Health Care Reform –Patient Protection Affordable Care Act (PPACA) Overview – Key Principles

DESCRIPTION:

Healthcare Reform/Patient Protection & Affordable Care Act (PPACA) were passed into law March 23. 2010. However, the provisions were spread out over the years following the passing of the law. The following timeline provide a brief overview of the highlights of the bill.

What follows is a brief summary of several PPACA / Reconciliation Act provisions to show the timeline impact Healthcare Reform will have on employers/insured. For more specifics, see http://www.healthcare.gov/law/index.html (this link gives you access to details and access to the full text of the law. It is recommended that legal counsel be sought for any implementation purposes.

DETERMINING 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 can be covered under their 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.
- Preexisting condition exclusions cannot be applied.
- 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?

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- 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).

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 without dollar limits
- 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.
- Remove pre-existing for all applicants is an ACA metal compliant plan.
- Allows groups to keep their current benefits, as allowed by their state department of insurance; these plans are referenced as "transitional plans" or "grandmother plans". The current states are allowing groups to keep their current benefits up to the date stated below:
    1. IL – renewals up to October 1. 2015
    2. IN, WI, & OH – renewals up to October 1, 2016
    3.

PPACA TIMELINE:

2015

- **Coverage mandate**: Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of $95 for 2014 (or 1% taxable income), $325 for 2015(or 2% taxable income), $695 for 2016 (or, up to 2.5 percent of income in 2016); after 2016 – amounts based on adjustments for inflation.
- "**Employer Responsibility Requirement"** imposed on large employers not offering affordable health insurance coverage will require paying a monthly penalty of $166.67 per full-time employee beyond the first 30, as long as the employer has at least one employee who receives subsidized coverage in the local health insurance exchange. The penalty amount will be adjusted annually after 2014 to reflect the national increase in insurance premium costs. No penalty applies to part-time workers (those working less than 30 hours a week) who are not offered coverage. Small employers (those with fewer than 50 FTEs) are exempt from the employer responsibility requirement.

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- (**affordable coverage defined** = covering at least 60% of medical costs and not extracting an employee contribution towards the price of that coverage in excess of 9.5% of that employees household income)
- Employers with 50 or more FTEs will pay a penalty of $250/month ($3,000 a year) for each full-time worker who is offered employer coverage but instead receives a premium credit to buy coverage in the exchange. The total amount that an employer will have to pay with respect to such employees will be capped at an amount equal to $2,000 times the total number of full-time workers in excess of 30 that the firm employs. These dollar amounts will be adjusted annually after 2014 by the growth in health insurance premiums.
- Will need to count employees who do not work full time (i.e.-part time employees) by dividing the aggregate # work hours worked for 1 month by 120;
- Will need to consider controlled group rules, as members of a controlled group will be treated as a single employer, and all employees will be treated as employed by a single employer; and
- Will not be considered to have employed more than 50 full time employees if the employer's workforce exceeds 50 full time employees for 120 days or fewer during the calendar year and the employees in excess of the 50 during the 120 day period were seasonal workers
  - Sample: In preceding year; ABC Manufacturing employs 35 employees working year round. They employ 40 seasonal employees for 90 days. This is not a large employer, as they exceeded 50 employees for less than 120 days (if group exceeded 50+ for 120 days including seasonal employees, they would be considered a large employer)

- **No Pre-x:** Health plans can no longer exclude coverage for treatments based on pre-existing health conditions (applies to all ages) for ACA metal compliant plans, grandfathered Plans, and large group plans. Other plans have no pre-x for dependents under the age 19 only.
- **Guaranteed issue:** Insurance carriers must accept every person and employer who applies for coverage (also see rating restrictions below)- applies to Small Group Only, and late applicants are subject to policy language.
- **Rating restrictions**: Insurance companies restricted from charging higher rates due to heath status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use (Small Group only)
- **No annual limits** -prohibits all employer plans from imposing annual limits on amount of coverage individual may receive (does not apply to grandfathered plans)
- **Cost Share limits**-Implement $6,350 Cost-sharing limits for individual coverage and $12,700 for family coverage
- **Essential benefit levels**-Implement new levels of essential benefit coverage, e.g., prescription drugs, disease management. ambulatory, emergency, mental nervous, substance use disorder, rehabilitative, laboratory, preventive, wellness, and pediatric services, hospitalization, maternity and newborn care, etc. for ACA metal compliant plans.
- **SF reporting:** Begin reporting self-insurance coverage to IRS
- **Waiting period maximum**: maximum waiting =90 days
- **Opens Health Insurance Exchanges (HIE).** This new option allows people to shop for standard health packages. It enables enrollment and administers tax credits, purpose is for people of all income ranges can obtain affordable coverage.
  - **Multistate National Plans** – will be offered to individuals and small employers through state exchanges
  - Health insurance exchanges will be **established at the state level** for individuals and small employers (generally <100 employees).
    - The exchanges may include large employers January 1, 2017.

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- **Large employer**: Federal definition of a large employer is an employer with 101 or more employees (small employer = 1-100 employees). However, the states can elect to change this large employer definition to 51 or more employees and small 1-50 employees (until 1/1/2016)
- **Health Care Premium Tax Credits** Available through the HIE to ensure people can obtain affordable coverage.
  - Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty ($88,000 for a family of four) who are not eligible for or offered other acceptable coverage.
  - Premium subsidies will be available for individuals and families with incomes between 133 percent and 400 percent of the poverty level, or $14,404 to $43,320 for individuals and $29,326 to $88,200 for a family of four.
  - Provides for health care premium subsidies on sliding scale (for example, a family of 4 earning 150 percent of the poverty level, or $33,075 a year, will have to pay 4 percent of its income, or $1,323, on premiums. A family with income of 400 percent of the poverty level will have to pay 9.5 percent, or $8,379.
- **HIPAA requirements for Wellness**: Wellness Plans must satisfy current HIPAA rules regarding wellness programs, with an increase in the limit applicable to wellness incentives from 20 percent to 30 percent.
  - This means that generally the reward for satisfying the wellness program, together with the reward for other wellness programs available under the plan, may not exceed 30 percent of the cost of employee-only coverage under the plan

- **Exchange eligibility:** Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an Exchange plan.
- **Free choice vouchers**: Employers must offer "free-choice vouchers" to employees whose share of the premium for employer-sponsored coverage would be between 8 and 9.5 percent of their income.
  - The amount of an employee's voucher would equal the contribution the employer would make to its own health plan on behalf of the employee, and the employee could use the voucher to purchase insurance in the exchange.
- **Reinsurance**; A temporary reinsurance program will be set up for individual market and funded by group and individual health plan assessments

2018

- **New Tax:** Excise tax on high cost employer-provided health plans takes effect.
  - **Cadillac health plans tax-**. 40% for amount > $10,200 for individuals and $27,500 for family plans paid by insurance companies and administrators.

EMPLOYER GUIDANCE

EMPLOYER REPORTING:

- 2011 -Employers mandated to disclose the value of health care benefits on each employees annual W-2
- Employee notification- employer must notify employees of:
  - **Exchange availability** – new employees at hire time, current employees **by 3/1/2013**
  - Possibility of eligibility for subsidy under an exchange if the employers contribution to the plan is less than 60% of total allowed costs
    - If employee opts to take exchange, he/she will lose employer premium contribution

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- 2014-large employers will be subject to expand 5500 reporting to include information on health insurance coverage of their employees

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