Wells Fargo Insurance Services

Legislative Alert

Summary of Federal Healthcare Reform Law

Updated as of September 27, 2011

The Patient Protection and Affordable Care Act (H.R. 3590) was signed into law by President Obama on March 23, 2010. The companion bill, the Health Care and Education Reconciliation Act (H.R. 4872), was signed into law on March 30, 2010. Together, these two bills constitute what is now commonly referred to as the "Affordable Care Act" or "ACA." Set forth below is a brief summary of some of the key changes that will affect employers and employees under the ACA.

Important notes

- **Fully-insured vs. self-insured group health plans.** Except as otherwise noted, all of the items below that are applicable to group health plans apply to both fully-insured and self-insured group health plans.
- **Grandfathered plans vs. non-grandfathered plans.** Group health plans existing on March 23, 2010, are "grandfathered" under the ACA. Grandfathered plans are deemed to be "minimum essential coverage," have special effective date rules for certain health reform changes, and are completely exempt from certain other changes (as noted in the chart below). A grandfathered plan is allowed to enroll new employees (both newly hired and newly enrolled) and their families without losing its grandfathered status. In regulations issued on June 14, 2010, and subsequent amendment to the regulations issued on November 15, 2010, federal regulators provided that grandfathered status would be lost if various actions were taken with respect to the plan (such as changing insurance carriers prior to November 15, 2010, eliminating benefits, raising percentage cost-sharing requirements, significantly raising fixed-amount cost-sharing or co-payment requirements, significantly lowering employer contributions, imposing new or decreased annual dollar limits, etc.).
- **Collectively-bargained plans.** For insured group health plans maintained under one or more collective bargaining agreements ratified before March 23, 2010, there is a provision in the ACA that grants grandfathered status to such plans until the termination date of the last collective bargaining agreement relating to the plan. This special collectively-bargained grandfathered status will allow insured collectively-bargained plans (but not self-insured plans) to take certain actions (as noted above) that would otherwise result in loss of grandfathered plan status. Nevertheless, like any other group health plan there are some market reform changes (such as limits on lifetime and annual dollar limits, extension of dependent coverage to adult children up to age 26, phase-out of pre-existing condition limitations, prohibition on rescissions, etc.) that will apply to every insured or self-insured collectively-bargained plan regardless of whether the plan is considered grandfathered or not.

The following chart highlights applicable provisions in chronological order for each employer size grouping.

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Employers with two to 25 employees				
Premium tax credit for small employers (fewer than 25 employees)	The government provides a 35 percent premium tax credit to small employers (up to 25 employees with average annual wages of less than $50,000) that contribute toward health insurance premiums for employees; generally increases to 50 percent in 2014 (available for only two years) but only if employer offers coverage through an insurance exchange (see "Insurance exchanges," below)	2010	2010	Apply for tax credit, if applicable
Employers with two to 100 employees				
Temporary wellness program grants for small employers (fewer than 100 employees)	Small employers (those with fewer than 100 employees who work 25 hours or more per week) that did not have a workplace wellness program in place on March 23, 2010, may apply for government grants to help subsidize workplace wellness programs that satisfy certain criteria	2011; the program ends on the earlier of $200 million in funding being exhausted or December 31, 2015	2011; the program ends on the earlier of $200 million in funding being exhausted or December 31, 2015	Monitor governmental grant submission requirements, and apply for grant if program applicable
Simple cafeteria plans for small employers (fewer than 100 employees)	Internal Revenue Code § 125 cafeteria plans maintained by small employers (with an average of 100 or fewer employees during either of the two preceding years) are deemed to be nondiscriminatory if all employees with at least 1,000 hours of service in the preceding year are eligible to participate; certain nondiscrimination standards are met; and employer contribution are either: • a uniform percentage (at least two percent) of employee compensation, or • not less than six percent of employee compensation (or, if less, two times the employee contribution amount)	2011	2011	Consider adopting a simple cafeteria plan, if applicable

