



**SELF-INSURANCE INSTITUTE  
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*Protecting and Promoting Self-Insurance and Alternative Risk Transfer Since 1981.*

## **SIIA Reports Federal Healthcare Reform**

*How the Patient Protection and Affordability Care Act (PPACA)  
Affects Self-Insured Plans*

### **Insurance Market Reforms:**

The PPACA amends the Public Service Health Act in an effort to increase both coverage access and consumer protections for all health plan beneficiaries. While these provisions were included to reform the commercial health insurance marketplace, many will have direct and/or indirect effects on self-insured health plans.

*(Applicable to self-insured plans unless otherwise noted):*

- No lifetime limits - Prohibits all plans from establishing lifetime limits.
- Annual limits - Prohibits all plans from establishing annual limits on the dollar value of benefits starting in 2014. Prohibits plans from setting limits that would “impair essential health benefits” in subsequent years.
- Prohibition on rescissions - Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation.
- Coverage of preventive health services - Requires all plans to cover preventive services and immunizations, recommended by various Federal agencies, without any cost-sharing – first dollar coverage.
- Dependent coverage - Requires all plans offering dependent coverage to make coverage available to dependents under the age of 26 and unmarried. Plans are not required to cover dependents of dependents.
- Prohibition of discrimination based on salary – Prohibits plans from limiting eligibility for coverage based on the salaries of full-time employees.
- Minimum loss ratio – Group plans required to spend a minimum of 85% on claims payment. Through 2013, plans required to rebate beneficiaries the amount of premium revenue spent on non-claims costs which exceed 20%. Plans are required to report compliance.

- Guaranteed renewability of coverage - Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.
- Prohibition of preexisting conditions - No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.
- Prohibiting discrimination based on health status - No group health plan may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information or evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 % for employee participation in certain health promotion and disease prevention programs.
- Prohibition on waiting periods - Prohibits any waiting periods for group or individual coverage that exceed 60 days. Employers are penalized \$600 per full-time employee for each employee required to wait beyond 60 days.
- Rating rules – Premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1). *Not applicable to self-insured plans*

### **Explanations and Standardized Definitions**

Plans will now be required to provide increased disclosure of plan information to all beneficiaries and prospective beneficiaries. Plans will be required to provide summaries, in an understandable fashion, of plan structure and offered benefits.

- Requires plans to issue a summary of benefits and explanation of coverage with the following criteria:
  - In uniform format
  - In “easily understood” language
  - Inclusion of uniform definitions of standard insurance and medical terms
  - Explanation of cost-sharing exceptions, reductions and limitations on coverage
  - Provide common benefits scenarios

### **Appeals Process Implementation**

The PPACA requires that all beneficiaries have access to, and are made aware of, a process of appeals for any denial of coverage or a dispute of claims cost-sharing.

- Requires plans to implement a process for appeals of coverage determinations and claims.
- Secretary of HHS authorized to review appeals process.

### **Early-Retiree Reinsurance Fund**

Employer-sponsored plans will be eligible to participate in a temporary reinsurance program designed to partly cover catastrophic claims of plan's early-retiree (ages 55-64) beneficiaries.

- Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families.
- The program reimburses participating employment-based plans for 80 % of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000.

### **Plan Sponsored Wellness Program Provisions and Restrictions**

The PPACA provides restrictions on incentives that a plan can offer for participation in offered wellness and prevention programs.

- Permits employers to:
  - Establish premium discounts
  - Rebates
  - Modify co-pays or deductibles up to 30 %
- The Secretary would have authority to issue regulations to allow financial incentives up to 50 %. *(Existing regulations limit these rewards or incentives up to 20 % of the cost of employee-only coverage.)*
- Current law privacy and non-discriminatory provisions of the HIPAA regulations would continue to apply.

### **Health Information Technology**

The PPACA accelerates the U.S. Department of Health and Human Services' (HHS) adoption of uniform standards and operating rules for the electronic transactions that occur between providers and plans that are governed under the Health Insurance Portability and Accountability Act (HIPAA).

- HIT standards to be determined by HHS:
  - Benefit eligibility verification
  - Prior authorization
  - Electronic funds transfer payments
- HHS to regularly update the standards and operating rules for electronic transactions.

- Plans are required to certify compliance or face financial penalties collected by the Treasury Secretary.

### **Healthcare Cooperatives**

The PPACA provides funding for the establishment and rules for operation of health insurance cooperatives (CO-OPs). The CO-OPs are intended to compete with commercial insurance companies within the enacted State Exchanges. The CO-OPs are encouraged to enter into collective purchasing agreements with claims administrators, actuaries, employee benefits attorneys, and other benefits professionals.

- Loans and grants will be made available by the Secretary of HHS for start-up costs and to meet required solvency limits up until 7/1/2013.
- CO-OPs are required to be non-profit and member-run.
- CO-OPs to be offered as exchange options.
- Exempts participants from taxation.

### **Low-Income Tax Credits**

The PPACA provides for government subsidies to be made eligible to low-income workers for use in purchasing health coverage in an Exchange participating plan. Subsidies are not allowed to be used for purchase of employer-sponsored coverage.

