With Passage of Reconciliation Bill, Congress Completes Health Care Reform

After more than a year of debate, Congress has completed work on a comprehensive health care reform package.

The “Patient Protection and Affordable Care Act” (PPACA) (P.L. 111-148) became law on March 23, 2010. Following House passage of the “Health Care and Education Reconciliation Act of 2010” (H.R. 4872) on March 21, 2010, the Senate approved the reconciliation bill on March 25, 2010 by a vote of 56-43 (only 51 votes were needed to pass the reconciliation bill). However, due to some changes the Senate made to the bill (unrelated to health reform), the reconciliation bill had to go back to the House for another vote. The House approved the Senate changes to the reconciliation bill later in the evening of March 25, 2010, and President Obama signed it into law on March 30.

This Special Report provides a preliminary analysis of the new law and its impact on employers.

Some of the high-impact items of the new law for employers are as follows:

- **Individual Mandate**: The law requires individuals to purchase health insurance coverage or pay an income tax penalty beginning in 2014. Enrollment in an employer group health plan satisfies the individual mandate.

- **Health Insurance Exchanges**: Beginning in 2014, states are required to create Health Insurance Exchanges where individuals and small employers can purchase health insurance.

- **Employer Responsibilities**: Employers are subject to a “free rider” penalty, under which employers with at least 50 full-time employees must pay a penalty if a full-time employee receives a federal subsidy to purchase health insurance in the exchanges. A penalty is assessed if the employer does not offer health coverage at all, if the employer offers coverage that is considered “unaffordable,” or the employer’s plan has an actuarial value of less than 60%.

  In addition, employers that offer health care coverage and make a contribution toward the cost of the health care coverage must provide “free choice vouchers” to qualified employees for the purchase of qualified health plans through the exchanges.
Grandfathered Plans: Grandfathered plans are subject to certain insurance reforms, such as extending coverage to children until age 26, prohibiting lifetime and annual limits and prohibiting waiting periods beyond 90 days, among others.

Automatic Enrollment for Employees of Large Employers: Employers with more than 200 employees must automatically enroll new full-time employees in health care coverage (subject to any waiting period authorized by law).

Reinsurance Program for Early Retirees: A $5 billion fund is created to finance a temporary reinsurance program to help employers offset the costs of expensive health claims for retirees ages 55–64 and their families.

Excise Tax on High-Cost Health Plans: A 40% excise tax will be imposed on the value of health coverage offered by employers that exceeds a certain threshold.

Inclusion of Cost of Employer-Sponsored Health Coverage on Form W-2: Employers are required to report the annual cost of health care coverage received by their employees.

Limit on Flexible Spending Arrangement (FSA) Contributions: Annual contributions to employer-provided health care FSAs are capped at $2,500 (indexed) and reimbursement of over-the-counter medicines are limited to those that have a prescription.

Additional Medicare Taxes: An additional Medicare tax of 0.9% on wages and 3.8% on unearned income will be imposed on individuals receiving wages in excess of $200,000 (single taxpayers) or $250,000 (couples). These new taxes are imposed only on the employee portion of the Medicare tax, not on the employer portion.

Medicare Part D Retiree Drug Subsidy (RDS): Effective in 2013, the law eliminates the deduction for expenses allocable to the Medicare Part D subsidy paid to employers that maintain prescription drug plans for their Medicare Part D-eligible retirees.

Note: To protect the confidential and proprietary information included in this material, it may not be disclosed or provided to any third parties without the approval of Hewitt Associates LLC.

Hewitt Associates is not a law firm. This bulletin is for informational purposes only and does not replace or supersede the advice of client legal counsel.

