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The Patient Protection and Affordable Care Act Summary

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The **Patient Protection and Affordable Care Act ("PPACA"),** as amended, contains significant new requirements for employers and their health plans. This summary describes the main provisions of PPACA, but not every provision of PPACA.

This summary is divided into five sections:

1. Plan Changes – Describes what health benefits a plan must cover (e.g., preventive care without cost-sharing) and restrictions a plan must eliminate (e.g., lifetime limits). Also includes new enrollment rules (e.g., covering older children).
2. Employer and Insurer Administrative Requirements – Describes the administrative actions employers and insurers must take (e.g., reporting the value of health plan coverage on Form W-2).
3. Tax Incentives / Penalties for Employers, TPAs and Insurers – An overview of tax benefits provided under PPACA (such as the early retiree reinsurance program), tax increases (e.g., additional FICA tax of 0.9%) and tax penalties that can apply (e.g., the $2,000 and $3,000 penalties that can apply under the "pay or play" rules) to employers, third party administrators ("TPAs") and insurers.
4. Exchanges and Co-Ops – The new rules for health plan "exchanges" are described.
5. Requirements, Taxes and Benefits for Individuals – An overview of the requirements individuals must follow (such as obtaining "minimum essential coverage" as of 2014), along with related tax credits and penalties.

Article By
Michael Best & Friedrich
Michael Best & Friedrich LLP

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Grandfathered Plan Exceptions. Some PPACA changes do not apply to a "grandfathered" health plan (a "GF" health plan). Where applicable, this is noted in the "Comments" heading. For details on what constitutes a "grandfathered" plan and how that status can be lost, see our June 22, 2010 alert entitled IRS, DOL & HHS Issue Final Regulations on Grandfathered Plan Status (found here).

Notices and Plan Amendments: We state in the "Comments" section whether PPACA requires a specific notice relating to the change. In addition, many plan changes will require an amendment and a related summary of material modifications ("SMM").

Which Plans are Usually Affected? PPACA's changes generally apply to "group health plans." However, PPACA does not apply to every group health plan. In general, PPACA applies to:

Major Medical Plans	"Mini Med" Plans
Many Employee Assistance Plans ("EAPs") – EAPs are likely covered by PPACA to the extent they provide	**Health Reimbursement Arrangements ("HRAs")** – But, see the Comments section below (year 2010) for

medical benefits (e.g., 3-5 visits with a trained counselor) but likely are not covered by PPACA if they are a "referral only" EAP	how HRAs are affected by the "Restricted Annual Dollar Limit" rule
Government Medical Plans	**Executive Medical Expense Reimbursement Plans**
Some Dental and Vision Plans – Most stand-alone dental or vision plans will be an "excepted benefit" under HIPAA and will therefore avoid PPACA's requirements. However, a minority of stand-alone dental or vision plans will not be an "excepted benefit" under HIPAA and will be subject to PPACA's requirements	**Some Health Flexible Spending Arrangements (a "Health FSA")** – Most Health FSAs will be an "excepted benefit" under HIPAA and therefore avoid most of PPACA's requirements. A minority of Health FSAs will not be an "excepted benefit" under HIPAA and will be subject to PPACA's requirements. All Health FSAs (whether or not they are an excepted benefit) are affected by PPACA's requirement that employee elective deferrals be limited to $2,500

Which Plans are Usually Not Affected?

Most Fixed Indemnity Policies	**Most Dental Plans**
Most Health FSAs	**Medigap Policies**
Most Specified Disease Policies	**Most Vision Plans**
Most Retiree-Only Plans	**Some EAP**

1. Plan Changes			
2010			
	Summary of Change	**Effective Date**	**Comments**
a. Coverage of Older Children	If plan covers dependents, adult child must be allowed coverage until age 26 (i.e., through age 25). No requirement to cover child of such a dependent child (i.e., the grandchild). Coverage of adult child generally is not taxable until year in which child will attain age 27	Plan years beginning on or after September 23, 2010 (tax change effective March 30, 2010)	Limited exemption for GF plans. GF plans can, prior to 2014, refuse to provide coverage to older child if child is eligible to enroll in an "eligible employer-sponsored health plan." If applicable, one-time notice must be sent no later than first day of first plan year beginning on or after September 23, 2010. Sample language available here: http://www.dol.gov/ebsa/dependentsmodelnoti

