

Healthcare Reform Bulletin

Employee Impact
March 31, 2010



The Patient Protection and Affordable Care Act, signed into law by President Obama last Tuesday, will have a profound impact on consumers, giving both individuals and employees more choices about healthcare for themselves and their families. The majority of changes will take place between 2010 and 2014. Below is a summary of how the consumer will be affected by them.

All Consumers

Mandated Coverage (January 2014)

All U.S. citizens and legal residents will be required to have qualifying health coverage or risk tax penalties. The penalties will vary based on income and will be phased in between 2014 and 2016, and in 2016, will increase annually according to the cost-of-living adjustment.

Coverage Decisions

Individuals will need to elect coverage (beginning in 2014). Essentially, there will be three choices to consider:

- Purchase directly through a State Exchange and potentially be eligible for premium credits
- Elect coverage through an employer (and determine if eligible for a free voucher based on income)
- Pay a tax penalty if not electing coverage

Income Requirements

Individuals and employees will need to be aware of how their income ties to eligibility for healthcare premium assistance. Employees and individuals could be eligible for assistance if their income falls between 133% -400% of federal poverty guidelines (effective January 1, 2014).

Federal Poverty Guidelines

Eligibility for many features of the healthcare reform package is tied to the federal poverty level (FPL) guidelines.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia		
Persons in family	Poverty Guideline	Times 400%
1	\$10,830	\$43,320
2	14,570	\$58,280
3	18,310	\$73,240
4	22,050	\$88,200
5	25,790	\$103,160
6	29,530	\$118,120
7	33,270	\$133,080
8	37,010	\$148,040

For families with more than 8 persons, add \$3,740 for each additional person.

Premium Credits (January 1, 2014)

Individuals with incomes between 133% -400% of the federal poverty level will be eligible for premium credits if they purchase through a State Exchange. Premium credits will be tied to the silver plan (the second lowest cost plan of four to be offered) and will be set on a slide scale tied to income levels:

- Up to 133% FPL – 2% of income
- 133-150% FPL -- 3-4% of income
- 150-200% FPL - 4-6.3% of income
- 200-250% FPL – 6.3-8.05% of income
- 250-300% FPL – 8.05% - 9 > 5% of income
- 300-400% FPL – 9.5% of income

State Exchanges

Once operational, individuals will be allowed to purchase insurance through State Exchanges, which will facilitate administration, customer service and enrollment. Funding to establish the Exchanges will be available to the states until January 1, 2015.

Benefit Plan Designs

Consumers who purchase through a State Exchange can select from four plans that meet essential benefit guidelines and represent minimum creditable coverage (called Platinum, Gold, Silver and Bronze), as well as one catastrophic plan. Premium credits will be tied to the Silver plan. Gold and Platinum plans will require additional cost sharing by the consumer, and the Bronze plan will cost less than the Silver. The catastrophic plan will only be available to consumers up to age 30 or to those who are exempt from the mandate to purchase coverage; it will not be offered to employees of employers (available once State Exchange is operational).

Basic Health Plan (Optional by State)

The states can choose to create a basic health plan for uninsured individuals with incomes between 133-200% of the federal poverty level who would otherwise be eligible to receive premium subsidies through the Exchange. This level of insurance will be for essential benefits only and covered individuals can not pay more in premiums than they would through the Exchange. Also, cost-sharing requirements can not exceed the costs of the Platinum plan for those with incomes less than 150% of FPL or the Gold plan for all other enrollees. Individuals who opt for this basic health plan will not be eligible for subsidies offered through the Exchanges.

Essential Benefits Package (January 1, 2014)

All qualified health plans, including those offered through the Exchanges, must offer essential benefits. The value of this plan will cover at least 60% of the actuarial value of the comprehensive set of services that will be defined. Cost-sharing can not exceed the current law HSA limits (\$5,950 individual and \$11,900 family). The Bronze plan within the State Exchange will meet these essential benefits package requirements.

Dependent Coverage

(Effective six months from March 23, 2010)

Children up to age 26 will be allowed to stay on family plans for all individual and employer policies. It is undetermined if this change will be effective on September 23, 2010 for all plans or upon plan year renewal.

Lifetime Limits (January 2014)

Individual and group health plans will no longer have lifetime limits on the dollar value of coverage, and insurers can not rescind coverage except in cases of fraud.

Coverage for Preventive Services

(Effective six months from March 23, 2010)

The law requires all qualified health plans to provide minimum coverage with no cost-sharing for preventive services that are rated A or B by the U.S. Preventive Services Task Force, including: recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.

Grandfathered Coverage (2014)

Existing policies for individual and group plans will be grandfathered with respect to new benefit standards, but these plans will have to extend dependent coverage to age 26, prohibit rescissions of coverage and eliminate waiting periods for coverage if greater than 90 days, and eliminate lifetime limits.

Consumer Protections

- Beginning July 1, 2010, consumers will have access to a website to help them identify their healthcare options.
- Within 24 months of March 23, 2010, insurers will have standards to follow in providing information on benefits and coverage.

Tax Changes for Individuals and Employees

- Beginning in 2014, individuals who do not elect coverage will face a tax equal to the greater of \$695 per year up to a maximum of three times that amount or 2.5% of household income.
- The distribution tax for nonqualified withdrawals from Health Savings Accounts will increase from 10% to 20%, effective January 1, 2011.

- The Medicare Part A (hospital insurance) tax rate on wages will increase from .45% to 2.35% on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly, beginning January 1, 2013.
- Effective January 1, 2013, higher-income taxpayers will be assessed a 3.8% tax on unearned income.

Employees

Waiting Periods (Effective size months following enactment)

Waiting periods of greater than 90 days will be prohibited.

Employer Coverage Requirements

Employees who are offered coverage by an employer must take that coverage unless their income falls within 100-400% of federal poverty guidelines. If the employee's income falls within these guidelines, the employee can instead elect to purchase through a State Exchange and be eligible for a premium credit OR accept a free voucher from the employer to purchase through an Exchange.

Free Vouchers (Effective January 1, 2014)

Employers that offer coverage must provide a free choice voucher to employees who choose to enroll in a State Exchange plan if their incomes are less than 400% of the poverty level and their share of the premium exceeds 8% but is less than 9.9% of their income. The voucher is equal to what the employer would have paid to provide the employee coverage under the employer's plan. The employee can use this amount to offset the premium costs for the plan in the Exchange.

Auto Enrollment (Effective January 1, 2014)

Employees who work for employers with more than 200 employees will be automatically enrolled into the employers' health insurance plans, but can then opt out of coverage.

Flexible Spending Account Changes

- Employees will no longer be able to use FSAs to purchase over-the-counter drugs unless prescribed by a doctor, effective January 1, 2011.
- Beginning January 1, 2013, FSA annual contributions will be capped at \$2500 per year (increased annually for cost-of-living adjustments).

Providing consumers with access to reliable and trustworthy information will be vital to educated and informed decision making. Call us at 1-800-678-1700 to talk to your benefit advisor at Cornerstone Group for more information on how to communicate this important information to your employees.