More Information
For more information on the new health care reform law, please contact your Hewitt Consultant.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Reforms</td>
<td>1</td>
</tr>
<tr>
<td>Individual Mandate</td>
<td>1</td>
</tr>
<tr>
<td>Health Insurance Exchanges</td>
<td>1</td>
</tr>
<tr>
<td>Health Insurance Reforms</td>
<td>1</td>
</tr>
<tr>
<td>Employer Responsibilities</td>
<td>3</td>
</tr>
<tr>
<td>“Free Rider” Penalty</td>
<td>3</td>
</tr>
<tr>
<td>Free Choice Vouchers</td>
<td>3</td>
</tr>
<tr>
<td>Grandfathered Plans</td>
<td>4</td>
</tr>
<tr>
<td>Reporting of Employer Health Insurance Coverage</td>
<td>4</td>
</tr>
<tr>
<td>Exchanges and Pretax Premiums</td>
<td>4</td>
</tr>
<tr>
<td>Automatic Enrollment for Employees of Large Employers</td>
<td>5</td>
</tr>
<tr>
<td>Reinsurance Program for Early Retirees</td>
<td>5</td>
</tr>
<tr>
<td>Employer-Sponsored Wellness Programs</td>
<td>5</td>
</tr>
<tr>
<td>Release of Medicare Claims Data</td>
<td>5</td>
</tr>
<tr>
<td>CLASS Act</td>
<td>5</td>
</tr>
<tr>
<td>Revenue-Raisers</td>
<td>6</td>
</tr>
<tr>
<td>Excise Tax on High-Cost Health Plans</td>
<td>6</td>
</tr>
<tr>
<td>Inclusion of Cost of Employer-Sponsored Health Coverage on Form W-2</td>
<td>6</td>
</tr>
<tr>
<td>Reimbursements for Medical Expenses Must Be for Prescribed Drugs or Insulin</td>
<td>6</td>
</tr>
<tr>
<td>Excise Tax on Indoor Tanning Services</td>
<td>6</td>
</tr>
<tr>
<td>Increased Penalty for Use of HSA Funds for Non-Qualified Medical Expenses</td>
<td>6</td>
</tr>
<tr>
<td>Limit on Flexible Spending Arrangement (FSA) Contributions</td>
<td>6</td>
</tr>
<tr>
<td>Industry Fees</td>
<td>7</td>
</tr>
<tr>
<td>Impact on Medicare</td>
<td>8</td>
</tr>
<tr>
<td>Additional Medicare Taxes on High-Income Individuals</td>
<td>8</td>
</tr>
<tr>
<td>Medicare Retiree Drug Subsidy (RDS)</td>
<td>8</td>
</tr>
<tr>
<td>Medicare Part D Coverage Gap</td>
<td>8</td>
</tr>
<tr>
<td>Efforts to Improve the Efficiency of Medicare</td>
<td>9</td>
</tr>
<tr>
<td>Medicare Advantage Plans</td>
<td>9</td>
</tr>
<tr>
<td>Next Steps</td>
<td>10</td>
</tr>
<tr>
<td>Next Steps for Employers</td>
<td>10</td>
</tr>
<tr>
<td>More Information</td>
<td>10</td>
</tr>
</tbody>
</table>
Health Insurance Reforms

Individual Mandate
The law requires individuals to purchase health insurance coverage or pay an income tax penalty beginning in 2014. Enrollment in an employer group health plan satisfies the individual mandate. Individuals who do not maintain insurance coverage are subject to a penalty that is the higher of either a flat dollar amount or a percentage of income. The penalties are the greater of a) $95 in 2014, $325 in 2015, and $695 in 2016 and beyond; or b) 1% of income in 2014, 2% of income in 2015, and 2.5% of income in 2016 and subsequent years. A hardship exemption is available for individuals with income below the tax filing threshold ($18,700).

After 2016, dollar amounts would increase by the annual cost-of-living adjustment. There would be no penalty if the cost of the least expensive available plan exceeds 8% of income. PPACA provides exemptions from the mandate for religious reasons for taxpayers with incomes under 100% of the Federal Poverty Level (FPL), those who have received a hardship waiver, and those who were not covered for a period of less than three months during the year.