			ce.doc
b. New Appeals Process / External Review	A new health plan appeals process must be followed. The new appeals process must permit participants to present testimony, receive continuing coverage and receive certain new appeal rights. An external review process must be implemented	Plan years beginning on or after September 23, 2010	Does not apply to GF plans
c. Any Available Primary Care Provider / Pediatrician	If plan requires or allows designation of participating primary care provider, plan must allow any who are available. Similar rules for pediatric care	Plan years beginning on or after September 23, 2010	Does not apply to GF plans. If applicable, a notice is required to be distributed in summary plan description ("SPD") or other, similar description of benefits. Sample language available here: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc
d. Coverage of Emergency Services	Emergency services must be covered without prior authorization and as though services were in-network	Plan years beginning on or after September 23, 2010	Does not apply to GF plans
e. Access to Ob/Gyn Care	For female enrollees, cannot require authorization or referral for Ob/Gyn care from participating Ob/Gyn specialist	Plan years beginning on or after September 23, 2010	Does not apply to GF plans. If applicable, a notice is required to be distributed in SPD or other, similar description of benefits. Sample language available here: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc
f. Preexisting Condition Exclusions Eliminated (Under Age 19)	Plan cannot impose any preexisting condition exclusion with respect to plan coverage for enrollee under age 19	Plan years beginning on or after September 23, 2010	
g. No Lifetime	Lifetime dollar limits	Plan years beginning	Notice must be

Dollar Limits on Essential Health Benefits	for “essential health benefits” are eliminated. Benefits that are not "essential" may have lifetime limit. Term "essential health benefits" not yet defined	on or after September 23, 2010	provided to individuals who reached a lifetime limit and are otherwise still eligible for benefits or coverage under the plan. Must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Sample language available here: http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc **Note:** Sample language likely is too broad. Employer should modify language to state that: (i) plan may not cover all benefits; and (ii) plan can impose lifetime limits on non-essential health benefits
h. Restricted Annual Dollar Limits on Essential Health Benefits	Annual dollar limits on "essential health benefits" prior to January 1, 2014 are subject to a “restricted annual limit." Benefits that are not “essential” may have annual limits. Term "essential health benefits" not yet defined	Plan years beginning on or after September 23, 2010	Internal Revenue Service ("IRS"), Department of Labor ("DOL") and Department of Health and Human Services ("HHS") are seeking comments on how this rule applies to a stand-alone, active-employee HRA
i. No Rescission	Plan generally cannot retroactively rescind coverage once individual is enrolled unless fraud or intentional misrepresentation of material fact and plan’s term prohibit such fraud / misrepresentation	Plan years beginning on or after September 23, 2010	Sponsor must provide 30 days advance notice of rescission (no government model language)
j. Preventive Health Coverage	Plan must cover, generally without cost-sharing, certain preventive services (e.g., immunizations and infant screenings)	Plan years beginning on or after September 23, 2010	Does not apply to GF plans
k. Automatic Health Plan	Employers with 200 or more employees	Unclear; seems to be March 23, 2010 but	Opt out notice must be provided. No model

Enrollment	generally must automatically enroll new, full-time employees into health insurance plan offered by employer. Employees may opt out of coverage	likely need to wait for additional guidance	notice available. Likely wait for additional guidance
l. Native American Plans are Payer of Last Resort	Certain Notice American health programs are the payer of last resort, notwithstanding other laws	Apparently March 2010	
2011			
	Summary of Change	**Effective Date**	**Comments**
m. Simple Cafeteria Plans	A small employer (average 100 or fewer employees during either of last two years) can adopt a new type of cafeteria plan. If adopted, plan has a safe harbor from nondiscrimination rules if minimum employer contributions are made	January 1, 2011	
n. Over-the-Counter Medicines	Cost of over-the-counter medicine (other than prescribed and insulin) may not be reimbursed through health FSA, HRA, HSA or Archer MSA	Tax years beginning January 1, 2011	
2012			
	Summary of Changes	**Effective Date**	**Comments**
o. No Questions on Firearms	Certain wellness plans cannot require disclosure of lawful firearm or ammunition ownership, storage, or use	Unclear (perhaps 2012)	

