National Association of Health Underwriters

How the Health Care Reform Legislation Will Impact Your Individual and Employer Clients

March 25, 2010

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Immediately	
	Individuals and employer group plans that wish to keep their current policy on a grandfathered basis can if the only plan changes made are to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement. The reconciliation bill, if enacted, would eliminate the ability of plans to grandfather in a number of areas.
	Eligible small businesses (no more than 25 FTEs, pay average annual wages of less than $50,000 and provide qualified coverage) are eligible for phase one of the small business premium tax credit. Small employers will receive a maximum credit, based on number of employees, of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost.
	Employers that provide a Medicare Part D subsidy to retirees will have to account for the future loss of the deductibility of this subsidy on liability and income statements. Current law eliminates this subsidy for the 2011 plan year, and the reconciliation package, if enacted, could delay it to 2013, but there is an immediate accounting impact.
In 2010	
	Temporary reinsurance program for employers that provide retiree health coverage for employees over age 55 begins within 90 days of enactment.
	Temporary high-risk pool program for people who cannot obtain individual coverage due to preexisting conditions begins within 90 days of enactment. Employers are prohibited from sending individuals to the high-risk pool, with associated fines.
	Group plans (except for self-insured 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*)* within six months of enactment.
	Lifetime limits on the dollar value of benefits for any participant or beneficiary for all fully insured and self-insured groups and individual plans are prohibited by current law within six months of enactment. Annual limits will be allowed only through plan years beginning prior to January 1, 2014 only on DHHS-defined non-essential benefits, and after than be prohibited. The reconciliation package, if enacted, would extend this requirement to grandfathered plans.
	All group and individual plans, including self-insured plans, within six months of enactment, will have to cover dependents up to age 26 under current law. The

	reconciliation package, if enacted, would extend this requirement to grandfathered plans. It also would establish that dependents could be married and would be eligible for the group health insurance income tax exclusion. However, through 2014, grandfathered group plans would only have to cover dependents that do not have another source of employer-sponsored coverage.
	All group and individual health plans, included self-insured plans, will have to cover preexisting conditions for children 19 and under for plan years beginning on or after six months after date of enactment. Grandfathered status applies for group health plans.
	Health coverage rescissions, within six months of enactment, will be prohibited for all health insurance markets, including self-insured plans, except for cases of fraud or intentional misrepresentation. The reconciliation package, if enacted, would extend this requirement to grandfathered plans.
	All group and individual plans, including self-insured plans, will have to cover specific preventive care services with no cost-sharing. They also will have to cover emergency services at the in-network level regardless of provider, allow enrollees to designate any in-network doctor as their primary care physician (if they require a primary care physician designation already) and have a coverage appeal process.
	Federal grant program for small employers providing wellness programs to their employees will take effect.
In 2011	
	All employers must include on the W2s the aggregate cost of employer-sponsored health benefits. If an employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs. Applies to benefits provided during taxable years after December 31, 2010.
	The tax on distributions from a health savings account that are not used for qualified medical expenses increases from 10 to 20%.
	OTC drugs will no longer be reimbursable under HSAs, medical FSAS, HRAs and Archer MSAs unless they are prescribed by a doctor.
	FSA contributions for medical expenses are limited to $2500 per year, with the cap annually indexed for inflation. The reconciliation package, if enacted, would delay this provision till 2013.
	Small employers (less than 100 lives) will be allowed to adopt new “simple cafeteria plans.”
	All employers would be required to enroll employees in a new national public long-term care program, unless the employee opted out.
	All business owners will be subject to new expanded federal income tax requirements on payments of fixed or determinable income or compensation.
	Under current law premium taxes on most private health insurers based on premium volume take effect, which can be passed directly down to fully-insured plan consumers. This tax does NOT apply to self-insured plans, governmental entities (other than those providing insurance through the Act’s community health insurance option), certain nonprofit insurers of last resort, and certain nonprofit insurers with a medical loss ratio of 90 percent or more. The reconciliation package, if enacted, would delay the

