



# HEALTH REFORM SUMMARY

## PATIENT PROTECTION & AFFORDABLE CARE ACT

### Small Business Health Reform Summary | Patient Protection and Affordable Care Act

On March 23, 2010 President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (PPACA), the largest expansion of the public health care system since the passage of legislation in 1965 that created the Medicare and Medicaid programs. This HealthPass policy brief outlines the provisions that affect small businesses, both in the near- and long-term.

KEY SMALL BUSINESS HEALTH REFORM PROVISIONS	
<b>EMPLOYER COVERAGE REQUIREMENT (MANDATE)</b>	
<ul style="list-style-type: none"> <li>All employers with <b>50 or fewer employees</b> are <b>exempt</b> from any and all employer coverage mandates and related penalties</li> <li>Employers with 51 or more employees are subject to penalties if they don't meet certain requirements, as described below.</li> <li>In calculating the number of employees and penalties, only full-time employees are counted               <ul style="list-style-type: none"> <li>Full-time employment is considered as a worker who is employed on average for at least 30 hours per week</li> <li>Seasonal workers who provide less than 120 days during a tax year are exempt from the employee calculation</li> </ul> </li> </ul>	
<b>Employers that DO NOT provide coverage</b>	<ul style="list-style-type: none"> <li>Effective January 1, 2014</li> <li>Employers with 50 or more employees that <b>do not provide health coverage</b> will be assessed \$2,000 for <b>each</b> full-time employee in its workforce</li> <li>Penalty calculation excludes first 30 full-time employees</li> <li>For <b>example</b>, a firm with 80 employees would pay a (\$2,000 x 50 EE's =) \$100,000 annual penalty or \$8,333 per month</li> </ul>
<b>Employers that DO provide coverage</b>	<ul style="list-style-type: none"> <li>Effective January 1, 2014</li> <li>Employers that do provide coverage and have one or more full-time workers qualifying for a premium tax credit or a cost-sharing reduction will pay <b>the lesser</b> of \$3,000 (\$250 per month) for each employee receiving a premium credit or reduction OR \$2,000 for each full-time employee in the firm</li> <li>Penalty calculation excludes first 30 full-time employees</li> <li>For <b>example</b>, a firm with 80 total employees, 10 of which receive a credit or reduction would be faced with paying either:               <ul style="list-style-type: none"> <li>\$2,000 x 50 total full-time EE's = \$100,000 per year vs.</li> <li>\$3,000 x 10 full-time EE's receiving a credit or reduction = <b>\$30,000 per year</b></li> </ul> </li> </ul>
<b>INDIVIDUAL REQUIREMENTS (MANDATE)</b>	
<ul style="list-style-type: none"> <li>Requires U.S. citizens and legal residents to have qualifying health coverage</li> <li>Those without coverage pay a tax penalty of the <b>greater of \$695 per year</b> (up to a maximum of three times that amount - \$2,085) per family <b>or 2.5% of household income</b>.</li> <li>The penalty will be phased-in according to the following schedule:               <ul style="list-style-type: none"> <li><b>\$95 or 1%</b> in 2014</li> <li><b>\$325 or 2%</b> in 2015,</li> <li><b>\$695 or 2.5%</b> in 2016</li> </ul> </li> <li>Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment</li> <li><b>Exemptions</b> will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's 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)</li> </ul>	