2013			
	Summary of Changes	**Effective Date**	**Comments**
p. Cap on Health FSA Salary Reductions Contributions	Health FSA salary reduction contributions limited to $2,500	Tax years beginning January 1, 2013	
q. Medicare Part D Subsidy Deductions	Deduction for Medicare Part D subsidy eliminated	Tax years beginning January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
r. Coverage for Clinical Trials; No Discrimination	Plan cannot deny participation in approved clinical trial, deny routine costs of same or otherwise discriminate based on participating in clinical trial for treatment of certain cancers or other life-threatening conditions	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
s. Limits on Waiting Periods	Plan cannot impose any waiting period that exceeds 90 days	Plan years beginning on or after January 1, 2014	
t. Pre-Tax Payments for Exchange Individuals	Plan can allow pre-tax premium payments for exchange-eligible individuals only if employer is a “qualified employer"	January 1, 2014	
u. Codification of HIPAA Nondiscrimination Regulations	Codifies many existing HIPAA nondiscrimination regulations	Apparently plan years beginning on or after January 1, 2014	Appears GF plan need not comply; however, similar HIPAA regulations likely would apply
v. Wellness "Carrot / Stick" Limits Raised	Raises current 20% cap on wellness discount / surcharge to 30% of coverage cost. Allows HHS, IRS	Apparently plan years beginning on or after January 1, 2014	

	and DOL to increase amount to 50%		
w. Preexisting Condition Exclusions Eliminated (for Enrollee of Any Age)	Plan cannot impose preexisting condition exclusion with respect to plan coverage	Plan years beginning on or after January 1, 2014	
x. No Discrimination Against Health Care Providers	Plan and insurer may not discriminate against any health care provider acting within the scope of that provider's license or certification. Does not require plans to contract with any willing provider or to refrain from establishing varying reimbursement rates based on quality or performance measures	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
y. No Annual Dollar Limit on Essential Health Benefits	Plan cannot impose annual dollar limit on essential health benefits (applies regardless of enrollee's age)	Plan years beginning on or after January 1, 2014	
z. Cost-Sharing Limitations	Cost-sharing requirements are limited to those applicable to high deductible health plans (i.e., HSA–related plans). Insured plans, and likely self-insured plans, cannot impose deductibles that are higher than $2,000 for single coverage and $4,000 for any other coverage (increased by amount of employer contributions to health FSA)	Plan years beginning on or after January 1, 2014	
2. Employer and Insurer Administrative Requirements			
2010			

	Summary of Change	Effective Date	Comments
a. No Retaliation	Employer cannot discharge or discriminate against an employee for objecting to, or refusing to participate in, a violation of certain provisions of the health care reform law	March 23, 2010	
b. Health Program or Activity May Not Discriminate	A "health program or activity" receiving federal financial assistance cannot discriminate in violation of certain federal laws. Term "health program or activity" not yet defined	March 23, 2010	Unclear if provisions will significantly impact employers and their health plans
c. Notice of Grandfathered Plan Status	Sponsor must provide notice that plan is grandfathered in order to maintain GF status	Apparently June 14, 2010	Sample language available here: http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc
d. Fully Insured Plans Subject to Nondiscrimination Rules	Fully-insured group health plans must satisfy nondiscrimination rules of Code Section 105(h)(2) (eligibility to participate and eligibility for benefits)	Plan years beginning on or after September 23, 2010	Does not apply to GF plans
2011			
	Summary of Change	**Effective Date**	**Comments**
e. Report Plan Cost on W-2	Aggregate cost of employer-sponsored health plan coverage must be reported on employee's W-2. Some health plans excluded (e.g., stand-alone, fully-insured dental and vision plans)	2011 (for W-2 distributed no later than January 2012)	
f. Insurer Report	Insurer must report	January 1, 2011	

on Costs	various costs to federal government. Insurer may need to provide rebates based upon minimum loss ratios		
2012			
	Summary of Change	**Effective Date**	**Comments**
g. Standardized Plan Summary / Advance Notice of Plan Changes	Secretary to develop standards for plans to compile and provide to applicants and enrollees a summary of benefits and coverage explanation. Cannot exceed 4 pages with 12-point font. Various contents required (e.g., description of cost sharing and coverage). Related rule seems to require 60 days advance notice of plan changes if change affects contents of summary	Standards developed no later than 12 months after enactment. Plan to distribute no later than 24 months after enactment	
h. Quality of Care Reporting	Secretary to develop reporting requirements related to various quality of care items (e.g., effective case management, preventing hospital readmissions). Plan must then annually submit to Secretary and enrollees a report on these items	Standards developed within 24 months after enactment. Unclear when plans must report	Does not apply to GF plans
2013			
	Summary of Change	**Effective Date**	**Comments**
i. Provide Notice of Exchange	Employers must provide to employees notice of exchange	March 1, 2013	

