Health Care Reform Impact on Employer-Sponsored Health Plans

Excerpted from Various Insurance and Benefits Industry Sources
(impact on self-insured plans is annotated in green text below)

- Prohibition of lifetime limits - Prohibits all plans from establishing lifetime limits. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Prohibition of annual limits - Prohibits all plans from establishing annual limits on the dollar value of benefits starting in 2014. Prohibits plans from setting limits that would "impair essential health benefits" in subsequent years. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Prohibition on rescissions - Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Coverage of preventive health services - Requires all plans to cover preventive services and immunizations, recommended by various Federal agencies, also specifically includes certain child preventive services and women's preventive care. Plans are prohibited from imposing any cost-sharing requirements. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Dependent coverage - Requires all plans offering dependent coverage to make coverage available to dependents that are under the age of 26 and unmarried. Plans are not required to cover dependents of dependents. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Prohibition of preexisting conditions - No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Prohibiting discrimination based on health status - No group health plan may set eligibility rules based on health status, medical condition, claims-experience, receipt of healthcare, medical history, genetic information or evidence of insurability - including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 % for employee participation in certain health promotion and disease prevention programs. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Prohibition on waiting periods - Prohibits any waiting periods for group or individual coverage that exceed 60 days. Employers are penalized $600 per full-time employee for each employee required to wait beyond 60 days. **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Required Plan Information Disclosure

  Requires plans to issue a summary of benefits and explanation of coverage to beneficiaries with the following criteria:

  - In uniform format
  - In "easily understood" language
  - Inclusion of uniform definitions of standard insurance and medical terms
  - Explanation of cost-sharing exceptions, reductions and limitations on coverage
  - Provide common benefits scenarios

- Expanded Beneficiary Appeals Availability

  - Requires plans to implement a process for external appeals of coverage determinations and claims
  - **Requires self-insured plans to comply with minimum standards to be established by the Secretary of DOL**
  - **Only applicable to self-insured plans established after 6 months from date of enactment.**

- Health Information Technology Standards and Plan Requirements
    - Adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under HIPAA (such as benefit eligibility verification, prior authorization and electronic funds transfer payments)
    - Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary
- "Young Invincibles" Plan
    - Allows health insurers to offer a catastrophic, high-deductible plan as an exchange option
    - To be eligible for plan, individuals must be either
        - Under the age of 30
        - Exempt from the individual responsibility requirement because coverage is unaffordable to them
        - Individuals with access to employer-sponsored plans who meet criteria may join
        - Plan must
            - ◊ Cover essential health benefits
            - ◊ Cover at least 3 primary care visits
            - ◊ Require cost-sharing up to the HSA out-of-pocket limits
- Allowable Prevention and Wellness Incentives
    - Allows employers to discount up to 30% of the premium or cost-sharing requirements for participants in a workplace wellness program
    - Provides discretion to HHS to permit discounts up to 50%
- Low-Income Tax Subsidies Effects on Employer-Sponsored Health Plans
    - Employees with access to employer-sponsored coverage are eligible for credit (for use in an Exchange only), if:
        - Plan covers less than 60% of total coverage cost
        - The premium exceeds 9.8 of total income
- Employer Responsibility
    - Requires an employer with more than 50 full-time employees that offers coverage, but has employees receiving the "premium assistance" tax credit, to pay the lesser of $3,000 for each employee receiving the credit, or $750 for each full-time employee - adjusted annually and non-deductible
    - An employer with more than 50 full-time employees that maintains an enrollment waiting period would be required to pay
        - $600 for any full-time employee subjected to longer than a 60 day waiting period – adjusted annually and non-deductible
- Employee "Free Choice" Voucher

Allows employees with access to an employer-sponsored plan, under certain income eligibility, to receive a voucher from their employer, equal to their employer's contribution ("free choice" voucher), to purchase coverage through an Exchange participating plan.

- To be eligible for a voucher, an employee would have to meet both of the following criteria:
    - The cost of the employee's coverage needs to be between 8% and 9.8 percent of the employee's household income
    - Employee has a household income below 400% FPL
    - The contribution amount to the voucher must be equal to the amount the employer contributes to their own health plan.

- If the employee chooses coverage that costs less than the voucher, the employee keeps the remainder amount
- Vouchers cannot be taxed as income

- Automatic Employee Enrollment

Requires employers with more than 200 employees to automatically enroll new full-time employees in Coverage

Requires employers to provide adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in

- Reporting Requirements for Employer-Plan Sponsors

Requires large employers (over 200 employees) to report the following

- Whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan
- The length of any applicable waiting period
- The lowest cost option in each of the enrollment categories under the plan
- The employer's share of the total allowed costs of benefits provided under the plan
- The number and names of full-time employees receiving coverage
- Disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2

- Requirement to Disclose Coverage Options

Requires that an employer provide notice to their employees informing them of the existence of an exchange

- Excise Tax on Generous Plans

Levies an excise tax of 40% on insurance companies and plan administrators for any health coverage plan that is above the threshold of:

- $8,500 for single coverage
- $23,000 for family coverage

- Fees on Self-Insured Plans
  - **In 2013, the plan sponsor of a self-insured plan is required to pay $2 multiplied by the average number of covered lives**
  - **From 2013-2019 the previous year's fee is multiplied by projected per-capita amount of National Health Expenditures**
  - **Plans are not required to pay fees beyond 2019**

- Termination of Deductibility of Medicare Prescription Drug Subsidies
  - Elimination of the deductibility of Federal subsidies for Medicare Rx programs

- Limitation on Health Flexible Spending Arrangements
  - Limits the amount of contributions to health FSAs to $2,500 per year indexed by CPI

- Annual Report on Self-Insured Plans

Requires the Secretary of DOL to prepare an annual report, using information obtained from submitted Form 5500, on various aspects of self-insured, group health plans. Report will include:

- **Plan type**
- **Number of participants**
- **Benefits offered**
- **Funding arrangements**
- **Benefit arrangements**
- **Data from the financial filings including:**
  - **Information on assets**
  - **Liabilities**

- **Contributions**
- **Investments**
- **Expenses**

- Indirect Health Industry Fees Likely to Increase Plan Costs

  - Fees on Pharmaceuticals
    - Imposes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector beginning in 2010

  - Fee on Medical Devices
    - Imposes an annual flat fee of $2 billion on the medical device manufacturing sector in years 2011 – 2017
    - Imposes an annual flat fee of $3 billion on the medical device manufacturing sector in years after 2017