Overview of the Patient Protection and Affordable Care Act (PPACA)

2012 to 2018

Below is a brief description of the PPACA requirements that go into effect 2012 through 2018 as they relate to employers and health care coverage. Some requirements have been delayed while many others are anticipated to receive further clarification. Due to the frequent updates coming from the DOL, IRS and DHHS the accuracy of this document is time sensitive. We will continue to update periodically. Please note the date on the document when referencing.

Provision	Description	Groups Impacted	Effective Date
2012			
Summary of Benefits and Coverage	HHS guidance issued on format and content Summary of Benefits and Coverage), including guidance on 60 day Advanced Notice on Material Modification.	All employers	Plan years beginning on or after 9/23/12
Medical Loss Ratio and Rebates	Health plans must provide rebates to enrollees if their medical loss ratio – the percentage of premiums spent on medical claims, reimbursement for clinical services and activities that improve health care quality – does not meet the minimum standards for a given plan year. Large group insurers must spend at least 85% of premium dollars on claims and activities to improve health care quality. Individual and small group insurers must spend at least 80%.	Employers with fully-insured group plans	Beginning August 2012
Comparative Effectiveness Research (CER) Fee	Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. Fee adjusted annually.	All employers providing health insurance coverage	First plan year ending after 9/30/2012; through 2019
Women's Preventive Health Care Services	Preventive health care services expanded to include Women's Preventive Health Care services, such as contraception (birth control), well-woman visits, interpersonal and domestic violence screening, and more. These services are required to be covered at 100%. Certain exemptions apply.	All employers providing health insurance coverage	Plan years beginning 8/1/2012
Form W-2 Reporting of Employee Coverage	Employers are required to report the aggregate cost of employer-sponsored health insurance coverage on employees' W-2 forms. **Note**: Employers filing fewer than 250 W-2 forms won't have to report until the IRS issues further guidance.	Employers who issue more than 250 W-2 forms.	Tax year 2012 to be reported January 2013

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2013			
Tax Changes	• Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers. • $2,500 Limit on Flexible Spending Accounts (Medical), it increased to $2550 in 2015.	All employers providing health insurance coverage	1/1/2013
Employee Notice of Exchanges/Marketplace	Notice to employees providing information of exchange (health insurance marketplace). Two (2) versions provided. One for employers who offer coverage and 2nd for employers not offering coverage. Employers will be required to provide the notice upon hire and upon request. Notice must be provided to new employees with 14 days of hire.	Individuals and small groups.	10/1/ 2013
2014			
State Exchanges	Exchanges are operational for small groups and individuals. Tax credits will only be available to small groups when coverage is purchased through an Exchange. ○ **Health Insurance Marketplace** – for Individuals to purchase health insurance coverage. May qualify for a tax credit or premium subsidy based on household income. ○ **SHOP** (Small Employer Health Options Program) – for Small Businesses to purchase group health insurance coverage. The business may apply for the small business tax credit. Maine has a Federally Facilitated SHOP.	Individuals and small groups.	1/1/2014
Essential Health Benefits (EHB)	Institute of Medicine provided suggestions to HHS on October 7, 2011. Each state determined its own benchmark plan based upon a common plan in the state offered by small group and individual plans both inside and outside Exchanges. • Essential Health Benefits must include items and services within at least the following 10 categories: Ambulatory Patient Services,	Individual and small group plans. More limited applicability to large employers.	1/1/2014

Provision	Description	Groups Impacted	Effective Date
	Emergency Services, Hospitalization, Maternity and Newborn, Mental Health and Substance Use Disorder Services, Prescription Drugs, Rehabilitative and Habilitative Services and Devices, Laboratory Services, Preventive and Wellness Services and Chronic Disease Management, and Pediatric Services including oral and vision care. .		
Plan Design—further modifications	• No pre-existing condition restrictions on any covered beneficiary • Waiting periods must be less than 91 days (max 90 days) • Coverage to age 26 for adult children even if eligible for employment based plans (grandfathered plans) • Treatments relating to certain aspects of specified clinical trials	All employers providing health insurance coverage	1/1/2014
Wellness Incentives	Currently, under the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules, employers are allowed to give a premium discount, rebate or other reward of up to 20% of the costs of coverage for employees who participate in wellness programs and satisfy a standard related to health status. Under the PPACA, employers will be able to allow discounts of 30% of the cost of individual or family health care premiums. That amount could go up to 50% if the Secretaries of Health and Human Services, Labor and Treasury deem it appropriate.	All employers providing health insurance coverage	1/1/2014
Individual Mandate	Requires U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty. Exemptions will be granted for financial hardship, religious objections, and others.	Individuals	1/1/2014
Transitional Reinsurance Program	The Affordable Care Act (ACA) provides for a transitional reinsurance programs to help stabilize premiums for coverage in the individual health insurance market during the first three years of operation of the Exchanges (2014-2016). The program is funded through contributions from fully insured and self-insured plans. The 2014 fee was $5.25 per member per month, or $63 per person per year. **2015 Fees** - $3.66 per member per month or $44 per member per year**. 2016 Fees** - $2.25 per member per month or $27 per member per year	Fully insured and Self-funded employer plans.	All employers January 2014.

