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Health Care Reform

Revised January 2013

On March 21, 2010, the House of Representatives passed the Senate-version legislation, the Patient Protection and Affordable Care Act (PPACA) (HR 3590). A separate budget reconciliation bill, the Health Care and Education Reconciliation Act of 2010 (HR 4872) (the Reconciliation Act), addresses the House Democrats' desired modifications to PPACA. The president signed PPACA into law on March 23, 2010, and signed the Reconciliation Act into law on March 30, 2010.

References to PPACA herein refer to the combination of the Senate version of PPACA and the Reconciliation Act. As the health care reform legislation stands today, the issues affecting individuals and employers are outlined below in order of implementation deadline.

Immediate

Nursing Mothers

PPACA amended the Fair Labor Standards Act (FLSA) to require employers to provide breaks for mothers to express breast milk each time the employee has a need to do so. In addition, the employer must provide a place, other than a bathroom, that is private and free from intrusion from co-workers for mothers to express breast milk. Employers with fewer than 50 employees are not required to provide the breaks "if such requirement would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature or structure of the employer's business." Many states have passed similar laws, and FLSA will not pre-empt any state law that provides greater protection for employees.

Grandfathered Health Plans

A grandfathered health plan is a plan in which an individual was enrolled on March 23, 2010 (the PPACA enactment date). Grandfathered plans are exempt from certain market reform requirements, including: preventive care mandates; internal and external review; nondiscrimination based on income; choice of provider; emergency care at in-network rates; clinical trial coverage; cost-sharing and deductible maximums; guarantee issue/renewal; and rating restrictions. Grandfathered health plans are not exempt from requirements related to annual and lifetime limits, dependent coverage to age 26, rescission, pre-existing condition exclusions, waiting periods, employer mandates and tax provisions.

A plan will lose grandfathered status if there is: an elimination of a benefit that treats a particular condition; an increase in coinsurance; an increase in deductible or out-of-pocket maximums by more than 15 percent (plus medical inflation); an increase in copayment by more than 15 percent (plus medical inflation) or $5 (plus medical inflation); or a decrease in the employer contribution rate toward the cost of any tier of coverage by more than 5 percentage points. Any changes to plan design should be compared against the plan's terms on March 23, 2010.

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A plan will not lose its grandfathered status if it changes insurance carriers or third-party administrators, which was a later amendment to the grandfathered rules issued for insured policies that changed carriers on or after Nov. 15, 2010.

90 Days After Enactment

Temporary Early Retiree Reinsurance Program — Program Suspended / Funds Exhausted
A federal reinsurance program was available for employers providing insurance for retirees over age 55 who were not eligible for Medicare. Congress appropriated $5 billion for this program, and the funds have been exhausted. The program reimbursed employers for 80 percent of claims incurred for the retirees between the ages of 55 and 64 for costs between $15,000 and $90,000, less negotiated price concessions. Plans were required to use these proceeds (proceeds were excluded from gross income) to lower health care costs for enrollees (e.g., premium contributions, copayments and deductibles). Due to the lack of available funds, employers must have submitted an application to the U.S. Department of Health and Human Services (HHS) by May 6, 2011, to have participated in the program.

The Centers for Medicare and Medicaid Services (CMS) issued further guidance informing plan sponsors that claims incurred after Dec. 31, 2011, would not be accepted. CMS also announced that any claim list that includes a claim incurred after Dec. 31, 2011, would be rejected in its entirety. Claims incurred on or before Dec. 31, 2011, but paid after that date may still be submitted, but not until the claim has been paid. This applies to self-insured and fully insured plans.

National High-risk Pool
Federally subsidized high-risk pools have been established in certain states for individuals with pre-existing conditions who have been uninsured for at least six months. There are certain restrictions for variance of premiums according to age, and a maximum cost sharing of $5,950 for individuals and $11,900 for families. PPACA appropriates $5 billion for this high-risk pool. This national program can work with existing state high-risk pools and will end on Jan. 1, 2014, once the exchanges are operational and other pre-existing condition and guarantee issue provisions take effect. A number of states chose to operate the federal high-risk pool themselves, while other states opted for HHS to administer the program.

