The Patient Protection & Affordable Care Act (PPACA)

FREQUENTLY ASKED QUESTIONS & ANSWERS

As changes to our health care system are being implemented, many consumers, business owners, human resources professionals, and insurance brokers are assessing what the Patient Protection and Affordable Care Act (PPACA), commonly known as health care reform, means for them.

Although some aspects of the law are subject to change as regulations are written or through additional legislation, planning ahead and preparing for a new era should not be delayed. The following is a list of common questions and answers about health care reform to help individuals and businesses ascertain what PPACA means for them, what options will be at their disposal, and what steps they will be required to take by law.

Q: WHAT DOES MY ORGANIZATION NEED TO KNOW TO PREPARE FOR AND COMPLY WITH PPACA?

A: Although many aspects of the new law are already in effect, much of the law will be phased in over the next several years, and regulations to implement those parts of the law may not be published for some time. Facing so much uncertainty, developing a long-term plan to comply with the law and manage health care costs can be a cumbersome and overwhelming task.

For organizations just now tackling this issue, one option is to determine if your current plan qualifies as a grandfathered health plan. If so, you may want to consider retaining that plan. However, 90 percent of employers believe their current health care plans will lose their grandfathered status by 2014. A second option is to offer a new qualified health benefit plan, or finally, drop employer-sponsored coverage altogether. Retaining a grandfathered plan may give companies more time to develop a long-term health care strategy for your organization without giving up the coverage your employees need.
**Q: WHAT ARE GRANDFATHERED PLANS, AND WHY DOES GRANDFATHERED STATUS MATTER?**

**A:** A grandfathered health plan is one in which at least one employee continues to be enrolled since March 23, 2010. They are exempt from most of the new qualified health plan mandates. Grandfathered plans may stay in effect indefinitely, as long as they meet certain conditions set forth by the PPACA. Beginning September 23, 2010, all grandfathered plans were required to comply with the following plan provisions:

- No lifetime dollar limits on coverage.
- Maximum waiting period for new employee coverage is no more than 90 days.
- Reasonable annual limits.
- For insured plans, required medical loss ratio of at least 85 percent for large employers and at least 80 percent for small employer and individual plans.
- No rescissions (retroactive terminations).
- Coverage for children up to age 26 on family policies, unless they have access to employer-provided coverage.
- No pre-existing condition exclusions for covered individuals younger than 19.

If your business has a grandfathered plan, you can continue to add new participants and cease to cover employees who terminate employment. You can also transfer employees to another plan or plan option if there is a bona fide employment-based reason for the transfer. Grandfathered plans cannot do any of the following without losing their status:

- Significantly cut or reduce benefits to diagnose or treat a particular condition (i.e. diabetes, AIDS/HIV).
- Raise coinsurance percentage to any extent.
- Lower the employer-provided contribution as a percentage of total cost by more than 5 percent.
- Lower annual limits, or add new annual limits, on what the insurer pays.
- Significantly raise deductibles by more than the rate of medical inflation.
- Raise copayment charges by more than $5 or, if greater, the rate of medical inflation.

**Q: HOW WILL PPACA IMPACT A COMPANY’S GRANDFATHERED HEALTH PLAN?**

**A:** Employers need to understand and prepare for the potential financial implications of health care reform. The law includes several provisions that may result in increased premiums for companies, even those with grandfathered plans. They include:

- 100 percent coverage for preventive care.
- Required coverage for pre-existing conditions.
- A requirement to cover children up to age 26, regardless of marital status.
- Coverage for “essential benefits.”*  

At this point, the PPACA provides little guidance about what “essential” specifically means, noting that it will be defined by the Department of Health and Human Services (HHS), and the benefits have to include at least these broad categories of services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. HHS must ensure that the scope of these benefits is equal to that of a typical employer-sponsored benefit plan.

Businesses must ensure their medical coverage plans meet these new mandates, including those that relate to grandfathered plans.
Q: Our carrier plans to increase our current plan premiums by a significant percentage next year. My company and our employees cannot afford this increase. What are our options?

