



Issue Brief: HEALTH CARE REFORM

Updated May 2010

Overview

The new health care law, the Patient Protection and Affordable Care Act (Public Law No. 111-148) and the Health Care and Education Reconciliation Act (Public Law No. 111-152), contain many provisions of interest to states and localities who are both plan sponsors and providers of health care.

Below is an overview of these provisions.

Governmental Plan Sponsors

- **Employer Notice of Coverage Requirements** - Plan administrators, sponsors and insurers by March 2012 must provide a summary plan description of benefits and coverage under the group health plan to participants prior to enrollment. The Secretary of the Department of Health and Human Services (HHS) is required to publish guidance for developing this summary.
- **Automatic Enrollment** – Beginning in 2014, employers with 200 or more full-time employees will be required to automatically enroll employees into their employer provided health plan.
- **Coverage Reforms** – Some highlights include:
 - Group health plans will be prohibited from imposing lifetime and annual limits on the value of essential benefits, such as hospitalization and prescription drugs. (*effective for plan years beginning on or after September 23, 2010, applies to both newly created and existing health plans*)
 - Group health plans that provide coverage for dependent children will be required to continue to make that coverage available until the child reaches age 26. (*effective for plan years beginning on or after September 23, 2010, applies to both newly created and existing health plans*). The Departments of Treasury, Labor and HHS issued an interim final rule implementing this provision available at: (http://www.federalregister.gov/OFRUpload/OFRDData/2010-11391_PL.pdf). The interim final rule defines who is covered by this new requirement and provides for a transition rule for adult children who become eligible for coverage. In addition, the IRS announced the release of a new Treasury Notice (Notice 2010-38) on the law's tax treatment of group health plan coverage for adult children. The IRS guidance can be found at: (<http://www.irs.gov/pub/irs-drop/n-10-38.pdf>.)
 - Preexisting condition exclusions cannot be imposed with respect to children under age 19. (*effective for plan years beginning on or after September 23, 2010, applies to both newly created and existing health plans*)
 - Group health plans can not rescind health care coverage, except in the case of fraud or intentional misrepresentation. (*effective for plan years beginning on or after September 23, 2010, applies to both newly created and existing health plans*)
 - Group health plans must provide preventative care and immunizations without any cost sharing requirements, as well as annual out-of-pocket maximums in the amount of \$5950 for an individual and \$11,900 for a family. (*effective for plan years beginning on or after September 23, 2010, applies to newly created health plans*)
 - Group health plans will be required to end *all* pre-existing condition exclusions and limit waiting periods for health care coverage to 90 days or less. (*beginning in 2014, applies to both newly created and existing health plans*)
- **Employer W-2 Reporting** – Effective for coverage provided in 2011 and thereafter, employers will be required to disclose the value of the benefits provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

- **A Temporary Retiree Reinsurance Program** - This program becomes effective on June 23, 2010 and will reimburse plan sponsors for 80 percent of claims between \$15,000 and \$90,000 for pre-Medicare retirees aged 55-64. Additional information on the retiree reinsurance program can be found in a White House memorandum available at: http://www.whitehouse.gov/sites/default/files/rss_viewer/reinsurance_early_retirees_fact_sheet.pdf. The Department of HHS released an interim final rule describing the operation of the program available at: (<http://edocket.access.gpo.gov/2010/2010-10658.htm>)
- **Medicare Prescription Drug Plans** - Sponsors of Prescription Drug Plans should be aware of several Part D changes. Part D Medicare beneficiaries who reach the doughnut hole in 2010 will receive a \$250 rebate. In 2011, Part D Medicare beneficiaries who reach the doughnut hole are eligible for a 50 percent discount in brand name drugs. The doughnut hole will be eliminated by 2020.
- **Wellness** - Employers can establish wellness programs that provide a premium discount or rebate or other reward for participation with maximum possible incentives up to 30 percent of the total plan costs. The Secretaries of the Departments of Labor, HHS and the Treasury may by regulation increase the reward available to up to 50 percent of the cost of coverage. (*effective January 1, 2014, applies to both existing and newly created health plans*)
- **Appeals** - Employer group health plans are required to have an external review process for appeals of coverage determinations and claims that meet certain standards. (*effective January 1, 2011, applies to newly created health plans*)
- **Collectively Bargained Plans** – These plans have a delayed effective date. Coverage maintained pursuant to a collectively bargained agreement ratified before March 23, 2010 does not appear to be subject to many of the requirements discussed above until the expiration of the collectively bargained agreement.
- **Employer Penalties**– Beginning in 2014, an employer with 50 or more full-time employees will be required to pay annual penalties if employees receive subsidies to purchase insurance in the state created exchanges either because the employer does not offer coverage or the cost of coverage is too high. Additional information about employer penalties can be found at <http://healthlegislation.blogspot.com/2010/04/summary-of-potential-employer-penalties.html>
- **Free Choice Vouchers** – Beginning in 2014, the law requires that employers that offer health coverage and pay any portion of it offer Free Choice Vouchers to employees who meet certain income standards and do not participate in the employer's plan.
- **State Exchanges** - By January 1, 2014, the law requires each state to create an exchange or marketplace in which individuals and small businesses can purchase insurance.