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Insurance exchanges	Individuals (U.S. citizens and legal immigrants) and small employers (those having an average of 100 or fewer employees in the previous calendar year, although states can set the number at 50 or fewer for plan years beginning prior to 2016) may purchase insurance from state-run exchanges beginning in 2014; if the state agrees, large employers (having an average of at least 101 employees in the previous calendar year) also may purchase from the exchange beginning in 2017 Five tiers of coverage are offered through the exchange: • Bronze – provides essential health benefits, covers at least 60 percent of actuarial value of covered benefits, with out-of-pocket limit equal to current limits on HSAs ($5,950 for individuals and $11,900 for families, in 2010) • Silver – provides essential health benefits, covers at least 70 percent of actuarial value of covered benefits, with HSA out-of-pocket limits • Gold – provides essential health benefits, covers at least 80 percent of actuarial value of covered benefits, with HSA out-of-pocket limits • Platinum – provides essential health benefits, covers at least 90 percent of actuarial value of covered benefits, with HSA out-of-pocket limits • Catastrophic – similar to high-deductible health plan, except available only to individuals up to age 30 in the individual market (not through an exchange) Deductibles for plans in the small group market are limited to $2,000 for individuals or $4,000 for families, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement. (Awaiting further guidance on this mandate.) Reduced out-of-pocket limits apply to individuals with incomes up to 400 percent of the federal poverty level	2014	2014	Monitor government developments

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Employers with 50 or more employees				
Form W-2 reporting to employees (based on number of W-2 forms filed by employer, not number of employees)	Although not taxable, the aggregate value (using rules similar to COBRA) of employer-provided medical coverage provided to each employee must be disclosed on Form W-2	For 2012 tax year	For 2012 tax year	Develop reporting mechanism Applicable to employers who file 250 or more W-2 forms in a year
Employer "play or pay" mandate	Employers with more than 50 full-time employees in the preceding calendar year (working an average of at least 30 hours per week, or 130 hours per month) can "play" by offering "minimum essential coverage" to all of its full-time employees and their dependents; solely for purposes of determining whether the employer has more than 50 full-time employees, part-time workers are converted to full-time equivalents by adding all hours worked by part-timers during the month and dividing by 120; special rules apply with respect to seasonal employees working for employers close to satisfying the more-than-50 full-time employee standard. Employers with more than 50 full-time employees that do not offer "minimum essential coverage" must pay an excise tax of $2,000 times the total number of full-time employees of the employer (excluding the first 30 employees) if at least one full-time employee receives government-subsidized coverage through an insurance exchange (discussed below). If the employer offers "minimum essential coverage," but the coverage for the employee is "unaffordable" (employee cost for single coverage is greater than 9.5 percent of the employee's household modified adjusted gross income (MAGI) and the employee receives government-subsidized coverage through an insurance exchange, the employer is required to pay an annual excise tax equal to $3,000 for each employee receiving subsidized exchange coverage (this assessment cannot exceed the assessment for not providing minimum essential coverage described above). In either penalty situation, these nondeductible excise taxes are calculated and assessed on a monthly basis.	2014	2014	Evaluate "play or pay" strategy; monitor government developments