Health Insurance Exchanges
Beginning in 2014, states are required to create Health Insurance Exchanges where individuals and small employers can purchase health insurance. Individuals can purchase coverage through the exchanges if they did not have qualifying coverage through an employer or a public program. The exchanges are open to employers with 100 or fewer employees, but states may limit participation before 2017 to employers with 50 or fewer employees. Although the exchanges are open initially only to individuals and small employers, states can allow larger employers to participate after 2016.

The exchanges must offer health insurance plans at four different levels of “actuarial value” (the percentage of covered expenses paid by the plan). The four levels of health plan offered are bronze (60% actuarial value), silver (70% actuarial value), gold (80% actuarial value), and platinum (90% actuarial value). In addition, the exchanges must offer a lower cost catastrophic coverage health plan, including preventive benefits, that is limited to individuals age 30 or younger.

The federal Office of Personnel Management (OPM) must contract with health insurers to offer at least two multi-state qualified health plans (at least one of which must be a nonprofit company) through the exchange in each state. The contracts must be negotiated in a manner similar to that in which OPM negotiates contracts for the Federal Employees Health Benefits Program (FEHBP). OPM can prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums from participating in the exchange. The new program will be separately administered and have a separate risk pool from the FEHBP.

Individuals with incomes up to 133% of the FPL are entitled to health insurance coverage under Medicaid. Federal subsidies to purchase health insurance on the exchanges will be available on a sliding scale to individuals with incomes between 133% and 400% of FPL.

Health Insurance Reforms
For individual and small group health insurance plans, the law includes a number of reforms, such as guaranteed issue and a prohibition against exclusions for preexisting health conditions. Health insurance rates may vary based only on tobacco use (1.5:1), age (3:1), family composition, and geographic location. A “small group” is defined as up to 50 employees (or up to 100 depending on state law). Large groups participating in the exchanges must also follow these rating rules.
Insurers in the individual and small group insurance markets must maintain a medical loss ratio of not less than 80% (85% for the large group market). As a result, health insurers must spend more of their premium revenues on clinical services, with less going to administrative costs and profits, or else pay rebates to policyholders. This medical loss ratio rule is effective beginning in 2011 and applies to all insured plans (including grandfathered plans), but not self-insured plans.

The law requires the extension of health insurance coverage to an adult child until the child turns age 26. Fully insured plans cannot establish eligibility rules based on employee salaries or wages or any eligibility rules that discriminate in favor of higher paid employees.

Effective January 1, 2011 for calendar year plans, all plans are prohibited from establishing lifetime limits on the dollar value of benefits. Beginning in 2014, all plans are prohibited from establishing annual limits on the dollar value of benefits. Prior to 2014, plans may only establish restricted annual limits, as defined by the Secretary of Health and Human Services (HHS), on the dollar value of benefits with respect to the “essential health benefits.” Beginning in 2011, health insurance plans must provide first dollar coverage for preventive health services. Beginning in 2014, health insurance plans may not impose cost-sharing limits greater than the cost-sharing limits in effect for health savings accounts (HSAs).

Group health plans and insurers must establish both an internal and external appeals process. The internal appeals process can follow current law but must be updated if the Secretary of Labor issues any new standards. Fully insured plans must comply with any applicable state external appeals process. Self-insured plans will be subject to an external appeals process set forth by the Secretary, which has the authority to deem compliant the external review process of any group health plan (self-insured or fully insured) or insurer that was in place prior to enactment of the new law. There is no similar deeming authority for the internal review process. The law is silent on whether the Secretary of Labor or HHS will be issuing rules on an external appeals process.
Employer Responsibilities

“Free Rider” Penalty
The new law does not require employers to offer health insurance coverage to their employees. However, if an employer with 50 or more employees does not offer qualified health care coverage to its full-time employees (and dependents) or offers “unaffordable” coverage and the full-time employee enrolls in a plan through the exchange and receives a federal subsidy, the employer will be assessed a “free rider” penalty.