September 23, 2010

Dependent Coverage
For plan years beginning on or after Sept. 23, 2010, new and grandfathered plans (self-insured and fully insured) must provide coverage for an adult child (e.g., biological child, stepchild, foster child or adopted child) up to age 26. HIPAA-excepted benefits, such as dental, vision and other health benefits, are exempt. Grandfathered plans are only required to provide such coverage if the adult child is not eligible to enroll in his or her employer-sponsored plan. This exception for grandfathered plans ends in 2014. Plans may not include other restrictions on dependent coverage, including marital status, student status, tax dependent, etc. The Internal Revenue Code (IRC) has been amended so that the cost of health coverage for dependent children through the calendar year in which the child turns 26 is excluded from taxable income. Thus, the coverage is non-taxable for federal income tax purposes even if the child is not the employee's "dependent" for federal tax purposes. There is no coverage requirement for spouses or children of adult dependents.

No Rescissions
For plan years beginning on or after Sept. 23, 2010, plans are prohibited from rescinding coverage except in the case of fraud or intentional misstatement of material fact. This applies to new plans, grandfathered plans and self-insured plans.

No Lifetime/Restrictive Annual Limits
For plan years beginning on or after Sept. 23, 2010, new and existing fully insured and self-insured plans are prohibited from having lifetime limits on the dollar value of essential benefits. This applies to grandfathered plans. Also, annual limits on the dollar value of essential benefits are restricted to a minimum of $750,000 in 2010–2011, $1.2 million in 2012 and $2 million in 2013. They are completely prohibited in 2014. This applies to grandfathered plans. It is presumed that a plan may include day and visit limits, although the agencies have informally indicated that day or visit limits combined with specific dollar limits would be impermissible. However, day or visit limits paid at a uniform, customary and reasonable rate might be acceptable. A waiver process was implemented for limited medical plans to request exemption from the annual and lifetime maximum restrictions, but it is now closed. The waiver process required submission of an application by Sept. 22, 2011, for all waiver extensions and new waiver requests.

Waivers granted to new applicants will be valid until Jan. 1, 2014, subject to the requirement to submit updated filings, provide a notice explaining to participants that the plan does not meet the annual limit requirements, and comply with certain record retention obligations.

Stand-alone health reimbursement accounts (HRAs) in effect prior to Sept. 23, 2010, are exempt as a class from the annual limit restrictions if they comply with the record retention and annual notice requirements of the waiver rules. HRAs in effect after Sept. 23, 2010, must comply by being integrated with other coverage as part of a (more comprehensive) group health plan, so long as the other coverage meets the requirements of the annual limit rules on its own.

Pre-existing Conditions
For plan years beginning on or after Sept. 23, 2010, there can be no pre-existing condition limitation for coverage of children under age 19. The Secretary of HHS stated that this provision prohibits a plan from denying enrollment to an eligible child under age 19 with a pre-existing condition, and insurers from denying treatment based on a pre-existing condition. This applies to new and grandfathered plans.

Preventive Care Mandate
For plan years beginning on or after Sept. 23, 2010, certain preventive coverage must be provided with no cost sharing. Preventive care includes that which the U.S. Preventive Services Task Force rates A or B; immunizations recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention; and evidence-informed preventive care and screenings provided for infants, children and adolescents in compliance with the comprehensive guidelines supported by the Health Resources and Services Administration.

Additional services for women are also included. The guidelines for women were issued on Aug. 1, 2011, and include coverage for a broad range of items and services, including contraceptive methods and counseling (with a religious exemption for certain religious employers), breastfeeding support and supplies, and screening and counseling for interpersonal and domestic violence. This applies to fully insured and self-insured plans. Grandfathered plans are exempt. The list of mandated preventive services can be found at www.healthcare.gov.

Discrimination Rules
For plan years beginning on or after Sept. 23, 2010, a plan sponsor of a fully insured group health plan may not establish rules relating to benefits and eligibility that are based on the total hourly/annual salary of the employee. The plan sponsor also may not establish eligibility rules that have the effect of discriminating in favor of higher wage employees. This requirement is similar to the rules already in existence for self-insured plans (IRC § 105(h) nondiscrimination testing).

Fully insured plans may continue to have bona fide classifications (hourly vs. salary, geographic, etc.) as long as the classes are nondiscriminatory. A fully insured plan found to be discriminatory will pay an excise tax of $100 a day per person discriminated against. Grandfathered plans are exempt. Enforcement and penalties have been delayed until the Internal Revenue Service (IRS) issues further guidance on how IRC § 105(h) will apply in the fully insured context.