	and related items (such as tax credits or cost-sharing reductions)		
j. Certify Compliance with Certain HIPAA Transactions	By December 31, 2013, health plans must certify to HHS that their data and information systems comply with, and have tested, current standards and operating rules for certain Standard Transactions	Compliance required by December 31, 2013	
k. New HIPAA Transactions	New Standard Transactions include health claim status (by 1/1/2013), electronic funds transfer (by 1/1/2014) and health claims attachments (by 1/1/2016)	Compliance date varies (2013, 2014, 2016)	
2014			
	Summary of Change	**Effective Date**	**Comments**
l. Report to IRS on Plan Coverage	Employers offering minimum essential coverage must report to IRS about health coverage (including the name of each employee and dependent covered by plan, portion of premium paid by employer, and other items)	January 1, 2014	
m. Summary Report to Employees	Summary of information provided to federal government, above, in 2.k, must be provided to each covered individual	January 1, 2014	
n. Transparency Reporting	Health plans must disclose certain plan-related information (e.g., claims payment policies, enrollment	Apparently 2014	Rule is tied to exchange coverage. Impact on employers uncertain. Possible that GF plans need not

	data) to federal and state governments		comply
o. Fair Health Insurance Premiums	An insurer offering coverage in the individual or small group market may vary premium rates only according to certain criteria, including (i) individual or family coverage, (ii) rating area and (iii) age	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
p. Guaranteed Availability and Guaranteed Renewability of Coverage	Insurers in the individual or group markets generally must accept every employer and individual in the state that applies for coverage, and generally must renew or continue in force such coverage at the option of the plan sponsor or the individual	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
q. Comprehensive Health Insurance Coverage	A health insurance issuer offering coverage in the individual or small group market must offer certain essential health benefits, limit cost-sharing and provide certain levels of coverage	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
r. Free Choice Vouchers to Qualified Employees	If employer offers "minimum essential coverage" to employees and pays any portion of plan's cost, employer must offer "free choice vouchers" to "qualified employees." "Qualified employee" status based on employee contribution being between 8% and 9.8% of "household income". Amount of voucher equals amount employer would have paid for self-only	January 1, 2014	

	coverage (or family if elected by employee). Employee can credit voucher towards cost of exchange-provided coverage		
s. Report to IRS on Opportunity to Enroll	"Applicable large employers" (generally those with at least 50 full-time employees) and "offering employers" (generally employers that: (i) offer minimum essential coverage; (ii) pay any portion of plan costs; and (iii) require any employee to pay a contribution exceeding 8% of wages) must report certain information to IRS. Information includes: employer's name and months during which minimum essential coverage was provided	January 1, 2014	
t. Statement to Full-Time Employees	Employers noted in 2.s., above, must provide a written statement to each full-time employee	Likely 2014 or 2015	
2015			
	Summary of Change	**Effective Date**	**Comments**
u. Certify Compliance with Certain HIPAA Transactions	By December 31, 2015, health plans must certify to HHS that they comply with certain Standard Transactions	Compliance required by December 31, 2015	
3. Tax Incentives / Penalties for Employers, TPAs and Insurers			
2010			
	Summary of Change	**Effective Date**	**Comments**

a. Credits to Small Employers	Limited tax credit (35% for most employers; 25% for tax-exempt employers) to small employers to provide health insurance. Credit amounts increase in 2014 to 50% and 35%, respectively, in 2014	Tax years beginning after 2009	
b. Early Retiree Reinsurance Program	Federal government to reimburse eligible plans (including multiemployer plans or VEBAs) 80% of "early retiree" (age 55+ but not eligible for Medicare) health claims that exceed $15,000 and do not exceed $90,000. Program ceases by 1/1/2014 (could be earlier if $5B funding is exhausted). Plan must satisfy various application and submission rules to qualify	June 2010	
2011			
	Summary of Change	**Effective Date**	**Comments**
c. Wellness Grants	Small business (generally, with less than 100 employees who work 25 hours or more per week) that did not have a wellness program as of March 23, 2010 can apply for a federal grant to establish a comprehensive workplace wellness program	2011	
d. Comparative Effectiveness Research Fees	Plan sponsors must pay annual fees of $1 or $2 per plan participant (amount varies based on year). Fees used to fund comparative effectiveness	Apparently plan years beginning on or after October 1, 2011	