Under the free rider penalty, health care coverage must have an actuarial value of at least 60% (i.e., the plan must pay at least 60% of covered expenses) and must be “affordable” (employee premiums may not exceed 9.5% of household income). For purposes of determining if employer coverage is affordable, pretax salary reduction contributions under a cafeteria plan are treated as payments by the employee, not the employer. A “full-time employee” is defined as an employee who is employed an average of 30 hours per week, determined on a monthly basis. There is no “free rider” penalty for workers in a waiting period but the length of any waiting period cannot exceed 90 days beginning in 2014.

The “free rider” penalty is calculated as follows:

- An employer that does not offer qualifying health care coverage to its full-time employees will pay $2,000 per year (prorated monthly) times the total number of full-time employees if even one full-time employee receives a federal subsidy, but excluding the first 30 full-time employees from this calculation.

- If the employer provides health care coverage to a full-time employee that is either unaffordable (employee premiums greater than 9.5% of household income) or that has an actuarial value of less than 60%, the full-time employee would get access to a plan in the exchange and to federal subsidies based on household income. The free rider penalty is $3,000 per year (prorated monthly) for each full-time employee receiving a federal subsidy. This penalty is limited to a maximum amount of $2,000 times the total number of full-time employees, but excluding the first 30 full-time employees. The exchange will make the determination of whether any individual employee is eligible for the subsidy and will base that decision on family income information collected from the employee. If an employee then qualifies, the exchange will provide certification to the employer for purposes of paying the penalty.

The Congressional Budget Office (CBO) estimates that the average exchange subsidy per subsidized enrollee will be $5,200 in 2015, rising to $6,000 per subsidized enrollee in 2019.

Health care coverage offered outside the exchanges by an employer of any size, whether fully insured or self-insured, is not required to comply with the list of benefits required of plans in the non-group and small group markets. However, in order for employees who elect employer coverage to satisfy the individual mandate, the employer plan in which they are enrolled must provide first dollar coverage for preventive services (except where value-based insurance design is used), and the plan cannot have a maximum out-of-pocket limit greater than that provided by the standards established for HSAs.

Free Choice Vouchers
Effective in 2014, workers who qualify for an affordability exemption to the individual mandate but do not qualify for tax credits could take their employer contribution and join an exchange plan. The law requires employers that offer coverage and make a plan contribution to provide “free choice vouchers” to qualified employees for the purchase of qualified health plans through the exchanges. If the employer offers a choice

Copyright © 2010 Hewitt Associates LLC
of plans, the reference plan for the free choice voucher would be the plan for which the employee is eligible and to which the employer contributes the greatest portion of the cost. Employers are permitted to age-rate the cost of the plan when determining the amount of the voucher.

An employee qualifies for the free choice voucher if the employee’s required contribution under the employer’s plan is between 8% and 9.8% of income and the employee’s income is at or below 400% of FPL. The free choice voucher is available to any qualifying employee, regardless of whether the employee is full-time or part-time. Free choice vouchers are tax-free, and voucher recipients are not eligible for tax credits. Employers can deduct the amount of the free choice voucher as an ordinary and necessary business expense.

Grandfathered Plans
Existing plans are grandfathered from the insurance reforms with some important exceptions. For plan years beginning six months after the date of enactment (January 1, 2011 for calendar year plans), grandfathered plans are required to:

- Cover adult children up to age 26;
  — For group health plans only, prior to 2014, the requirement to cover adult children up to age 26 applies only if the adult child is not eligible to enroll in an employer-provided plan other than the grandfathered plan.

- Eliminate preexisting condition exclusions for enrollees under age 19;

- Have no lifetime limits and no restrictive annual limits (as determined by the HHS Secretary);

- Have a minimum loss ratio of 85% for fully insured plans only;

- Distribute a uniform summary of benefits to participants for fully insured plans only (regulations required within 12 months after the date of enactment); and

- Bar rescissions of health insurance coverage.

Beginning in 2014, grandfathered plans are prohibited from having:

- Annual limits on essential health benefits;
- Preexisting condition exclusions; and
- Waiting periods in excess of 90 days.

