

PPACA Checkup

Planning for the future impact of PPACA

MOST employers have spent the last year and a half studying new regulations, amending their health plans, and notifying participants of changes.

Now they are taking a step back to double-check their lists, and looking forward to see what is next for health-care reform.

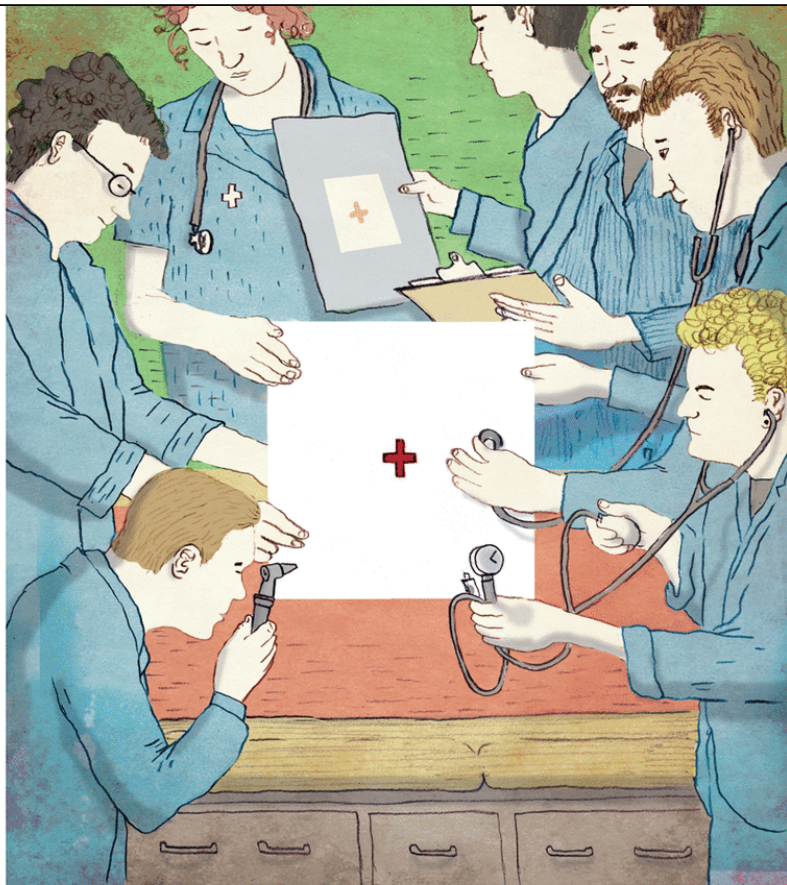
What Changes Should Employers Already Have Made?

As we have reported previously, there are a number of health plan amendments that were required for 2011:

- No more lifetime dollar limits on essential health benefits
- Restricted annual limits on essential health benefits (must be at least \$750,000 in 2011)
- No rescissions
- No pre-existing condition exclusions for enrollees under age 19
- Coverage for adult children to age 26
- Preventive care coverage (except grandfathered plans)
- Choice of providers (except grandfathered plans)
- Coverage for emergency care (except grandfathered plans)
- Internal and external appeals changes (except grandfathered plans)
- No coverage for over-the-counter drugs from HSAs, HRAs, or FSAs.

What Responsibilities Will Employers Face Next?

Employers should be planning now for a number of additional responsibilities that they must take on over the next few years.



- Summary of Benefits (2012)—Must provide a uniform summary of benefits in the format set out in regulations.
- Annual Limits (2012 and 2013)—Phase-in of the annual limit rule increases the minimum annual dollar limit on essential health benefits to \$1.25 million in 2012 and \$2 million in 2013.
- Limits on Health FSA (2013)—Health FSA contributions limited to \$2,500.
- W-2 Reporting (2013)—Must report value of health benefits on new Box 12 (code DD) on W-2 for 2012 tax year (January 2013 W-2).
- Exchange Notice (2013)—Must provide notice that informs employees of availability of new Exchange coverage.
- Plan Amendments (2014)—Additional plan amendments required in 2014: no more pre-existing condition exclusions, no more annual dollar

limits on essential health benefits, expanded coverage of clinical trials (except grandfathered plans), waiting periods limited to 90 days, deductible limit must be \$2,000 per individual/\$4,000 family (except grandfathered plans), out-of-pocket limits must be \$5,950 individual/\$11,900 family (except grandfathered plans), wellness incentive increased to 30% of cost of coverage.

- Informational Returns (2014)—Employers providing “minimum essential coverage” must file Form 6055 with information about covered persons; large employers must file Form 6056 with information about premiums and contributions (these may be streamlined).
- Automatic Enrollment (2014)—Employers with 200 or more full-time employees must auto-enroll new employees and continue enrollment of existing employees, with opportunity

to opt out.

- Coverage Mandate (2014)—Employers with at least 50 full-time employees must provide “minimum essential coverage” that meets certain affordability and value tests or pay a penalty. If employer offers no coverage and at least one employee receives premium assistance through Exchange, generally must pay \$2,000 per employee for all full-time employees. If employer offers minimum essential coverage but does not meet affordability and value tests, generally must pay \$3,000 for each full-time employee receiving premium assistance through Exchange.
- Cadillac Plan Tax (2018)—40% excise tax on coverage in excess of high-cost plan limits (\$10,200 single/\$27,500 family).

What Is Required Under the New Preventive Health Guidelines?

EARLIER this year, the Department of Health and Human Services (HHS) adopted new preventive care guidelines for women, which will be required to be covered under the PPACA preventive care rules.

These new guidelines have prompted plans to ask questions about exactly what is required under the preventive care rules and when.

What preventive care coverage does PPACA require?

PPACA requires nongrandfathered group health plans to cover the following recommended services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task

Force (USPSTF)

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by Health Resources and Services Administration (HRSA), which is a part of HHS
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA (these are the new, recently adopted guidelines).

Plans are required to cover these services free of charge, without cost-sharing (for example, without imposing co-payments or co-insurance).

More detail on these recommendations can be found at www.healthcare.gov/

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These Q&As first appeared on www.plansponsor.com in August 2011. As health-care law is evolving rapidly, there may be further developments since the initial publication.

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[center/regulations/prevention/taskforce.html](#).

When do these requirements apply?

The requirement to cover these preventive care services applies to plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans). These requirements do not apply to grandfathered plans.

What do the new, recently adopted guidelines require?

The new guidelines require coverage in the following categories:

- Well-woman visits
- Screening for gestational diabetes
- HPV testing
- Counseling for STD infections
- Counseling and screening for HIV
- Contraceptive methods and counseling (with an exemption for certain religious employers)
- Breastfeeding support, supplies, and counseling
- Screening and counseling for interpersonal and domestic violence. —PS