employer subsidy required.	<p><i>This penalty for not offering coverage might be so low as to encourage some employers to drop coverage.</i></p> <p><i>Employer is not required to offer a plan with a value of at least 60%, nor is employer required to provide any minimum employer contribution level. Exchange will determine if coverage is deemed unaffordable.</i></p> <p><i>Even employers who offer a qualifying plan can be subject to penalties for opt-outs; However penalty is less than typical average employer cost.</i></p> <p><i>Increases potential of anti-selection. However, few if any employees may be eligible for many employers.</i></p> <p><i>Similar to Part D Creditable Coverage notices; increased administrative burden.</i></p>
2	<b>Minimum Value of Employer Coverage or "Unaffordable" Employer Coverage</b>	If actuarial value of the plan is below 60%, or if employee contributions are above 9.5 % of household adjusted gross income (AGI), employees under 400% of federal poverty level (FPL) are eligible for subsidized Exchange coverage and, if elected, employer is assessed the play <u>and</u> pay penalty.	
3	<b>Play <u>and</u> Pay Penalty for opt-outs electing coverage through the Exchange</b>	\$3,000 (indexed) for each FTE who enrolls in Exchange and receives subsidy; aggregate cap of \$2,000 times total number of FTEs (excluding first 30 FTEs).	
4	<b>Employee Vouchers for Exchange</b>	Employers must offer cash vouchers to employees under 400% of FPL with employee contributions between 8.0% to 9.8% AGI.	
5	<b>Employer Reporting Requirements</b>	Reporting to both Secretary and employees regarding minimum essential coverage.	

## Individual Mandate

6	<b>Play or Pay Penalty</b>	Greater of 1.0% of AGI or \$95/person in 2014, 2.0% or \$325/person in 2015, 2.5% or \$695/person in 2016; indexed. Family dollar amount capped at 300% of individual penalty.	<p><i>Employer cost will increase with higher enrollment and fewer waivers.</i></p>
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## Provisions Applying to Employer Plans

7	<b>Expansion of Child Coverage</b>	Up to age 26 for medical. Excludes dental & vision. Cannot charge more than for other similarly situated individuals.	<p><i>Increased enrollment and costs for covering more dependents.</i></p> <p><i>Simplifies payroll administration. 2010 effective date allows employers to change imputed income immediately.</i></p> <p><i>Plans might need to be improved: stop-loss would become more important. Special 30 day enrollment period required.</i></p> <p><i>Plans might need to be improved: stop-loss would become more important.</i></p> <p><i>Employers may need to establish refund mechanism.</i></p> <p><i>Will need to be coordinated with other employee communications materials.</i></p> <p><i>Limited impact on most employer plans.</i></p>
8	<b>Income Tax Exclusion of Adult Children for Employer Health Benefits</b>	Exclusion through end of calendar year child turns 26. Includes dental, vision and health FSA. Initial 30 day open enrollment period required. Effective March 2010.	
9	<b>Lifetime Dollar Limits</b>	Prohibits in- and out-network lifetime limits on dollar value of essential benefits. Notice required to eligible individuals who previously exceeded limit. 30 day enrollment period.	
10	<b>Restricted Annual Dollar Limits</b>	Annual limits on essential benefits prohibited. Aggregate annual limit of \$750,000 allowed in first plan year.	
11	<b>Cost Reporting and Rebates</b>	Rebates made to enrollees in insured plans where loss ratio is less than 85%. (Ratio of claims to premium.)	
12	<b>Uniform Explanation of Coverage</b>	Prescribed appearance, content, language and timing. Notice due within two years of enactment. Notice of coverage change required 60 days prior to effective date.	<p><i>Value of coverage is disclosed but not taxed directly to employees.</i></p> <p><i>This change affects only OTC drugs, and medicines - bandages, home health-aids and other OTC items will still be eligible</i></p> <p><i>Plan sponsors may want to communicate.</i></p> <p><i>Employer redesign required.</i></p> <p><i>Reduced job lock might spur higher turnover.</i></p> <p><i>Plans might need to be improved: stop-loss would become more important.</i></p> <p><i>Increased cost due to higher enrollment and more complex administration.</i></p> <p><i>A critical provision for high-turnover firms.</i></p>
13	<b>Pre-existing Condition Exclusions for Children</b>	Pre-existing condition exclusions prohibited for children under 19.	
14	<b>Reporting Plan Value on W-2</b>	Total cost of medical on an employee specific basis for 2011. Excludes FSAs, and HSAs.	<p><i>Employer redesign required.</i></p> <p><i>Reduced job lock might spur higher turnover.</i></p> <p><i>Plans might need to be improved: stop-loss would become more important.</i></p> <p><i>Increased cost due to higher enrollment and more complex administration.</i></p> <p><i>A critical provision for high-turnover firms.</i></p>
15	<b>Standardize Definition of Medical Expenses</b>	Prohibits reimbursement of over the counter drugs purchased after December 31, 2010 from FSAs, HRAs and HSAs, unless prescribed by physician.	
16	<b>HSA Nonqualified Withdrawals</b>	Penalty increased from 10% to 20%.	<p><i>Employer redesign required.</i></p> <p><i>Reduced job lock might spur higher turnover.</i></p> <p><i>Plans might need to be improved: stop-loss would become more important.</i></p> <p><i>Increased cost due to higher enrollment and more complex administration.</i></p> <p><i>A critical provision for high-turnover firms.</i></p>
17	<b>Health FSA Cap</b>	Employee capped at \$2,500 in 2013; indexed.	
18	<b>Pre-existing Condition Exclusions for all Enrollees</b>	Pre-existing condition exclusions prohibited for all enrollees.	<p><i>Deferral of excise tax to 2018 mitigates impact. However, in 2018 the tax will apply to many employer plans. Elimination of executive programs.</i></p>
19	<b>Annual Dollar Limits</b>	Annual limits on the dollar value of essential benefits prohibited. FSAs, HSAs and integrated HRAs exempt.	
20	<b>Auto Enrollment</b>	Auto enrollment required with employee having ability to opt out of coverage. Effective date not clear.	
21	<b>Waiting Periods</b>	Waiting periods over 90 days prohibited.	<p><i>Deferral of excise tax to 2018 mitigates impact. However, in 2018 the tax will apply to many employer plans. Elimination of executive programs.</i></p>
22	<b>"Cadillac Plan" Excise Tax</b>	40% tax on value above \$10,200/individual and \$27,500/family (Indexed at CPI-U+1% for 2019, CPI-U only after 2019). \$11,850/\$30,950 for pre-Medicare retirees. Adjusted for high risk industries, age, gender. Excludes dental and vision. For multiemployer plans all coverage is considered family.	