Reporting of Employer Health Insurance Coverage
Large employers must report whether they offer to their 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, and the employer’s share of the total allowed costs of benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage.

Exchanges and Pretax Premiums
An employee’s share of premiums for employer-provided health care coverage offered through the exchange can be paid on a pretax basis through a cafeteria plan. However, exchange coverage that is not employer-offered cannot be offered on a pretax basis.
Automatic Enrollment for Employees of Large Employers
Employers with more than 200 employees must automatically enroll new full-time employees in health care coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. While the law is silent regarding an effective date for this provision, the intent appears to be that this provision will become effective in 2014.

Reinsurance Program for Early Retirees
A $5 billion fund is created to finance a temporary reinsurance program to help offset the costs of expensive health claims for employers that provide health benefits for retirees ages 55–64 and their families. The program reimburses plans for 80% of the cost of care provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne by the plan, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions. The fund will be established 90 days after enactment and will end at the earlier of the date funds are exhausted or 2014.

Employer-Sponsored Wellness Programs
The law codifies the Health Insurance Portability and Accountability Act (HIPAA) regulations on employer-sponsored wellness programs, which allow for rewards to be provided to employees for wellness program participation or for meeting certain health status targets related to a wellness program. In practice, this means that HIPAA rules, such as the monetary limit on wellness incentives (which will now be 30% of the cost of coverage, rather than 20%) and the rules regarding availability of a reasonable alternative to satisfying a health status factor, will become statutory and thus not be subject to change by regulatory agencies.

The Department of Labor (DOL), the Internal Revenue Service (IRS), and HHS are authorized to conduct a study of wellness programs. The study must include a determination of the Secretaries as to whether there is a threshold level of increase in the permissible HIPAA incentive above which any additional increase will be punitive in nature as to other enrollees and employees; discourage non-participating employees from accepting employer coverage; or lack any marginal benefit in encouraging employees to participate in the wellness program. Upon completion of that study, the agencies could then raise the permissible wellness incentive to 50% of the cost of coverage if the agencies determine that adequate safeguards could be put in place to assure that the rewards would accomplish the wellness program goals and not be punitive in nature.

Release of Medicare Claims Data
The law provides a mechanism by which private-sector purchasers can obtain Medicare claims data to measure provider/supplier performance. Extracts will be available to qualified purchasers that combine their data with Medicare data to construct measures of provider and supplier performance, thus enabling purchasers to create pay-for-performance programs that focus on increasing health care quality and efficiency.

CLASS Act
The law includes the Community Living Assistance Services and Supports (CLASS) program, a voluntary federal program for long-term care insurance. Only active workers are eligible to participate. The CBO estimates that the monthly insurance premium will average about $123 in 2011 and that the law will reduce budget deficits by about $72 billion over the 2010–2019 period but then increase deficits beyond that. For those enrollees whose employers participate, premiums will be paid through payroll deductions.
Revenue-Raisers

Excise Tax on High-Cost Health Plans
Effective in 2018, an excise tax will be imposed on health plans costing more than $10,200 for singles and $27,500 for families. In 2019, these amounts will be indexed to general inflation plus one percentage point. In 2020 and beyond, the threshold will be indexed to general inflation only. Stand-alone dental and vision benefits are excluded from the excise tax calculation, creating more room under the threshold and simplifying employer administration of this provision.

If, by 2018, health care costs increase more than expected, the initial threshold will be automatically adjusted upwards. This will occur if the cost of coverage for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Program (FEHBP) increases more than 55% between 2010 and 2018.

There is also a permanent adjustment in the threshold for retirees ages 55–64 and for employees in high-risk jobs, raising it to $11,850 for singles/$30,950 for families in 2018. Alternatively, there is also an adjustment available for companies whose health care costs are higher because of the age or gender of their workers, relative to a national pool.

