Health Care Reform - Patient Protection Affordable Care Act (PPACA) - Overview

DESCRIPTION

Healthcare Reform/Patient Protection Care Act (PPACA) was passed into law on March 23, 2010. However, the provisions were spread out over the years following the passing of the law. The following timeline provides a brief overview of the highlights of the bill. What follows is a brief summary of several PPACA Reconciliation Act provisions to show the most recent timeline impact Healthcare Reform will have on employers/insureds. For more specifics, see http://www.healthcare.gov/law/index.html. It is recommended that legal counsel be sought prior to any implementation purposes.

GRANDFATHERED VS NON-GRANDFATHERED:

Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act (PPACA), provision was made to allow people already covered by health insurance to keep that coverage. The term “grandfathered plan” was created to describe those plans that were in existence on March 23, 2010. Grandfathered plans are exempt from much of the new insurance reforms of the PPACA, as long as they retain their grandfathered status.

What PPACA Requirements Apply to a Grandfathered Plan?

For our grandfathered group plans, effective January 1, 2011, the following changes apply:

- A child of the insured who is not eligible for employer-sponsored health benefits on his or her own (cannot be eligible for own coverage requirement ends 1/1/2014) can be covered under the parent’s coverage to age 26.
- Can be married and still be eligible
- Lifetime benefit limits on essential health benefits are prohibited.
- Rescission of coverage is prohibited except in the case of fraud or intentional misrepresentation of material fact.
- Pre-existing condition exclusions cannot be applied to persons under the age of 19.
- Annual limits on the dollar value of essential health benefits are restricted.
- An internal and external appeals procedure must be provided.

What Changes Cause a Plan to lose Grandfathered Plan Status?

Examples of changes that will cause a plan to lose grandfathered status are:

- Increasing an employee’s premium contribution rate by more than 5%.
- Eliminating benefits for a particular condition.
- Increasing an insured’s coinsurance percentage by any amount.
- Increasing a fixed deductible amount or an out of pocket limit by more than the rate of medical inflation plus 15%.
- Increasing a fixed amount copayment by more than the lesser of $5 plus medical inflation or medical inflation plus 15%.
- Eliminating a plan option.

What Benefit Changes Will Not Cause a Plan to Lose Grandfathered Plan Status?

- Adjusting plan eligibility rules.
- Conducting dependent eligibility audits to ensure only eligible dependents are covered by the plan.
- Adding employees and dependents to the plan.
- Making changes to comply with state and federal law.
- Voluntarily changing benefits to comply with health reform.
- Adding benefits.
- Making changes to dental & vision programs.
- Making changes to the PPO networks.
- Changing insurance carriers, so long as the structure of the coverage doesn’t violate one of the other rules for maintaining grandfathered plan status (amended 11/17/2010).

(Disclaimer): This information is only an overview; it is not all encompassing and it is not intended to cover all the law’s details and it not to be used for legal recommendation for any implementation process. It is advised that legal advice be sought regarding any specifics of and it is not intended to cover all the law’s details and it not to be used for legal recommendation for any implementation process. It is advised that legal advice be sought regarding any specifics
Non-Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act (PPACA), a “non-grandfathered plan” is a plan that came into existence on or after March 23, 2010, or a previously grandfathered plan that made changes that were significant enough to cause it to lose its grandfathered status. Non-grandfathered plans are subject to all of the new insurance reforms of the PPACA.

What PPACA Requirements Apply to a Non-Grandfathered Plan?

As of September 23, 2010, new non-grandfathered plans must:

- Allow a child of the insured to be covered under the parent's coverage to age 26, even if married.
- Provide unlimited lifetime benefits for essential health benefits.
- Only allow rescission of coverage in the case of fraud or intentional misrepresentation of material fact.
- Remove preexisting condition exclusions for persons under the age of 19.
- Provide essential health benefits.