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Employers who offer a medical plan, regardless of employer size				
Temporary government subsidies for early retiree plans	For employers with early retiree medical plans, the government will reimburse eligible employers for 80 percent of the cost of medical benefits (between $15,000 and $90,000) for retirees age 55 to 64 and their dependents; subsidy must be applied only as permitted	June 1, 2010; the program ends on the earlier of $5 billion in funding being exhausted or December 31, 2013	June 1, 2010; the program ends on the earlier of $5 billion in funding being exhausted or December 31, 2013	Apply for and seek reimbursement, if applicable
Lifetime dollar limits on plan benefits	Group plans may *not* place lifetime dollar limits on essential health benefits	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation
Annual dollar limits on plan benefits	Group plans may only place "restricted" annual dollar limits (not less than $750,000, phasing up to not less than $2 million for 2013 plan years) on essential health benefits as defined by the Secretary of Health and Human Services (HHS), with all annual dollar limits on essential health benefits prohibited starting in 2014 plan year; HHS may grant limited waivers from pre-2014 limitations in certain situations	Requirement for government-set limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Requirement for government-set limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Amend plan documentation
Rescinding coverage	Plans cannot rescind coverage of an enrollee, except in cases of enrollee fraud or material misrepresentation	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation
Pre-existing condition limits on plan benefits	Group plans may not impose a pre-existing condition exclusion with respect to children under age 19, with pre-existing condition exclusions eliminated for all participants starting in 2014 plan year	First plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	First plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Adult child coverage	• All group health plans must extend eligibility to children of the covered employee until the child turns 26 years of age (grandfathered plans can exclude an "adult child," if the child is eligible for coverage under another employer-sponsored group health plan, although this exception is eliminated in 2014) • Coverage must be extended regardless of marital status, student status, level of support provided, or residency of adult child; but does not need to extend to children of an adult child (that is, grandchildren of the employee) • Terms of group health plan providing dependent coverage cannot vary based on age up to age 26 (for example, no surcharges allowed for adult child coverage) • Healthcare benefits for adult children are excludible from taxable income through the end of the calendar year in which the adult child turns age 26, effective as of March 30, 2010 • State laws extending insured coverage for dependents past the age of 26 are still enforceable	First plan year beginning after September 23, 2010, but plans can exclude an adult child eligible to enroll in another employer-sponsored health plan (not including a parent's plan) Effective with first plan year beginning in 2014, coverage must be extended to all children up to the age of 26 Tax exclusion effective March 30, 2010	First plan year beginning after September 23, 2010 Tax exclusion effective March 30, 2010	Amend plan documentation
Preventive care coverage	Employer plans must provide coverage, without cost-sharing, for preventive services rated A or B by the U.S. Preventive Services Task Force; recommended immunizations; preventive care for infants, children, and adolescents; and preventive care and screenings for women	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Appeals procedures	All group plans must have both internal claims and appeals procedures and external review procedures that are expanded beyond current requirements; federal grants available to states to strengthen assistance programs for individual claimants	Not applicable, except that federal grants for state government assistance programs effective with 2010 fiscal year	Internal claims and appeals (in addition to existing DOL claims procedure): • For plan years beginning on or after September 23, 2010, plans must · treat a recission of coverage as an adverse benefits determination · allow claimants to review their claim file and present evidence as part of internal appeals process · provide claimants with any new or additional evidence and allow an opportunity to respond • For plan years beginning on or after July 1, 2011, additional content is required for adverse benefit determinations and plans must describe internal and external review process and disclose contacts for additional assistance.	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Appeals procedures (continued)			• For plan years beginning on or after January 1, 2012 · Internal claims and appeals will be deemed exhausted where the plan fails to satisfy new internal review requirements unless failure is de minimis and non-prejudicial to the claimant · There are new content requirements for adverse benefit determinations · Plans must issue notices and provide language assistance to participants in their native language if at least ten percent of the population in the claimant's county is literate only in the same non-English language	

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Appeals procedures (continued)			External review procedures: For plan years beginning on or after September 23, 2010, insured plans in states with an adequate external appeals process will follow those existing or revised procedures. Self-funded ERISA plans should use independent review organizations (IROs) as specified in the safe harbor review process or take part in an adequate state program. Self-funded non-ERISA plans, including non-federal governmental plans, and insured plans in states that do not have an adequate external review process can utilize the safe harbor IRO process or the review process administered by HHS.	
Nondiscrimination requirements	Insured health plans will now be required to comply with Internal Revenue Code § 105(h)(2) nondiscrimination rules that previously only applied to self-insured health plans	Not applicable	Effective date delayed until further guidance issued, pursuant to IRS Notice 2011-1	Conduct testing, if applicable

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Access to certain healthcare providers	Plans that require designation of a primary care provider must allow the designation of any available participating primary care provider, including pediatricians for children; plans cannot require authorization or referral prior to seeking OB-GYN services; plans cannot require prior authorization for emergency services or set more restrictive cost-sharing requirements when emergency services are provided out of network	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation
Disclosure of plan information	In "plain language," plans must disclose to the Secretary of HHS and the relevant state insurance commissioner (and make available to the public) specified information, including: • claims payment policies and practices; • periodic financial disclosures; • data on enrollment, disenrollment, number of claims denied, and rating practices; • information on cost-sharing and payments with respect to any out-of-network coverage; • information on enrollee and participant rights under the Health Care Law; and • other information as determined appropriate by the Secretary of HHS	Not applicable	Under the statute, the additional information is first required in connection with the Health Exchanges beginning January 1, 2014	Monitor government data disclosure requirements
Community living assistance services and supports (CLASS) program	Employers may agree to participate in a national, voluntary long-term care program that, after a five-year vesting period, will provide individuals with functional limitations a cash benefit of not less than $50 per day to purchase non-medical services and supports to maintain community residence; participating employers must automatically enroll employees, who have an opt-out right	Details will be announced by the Secretary of HHS no later than October 1, 2012	Details will be announced by the Secretary of HHS no later than October 1, 2012	Evaluate whether to offer program
Over-the-counter drugs	Except for insulin, over-the-counter drugs without a prescription are not reimbursable from a health care flexible spending account (FSA) or health reimbursement account (HRA), and are not a tax-free reimbursement from a health savings account (HSA)	2011	2011	Amend plan documentation

