Looking at the New Health-Care Law

By Barrie Tabin Berger

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The new federal health-care reform, 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), contains many provisions that are of interest to states and localities that are both plan sponsors and providers of health care.

GOVERNMENTAL PLAN SPONSORS

Employer Notice of Coverage Requirements. By March 2012, plan administrators, sponsors, and insurers 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 in their employer-provided health plans.

Coverage Reforms. Group health plans that provide coverage for dependent children will be required to continue making that coverage available until the children reach the age of 26 (effective for plan years beginning on or after September 23, 2010; applies to both newly created and existing health plans). The Department of Treasury, Labor, and HHS issued an interim final rule implementing this provision, available at http://www.federalregister.gov/OFRUpload/OFRData/2010-11391_PI.pdf. The interim final rule defines who is covered by this new requirement, and it provides for a transition rule for adult children who become eligible for coverage. In addition, the Internal Revenue Service (IRS) released a new 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. Additional highlights are listed below. Unless otherwise stated, all of the following provisions are effective for plan years beginning on or after September 23, 2010, and all apply to both newly created and existing health plans.

- Group health plans will be prohibited from imposing lifetime and annual limits on the value of essential benefits such as hospitalization and prescription drugs.
- Preexisting condition exclusions cannot be imposed on children under age 19.
- Group health plans cannot rescind health-care coverage, except in the case of fraud or intentional misrepresentation.
- 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 $5,950 for an individual and $11,900 for a family.

- 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 they provide for each employee's health insurance coverage. The information will appear on the employee's annual W-2 form.

A Temporary Retiree Reinsurance Program. This program becomes effective 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 (the coverage gap in the Medicare Part D prescription drug program between the initial coverage limit and the catastrophic coverage threshold) 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, 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 in carrying out 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 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. This provision creates and authorizes $11 billion for a New Community Health Center Fund over five years.

Community Transformation Grants. These are 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 fiscal years 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 comprise safety net hospitals and community health centers, and they offer comprehensive and coordinated care for low-income populations. The law establishes and authorizes the secretary of HHS to provide grant funding for these networks in such sums as may be necessary to carry out the program between fiscal years 2011 and 2015.

Epidemiology and Lab Capacity Grant Program. Grants in the amount of $190 million per year will be made to states and local health departments between fiscal years 2010 and 2013 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 fiscal years 2010-2015, but 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 fiscal years 2010 through 2014.

HEALTH-CARE PROVIDERS: 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 also limits the amounts tax-exempt hospitals can charge individuals who are 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. In addition, 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.

ARRA Updates

New Reporting Quarter Begins. Reporting for the next quarter period (April 1-June 30, 2010) for recipients of funding under the American Recovery and Investment Act (ARRA) begins July 1, 2010, and goes through July 16, 2010. The Recovery Accountability and Transparency Board made several important reporting enhancements, which can be found at www.FederalReporting.gov.

OMB Issues Memorandum Regarding Recipient Accountability under the ARRA. On April 6, 2010, President Obama issued a memorandum, "Combating Noncompliance with Recovery Act Reporting Requirements." It directs federal agencies to use every means available to identify any prime recipient that is required to file a report on FederalReporting.gov, in conformity to ARRA, and has failed to do so; these recipients are to be held accountable to the fullest extent permitted by law. In response, the Office of Management and Budget (OMB) issued updated guidance, including additional actions and strategies, designed to assist agencies in carrying out their responsibilities to enforce recipient reporting compliance. The president's memorandum can be found at http://www.c-span.org/pdf/econ040610_stimulusoversight.pdf. The OMB memorandum can be found at http://www.whitehouse.gov/omb/assets/memoranda_2010/m-10-17.pdf.

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM

Effective 2014, states will be required to expand Medicaid to all non-elderly individuals with incomes of less than 133 percent of the federal poverty level. The federal government would pay 100 percent of the costs for newly eligible individuals 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

A number of tax provisions will go into effect.

- Employer plan sponsors will be assessed a tax of $2 ($1 in the case of plan years during fiscal 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 so-called Cadillac health-care plans offered to employees will be subject to a 40 percent excise tax, beginning in 2018. The tax 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, per year. Thresholds are $11,800 for individuals and $30,950 for families for retirees and employees in certain high-risk professions. These thresholds would be indexed

for inflation at the Consumer Price Index (CPI) rate plus 1 percent in 2019, and by the CPI rate thereafter.

- The tax on distributions from health savings accounts (HSAs) 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 (MSAs) 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 will no longer be reimbursable from FSAs, HSAs, and Health Reimbursement Arrangements (HRAs), unless prescribed by a health-care provider.
- Taxpayers who earn more than $200,000 for single filers or $250,000 for 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 be required to annually file a Form 1099 with the IRS for payments to a corporation of $600 and above. This is a change from current tax law, which requires a business or government to file a 1099 form for payments of $600 or more to a person or a business.

NEXT STEPS

Several different federal agencies will be responsible for publishing regulations to implement the provisions of the new law, including the Department of Health and Human Services, the Internal Revenue Service, and the Office of Personnel Management. The regulations will further define what is required of providers, sponsors, and insurers to comply with the law's requirements. The GFOA will continue to monitor and report on any new health-care reform developments, with a particular focus on the regulations promulgated by the federal agencies charged with implementing the new law.

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