Certain Covered Benefits
For plan years beginning on or after Sept. 23, 2010, fully insured group plans and self-insured group plans must cover emergency services at in-network levels regardless of provider, without prior authorization.

Also, enrollees must be permitted to designate any in-network primary care doctor as their primary care physician (PCP) (that is, the plan may not dictate who will be an insured's PCP), and there may be no referral requirement for OB-GYNs. Grandfathered plans are exempt.

New Appeals Procedures
For plan years beginning on or after Sept. 23, 2010, insurers of fully insured plans and self-insured plans must implement new mandated appeals processes with both internal and external appeal rights. The internal appeal procedures expand upon ERISA appeal procedures, including requirements that an urgent care benefit determination be made as soon as possible considering the medical exigency, but in no case later than 72 hours, and adverse determination notices be culturally and linguistically appropriate. Since fully insured plans can generally rely on the insurer to comply with the internal and external appeals and external review requirements, self-insured plans will be affected to a greater degree than will fully insured plans. Grandfathered plans are exempt.

Year 2010

Small Employer Tax Credit
For years 2010 through 2013, businesses with fewer than 25 employees and average wages of less than $50,000 are eligible for a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark

premium. Tax-exempt businesses meeting those requirements are eligible for the tax credits but are entitled to a maximum credit of 25 percent of their contribution toward the employee's health insurance premium.

The number of full-time equivalents (FTEs) an employer has is determined by aggregating the total payroll hours (but not more than 2,080 per employee) and dividing the total number by 2,080. Wages are determined by total wages paid divided by FTEs. Do not include partners, sole proprietors, 2 percent or more S corporation owners, more than 5 percent owners or seasonal workers (unless they work more than 120 days in a tax year). The amount of the credit is graduated, with the largest credit available for businesses with 10 or fewer employees and an annual salary of $25,000 or less. Nonprofits are eligible for the tax credit. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., hospital insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages for the year.

Medicare Prescription Drugs
The approximately 4 million Medicare beneficiaries who hit the so-called "donut hole" in the program's drug plan received a $250 rebate in 2010. In 2011, their cost of drugs in the coverage gap went down by 50 percent. As of 2011, PPACA also began phasing down the beneficiary coinsurance amount in the coverage gap so that it reaches the standard 25 percent beneficiary coinsurance by 2020.

Rate Review
HHS, in partnership with the states, must establish a process for reviewing unreasonable premium rate increases, requiring insurers to justify such increases prior to implementation. According to regulations, this means that any rate increase exceeding 10 percent will require justification. Insurers that have a pattern of unreasonable increases may be barred from participating in the state insurance exchange. Otherwise, the federal government does not have jurisdiction over insurers' rates and thus may not approve or disapprove rates outside of the state insurance exchange. States are required to report on trends in premium increases and recommend whether certain plans should be excluded from the exchange based on unjustified premium increases. Self-insured plans are exempt.

Small Employer Grant for Wellness Programs — On Hold
For employers with fewer than 100 employees (who work 25 or more hours per week) and that did not have a wellness program in place on March 23, 2010, federal grants will be available to support qualified wellness programs. The wellness program must have health awareness initiatives (health education, preventive screenings, health risk assessments), efforts to maximize employee participation, initiatives to change unhealthy behaviors (counseling, seminars, online programs and self-help material) and a supportive environment (workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity and improved mental health). The grant program will exist for five years after enactment. Because this program has not been provided funding, there is not an effective date for the program at this time.

Year 2011

Medical Loss Ratio
Effective in 2011, insurers must provide a rebate to consumers if the insurer's medical loss ratio (MLR) does not meet the standards set forth in PPACA. Insurers' revenue is divided between claims costs (including clinical costs and costs associated with improving health care quality) and administrative costs. Insurers in the large group market must have an MLR of 85 percent or higher, and insurers in the small group and individual market must have an MLR of 80 percent or higher. Regulations define activity that improves health care quality as that which is grounded in evidence-based medicine, designed to improve the quality of care received by an enrollee, and capable of being objectively measured and producing verifiable results and achievements.

Medicare Advantage Plans
PPACA froze Medicare Advantage (MA) payments for 2011 at the 2010 levels. MA payments were restructured by tying them to 100 percent of Medicare fee-for-service costs, providing bonuses for quality and making adjustments for unjustified coding patterns. The government currently pays the private plans an average of 14 percent more than traditional Medicare. Besides reducing payments overall, there will be a shift in funding, with some high-cost areas to be paid 5 percent below traditional Medicare and some low-cost areas to be paid 15 percent more than traditional Medicare.

