Illinois
New Mexico
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Texas

A Snapshot: Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (PPACA) was signed into law on March 23, 2010. PPACA will have significant impact on employer-sponsored group health plans and individual/family consumer policies. While the Departments of Health and Human Services (HHS), Labor, and Treasury will be issuing detailed regulations, what is known are the broad-based provisions that make up PPACA.

Grandfathered Plans

Plans in effect on the date of enactment may be considered "grandfathered health plans." In addition, health insurance coverage with collective bargaining agreements ratified before the date of enactment may be considered "grandfathered health plans" until the last agreement relating to the coverage terminates. Grandfathered health plans are not subject to certain PPACA provisions. However, it is unclear at this time whether certain changes or events may cause a plan to lose grandfathered status.

Rate Review

HHS, in conjunction with states, must establish a process for annual review of "unreasonable" premium increases starting with the 2010 plan year in all insured markets.

Medicare Part D "Donut Hole" Rebate

PPACA provides a $250 rebate for all Medicare Part D enrollees who enter the "donut hole" in 2010. Reform increases discounts in subsequent years and completely closes the donut hole by 2020.

High Risk Insurance Pool

HHS is required to create a temporary high-risk insurance pool within 90 days of enactment to provide coverage for eligible individuals until exchanges go into effect in 2014. PPACA allocates $5 billion in federal funds for claims and administration.

Employer Reinsurance of Early Retirees

PPACA establishes a temporary reinsurance program, effective June 1, to reimburse participating employment-based plans for 80% of costs for health benefits between $15,000 and $90,000 for early retirees (individuals 55 and older but not yet eligible for Medicare) and eligible dependents, up until Jan. 1, 2014. The program will be funded with $5 billion in federal grants.

No Lifetime Maximums

PPACA prohibits lifetime dollar limits on essential benefits.

No Annual Limits

PPACA prohibits annual dollar limits on "essential benefits." However, before 2014, PPACA permits restricted annual limits as determined by HHS. For plan years starting after 2014, annual dollar limits are prohibited entirely.

Essential Benefits

According to PPACA, essential benefits must be equal to the scope of benefits under a typical employer plan. HHS will further define the term "essential benefits." Essential benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including vision services

Dependent Coverage to Age 26

Group health insurance plans must continue coverage for an employee's children until age 26. This provision eliminates restrictive requirements on adult child dependents, such as student and marital status. Blue Cross and Blue Shield has implemented early for fully insured accounts and is offering early implementation to self-insured and mixed funding groups as well.

No Pre-Existing Conditions

Beginning with plan years starting six months after enactment, plans will not be able to apply pre-existing condition exclusion periods to children under age 19. Blue Cross and Blue Shield has extended this provision to children up to age 26. This provision is expanded to cover everyone in 2014.

100% Preventive Care

Beginning with plan years starting six months after enactment, PPACA requires coverage for certain preventive care services with no cost-sharing.

Medical Loss Ratio

Starting in 2011, PPACA requires rebates for medical loss ratios (MLR) below required levels. PPACA sets a MLR of 85% for the large group market and a MLR of 80% for the individual and small group markets. States can set higher percentages. The National Association of Insurance Commissioners (NAIC) is charged with establishing uniform definitions and standardized methodologies for calculating MLRs by December 31, 2010. HHS is to provide additional guidance.

Appeals Process

Beginning with plan years starting six months after enactment, PPACA requires health insurance plans to have an effective internal appeals process. In addition, plans must also have an external appeals process that complies with state requirements that, at minimum, includes the protection of the NAIC's Uniform External Review Model Act. PPACA permits HHS to deem an external review process in operation on the date of enactment as compliant with PPACA's requirements.

Non-Discrimination Based on Salary

Beginning with plan years starting six months after enactment, PPACA requires that fully-insured health plans meet Internal Revenue Code Section 105(h)(2) requirements prohibiting discrimination in favor of highly compensated individuals in terms of eligibility and benefits.