	implementation of tax until 2014 but increases the amount of fees once they become effective. It also would reduce the amount of the tax for certain insurers and exempt others.
	The Department of Labor will begin annual studies on self-insured plans using data collected from Form 5500.
In 2012	
	All group plans and group and individual health insurers (including self-insured plans) will have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees when they apply for coverage, when they enroll or reenroll in coverage, when the policy is delivered and id any material modification is made to the terms of their coverage. The summary and explanation can be provided electronically or in written form, and it must be no more than 4 pages in length with print no smaller than 12 point font written in a culturally linguistically appropriate manner. There is a $1000 per enrollee fine for willful failure to provide the information.
	All group plans (including self-insured plans) and all individual and group carriers will have to annually submit reports to the Secretary of DHHS on whether or not the benefits provided under their plans meet criteria to be established by DHHS on improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, and include wellness and health promotion activities. This report also must be provided to all plan participants during the annual open enrollment period and DHHS will make the reports public available through the Internet. The Secretary of DHHS can also create and impose fines for noncompliance by employers and plans.
In 2013	
	New federal premium tax on fully-insured and self-insured group health plans to fund comparative effectiveness research program begins. It imposes an annual fee on private insurance plans equal to $2 for each individual covered.
	Cadillac tax goes into effect for all group plans, including self-insured plans. The tax would be paid by the insurer in the case of a fully-insured group or the TPA in a self-insured arrangement, but would be passed on directly to the employer. Current law establishes a 40% excise tax on plans with values that exceed $8,500 for individual coverage and $23,000 for family coverage with higher thresholds for retirees over age 55 and employees in certain high-risk professions. Transition relief would be provided for 17 identified high-cost states. The tax would be indexed annually for inflation by the CPI plus 1percent. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs; also includes coverage for dental, vision, and other supplementary health insurance coverage. Excise tax does not apply to accident, disability, long-term care, and after-tax indemnity or specified disease coverage The reconciliation package, if enacted, would change the effective date from 2013 to 2018. It also would raise the threshold for premiums that are exempt from the assessment from $8,500 for individual coverage to $10,200 and from $23,000 for families to $27,500 and allow plans to take into account age, gender and certain other factors that impact premium costs. The value of stand-alone vision and dental plans

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	would also be excluded from the tax. However, the bill also reduces the formula for indexing the thresholds even further (to just inflation, not inflation plus 1%) so that more plans will fall under the tax faster.
	The Medicare payroll tax increase of 0.9% on self-employed individuals and employees with respect to earnings and wages received during the year above $200,000 for individuals and above $250,000 for joint filers will go into effect. The income eligibility levels for the tax are not indexed for inflation. The new tax does not change the employer's tax obligations, but self-employed individuals are not permitted to deduct any portion of the additional tax. The reconciliation package, if enacted, would also levy new 3.8% Medicare contribution on certain unearned income from individuals with AGI over $200,000 ($250,000 for joint filers).
	For those that itemize their federal income taxes, the threshold for deducting unreimbursed medical expenses will increase from 7.5% of AGI to 10% of AGI. The increase would be waived for those ages 65 and older through 2016.
	All employers must provide notice to their employees informing them of the existence of the state-based exchanges.
In 2014	
	The individual mandate requirement to purchase health insurance for all citizens and legal residents takes effect. There are specified exceptions and under current law and violators will be subject to a phased in excise tax penalty by 2016 of up to $750/person or up to 2 percent of income (capped at the annual cost of the average bronze level premium plan offered through the exchanges). All employer plans, including self-insured plans, will have to provide documentation of coverage to all covered employees and their dependents and the IRS. The reconciliation package, if enacted, would change the penalty structure for noncompliance to either a flat dollar amount per person or a percentage of the individual's income, whichever is higher. In 2014, the percentage of income determining the fine amount would be 1%, then 2% in 2015, with the maximum fine of 2.5% of taxable (gross) household income capped at the average family bronze-level insurance premium . The alternative is a fixed dollar amount that phases in beginning with $325 per person in 2015 to $695 in 2016.
	The employer responsibility requirements take effect for companies that employ more than 50 FTEs (with no exemption for seasonal workers). Under current law, if an employer does not provide coverage and one or more employee receives a premium assistance tax credit to buy coverage through the exchange, the employers must pay a fine of $750 per year for each full time employee. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. An employer with more than 50 employees that does offer coverage but has at least one FTE receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit or $750 for each of their full-time

