Health Reform Legislation Summary

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The Patient Protection and Affordable Care Act (PPACA) is now law. This act includes the recent Reconciliation Act, HR 4872, passed on March 21, 2010. As of the date of this summary, PPACA has been enacted, although it includes several items which are being addressed through numerous amendments proposed by both Republican and Democratic members of the Senate.

As we continue to learn more about the amendments to the PPACA, additional information will be made available to our clients. Below, we offer a comprehensive summary which outlines how the current health care reform measures will impact employers in the immediate term as well as over the following 4 to 8 years, barring major amendments to the Act. Although initial changes to individual and group health plans will occur this plan year, 2010; most MAJOR changes become effective in 2014. The timeline offered in this summary provides details for each year beginning in 2010 through 2018. By January 1, 2014 ALL states will be required to have established government based or NON-profit based exchanges to deliver subsidized health insurance to all those in need or that meet the requirements set forth in the attached summary. January 1, 2014 EMPLOYERS who do not offer insurance will be subject to penalties and fees depending on the size of their employee base. Should employers continue to offer health coverage, the PPACA provides strict guidelines regarding the benefits offered to employees.

We hope this brief summary assists you in understanding the new legislation and we look forward to working with you adjusting your current employer sponsored healthcare plan to best meet the changes The patient Protection and Affordable Care Act will bring.

Timeline

2010

- Health insurance providers remove pre-existing limitations for children under age 19
- Health insurance providers remove lifetime maximums on benefits
- Dependent coverage extends to age 26
- Small business tax credit begins (PHASE I - credit to up to 35% of employer's contribution amount)
- Temporary reinsurance program for employers with early retiree health benefits (ages 54 to 60)
- New group health plans must provide first-dollar coverage for preventive services (eventual removal of copays for preventative services)

2011

- Reporting health care coverage costs on Form W-2 required
- Exclude over-the-counter medicines that are purchased without a prescription from FSA, HRA, HSA reimbursement
- HSA tax on non-qualified, pre-65 medical expense withdrawals increases to 20%

2012

- Physician payment reforms are implemented in Medicare to enhance primary care services and encourage doctors to form organizations to improve quality and efficiency of care
- Incentive program is established in MEDICARE for acute care hospitals to improve quality outcomes
- Centers for Medicare and Medicaid Services, which oversees government programs, begins tracking hospital readmissions rates and puts in place financial incentives to reduce preventable readmissions

2013

- Reduce health FSA annual maximum contribution to $2,500
- Medicare Part D subsidy for plan sponsors will no longer be tax deductible
- Uniform standards/rules for electronic exchange of health information for health plans

2014

- State Health Exchanges open for small business and individuals
- Tax credits become available for those individuals and families whose income falls below 400% of the FPL or Federal Poverty Level. 400% of current FPL is set at $88,000 for a family of 4.
- Employers must offer Free Choice voucher to employees who qualify for affordability exemption, but do not qualify for health care premium tax credits
- Employers with 50 or more employees are issued a $2,000 penalty per full-time employee (excluding the first 30 employees) if they do not offer health coverage
- A $3,000 penalty is imposed on employers who offer coverage only for those employees who opt out of the plan and receive tax credits
- Health insurance companies will begin paying a FEE based on their market share

2015

- Medicare creates a physician payment program aimed at rewarding quality of care rather than volume of services

2018

- High-Cost Plan excise tax takes effect (40% tax on any plan above a pre-set threshold currently set at health plans valued at $10,200 for individuals and $27,500 for families

PLAN DESIGN CHANGES

Some impact from plan design changes may be felt this year or at renewal for the 2011 plan year. Benefit planning and management will need to account for plan design changes. The plan design changes below will affect the cost of your plan as early as this year:

- Waiting Period – a waiting period of longer than 90 days is not allowed
- Lifetime Limitation – plans can no longer have lifetime benefit maximums. This change will affect stop-loss coverage and rates for fully insured as well as self-insured plans
- Extension of dependent coverage – Dependent children up to age 26 must have access to coverage.
- Annual Limits – employer sponsored group health plans can no longer have annual limits.
- Pre-Existing Conditions – pre-existing condition limitations are eliminated.
- New Employees – automatic enrollment of new hires is required for employers with 200 or more employees
- Preventive Benefits – preventive care must be covered at 100% without any participant cost-sharing, such as copays, deductibles, or coinsurance.
- "Grandfathered" Plans – pending additional regulatory guidance, grandfathered plans may be able to continue indefinitely without changes to existing plan designs.
- Discrimination – discrimination based on individual health status is prohibited.
- Health Savings Accounts – HSAs will no longer cover over-the-counter, non-prescription medications.
- Flexible Spending Accounts – FSA contributions will be capped at $2,500. (2013) FSAs also will no longer cover over-the-counter, non-prescription medications.

- Out-of-pocket limits – the out-of-pocket limits cannot exceed the limits established for qualified High Deductible Health Plans. Gearing most health plans towards an H.S.A. qualified plan limiting total out-of-pocket costs to individuals and families

SUBSIDIES / FEES

Health insurance exchanges must be established in each State for implementation in the individual and small-group market in 2014. The exchange is intended to provide a competitive marketplace for purchasing health insurance. Subsidies for qualified individuals and families will be funded by fees assessed to employers. A summary of subsidies and fees is listed below:

- Individuals who earn less than 400% of the federal poverty level (FPL) will receive government assistance through subsidies to offset the cost of purchasing coverage.
- Insurance companies will provide regulated premium rates and will offer coverage without pre-existing condition limitations or exclusions.
- Some small businesses will also qualify for subsidies.
- In addition to the subsidies, Medicaid eligibility will expand to include individuals who earn up to 133% of the FPL. Medicaid enrollment is expected to grow about 50%.
- Employers who have at least 50 employees and do not offer health insurance will be assessed a per employee fee.
- Employers with employees who opt out of their company-sponsored plan and receive subsidized coverage through the exchange will be assessed a per employee fee.
- Individuals who choose not to purchase health insurance will be assessed and annual fee

FINANCIAL IMPACT

Each employer's financial impact will be different based upon the current health benefits offered, the value of the current healthcare plan and the demographics of each organization. The average salary of each employer will play a major factor as well as the number of employees who fall within 400% of the FPL (Federal Poverty Level).

ACTION STEPS

Regarding the legislation, Texas Insurance & Financial Services, Inc. is working hard to give our clients the tools and resources necessary. We will continue to update clients on the bill. The problem we are all facing now is there is far more questions, than answers right now. Texas Insurance & Financial Services, Inc. will continue to work on preparing for the required plan changes that will go into effect with your next renewal.

Disclaimer: The information presented in this document is for informational purposes only. It is far from complete, so please do not rely on it for any decisions – use it as a starting point only. The provisions described in this document are likely to change, and there are additional provisions that will apply to employers that are not included. Please be sure to consult with your attorney, tax advisor, and insurance agent on all important decisions. For additional information, may we advise that you take a look at the information on these websites:

www.HealthCare.gov

http://helathreform.kff.org

We will update this document as more information becomes available. For the most recent version of this document, please email Coby at cobyrod@txins.com.