<b>SMALL BUSINESS HEALTH CARE TAX CREDITS</b>	
<ul style="list-style-type: none"> <li>Employers that provide health coverage and have <b>25 or fewer employees</b> as well as <b>average annual wages of less than \$50,000</b> will be provided a tax credit</li> <li>Employer must contribute at least 50% of premium costs</li> <li>Applies to tax year 2010</li> <li>Both taxable and non-taxable (non-profit) firms qualify</li> <li>Generally, owners (and their families) of small businesses do not count as employees for purposes of determining eligibility for the credit</li> <li>For more detailed information including how to calculate average annual wages and full-time employees, <a href="#">click here</a> to access an Internal Revenue Service (IRS) guidance website</li> </ul>	
<b>Phase 1</b>	<ul style="list-style-type: none"> <li>Until health insurance exchanges are established in 2014, tax credits of up to <b>35%</b> of the employer's contribution towards the employee's health insurance premium if the employer contributes at least 50% of the total premium cost will be provided.</li> <li>The full 35% credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000</li> <li>The credit phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers</li> <li>For tax years beginning in 2010 through 2013, the maximum credit for a <b>tax-exempt qualified employer</b> is <b>25%</b> of the employer's premium expenses that count towards the credit</li> </ul>
<b>Phase 2</b>	<ul style="list-style-type: none"> <li>Beginning in 2014, eligible small businesses that purchaser coverage through the exchange may receive a tax credit up to <b>50%</b> of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium costs</li> <li>The credit is available for two years (through tax year 2015)</li> <li>A full 50% credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000</li> <li>The credit phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers</li> <li>Employer must offer at least one qualified health plan through the exchange</li> </ul>
<b>HEALTH INSURANCE EXCHANGES</b>	
<b>Creation and structure of exchanges</b>	<ul style="list-style-type: none"> <li>Creates state-based health insurance exchanges – an “American Health Benefits Exchange” for those receiving federal subsidies and “Small Business Health Options Program” (SHOP) exchanges for individuals and small businesses receiving coverage in the private marketplace</li> <li>Businesses with more than 100 employees may begin purchasing coverage through exchanges beginning in 2017</li> <li>States may form regional sub-exchanges that serve a distinct geographic area</li> </ul>
<b>Standardized benefit tiers</b>	<ul style="list-style-type: none"> <li>Four standardized benefit tiers must be offered through the exchange with each covering a specified percentage of benefit costs of the plan: <b>bronze</b> (60% of out-of-pocket costs of plan), <b>silver</b> (70%), <b>gold</b> (80%), and <b>platinum</b> (90%)</li> <li>Catastrophic plans must be made available only in the individual market to those up to age 30 or to those who are exempt from the individual mandate and provides catastrophic coverage only with the coverage level set at the HSA current law levels</li> </ul>
<b>Market &amp; rating rules</b>	<ul style="list-style-type: none"> <li>Requires guarantee issue and guarantee renewability</li> <li>Allows rating variation to factor in only age (limited to 3:1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5:1 ratio)</li> </ul>
<b>CO-OPs and national health plans</b>	<ul style="list-style-type: none"> <li>Allows for the establishment of state-based non-profit, consumer-owned co-op health insurers</li> <li>If established, co-op plans will compete alongside private commercial health plans in the exchange</li> <li>In addition, each state exchange is required to offer at least two multi-state health plans, one of which must be a non-profit insurer, negotiated by the federal Office of Personnel Management (OPM)</li> </ul>
<b>PREMIUM CREDITS AND COST-SHARING SUBSIDIES TO INDIVIDUALS</b>	
<b>Premium credits</b>	<ul style="list-style-type: none"> <li>Effective January 1, 2014</li> <li>Premium credits will be provided to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the exchanges</li> <li>The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: <ul style="list-style-type: none"> <li>Up to 133% FPL: 2% of income</li> <li>133-150% FPL: 3 – 4% of income</li> <li>150-200% FPL: 4 – 6.3% of income</li> <li>200-250% FPL: 6.3 – 8.05% of income</li> <li>250-300% FPL: 8.05 – 9.5% of income</li> <li>300-400% FPL: 9.5% of income</li> </ul> </li> </ul>