- “Premium assistance” credits available to low-income workers to subsidize the cost of coverage.
- Credit amount is calculated on sliding scale:
  - starting at two % of income for those at or above 100% of poverty
  - phasing out to 9.8 % of income for those at 400% of poverty

### **Small Business Tax Credits**

The PPACA provides for governmental assistance to small business under certain minimum requirements. Tax credits offered will only be allowed to be used to purchased coverage through an Exchange participating plan.

- Provides a tax credit to small employers who purchase coverage:
  - The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$20,000

- Sliding scale credit available for employers with 11-25 employees with average annual wages below \$40,000
- To be eligible for a tax credit, the employer must contribute at least 50% of the total premium cost.
- Eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50% of their contribution.

### **Individual Insurance Mandate**

Under the PPACA, all American citizens and legal residents would be required to obtain healthcare coverage.

- Requires all individuals to have healthcare coverage either through an exchange certified “qualified health plan” or through an employer plan that meets the minimum standards
- Penalty levels for non-compliance:
  - \$95 in 2014
  - \$350 in 2015
  - \$750 in 2016
  - 2017 and beyond:
    - (1) the average bronze-level insurance premium (60% actuarial); or
    - (2) the greater of either:
      - (a) 2% of taxable (gross) household income
      - (b) \$495 for each family member not covered, to a maximum of \$1,980

### **Employer Mandate**

The PPACA requires employers to take a “shared responsibility” in ensuring that their employees have access to “affordable” healthcare coverage. The Act sets payment requirements for plans that meet minimum standards and details penalty fees formularies for employers who do not offer coverage.

- Requires an employer, with more than 50 full-time (over 30 hours) employees, that does not offer coverage and who has at least one full-time employee receiving a “premium assistance” tax credit, to pay \$750 per full-time employee – adjusted annually and non-deductible.
- Requires an employer with more than 50 full-time employees that offers coverage, but has employees receiving the “premium assistance” tax credit, to pay the lesser of \$3,000 for each employee receiving the credit, or \$750 for each full-time employee - adjusted annually and non-deductible.

- An employer with more than 50 full-time employees that maintain an enrollment waiting period would be required to pay:
  - \$400 for any full-time employee in a 30-60 day waiting period - adjusted annually and non-deductible.
  - \$600 for any full-time employee in a 60-90 day waiting period - adjusted annually and non-deductible.

### **Employee Voucher Eligibility:**

The PPACA allows employees with access to an employer-sponsored plan, under certain income eligibility, to receive a voucher from their employer, equal to their employer's contribution ("free choice" voucher), to purchase coverage through an Exchange participating plan.

- To be eligible for a voucher, and an employee would have to meet Both the of following criteria:
  - The cost of the employer's contribution needs to be between 8% and 9.8 percent of the employee's household income
  - Employee has a household income below 400% FPL
- If the employee chooses coverage that costs less than the voucher, the employee keeps the remainder amount.
- Vouchers cannot be taxed as income.

### **Automatic Enrollment**

The PPACA requires employers who do offer health coverage that meets the minimum standards, to automatically enroll their full-time employees into their healthcare plan. Employers are allowed to delay enrollment in accordance with the allowable waiting periods enacted in the Act.

- Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage.
- If employer offers more than one plan choice option, employee will be enrolled in lowest cost option.
- Requires employers to provide adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in

### **Disclosure Coverage Options**

Under the PPACA, plans will be required to disclose to eligible employees all of their health coverage options.

- Requires that an employer provide notice to their employees informing them:
  - Of the existence of an Exchange
  - If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs, that the employee may be eligible for a premium assistance tax credit and cost-sharing reduction.

### **Reporting Requirements for Employer-Plan Sponsors**

In order to certify compliance with the PPACA's "minimum standard" requirements, employer-sponsored plans will be required to submit certain information. Employer-sponsors are also responsible for submitting to the IRS whether or not and for how long, each of their employees possessed minimum essential coverage.

- Requires large employers (over 200 employees) to report the following:
  - Whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan
  - The length of any applicable waiting period
  - The lowest cost option in each of the enrollment categories under the plan
  - The employer's share of the total allowed costs of benefits provided under the plan
  - The number and names of full-time employees receiving coverage
  - A disclosure of the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2

### **Excise Tax on "High-Cost" Plans**

Plans that provide coverage above a certain actuarial cost-threshold will be assessed an excise tax for any cost above the yearly allowable level.

- Levies an excise tax of 40% on insurance companies and plan administrators for any health coverage plan that is above the threshold of:
  - \$8,500 for single coverage
  - \$23,000 for family coverage
- Yearly threshold amounts indexed at CPI+1.
- Exceptions made for certain "high-risk" professions.

### **Tax Treatment of Medicare Rx Subsidy**

Currently, employer plans receive tax deductible Federal subsidies to provide prescription drug coverage for Medicare eligible beneficiaries.

- The PPACA eliminates the deductibility of Federal subsidies for Medicare Rx programs.