PPACA IMPLEMENTATION 2015 THRU 2020:

2015

Employer Mandate – Large Employers must offer health insurance of pay a penalty

Large employers (100 or more full time employee equivalents) must offer affordable health insurance, that provides minimum value to their full-time employees (including children up to age 26) or be subject to penalties. The employer mandate applies to employers with 50 or more full-time employees. It will be phased in during 2015 and 2016 based on employer size. In 2016, the employer mandate expands to include employers with 50 to 99 full-time employees and coverage must be offered to 95% of full-time employees and their children.

Minimum Essential Coverage Reporting – Insurers and self-insured plan sponsors required to report.

With regards to coverage in the 2015 calendar year, insurers and employers of self-funded group health plans must provide the IRS and all covered individuals information indicating whether the covered individuals had minimum essential coverage each month as required by the individual mandate. This reporting requirement applies to all size employer plans. Coverage during the 2015 calendar year will be reported in 2016. Filing deadlines have been extended for 2015 reporting only. Forms must be sent to employees by 3/31/2016, and forms must be sent to the IRS by 5/31/2016. Employers must report on minimum essential coverage for insured plans, by collecting and reporting Social Security numbers/tax identification numbers for all medical subscribers.

Large Employer Reporting

Effective for coverage offered in 2015, employers with 50 or more full-time employees and/or full-time equivalents must report the IRS and their employees information for the prior calendar year about the employer’s compliance with the employer mandate, including: if the employer offered its full-time employees and their dependents the option for enrollment in a plan with "minimum essential coverage," and each full-time employee's share of the cost for the lowest plan offering minimum value. Coverage offered in the 2015 calendar year will be reported in 2016. Filing deadlines have been extended for 2015 reporting only. Forms must be sent to employees by 3/31/2016, and forms must be sent to the IRS by 5/31/2016

PCORI Fees paid by July 31st each year-
  o paid by Self-funded and HRA plans
  o Paid to IRS using Form 720

2016

Embedded Deductible: Non-grandfathered (including large group and self-funded) family plans must have an "embedded" individual out-of-pocket maximum

Employer Mandate – Large Employers must offer health insurance of pay a penalty

The employer mandate expands from to include employers with 50 or more full-time and full-time equivalent (FTE) employees.

Small Employer: The definition of a small employer is 1-50 total employees, unless a state defines differently

Health Coverage Reporting- IRC Sections 6055 & 6056 (See your CPA for assistance or details; filing deadline 2/28/2016)
  - Form 1094-B – Filed to IRS
  - Form 1095-B –Filed with 2015 individual tax returns
  - Form 1094-C-File to IRS
  - Form 1095-C- File to IRS & copies to employees for 2015 individual tax returns

(Disclaimer): This information is only an overview; it is not all encompassing and it is not intended to cover all the law’s details and it not to be used for legal recommendation for any implementation process. It is advised that legal advice be sought regarding any specifics of and it is not intended to cover all the law’s details and it not to be used for legal recommendation for any implementation process. It is advised that legal advice be sought regarding any specifics.
Health Care Reform - Patient Protection Affordable Care Act (PPACA) - Overview

**PCORI Fees**
paid by July 31st each year
- paid by Self-funded and HRA plans
- Paid to IRS using Form 720

**Maximum out of pocket limits**
- $6850 individual ($6550 HDHP)
- $13,700 family ($13,100 HDHP)

**2017**
**Marketplace expansion option**
- With approval from Health and Human Services (HHS), states will have an option to open their public marketplace to any size employer
**Reporting:** Health Coverage Reporting- IRC Sections 6055 & 6056 (filing deadline 2/28/2017-subject to change; see your CPA for assistance or details)
  - Form 1094-B – Filed to IRS
  - Form 1095-B –Filed with 2015 individual tax returns
  - Form 1094-C-File to IRS
  - Form 1095-C- File to IRS & copies to employees for 2015 individual tax returns

**PCORI Fees**
paid by July 31st each year- paid by Self-funded and HRA plans
- Paid to IRS using Form 720

**Maximum out of pocket limits:**
- $7,150 individual
- $14,300 family

**2020**
**Cadillac Tax**
- Effective 1/1/2020, a tax on high cost employer-provided health plans takes effect. It imposes a 40 percent excise tax on employer-sponsored health care coverage that exceeds certain annual indexed dollar limits.