HSA/FSA/HRA Restrictions
SStarting in 2011, there will be no tax-free coverage for over-the-counter (OTC) drugs without a prescription under health savings accounts (HSAs), flexible spending accounts (FSAs), HRAs and Archer Medical Savings Accounts. In addition,

there will be a higher penalty (20 percent, up from 10 percent) for nonqualified HSA distributions. Non-drug OTC items, such as bandages and durable medical equipment, are not included within this prohibition.

Simple Cafeteria Plan Safe Harbor
Beginning on Jan. 1, 2011, small employers (generally those with 100 or fewer employees) were allowed to adopt new "simple cafeteria plans." Plans may choose to exclude employees working less than one year, those younger than 21, collectively bargained employees or nonresident aliens. In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan. An employer must contribute a uniform percentage of a qualified employee's compensation (not less than 2 percent) or the lesser of: (a) 6 percent of the employee's compensation or (b) twice the employee's contribution. A qualified employee is one who is not a key or highly compensated employee.

Year 2012

Employer W-2 Reporting
Starting with 2012 compensation, employers that provide "applicable employer sponsored coverage" must begin reporting information concerning an employee's insurance benefits on the employee's Form W-2 issued in 2013. If the employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage. The value of health coverage will equate to COBRA equivalent premium. The employer cannot add a 2 percent administrative fee when reporting the value of COBRA coverage. Applicable employer-sponsored coverage would not include disability insurance, long-term care coverage, HSA contributions, employee contributions to a health FSA, HRA contributions or employer contributions to a stand-alone dental and vision plan that are "HIPAA-excepted benefits."

There is a small employer exception for employers who filed fewer than 250 Forms W-2 for 2011. Unless changed by future guidance, those employers who file fewer than 250 Forms W-2 for one calendar year will be exempt for the next calendar year.

CLASS Act — Implementation Suspended
The Secretary of HHS is required to create procedures and protocols for the Community Living Assistance Services and Supports (CLASS) Act, which establishes a national voluntary long-term care insurance program for purchasing community living assistance services and supports. The timeline for implementation is unclear, but it appears the secretary has until October 2012 to develop such procedures. The Secretary of HHS is also required to establish procedures for individuals to automatically enroll in the CLASS program through an employer in the same manner in which an employer may automatically enroll employees in a 401(k) plan. There must be an "alternative" enrollment process (other than auto-enrollment) for individuals who are self-employed, who have more than one employer or whose employer does not elect to participate in the automatic enrollment process. On Oct. 14, 2011, HHS citing actuarial and solvency challenges, announced that it would halt implementation of the CLASS Act.

Summary of Benefits and Coverage
All group plans and group and individual health insurers (including self-insured plans) will have to provide a summary of benefits and coverage explanation that meets specified criteria to all enrollees. The summary and explanation can be provided electronically or in written form. There is a $1,000 per enrollee fine for willful failure to provide the information.

Comparative Effectiveness Research Fee
A fee, commonly referred to as the PCOR fee, will be assessed for issuers of insurance policies and plan sponsors of self-insured plans, starting with policies having a year ending after Sept. 30, 2012. The fee is $1 per average number of covered lives, increasing to $2 per covered life the following year. Then, starting with plan years ending after Oct. 1, 2014, the fee will increase based on a projected per capita amount of National Health Expenditures. This fee will fund comparative effectiveness research, and the fee will not apply to any policy year ending after Sept. 30, 2019.

Preventive Care Mandate: Women's Health Care Services
Non-grandfathered group health plans are required to provide coverage for certain health services related to women's preventive care. The services, if received in-network, must be covered with no cost sharing for participants. The services include well-women visits, screening for gestational diabetes, human papillomavirus testing, and contraceptive methods and counseling. In regards to coverage for contraception, there is an exception for certain religious employers.

Year 2013

Increase Tax for High-income Taxpayers
Effective 2013, for single taxpayers with an adjusted gross income (AGI) of $200,000 or more, and for joint filers with AGI of $250,000 or more, PPACA would add a 3.8 percent tax on investment income from interest, dividends, annuities, royalties, rents and capital gains (net gain from disposition of property). The tax would not include income that is derived in the ordinary course of a trade or business that is not a passive activity. This 3.8 percent tax is in addition to the 0.9 percentage-point increase in the Medicare payroll tax on earned income that is in PPACA. This additional tax would not apply to qualified plan distributions under IRC §§ 401(a), 403(a), 403(b), 408, 408A or 457(b).