	research		
2013			
e. Additional Payroll Taxes	Additional FICA and SECA payroll tax of 0.9% for individual wages over $200,000 ($250,000 for couples filing jointly)	January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
f. Large Employers Must Provide Minimum Essential Coverage ("Pay or Play")	Employers with at least 50 full-time employees that do not offer to full-time employees and dependents "minimum essential coverage" under an "eligible employer-sponsored plan" are assessed a $2,000 annual fee (determined on a month-to-month basis) for each full-time employee, provided at least one full-time employee receives certain cost-sharing reductions or credits under a "qualified health plan"	January 1, 2014	
g. Tax if Large Employer Offers Coverage but Employee Obtains Exchange Coverage ("Pay or Play")	Employer with at least 50 full-time employees that offers minimum essential coverage to full-time employees and dependents must pay a $3,000 annual fee (determined on a month-to-month basis) for each full-time employee who: (i) enrolls in a "qualified health plan"; and (ii) is eligible for a premium tax credit or cost-sharing reduction. No tax if employer	January 1, 2014	

	provides free choice voucher		
h. Fees on Certain Plans / Insurers	Annual fee on a "covered entity" that provides health insurance. Excludes self-funded employer but does not specifically exclude fully-insured plan	First payment due no later than September 30, 2014	
i. Reinsurance Fees Imposed on TPAs and Insurers	Third party administrators of group health plans and insurers contribute to a reinsurance program for individual policies administered by a non-profit for high risk cases in state	No later than January 1, 2014 (apparent sunset January 1, 2017)	
2018			
	Summary of Change	**Effective Date**	**Comments**
j. "Cadillac Tax" on Certain High-Cost Plans	40% excise tax on excess benefit of high-cost employer-sponsored health insurance (so-called "Cadillac tax"). Limit based on $10,200 annual limit for individual coverage and $27,500 annual limit for other than individual coverage. Numerous exceptions and adjustments based on states and job classifications	Tax years beginning January 1, 2018	
4. Exchanges and Co-Ops			
	Summary of Change	**Effective Date**	**Comments**
a. Co-ops Created	Non-profit co-ops created for individual and small employer market	Awards and grants provided by July 1, 2013	
b. State Exchanges	States establish	No later than January	

	exchange for individual and small employer market	1, 2014	
c. Individual Policies Across State Lines	States can form "health care choice compacts" to allow purchase of individual policies across state lines	No earlier than January 1, 2016	
d. Large Employers Eligible for Exchange	Employers with average of 101 or more employees (and at least one current employee) allowed into exchange	2017	
5. Requirements, Taxes and Benefits for Individuals			
2010			
	Summary of Change	**Effective Date**	**Comments**
a. Native Americans	Certain Indian Health Service or other Tribal health benefits not considered gross income	Apparently March 2010	
b. High-Risk Pools	A temporary insurance pool for uninsured individuals is created. Pools are expected to begin in 2010 and end in 2014	Generally July 2010	
2011			
	Summary of Change	**Effective Date**	**Comments**
c. HSA / Archer MSA Excise Tax	10% excise tax on HSA distributions (15% for Archer MSA distributions) for non-medical purposes is increased to 20%	Distributions beginning January 1, 2011	
2013			

	Summary of Change	Effective Date	Comments
d. Code Section 213 Medical Deduction Threshold Increases	Individuals who wish to deduct unreimbursed medical expenses will need to show that such expenses exceed 10% of income (up from 7.5%). Special transitional rule until 2017 if taxpayer or spouse is age 65	Taxable years beginning January 1, 2013	
e. 3.8% Tax on Unearned Income	A 3.8% tax will be applied to net investment income to the extent such income exceeds a specified threshold amount	January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
f. Individuals Must Maintain Minimum Essential Coverage	All individuals in U.S. must maintain "minimum essential coverage" through individual market, employer or certain other coverage (e.g., Medicare)	January 1, 2014	
g. Individual Credits and Reduced Cost-Sharing	Individuals can receive premium assistance credits if income between 100% and 400% of federal poverty level. Also, such individuals may be eligible for reduced cost-sharing requirements	January 1, 2014	
h. Penalties on Individuals	Individual noncompliance penalties start at $95 in 2014, phase to $695 per adult in 2017 (1/2 for child); various exceptions	January 1, 2014	

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