Limited Rescissions

Beginning with plan years starting six months after enactment, health benefits coverage can only be rescinded for fraud or intentional misrepresentation of material fact, and only with prior notice to the enrollee.

Minimum Essential Coverage

Beginning in 2014, employers with an average of at least 50 full-time employees in the prior year must offer "minimum essential coverage."

Free Rider Penalty

If an employer does not offer minimum essential coverage and at least one full-time employee (FTE) receives a tax credit or cost sharing subsidy through an exchange, the penalty is $2,000 per FTE (with the first 30 FTEs subtracted from the payment calculation). However, if the employer offers minimum essential coverage and at least one FTE receives a tax credit or cost sharing subsidy through an exchange (and the actuarial value is less than 60 percent or employee premiums exceed 9.5% of household income), the employer pays the lesser of $3,000 for each FTE receiving the tax credit or subsidy or $2,000 per FTE (with the first 30 FTEs subtracted from the payment calculation).

Free Choice Vouchers

If an employee's contribution would exceed 8% of household income (but not exceed 9.8% of household income), and the employee's household income is less than 400% of federal poverty level, an employer must offer that employee a "free choice" voucher to purchase coverage through a state-based health insurance exchange (described below). The amount of the voucher will be equal to the amount the employer would have paid to cover the employee under the plan with respect to which the employer pays the largest portion of the cost of the plan. If the cost of coverage in the exchange is less than the amount of the voucher, the excess amount will be paid to the employee.

Health Insurance Exchange

According to PPACA, states must establish exchanges to offer qualified health plans to small employers and individuals by 2014. The federal government will establish exchanges where it has been determined the state elects not to establish an exchange or will not have an exchange operational by 2014. Insurers can continue to sell outside the exchanges.

Small Business Tax Credits

Starting in 2010, PPACA provides a small business tax credit up to 35% of employer costs (25% for tax exempt) with a sliding scale for firm size and wages. In 2014, PPACA increases small business tax credit to 50% of employer cost (35% for tax-exempt employers) and credits will only be available on plans offered through health insurance exchanges.

"Cadillac Plan" Tax

Effective in 2018, PPACA imposes a 40% excise tax on the aggregate value of employer sponsored health coverage exceeding certain threshold amounts.

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Quick Reference Guide: Patient Protection and Affordable Care Act of 2010

Effective Immediately	• Automatic enrollment* • Grandfathering • Part D rebate • Small business tax credit	
Beginning June 1	• Temporary early retiree reinsurance program begins • National high risk pool established • HHS Web portal established	
Effective Plan Years Beginning On or After Sept. 23, 2010	• Adult children coverage to age 26 • No pre-existing conditions exclusions for children under age 19 • Restricted rescissions • Preventive care services with no cost sharing** • No lifetime dollar limits on essential benefits • Restricted annual dollar limits on essential benefits	• Revised appeals process** • Transparency disclosures** • Patient protections for emergency services** • Direct access to OB/Gyn** • Choice of PCP/pediatrician** • Non-discrimination rules extended to insured plans** • Medical loss ratio reporting
January 1, 2011	• No reimbursement for OTC drugs on HSAs • Form W-2 reporting of value of benefits • Increased penalty for non-qualified HSA withdrawals • Medical loss ratios rebate	
2012	• Summary of coverage requirement • 60-day notice in advance of modifications	
2013	• Medicare tax increase for high-earners • No deduction for retiree drug subsidy • Cap on health FSA contributions • Employer notification regarding exchanges	
2014	• Rate reviews begin** • MLRs based on three years of data begins • Individual mandate for minimum essential coverage • State-based insurance exchanges • Free rider penalty • Free choice vouchers • No pre-existing condition exclusions • Limit on employee out-of-pocket expenses**	• Increased wellness program incentives • Small employer tax credit increases to 50% • No annual dollar limits on essential benefits • Required coverage for clinical trials for life-threatening diseases** • 90-day limit on waiting periods • Early Retiree Reinsurance Program ends

**Effective date unclear **Generally subject to grandfathering provision*

Information Current as of June 1, 2010

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Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas,

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