Flexible Spending Arrangements
Effective 2013, contributions to an HSA are capped at a maximum of $2,500, which will be indexed for inflation in future years. Non-calendar-plan years do not have to comply with the $2,500 limit until the plan year that starts in 2013.

Taxation of Retiree Drug Subsidies
Currently, the law provides tax subsidies to encourage employers to maintain retiree drug coverage for their Medicare-eligible retirees. The subsidies are excluded from taxation so that employers will be incentivized to continue this benefit for retirees. In 2013, the employer tax deduction for prescription drug claims will be reduced by the Part D Retiree Drug Subsidy amount payable to the employer. Under accounting laws, employers must immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher liability. The expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income for the period that includes the enactment date. Therefore, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law may not be effective until later years.

Exchange Notice Requirement — Implementation Delayed/No Regulations Yet
As of March 1, 2013, all employers are required to provide notice to their employees informing them of the existence of the state insurance exchange and the availability of tax credits and premium subsidies for qualified individuals. The federal authorities will supply a standard template for compliance.

Year 2014

Insurance Reforms

Effective in 2014, the following market reforms will apply to insurers and self-insured plans:

- No pre-existing condition exclusion for individuals of any age (for children, the exclusions are prohibited starting six months after enactment)
- No annual limits on the dollar value of benefits (which were restricted on a gradual basis beginning six months after enactment of PPACA)
- Coverage for dependents up to age 26, regardless of whether they have access to another source of employer-sponsored coverage
- No waiting periods exceeding 90 days
- Guaranteed issue and guaranteed renewability
- Strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions (individual and small group market only, 100 lives and under) (self-insured plans are exempt)

Employer Mandate
Effective in 2014, applicable large employers that do not offer coverage and that have at least one full-time employee who receives a premium tax credit will be fined an amount equal to $2,000 per full-time employee, excluding the first 30 employees from the assessment. Applicable large employers with more than 50 employees that offer coverage, but such coverage is “unaffordable” or not “qualified,” and have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. Coverage would be considered unaffordable if the premiums for the class of coverage selected by the employee exceed 9.5 percent of family income. Coverage is qualified if the plan pays at least 60 percent of an average person’s medical cost (60 percent actuarial value).

An applicable large employer is one that employed at least 50 full-time employees on business days during the preceding year. “Full-time” employee means an individual who averages 30 or more hours per week. The determination

of number of employees includes "full-time equivalents," which is determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. Full-time equivalents are used to determine whether the 50-employee threshold is met. Full-time equivalents are not used to determine the amount of the penalty.

Employer Voucher — Repealed
Effective in 2014, employers that offer coverage would be required to provide a "free choice voucher" to employees with incomes less than 400 percent of the federal poverty level (FPL) whose share of the premium exceeds 8 percent but is less than 9.8 percent of their household income and who choose to enroll in a plan in the state exchange. The voucher amount is equal to what the employer would have paid to provide the greatest amount of coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan purchased through the exchange. Employers providing free choice vouchers will not be subject to penalties for employees receiving the vouchers. Employees may keep the amount of the voucher in excess of the cost of coverage in the exchange.
On April 15, 2011 President Obama signed legislation into law repealing the voucher program.

Auto-enrollment — Implementation Delayed/No Regulations Yet
Effective in 2014, employers with more than 200 employees must automatically enroll employees in coverage offered by the employer. Employees may opt out of coverage.

Small Business Tax Credit
As described above under "Year 2010," small employers with fewer than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees are provided with a tax credit. For 2014 and later, for eligible small businesses that purchase coverage through a state exchange, the tax credit available will be increased up to 50 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost. The credit will be available for two years. Tax-exempt businesses meeting the requirements above are eligible for the tax credits but will be entitled to a maximum credit of 35 percent of their contribution toward the employee's health insurance premium.