	employees total. 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. An individual with family income up to 400% of FPL is eligible for a premium assistance tax credit if the actuarial value of the employer's coverage is less than 60% or the employer requires the employee to contribute more than 9.8% of the employee's family income toward the cost of coverage. In enacted, the reconciliation package would increase the fine from $750 to $2000, but exempts the first 30 employees from the fine (i.e., if the employer has 51 employees and doesn't provide coverage, the employer pays the fine for 21 employees). However, when determining whether an employer has 50 employees, the reconciliation bill would change to the calculation of employees so that part-time employees must be taken into consideration based on aggregate number of hours of service. It also would revise the small employer exception to exempt employers with 50 or fewer FTEs and would reduce the contribution threshold that would make an individual eligible for a premium assistance tax credit from 9.8% to 9.5%.
	For employers that have a waiting period for coverage for new employees, under current law if they have a waiting period of more than 60 days they will have to pay a $600 per FTE employee fine. Waiting periods of more than 90 days are prohibited. If enacted, the reconciliation package would eliminate the fine for not providing qualified coverage in the waiting period of 90 or fewer days. Waiting periods of more than 90 days would still be prohibited, and this prohibition would also apply to grandfathered plans.
	All of the market reforms for all individual market and fully-insured group markets take effect. All plans must be offered on a guarantee issue basis, preexisting condition limitations are prohibited, annual and lifetime limits will be fully prohibited, and the size of a small employer group will be redefined to 1-100 employees (although states may elect to keep the size of a small groups at 50 employees until 2016). In addition, all fully insured individual and small groups up to 100 employees (and any larger groups purchasing coverage through an exchange) will have to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts will be allowed for group plans under specific circumstances. The reconciliation package, if enacted, would extend the lifetime and annual benefit limit prohibitions to grandfathered plans.
	States are required to have their exchanges up and running. Each state can have a separate exchange for employers and individuals or merge their exchanges to include

	both markets. States can also apply for a waiver on their exchange design from DHHS, and currently operational state exchanges are exempt.
	The standards for qualified coverage, which will apply to all fully insured group and individual products to be sold both inside and outside the exchanges, begin. The essential benefit standards will also used to determine if large employer coverage is sufficient enough relative to the employer responsibility requirements. The essential benefit standards include specific mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. They also allow for catastrophic-only policies for those 30 and younger.
	The employee free choice voucher program takes effect. It requires employers that provides and contributes to health coverage to give vouchers to each employee who is required to contribute between 8% and 9.8% of their household income (indexed to the premium growth rate) toward the cost of coverage, if such employee's household income is less than 400% of FPL and the employee does not enroll in a health plan sponsored by the employer. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount. The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the exchange) with respect to the plan to which the employer pays the largest portion of the cost.
	Employers of 200 or more employees will have to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage. **Important note: The effective date of this provision is unclear and may be determined via regulation to take effect earlier.**
	Employer-sponsored wellness program rules for all employer-group plans under HIPAA improve and employers can increase the value of workplace wellness incentives up to 30% of premiums with DHHS discretion to increase the incentives to 50%. In addition, a 10-state pilot program to extend wellness programs to the individual market begins, with the potential expansion to the entire individual market in 2017.
	Cooperative plans will be allowed to be sold. Multistate national plans will be offered to individual and small employers through the state-based exchanges.
	Premium assistance tax credits for individuals and families making up to 400% of FPL begin. These subsidies are available only for individual coverage purchased through the exchange, not employer-sponsored coverage.
	Expansion of the Medicaid program for all individuals, including childless adults, making up to 133% of the FPL begins. Mandatory state-by-state employer premium assistance programs begin for those eligible individuals who have access to qualified employer-sponsored coverage. States can also create a separate non-Medicaid plan for those with incomes between 133-200% of FPL that do not have access to employer-sponsored coverage.
In 2015	

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	The Children's Health Insurance Program must be reauthorized.
In 2017	
	States may elect to allow large employers (more than 100 employees) to purchase coverage through their exchanges.