Inclusion of Cost of Employer-Sponsored Health Coverage on Form W-2
Employers must disclose annually on the Form W-2 (beginning with the 2011 Form W-2) the value of the benefit provided by the employer for each employee’s health insurance coverage. Employers are not required to provide a breakdown of costs for employees’ health, dental, and vision coverage. Instead, they can report the total cost for all medical coverage. Contributions to a FSA are excluded for this purpose.

Reimbursements for Medical Expenses Must Be for Prescribed Drugs or Insulin
Effective January 1, 2011, the law conforms the definition of qualified medical expenses for HSAs, FSAs, and health reimbursement arrangements (HRAs) to the definition used for the medical expense itemized deduction. Over-the-counter medicine must be obtained with a prescription in order to qualify as a qualified medical expense.

Excise Tax on Indoor Tanning Services
A 10% tax on amounts paid for indoor tanning services will be imposed for services on or after July 1, 2010. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning.

Increased Penalty for Use of HSA Funds for Non-Qualified Medical Expenses
Effective in 2011, the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses is doubled to 20% from 10%.

Limit on Flexible Spending Arrangement (FSA) Contributions
Effective in 2013, the annual contributions to health FSAs is limited to $2,500, indexed to general inflation thereafter.
Industry Fees
The law imposes a total fee of $60.1 billion over ten years on health insurers beginning in 2014. The law exempts voluntary employees' beneficiary associations (VEBAs) not established by an employer and nonprofit providers that receive more than 80% of their gross revenues from government programs that target low-income, elderly, or disabled populations.

The law imposes a total fee of $27 billion over ten years on the pharmaceutical industry beginning in 2011.

The law imposes a 2.3% excise tax on the first sale for use of medical devices (with certain exceptions) beginning in 2013, for a total fee of $20 billion over ten years.
Impact on Medicare

Additional Medicare Taxes on High-Income Individuals
Effective in 2013, an additional Medicare tax of 0.9% on wages and a 3.8% tax on unearned income will be imposed on taxpayers with adjusted gross income (AGI) of $250,000 or more (joint return) or $200,000 or more (other filers). Unearned income includes income from interest, dividends, annuities, royalties, rents, and capital gains (“net gain from disposition of property”). The tax does not include income that is derived in the ordinary course of a trade or business that is not a passive activity. The tax on unearned income will not apply to qualified plan distributions under Code sections 401(a), 403(a), 403(b), 408, 408A, or 457(b).

Medicare Retiree Drug Subsidy (RDS)
Effective in 2013, the law eliminates the deduction for expenses allocable to the Medicare Part D subsidy paid to employers that maintain prescription drug plans for their Medicare Part D-eligible retirees.

Medicare Part D Coverage Gap
The law phases out the Medicare Part D coverage gap completely by 2020. In 2010, a one-time $250 rebate will be paid to each Medicare beneficiary who hits the coverage gap in 2010. Starting in 2011, to have their drugs covered by Medicare Part D, pharmaceutical manufacturers must provide a 50% discount off the negotiated price (minus dispensing fees) for brand name drugs covered under plan formularies for beneficiaries that enter the coverage gap. The full negotiated price will count toward a beneficiary’s true out-of-pocket (TROOP) costs to ensure that the coverage gap is not expanded. Further, in 2011, the beneficiary coinsurance amount in the coverage gap will begin to phase down so that it reaches the standard 25% beneficiary coinsurance by 2020. Beginning in 2014, the growth of the out-of-pocket cost threshold after which the catastrophic benefit would apply in Medicare Part D plans will be limited.

Beneficiaries are eligible for the 50% drug discount provided they do not qualify for low-income subsidies, do not have employer-sponsored coverage, or do not pay higher, income-related Medicare premiums under Part B or Part D. Pharmaceutical manufacturers that do not comply with the discount program will be subject to fines. Sponsors of Medicare prescription drug plans and Medicare Advantage prescription drug plans under Medicare Part D may waive copayments for first fills of generic drugs as an incentive for beneficiaries to try a generic formulation of a drug. This provision is effective January 1, 2011.