A: Because of the narrow range of changes that may be made to a grandfathered plan, many employers whose health insurance costs will increase may face a dilemma. If deductibles, copays or the percentage of employer contribution is increased by more than the amounts allowed under the new law, the plans will lose grandfathered status. If the plans lose grandfathered status, you may choose to offer a qualified health plan. If a new qualified health plan is offered, it must comply with all new insurance market reforms, including the new IRS nondiscrimination rules. You may also choose to terminate coverage altogether. If all coverage is terminated, not only employees but the business owners will lose the benefit of having health coverage paid with pre-tax dollars.

Q: Does health care reform affect my ability to offer voluntary worksite benefits to my employees?

A: No. Voluntary worksite benefits, also called supplemental or excepted benefits, include accident, disability, and stand-alone vision and/or dental plans, as well as cancer and hospital indemnity insurance. Unlike major medical insurance, supplemental coverage pays cash benefits directly to the policyholder to use as needed. The new health insurance reforms are aimed at improving access to major medical coverage and, therefore, don’t negate the need for supplemental products or affect an employer’s ability to make them available to employees.

Q: What are the new IRS nondiscrimination rules for qualified health plans?

A: PPACA imposes nondiscrimination rules on all new employer-sponsored qualified health plans, except grandfathered plans. In general, the purpose is to prevent highly compensated individuals from receiving better benefits or more generous employer contributions for those benefits than are available to other employees. As a general guideline, if your business covers 70 percent or more of your eligible workforce and charges all employees the same rate, the rules will be met. An excise tax — $100 per affected person per day — will be imposed on employers whose plans do not meet the nondiscrimination rules.
Q: **WHAT IS THE POTENTIAL FINANCIAL IMPACT OF HEALTH CARE REFORM ON MY BUSINESS AND MY EMPLOYEES?**

**A:** The Congressional Budget Office predicted that under PPACA the cost of health insurance will continue to rise at about the same rate until 2019, and then premiums should begin to level off. Employers everywhere are struggling to keep their health care costs in check and continue to provide the coverage their employees need. In the past most businesses have paid a portion of the premium increase and passed a portion on to their employees. But with a stagnant economy, many businesses are finding that they are unable to afford higher premiums, and more and more businesses are reluctant to pass the increase on to their employees. Given the circumstances, many employers are asking their insurer to increase the copayments, deductibles, and out-of-pocket maximums of their plan. It’s inevitable — one way or the other, employees are going to be responsible for more of their own health care expenses.

Given the growing complexities brought on by health reform, employers will need to invest in more frequent and effective communication to employees about their benefits programs, and potential changes and opportunities the employer makes available to help their employees manage their out-of-pocket costs.

Q: **HOW WILL HEALTH CARE REFORM IMPACT SUPPLEMENTAL OR VOLUNTARY INSURANCE BENEFITS?**

**A:** The primary focus of health care reform is to ensure that Americans of all ages and incomes are protected by creditable, comprehensive major medical health insurance. Because supplemental insurance isn’t major medical insurance, the reform does not pertain to those products. Supplemental insurance plans help people cope with incremental out-of-pocket costs associated with serious accidents or illnesses — costs major medical insurance was never intended to cover. In the event of a serious accident or illness, participants receive cash benefits that are often used to help pay for daily living expenses, such as rent, gas, groceries, babysitting and other necessities, as determined by the policyholder not to mention out-of-pocket medical expenses.

Q: **WILL THERE BE ANY CHANGES TO FSA/HRA/HSA ACCOUNTS?**

**A:** The law does include provisions that will hinder employees’ ability to fund their out-of-pocket health expenses through their FSA, HRA or HSA accounts. PPACA limits FSA contributions to $2,500 per year, and prohibits the purchases of over-the-counter medications through a FSA/HRA/HSA, without a prescription. These limitations and caps will likely create more out-of-pocket expenditures that are not eligible for individual reimbursement, resulting in less money available to pay for an unexpected emergency illness or injury. This, in turn, will make voluntary benefit plans such as critical illness and accident more important in offering workers financial protection and safety.
Q: WHAT DO I NEED TO KNOW ABOUT THE SMALL BUSINESS HEALTH CARE TAX CREDIT?