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Health savings accounts (HSAs)	Penalty on non-medical HSA distributions raised from 10 percent to 20 percent	2011	2011	Amend plan documentation, and notify HSA participants of new excise tax
Distribute Summary of Benefits and Coverage document and Uniform Glossary	Employers will be required to distribute to enrolled employees a summary of benefits with an explanation of coverage (in addition to a summary plan description) that accurately describes the benefits and coverage levels offered under the employer's plans according to uniform standards; employers also must notify enrollees if they intend to make any material modifications not reflected in the most recent summary within 60 days prior to the effective date of the modifications; each compliance failure can result in a $1,000 penalty	March 23, 2012	March 23, 2012	Review HHS guidance and prepare compliant benefits summaries for distribution to new and existing employees
Temporary tax on insured and self-insured group health plans to fund patient-centered outcomes research trust fund	Establishes a tax of $1 times the average number of lives covered (increases to $2 times the average number of lives covered for plan years ending in 2013)	Plan years ending after September 30, 2012; terminates for plan years ending after September 30, 2019	Plan years ending after September 30, 2012; terminates for plan years ending after September 30, 2019	Monitor government payment procedures
Health care flexible spending account (FSA) plans	Employee pre-tax contributions to a health care FSA are limited to $2,500 per year	2013	2013	Amend plan documentation, if applicable

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Administrative simplification	Health insurance administrators must comply with standards and associated operating rules to be adopted by the Secretary of HHS (including certification and documentation requirements) with respect to the following:			Monitor government developments
	• Eligibility verification and claims status;	2013	2013	
	• Electronic funds transfers and healthcare payments; and	2014	2014	
	• Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization.	2016	2016	
	A penalty of $1 per covered life per day will be assessed for noncompliance	2014	2014	
Employer notice to employees of coverage options	Notice must be provided to existing employees and new hires of the existence of and information regarding an insurance exchange (see "Insurance exchanges," below), the availability of a government subsidy (if applicable), and the consequences if the employee waives coverage under the employer plan in favor of obtaining coverage through the exchange	March 1, 2013	March 1, 2013	Develop reporting mechanism
Government-subsidized coverage through insurance exchange for individuals	A government subsidy is available to U.S. citizens and legal immigrants with incomes up to 400 percent of the federal poverty level to purchase coverage through an insurance exchange; however, an individual will not be eligible for a government subsidy if eligible for minimum essential coverage through an employer that is: • "affordable" (the employee's contributions do not exceed 9.5 percent of the employee's household income) and • provides "minimum essential coverage" (the plan pays at least 60 percent of the allowed costs of benefits)	2014	2014	None

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Waiting periods	Waiting periods in excess of 90 days are prohibited	First plan year beginning in 2014	First plan year beginning in 2014	Amend plan documentation, if applicable
Approved clinical trials	Group plans cannot deny qualified individuals' participation in certain clinical trials, including coverage for routine patient costs that would typically be covered outside the clinical trials	Not applicable	First plan year beginning in 2014	Amend plan documentation
Employer reporting to government	Employers must report to the government whether they offer minimum essential coverage to full-time employees and dependents, the length of the waiting period, the lowest-cost option for coverage, the employer's share of coverage costs, and the total number and names of employees receiving coverage from the employer's plan	2014	2014	Monitor government reporting mechanism
Wellness programs	Employers may offer financial incentives to employees of up to 30 percent (not just 20 percent) of the cost of coverage to participate in a wellness program that satisfies the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination requirements; the government can increase the limit to 50 percent if deemed appropriate	2014	2014	Amend plan documentation, if applicable; monitor government developments

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Excise tax on high-cost plans	A 40 percent excise tax is imposed on insurers (for insured coverage) and employers (for self-insured coverage) to the extent that the aggregate annual value of an employee's health coverage (including medical, prescription, HRA, health care FSA, and employer HSA contributions) exceeds $10,200 ($27,500 for more than employee-only coverage) Threshold values are indexed to changes in the consumer price index for urban consumers; thresholds are • raised by $1,650 for retirees age 55 to 64 ($3,450 for family coverage), for persons in certain high-risk professions (including law enforcement, fire protection, and others), and certain utility workers; and • adjusted to reflect higher healthcare costs attributable to age or gender in the workforce. The employer is responsible for calculating the value of excess coverage using COBRA rules, and making reports to insurers and the government	2018	2018	Evaluate whether group health plan would be subject to excise tax

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