Under current law, beneficiary premiums under Medicare Part D are not subject to income thresholds, though they are under Part B. Currently, beneficiary premiums account for 25.5% of Part D premium costs for standard coverage, with Medicare paying the remaining 74.5%. The Medicare portion or subsidy amount of average Part D premiums is determined annually and paid directly to plans on a monthly basis for each beneficiary they enroll. However, beneficiaries pay different monthly premiums depending on the plan they select and whether or not they are entitled to low-income premium subsidies. As a result, if a beneficiary chooses a plan with lower than average premiums, then the beneficiary’s share of the plan’s premium will be lower than the 25.5% set nationally.

Beginning in 2011, the Medicare premium subsidy amount for high-income beneficiaries enrolled in Part D will be reduced, similar to the reductions made for high-income Medicare Part B enrollees. As a result, Part D beneficiaries whose modified AGI exceeds the thresholds used for Part B premiums—in 2009, $85,000 for an individual and $170,000 for a couple—will have to pay higher Part D premiums. Income thresholds will be indexed to general inflation beginning in 2020.
Efforts to Improve the Efficiency of Medicare

The law contains a number of important delivery system reforms intended to reduce the rate of increase in future health care costs and Medicare spending. Among a lengthy series of changes, the law includes provisions intended to reduce future Medicare cost growth, including value-based purchasing and creation of a Medicare Independent Payment Advisory Board.

The Board is required to make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector. The Board must make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate but it is prohibited from making recommendations that would reduce premium supports for low-income Medicare beneficiaries. Beginning in 2020, the Board is required to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending. Such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare.

Medicare Advantage Plans

The new law freezes Medicare Advantage (MA) payments for 2011. MA payments will be restructured by tying them to 100% of Medicare fee-for-service costs, providing bonuses for quality, and making payment adjustments for unjustified coding patterns.

Plans will be ranked on a five-star quality system based on quality and beneficiary satisfaction ratings that will be the basis for increased base payment rates and premium rebates. Premium rebates to beneficiaries will be limited for low-quality plans.

Beginning in 2014, the law establishes an 85% minimum loss ratio (MLR) for all MA plans and applies penalties for lower MLRs.
Next Steps

Next Steps for Employers
Employers will need to take the following initial steps to address the short-term and long-term implications of health care reform:

■ Perform a detailed financial impact analysis;

■ Communicate the immediate and longer-term impact to employees;

■ Develop an administration and compliance strategy, along with a transition plan to meet the varying effective dates; and

■ Adjust income statements and FAS 109/106 liability for retiree health care programs.

More Information
A copy of an implementation timeline prepared by the Committees on Ways and Means, Energy and Commerce, and Education and Labor is available at: http://docs.house.gov/energycommerce/TIMELINE.pdf

Patient Protection and Affordable Care Act
The full text of the “Patient Protection and Affordable Care Act” (PPACA) (P.L. 111-148) is available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Health Care and Education Reconciliation Act of 2010
The full text of the “Health Care and Education Reconciliation Act of 2010” (H.R. 4872) is available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf

The CBO cost estimate of H.R. 4872, along with the Manager’s Amendment is available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf

CBO estimates that the new law will cost $938 billion in 2010–2019, and cut the federal budget deficit by $143 billion over that same period (of which $124 billion is estimated to come from the health care provisions versus the $19 billion deficit reduction estimated from the unrelated education provisions). In the ten years after 2019, CBO estimates that the new law will reduce federal budget deficits by roughly 0.5% of gross domestic product. CBO also estimates that the law will extend the solvency of Medicare by several years and expand health insurance coverage by 32 million (i.e., to 94% of U.S. residents excluding unauthorized immigrants or 92% of all U.S. residents).

The Joint Committee on Taxation has two reports available on its 2010 publications Web page: http://www.jct.gov/publications.html?func=select&id=48

■ Technical Explanation of The Revenue Provisions of The “Reconciliation Act Of 2010,” as Amended, in Combination With the “Patient Protection And Affordable Care Act”

■ Cost estimate of H.R. 4872