A: Eligibility Rules are:

• An employer must provide health care coverage to qualify: A qualifying employer must cover at least 50 percent of the cost of single health care coverage for its workers receiving coverage in 2010, and at least 50 percent of all coverage — whether single or family — beginning in 2011. Beginning in 2014, the credit will only apply to coverage purchased through an exchange, for two consecutive years. It is available for both taxable (for-profit) and tax-exempt firms.

• Firm size: A qualifying employer must have 24 or fewer full-time equivalent (FTE) workers (employers with more than 24 workers may be eligible if they still have fewer than 24 FTEs. For example, if you have 40 employees, but they all work half-time, you have 20 FTE employees and you would qualify in this group).

• Average annual wage: A qualifying employer must pay average annual wages of less than $50,000 (owners, their family members and seasonal employees are not counted).

• Amount of Credit

• Maximum amount: The credit is worth up to 35 percent (25 percent for tax-exempt employers) of a small business’ premium contributions beginning in 2010. On January 1, 2014, this rate increases to 50 percent (35 percent for tax-exempt employers) and is available for two consecutive years if coverage is purchased through an exchange.

• Phase-out: The credit phases out gradually for firms with average wages between $25,000 and $50,000, and for firms with between 10 and 25 FTE workers. The federal tax credit reduces your business’ tax if a tax liability exists. If a liability doesn’t exist in a given year, then the credit may be carried back one year (although not for a 2010 loss) or carried forward 20 years until it has been used. For tax-exempt entities, the federal tax credit reduces federal withholding and Medicare taxes.

Q: IS THERE AN EMPLOYER MANDATE TO OFFER COVERAGE TO EMPLOYEES BEGINNING IN 2014?

A: Technically, no; however, employers with 50 or more full-time equivalent (FTE) employees will pay an assessment if an employee opts to purchase coverage through an exchange and receives a premium subsidy. If you, as an employer, do not offer coverage, the fee will be $2,000 times your total number of FTE employee, excluding the first 30. If you do offer coverage, you will pay a fee of $3,000 for each employee who actually purchases coverage through an exchange and receives a subsidy.

Q: WILL EMPLOYER-OFFERED BENEFITS BECOME LESS IMPORTANT AS HEALTH REFORM IS ENACTED?

A: The short answer is no. Although the market can still be characterized as an employer’s market, it will begin to shift back to an employee-driven environment, where top talent will be in short supply and high demand. When this happens, a company’s ability to demonstrate value and goodwill to its workers by offering a benefits package unmatched by competitors will mean the difference in retention rates.
Business leaders know that in order to achieve new productivity expectations and requirements, they need productive employees. And productive employees deliver tremendous value for their company, but only in return for tangible and intangible value that enhances their lives.

One of the most sought after of these tangible rewards is comprehensive benefits. Consider that 76 percent of workers say benefits are influential over their job satisfaction, 69 percent say they influence loyalty, 63 percent say it impacts their likelihood to leave their employers, and 54 percent say benefits influence their productivity, according to the 2011 Aflac WorkForces Report.¹

Health reform will clearly have an impact on benefits. With the establishment of minimum benefits standards and the option to move from employer plans to exchange plans, major medical coverage will likely become more homogenous than it is today. This will make employer supplemental insurance policies and ancillary benefits offerings a greater differentiator than ever before in the battle to attract a talented workforce.

The delivery of benefits to workers will take on more significance and necessity than ever before.

¹The Aflac WorkForces Report included one survey of more than 2,000 benefits decision-makers and two surveys of workers (one of more than 3,000 workers in September 2010, the other of more than 1,188 workers in February 2011).