<p><b>Cost-sharing subsidies</b></p>	<ul style="list-style-type: none"> <li>• Provide cost-sharing subsidies to eligible individuals and families to reduce the cost-sharing amounts and annual cost-sharing limits</li> <li>• Designed to increase the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level: <ul style="list-style-type: none"> <li>○ 100-150% FPL: 94%</li> <li>○ 150-200% FPL: 85%</li> <li>○ 200-250% FPL: 73%</li> <li>○ 250-400% FPL: 70%</li> </ul> </li> </ul>
<p><b>MEDICARE HOSPITAL INSURANCE TAX ON HIGH-EARNERS</b></p>	
<ul style="list-style-type: none"> <li>• High-earner individuals with wages above \$200,000 (single return) or \$250,000 (joint return) would be subject to a <b>0.9 percent tax</b> on wages in excess of the thresholds. This is only applicable to the <b>employee portion of wages</b></li> <li>• High-earner individuals with total taxable income above \$200,000 (single return) or \$250,000 (joint return) from any source would be subject to a <b>3.8 percent tax on their net investment income</b> above the thresholds</li> </ul>	
<p><b>WELLNESS &amp; PREVENTION</b></p>	
<ul style="list-style-type: none"> <li>• <b>Small businesses</b> that establish wellness programs will be provided grants for up to five years</li> <li>• Employers are permitted to offer employees rewards - in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided – of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards</li> <li>• The reward limit may be expanded to 50% if deemed appropriate by the Department of Health &amp; Human Services</li> </ul>	
<p style="text-align: center;"><b>INSURANCE MARKET REFORMS</b></p>	
<p><b>LIFETIME BENEFIT LIMITS</b></p>	
<ul style="list-style-type: none"> <li>• Group health plans are prohibited from placing <b>lifetime limits</b> on the dollar value of coverage</li> <li>• Provision goes into effect 6 months post-enactment (i.e., September 23, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> </ul>	
<p><b>ANNUAL BENEFIT LIMITS</b></p>	
<ul style="list-style-type: none"> <li>• Group health plans are prohibited from placing <b>annual limits</b> on the dollar value of coverage beginning in 2014</li> <li>• Until 2014, the following annual limits are allowed: <ul style="list-style-type: none"> <li>○ <b>\$750,000</b> for a plan year beginning on or after September 23, 2010, but before September 23, 2011</li> <li>○ <b>\$1.25 million</b> for a plan year beginning on or after September 23, 2011, but before Sept. 23, 2012</li> <li>○ <b>\$2 million</b> for a plan year beginning on or after September 23, 2012, but before January 1, 2014</li> </ul> </li> <li>• Provision goes into effect 6 months post-enactment (i.e., September 23, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> </ul>	
<p><b>DEPENDENT COVERAGE</b></p>	
<ul style="list-style-type: none"> <li>• Group health plans that offer dependent coverage are required to extend coverage to dependents through age 26 (i.e. loses eligibility once s/he turns 27)</li> <li>• Provision goes into effect 6 months post-enactment (i.e., September 23, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> <li>• Applies to unmarried and married children, but not to married children's spouse</li> <li>• Does not apply to primary plan subscriber's grandchildren</li> <li>• Applies to all individual market plans and all non-grandfathered and new employer-based plans (small-group and large-group)</li> <li>• A 30-day open enrollment period must be offered to eligible adult dependent children</li> <li>• Beginning in 2014, children up to age 26 can remain on their parent's employer plan even if they have another offer of coverage through their own employer</li> <li>• The value of any employer-sponsored health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26</li> <li>• Employees may make cafeteria plan contributions for this benefit on a tax-free basis</li> </ul>	
<p><b>PRE-EXISTING CONDITIONS</b></p>	
<ul style="list-style-type: none"> <li>• Group health plans are required to cover pre-existing conditions for children age 19 and under</li> <li>• Provision goes into effect 6 months post-enactment (i.e., September, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> <li>• For adults, group health plans are required to eliminate pre-existing condition clauses by 2014</li> </ul>	
<p><b>PREVENTIVE SERVICES</b></p>	
<ul style="list-style-type: none"> <li>• Group health plans are required to cover certain evidence-based preventive services with no cost-sharing</li> <li>• Provision goes into effect 6 months post-enactment (i.e., September, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> <li>• Grandfathered plans are exempt</li> <li>• Immunizations, as recommended by the CDC Advisory Committee, are also required to be covered without cost-sharing</li> <li>• Preventive services are those that have received a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force</li> <li>• The complete list can be found at: <a href="http://www.healthcare.gov/center/regulations/prevention/taskforce.html">http://www.healthcare.gov/center/regulations/prevention/taskforce.html</a></li> </ul>	