Health Care Providers

Grant Programs

- **Community Health Center Funds** - Creates and authorizes \$11 billion for a New Community Health Center Fund over 5 years.
- **Community Transformation Grants** - Competitive grants to state and local governmental agencies and community based organizations for preventative health care activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective programming. The law authorizes such sums as may be necessary to carry out the program between FYs 2011 and 2014. The \$15 billion established for Prevention and Public Health Resources can also be used to finance this grant program.
- **Funding for Community-Based Collaborative Care Networks** – These networks are made up of safety net hospitals and community health centers and offer comprehensive and coordinated care for low-income populations. The law establishes and authorizes the Secretary of the HHS to provide grant funding for these networks in such sums as may be necessary to carry out the program between FYs 2011 and 2015.

- **Epidemiology and Lab Capacity Grant Program** – Grants in the amount of \$190 million per year between FY 2010 and FY 2013 to states and local health departments to improve monitoring and response to infectious diseases and other significant public health concerns.
- **Trauma Center Grants** – Establishes grant programs for trauma centers, including public trauma centers. Authorizes such sums as may be necessary for FYs 2010 – 2015, however, grants are capped at \$2 million per year. In addition, the law establishes a pilot program for emergency care response in which states or a partnership of states and local governments are permitted to compete. The law authorizes \$24 million in appropriations for each year from FYs 2010 through 2014.

Tax-Exempt Hospitals

- Tax-exempt hospitals must conduct a community needs assessment at least once every three years and adopt an implementation strategy disclosed on the hospital's IRS Form 990. Failure to comply will result in a penalty of \$50,000.
- The new law limits the amounts tax-exempt hospitals can charge individuals eligible for assistance under the hospital's financial assistance policy to the "amount generally billed" to individuals who have insurance. Each hospital must adopt and make public a written financial assistance policy.
- All hospitals in the United States must annually compile, update and make public a list of the hospital's standard charges for items and services provided by the hospital.

Medicaid and Children's Health Insurance Program

- Effective 2014, states will be required to expand Medicaid to all non-elderly individuals up to 133 percent of the federal poverty level. The federal government would pay 100 percent of the costs for new eligibles from 2014 to 2016, 95 percent for 2017, 94 percent for 2018, 93 percent for 2019 and 90 percent for 2020 and beyond. Initial guidance on the new Medicaid state plan option to cover low-income childless adults is available at: <http://www.cms.gov/smdl/downloads/SMD10005.PDF>

Tax Provisions

- Employer plan sponsors will be assessed a tax of \$2 (\$1 in the case of plan years during FY 2013) per covered life to fund a comparative effectiveness research program. (*effective for policy plan years ending 2012, sunsets in 2019*)
- Employers will be responsible for collecting an additional Medicare hospital insurance tax equal to 0.9 percent on wages in excess of \$200,000 for single filers or \$250,000 for joint filers. (*effective January 1, 2013*)
- High-cost or "Cadillac" health-care plans offered to employees will be subject to a 40 percent excise tax, beginning in 2018, which would be paid by the insurance company or in the case of self-insured plans, the third-party administrator. High cost plans are those that cost more than \$10,200 for individuals and \$27,500 for a family; with thresholds in the amount of \$11,800 for individuals and \$30,950 for families for retirees and employees in certain high-risk professions, and would be indexed for inflation by the CPI plus one percent in 2019, and by the CPI thereafter.
- The tax on distributions from health savings accounts (HSA) for non-qualified medical expenses will increase from 10 to 20 percent. (*effective January 1, 2011*)
- The tax on distributions from Archer Medical Savings Accounts (MSA) for non-qualified medical expenses will increase from 15 to 20 percent. (*effective January 1, 2011*)
- Contributions to a health care flexible spending account (FSA) under a cafeteria plan will be capped at \$2,500. (*effective January 1, 2013*) In addition, beginning on January 1, 2011, over the counter drugs are no longer reimbursable from FSAs, HSAs, and Health Reimbursement Arrangements (HRAs), unless prescribed by a health care provider.

- Taxpayers who earn in excess of \$200,000 (single filers) or \$250,000 (joint filers) will be required to pay a new 3.8 percent tax on net investment income, including capital gains, dividends, and interest. (*effective January 1, 2013*)

New 1099 Filing Requirements

- Effective January 1, 2012, governments and businesses will now be required to annually file a Form 1099 with the IRS for payments in the amount of \$600 and above to a corporation. This is a change from current tax law, which requires the filing of a Form 1099 by a business or government for payments of \$600 or more to a person or a business.

Next Steps

Several different federal agencies will have responsibility for publishing regulations to implement the various provisions of the new law, including the Departments of Health and Human Services and Labor, the Internal Revenue Service and the Office of Personnel Management. The regulations will further define what is required of providers, sponsors and insurers in order to comply with the law's requirements.

GFOA Advocacy

GFOA will continue to monitor and report on any new health care reform developments, with a particular focus on the regulations promulgated by the various federal agencies charged with implementing the new law.

Related GFOA Policy Statements (www.GFOA.org)

- Health Care Reform Policy (2006)