## Provisions that do not apply to Grandfathered Employer Plans

23	<b>Preventive Care/Immunizations</b>	Preventive care services must be covered at 100%.	<p><i>Plans that were in effect on March 23, 2010 are grandfathered, and as long as they retain grandfathered status are not subject to these health reform requirements. However 2011 plan design and contribution changes must be carefully reviewed to determine whether they would result in loss of grandfathering, and the plan becoming subject to these requirements.</i></p>
24	<b>Discrimination Requirements</b>	Prohibits discrimination under insured plans.	
25	<b>OB/GYN, Pediatrician, ER Services</b>	Preauthorization or referral requirements prohibited.	
26	<b>Reporting Requirements</b>	New plan reporting requirements to HHS and enrollees.	
27	<b>Appeals Process</b>	Mandatory internal and external appeals process.	
28	<b>Clinical Trials</b>	Required coverage during clinical trials.	<p><i>Plans that were in effect on March 23, 2010 are grandfathered, and as long as they retain grandfathered status are not subject to these health reform requirements. However 2011 plan design and contribution changes must be carefully reviewed to determine whether they would result in loss of grandfathering, and the plan becoming subject to these requirements.</i></p>
29	<b>HIPAA Wellness Incentives</b>	Codifies HIPAA wellness incentives, but increased to 30%.	

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## Retiree Health

30	<b>Reinsurance Program for Early Retirees (55-64) and Dependents</b>	\$5B to subsidize 80% of costs between \$15K-\$90K. Terminates December 31, 2013 or when funds expended.	June 1, 2010	<i>Temporary bridge to support employer retiree plans until Exchange is effective; administration appears similar to RDS.</i>
31	<b>Application of Plan Requirements to Retiree Plans</b>	"Retiree only" programs are not subject to market reform requirements such as lifetime dollar limits and adult child coverage. No definition of "retiree only" plan provided.	Various	<i>Opportunity for employers to establish retiree programs to avoid with health reform market place reforms.</i>
32	<b>Phase out of Donut Hole</b>	\$250 rebate in 2010 for beneficiaries who reach donut hole. Phases out donut hole by 2020 in combination with brand drug discount.	2010	<i>Makes participation in Part D more attractive to employers relative to RDS.</i>
33	<b>Brand Drug Coverage in Part D Donut Hole</b>	Drug manufacturers required to discount brand drugs in donut hole by 50%.	2011	<i>Makes participation in Part D more attractive to employers relative to RDS.</i>
34	<b>Means Based Medicare Part D Premiums</b>	Increased for higher income retirees.		<i>Makes employer-provided Rx that much more attractive to high income retirees.</i>
35	<b>Medicare Advantage Plan Funding</b>	Payments frozen in 2011; reduced benchmarks starting in 2012.		<i>Increased retiree premiums for Medicare Advantage plans; reduced enrollment.</i>
36	<b>Taxability of RDS Payments to Employers</b>	Yes. While taxability is not effective until 2013, non-public employers will need to reflect impact in first quarter 2010.	2013	<i>Increases retiree plan costs; makes employer Part D (EGWP) plans more attractive.</i>