<b>PROHIBITION ON RESCISSIONS</b>
<ul style="list-style-type: none"> <li>Group health plans are prohibited from rescinding coverage for a covered enrollee except in cases of fraud or intentional misrepresentation of a material fact.</li> <li>Provision goes into effect 6 months post-enactment (i.e., September 23, 2010), but applies to <b>new plan years</b> that begin on or anytime after 6 months of enactment</li> </ul>
<b>PATIENT PROTECTIONS</b>
<ul style="list-style-type: none"> <li>Group health plans are required to implement an effective internal and external claims appeals process</li> <li>The plan administrator or insurer must provide notice to employees, in a culturally and linguistically appropriate manner, of the availability of these appeals processes</li> <li>An enrollee must be allowed to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process</li> </ul>
<b>COVERAGE OF EMERGENCY SERVICES</b>
<ul style="list-style-type: none"> <li>Group health plans are mandated to cover emergency services at in-network rates regardless of provider</li> </ul>
<b>DESIGNATION OF PRIMARY CARE PROVIDER</b>
<ul style="list-style-type: none"> <li>Group health plans that require or provide for the designation of a primary care provider must allow each enrollee to designate any participating primary care provider who is available to accept such individual</li> </ul>
<b>MEDICAL LOSS RATIO STANDARDS</b>
<ul style="list-style-type: none"> <li>Large group health plans are required to spend <b>85%</b> of premium dollars on clinical services, quality, and other costs</li> <li>Plans in the individual and <b>small group markets</b> (100 employees or fewer) are required to spend <b>80%</b> of premium dollars on clinical services, quality, and other costs</li> <li>Rebates are required to be disbursed to consumers if the medical loss ratio (MLR) is less than the required percentage</li> </ul>
<b>ACCOUNT-BASED HEALTH INSURANCE</b>
<ul style="list-style-type: none"> <li>Contributions to FSAs would be limited to \$2,500 starting in 2013 and indexes this amount by CPI starting in 2014</li> <li>The costs of over-the-counter prescription drugs not prescribed by a physician cannot be reimbursed through an HRA or health FSA or reimbursed on a tax-free basis through an HSA</li> <li>The tax on distributions from an HSA that are not used for qualified medical expenses increases from 10% to <b>20%</b></li> </ul>
<b>PREMIUM RATE REVIEW</b>
<ul style="list-style-type: none"> <li>Establishes a federal review process of health insurance premium rate increases</li> <li>Requires states to report on trends in premium changes and requires plan to justify rate increases</li> <li>Plans with a pattern of unreasonable rate increases may be barred from offering coverage in the exchange</li> <li>\$250 million appropriated for state grants to support efforts to review rates and approve premium increase</li> </ul>
<b>HEALTH INSURANCE INDUSTRY FEE</b>
<ul style="list-style-type: none"> <li>Imposes new annual fees on the health insurance sector, according to the following schedule: <ul style="list-style-type: none"> <li>\$8 billion in 2014;</li> <li>\$11.3 billion in 2015-2016;</li> <li>\$13.0 billion in 2017</li> <li>\$14.3 billion in 2018</li> </ul> </li> <li>In subsequent years, the fee will be the amount from the previous year increased by the rate of premium growth</li> <li>For non-profit insurers, only 50% of net premiums are used in calculating the fee</li> </ul>

For more information, please contact Shawn Nowicki, Director, Health Policy at [snowicki@healthpass.com](mailto:snowicki@healthpass.com) or 212.252.7440 x227.

**© HealthPass, 2010**

This NYBGH Health Policy Dispatch is for informational purposes only. The information contained in this email and/or any related document is not intended as and should not be construed as tax and/or legal advice. Please consult your company's general counsel, tax professionals, or other professional services for proper assistance and guidance.

**HealthPass**

61 Broadway, Suite 2705 | New York, NY | 10006 | 212.252.8010 | Fax: 212.252.7448

[www.healthpass.com](http://www.healthpass.com)

HealthPass is a New York-based commercial health insurance exchange serving sole proprietors and small businesses. Begun in 1999 as an innovative collaboration between New York Business Group on Health, the City of New York, and the health insurance industry, HealthPass offers employees the ability to choose, from an ever-growing menu, the healthcare insurance option that fits their needs and budget. With access to over 200,000 doctors, dentists, nurses and other healthcare professionals, HealthPass provides greater network flexibility than any single plan. HealthPass currently serves all five boroughs of New York City, Long Island, and the counties of Westchester, Rockland, Orange, Putnam, Dutchess, Ulster, and Sullivan.