Individual Mandate
Effective in 2014, citizens and legal residents are required to have "minimum essential coverage." Those without coverage will pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5 percent of household income. The penalty will be phased in according to the following schedule: $95 in 2014, $325 in 2015 and $695 in 2016, or the flat fee or 1 percent of taxable income in 2014, 2 percent of taxable income in 2015 and 2.5 percent of taxable income in 2016. After 2016, the penalty will be increased annually by the cost-of-living adjustment.

Exemptions will be granted for those for whom the lowest cost plan option exceeds 8 percent of their income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). Additional exceptions include people with financial hardship, religious objectors, American Indians, people with coverage for less than three months, undocumented immigrants and incarcerated individuals.

Individual Subsidies
Premium tax credits and subsidies will be available to "eligible" individuals and families with incomes between 133 and 400 percent of FPL to purchase insurance through the state exchanges. Eligibility is limited to American citizens or legal residents who lack affordable employer-sponsored coverage and fit within the income levels outlined above. The tax credits will be tied to the second-lowest cost plan in the area and will be set on a sliding scale. For example, people with incomes under 133 percent of FPL will pay only 2 percent of income toward premiums, while people between 300 and 400 percent of FPL will pay 9.5 percent of income toward premiums. There are also cost-sharing subsidies so that certain low-income people will pay only a small percentage of their income toward their insurance expenses.

Benefit Design
Effective in 2014, all qualified health benefits plans, including those offered through the state exchanges and those offered in the individual and small group markets (except grandfathered plans), are required to offer an "essential health benefits package." An essential health benefits package is one that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual cost sharing to the current HSA limits ($5,950/individual and $11,900/family in 2010), and imposes maximum deductible amounts ($2,000/individual and $4,000/family) on small group plans. Abortion coverage is prohibited from being required as part of the essential health benefits package.

Expanded Medicaid Eligibility
Starting in 2014, states will have the option to expand Medicaid eligibility to non-elderly, non-pregnant individuals who are not otherwise eligible for Medicare, with incomes up to 133 percent of FPL. From 2014 through 2016, the federal government will pay 100 percent of the cost of covering newly eligible individuals.

Health Insurance Exchanges
Effective in 2014, state-based health insurance exchanges will be a marketplace through which individuals and small businesses with up to 100 employees can purchase qualified coverage. These exchanges must be established and administered by a governmental agency or nonprofit organization. States are permitted to allow businesses with more than 100 employees to purchase coverage in an exchange beginning in 2017. States may form regional exchanges or allow more than one exchange to operate in a state as long as each exchange serves a distinct geographic area. Funding is available to states between March 23, 2011, and Jan. 1, 2015.

Wellness Initiatives
Effective for plan years beginning on or after Jan. 1, 2014, the HIPAA wellness program incentive limit will increase from 20 percent to 30 percent of total cost of coverage; regulations may increase the 30 percent up to 50 percent.

New Reporting Requirements
Effective in 2014, health plans must provide to the IRS and individuals an annual statement (Form 1099-HC) reflecting the months during the calendar year for which the individual had "minimum essential coverage." Also, plans must report to the IRS and individuals information about the quality and affordability of coverage provided, including details of coverage provided, eligibility, premium costs, employer contributions, etc. Penalty for noncompliance is $50 for each missed statement up to a maximum of $100,000.

Reinsurance Fee
Beginning in 2014, each state that operates an exchange is required to establish a temporary reinsurance program for the individual market, to which health insurers and group health plans are required to contribute. The reinsurance program will be in operation from 2014 to 2016. There will be a national uniform contribution rate of $63 per covered life per year ($5.25 per month) payable annually. For fully insured major medical coverage, insurers are liable for the contributions. They will presumably pass along the cost as part of premiums or other fees. For self-insured plans, the plan is ultimately liable for the contributions, although a third-party administrator can be used to remit the contributions on the plan's behalf.

Year 2018

Tax on Cadillac Plans
PPACA delayed implementation of the tax on Cadillac plans and increased the threshold above which the tax applies. Effective in 2018, an excise tax is imposed on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax is equal to 40 percent of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a health FSA for medical expenses or HRA, employer contributions to an HSA and coverage for supplementary health insurance coverage, excluding stand-alone dental and vision coverage.

If health care costs increase more than expected, as determined by the cost of an identified standard benefit option under the Federal Employees Health Benefits Program, then initial threshold will be automatically adjusted upward. This provision also includes an adjustment for retirees ages 55–64 and for employees in high-risk jobs, and an adjustment for age and gender in calculating health care costs that are subject to the tax.

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