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	Note: Maine implemented a state based program called Maine Guarantee Access Reinsurance Association (MGARA). MGARA will be suspended for the time period the federal program is operational.		
Insurer Assessment	An annual fee to be paid by health insurance companies to pay for premium subsidies and tax credits to be made available to qualifying individuals purchasing health insurance coverage through Exchanges beginning in 2014. Fee estimated to be $8 billion in 2014 growing to $14.3 billion in 2018, increasing by the rate of premium growth after that. Fee likely to be shifted to insurance premiums.	Insured plans only. Does not apply to Self-Funded plans.	1/1/2014 *Fee is suspended for 2017*
Benefit Changes	**All Plans** – The health insurance plan out-of-pocket amounts cannot exceed the out-of-pockets amounts set for high deductible health plans. • 2015: $6,600 Individual and $13,200 Family • 2016: $6,850 Individual and $13,700 Family • 2017: $7,150 Individual and $14,3000 Family All cost sharing (deductibles, coinsurance, copayments, prescription, etc. accumulate to the out-of-pocket maximum).	Large and Small Group Plans – Out of pocket limits	1/1/2014
Small Group Changes	**Benefit Plans:** All small group plans (except Grandfathered plans) were replaced with plans that are Bronze (60% value), Silver (70%), Gold (80%) or Platinum (90%). This applies to plans sold inside and outside the Exchange. **Premium Rates:** Upon renewal in 2014, small group plan rates are member specific based on age, geographic location and tobacco status.		Plan years beginning 1/1/14
Nondiscrimination – Insured Plans *	Prohibits fully insured, non-grandfathered plans from establishing eligibility rules that discriminate in favor of highly compensated individuals. Self-insured plans are already subject to similar rules, under IRS Code Section 105(h).	Fully insured, non-grandfathered plans	Delayed until regulations issued.
2015			
Shared Responsibility (also referred to as "Pay or Play")	Employers with 50 or more Full-Time Equivalent Employees (FTE) will be responsible for paying an assessment/penalty if at least one FTE obtains coverage in an Exchange and is eligible for financial assistance, as follows:	Employers with an average of 50 or more full-time employees (FTE)	1/1/2015 For employers with between 50 – 99

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	• The employer **does <u>not</u> offer** Minimum Essential Coverage to at least 95% of full-time employees, and has at least one full-time employee who enrolls in the Exchange and receives a premium tax credit, the employer is assessed a fee of $2,000 annually per full-time employee, excluding the first 30 employees. • The employer **does offer** coverage, however the coverage is not Affordable and/or meet the Minimum Value standard – and one or more full-time employees enrolls in the Exchange and receives a premium tax credit, the employer will pay the lesser of $3,000 annually for each employee receiving a premium credit **or** $2,000 annually for each full-time employee, excluding the first 30 employees. FTE defined as "employed an average of 30 hours/week or 130 hours per month". The employer's plan must be Affordable and meet Minimum Value requirements for all full-time employees to avoid any Shared Responsibility Penalty: o Affordability is when an employee's contribution for individual coverage does not exceed 9.5% of the employee's wages. The IRS has provided 3 Safe Harbor methods to calculate Affordability. The calculation would be based on single coverage for the lowest cost plan that meets Minimum Value. o The health coverage meets the Minimum Value requirement when the actuarial value of the medical coverage is 60% or more. (See below for more information.) The $2000/$3000 assessments and 9.5% affordability safe harbor will be adjusted annually.		FTEs, Shared Responsibility was delayed until 1/1/16.
Employer Reporting – Forms 1094-C and 1095-C	Applicable Large Employers began reporting 2015 information to their employees and the IRS in 2016 to assist the federal government in administering the Shared Responsibility and Individual Mandate requirements: o **Form 1094-C** – Cover sheet to IRS only	Large Employers (50+ FTEs)	Calendar year 2015 data reported in 2016

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	○ **Form 1095-C** – To employee and IRS. Outlined coverage employee eligible and enrolled if applicable. Self-funded employers provide more information.		
Auto Enrollment	Requires employers with 200 or more employees to auto-enroll all new employees into any existing employer-sponsored health insurance plan. Employees may opt out if they have other coverage.	Employers with 200 or more employees.	*Repealed*
2016 to 2018			
Cadillac Tax	To be imposed on "high cost plans." Such determination to be made based on the annual premium charged for the plan. A tax will be assessed on the amount of annual premium in excess of certain stated levels. Some relief may be granted to employers in states recognized as "high cost" by HHS.	Employers with "high cost plans"	1/1/2018 *Delayed until 1/1/20*

As always, please note that EBS is sharing this information to assist you with your compliance planning. We recommend that you contact your legal counsel with specific questions relating to these laws.