## Insurance Market Reform for Individuals and Small Groups

37	<b>Minimum Benefit Package</b>	Bronze, Silver, Gold and Platinum with actuarial values of 60% - 90%. Catastrophic plan for individuals under 30.	2014	<i>Sponsors would retain some (but not complete) latitude in setting plan design for programs offered through the Exchange.</i>
38	<b>Guaranteed Issue and Renewability</b>	Yes. Also includes interim high risk pool for currently uninsured (starting 90 days after enactment).		<i>More robust individual market is especially valuable to former employees and retirees.</i>
39	<b>Required Service Categories &amp; Coverage</b>	Mandatory statutory list, to be supplemented by Secretary of HHS. Limited to insured plans.		<i>Only applies to plans offered in Exchange.</i>
40	<b>Maximum Out-of-pocket Limit</b>	Cannot exceed the OOP limit for HSA-compatible HDHP; indexed.		<i>Only applies to plans offered in Exchange.</i>
41	<b>Community Rating – Limits on Age Rating</b>	3 to 1 ratio maximum (50% surcharge also permitted for tobacco use).		<i>The need for COBRA declines but adverse selection worsens.</i>
42	<b>Medical Loss Ratios - Minimum Standards</b>	80% minimum loss ratio for individual market and small groups. (Ratio of claims to premium.)	Plan years beginning on/after March 23, 2010	<i>More robust individual market is especially valuable to former employees, particularly early retirees.</i>
43	<b>Small Employer Subsidies</b>	Tax credits of up to 35% available to small employers (up to 25 employees).	2010	<i>Will some large employers now be at a competitive disadvantage?</i>

## Purchasing Exchanges

44	<b>Exchanges</b>	State-based exchanges for individuals and small employers (under 101 employees). In 2017 states can make available to large employers.	2014	<i>Availability of Exchanges with subsidies and community rating limits need for pre-65 retiree programs.</i>
45	<b>Low Income Premium Subsidy in the Exchange</b>	Medicaid eligibility expanded to 133% of FPL. Subsidies available between 133% and 400% of FPL. Employees are only eligible for subsidies if employer coverage is below minimum value or contributions are unaffordable.		<i>With generous subsidies to low income, employers might not want to duplicate these efforts with salary-based cost-sharing.</i>

## Taxes

46	<b>Tax on Indoor Tanning Services</b>	10% tax on indoor tanning services, starting in July, 2010.	July, 2010	<i>Generally will not impact employer plans.</i>
47	<b>Pharmacy Manufacturer Tax</b>	\$2.5B in 2011 increasing to \$4.2B in 2018; \$2.8B in 2019+	2011	<i>Increased cost-shifting.</i>
48	<b>Comparative Effectiveness Research</b>	Tax on insured and self-funded plans of \$1/participant/yr first year; \$2 second year; indexed thereafter.	Plan years ending after Sept. 30, 2012	<i>Potential for increased or additional taxes in the future.</i>
49	<b>Income Tax Provisions</b>	Itemized medical deduction threshold increased from 7.5% to 10%.	2013	<i>Even greater pressure on employers to offer tax-advantaged compensation and benefits.</i>
50	<b>Medicare Hospital Insurance Tax</b>	Tax rate increased from 1.45% to 2.35% starting for high income earners. 3.8% tax on net investment income. (Income in excess of \$250K joint filers; \$200K others)		<i>Payroll tax increase only applies to employees, not employer. Increased interest by high paid employees in tax deferrals.</i>
51	<b>Medical Device Excise Tax</b>	2.3% excise tax.		<i>Increased cost-shifting.</i>
52	<b>Health Insurance Industry Tax</b>	\$8B in 2014 increasing to \$14.3B in 2018; trended after 2018	2014	<i>Increased cost-shifting.</i>
53	<b>Exchange Reinsurance Program</b>	\$25B tax on insurers and TPAs from 2014 to 2016 for Exchange reinsurance program		<i>Potential for increased cost-shifting.</i>

## Collectively Bargained Coverage

54	<b>Coverage Maintained Under CBA</b>	Very limited CBA deferral. For <i>insured</i> coverage maintained under a CBA ratified before March 23, 2010, health reform changes apply at the termination date of the last CBA. No deferral for <i>self-funded</i> plans.	March 23, 2010	<i>Very limited CBA deferral provision requires employers to implement health reform marketplace provisions with the same effective dates as non-union plans.</i>
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## CLASS Act

55	<b>Voluntary Long-term Care Program</b>	Government run long-term care program. While not required, employers can allow payroll deductions and automatically enroll employees.	2011	<i>Federal program is intended to supplement and not replace private long-term care programs.</i>
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