



CLOSE-UP: 2011 PPACA Changes

January 24, 2011

Six provisions relevant to employers are among the PPACA changes that became effective on January 1, 2011. Brief summary descriptions of these changes are provided below. For additional information, please go to the Highmark health care reform website at www.HighmarkOnHealthReform.com.

Medical loss ratio rebates – Insurers providing large group insurance coverage must use at least 85 percent of their premium dollars for clinical services and quality improvement activities. For individual and small group coverage, insurers must use at least 80 percent of their premium dollars for clinical services and quality improvement activities. Beginning in 2012, plans are required to pay rebates to subscribers if they fail to meet these requirements. This provision applies to grandfathered individual and group health insurance coverage, but it does not apply to self-funded plans.

More information on Medical Loss Ratio will be available in our February 7 Close-up.

Disclosing the value of coverage on W-2 forms – Employers must disclose the aggregate value (the employee plus the employer portion) of an employee's employer-sponsored health coverage for the year on the employee's Internal Revenue Service Form W-2 issued to employees beginning in January 2012. Initially, this requirement was to be effective for the 2011 tax year, generally meaning that the information would have been required on Forms W-2 issued January 2012. However, the Internal Revenue Service deferred the reporting requirement, generally meaning that the information must be included on Forms W-2 issued in January 2013.

But employers should be prepared to comply during 2012 with respect to employees who terminate during 2012.

Some of the coverage costs that must be reported include medical plans, prescription drug plans, employee assistance programs, and dental and vision plans that are not "stand-alone" plans but that are integral to the medical coverage. Employers are not required to report

the amount of any salary reduction contributions to a Flexible Spending Account (FSA) (within the meaning of Section 125 of the Internal Revenue Code) or employee contributions to a Health Spending Account (HSA) or Archer MSA. Generally, the value of health care coverage is the aggregate premium calculated under the COBRA continuation coverage rules.

New Rules Impacting Spending Account Funds and Debit Card Purchases – PPACA has changed the rules regarding purchases of over-the-counter (OTC) medicines or drugs other than insulin with funds from spending accounts including Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs). As of January 1, 2011, funds from these accounts can no longer be used to purchase OTC medicines or drugs without a prescription. Additionally, new substantiation rules apply to the use of debit cards to purchase OTC medicines or drugs. Members should contact their pharmacy with questions about acceptance and purchase rules regarding their spending account debit card.

Beginning January 1, 2011, the tax applicable to distributions from HSAs and Archer MSAs that is not used for qualified medical expenses increases to 20 percent. Under current law, such distributions are subject to an additional 10 percent tax, on top of ordinary income tax.

Small Business Health Care Tax Credit – Qualified small employers with less than 25 full-time equivalent employees (FTE) and average annual wages of less than \$50,000 per FTE that pay at least half of the premiums for single health insurance coverage for their employees may receive a sliding scale tax credit that generally can be claimed beginning with the 2010 tax return through the 2013 tax return. On December 2, 2010, the Internal Revenue Service released final guidance for small employers that are eligible to claim the new small business health care tax credit for tax year 2010. This release includes a one-page form and instructions small employers can use to claim the credit.

Form 8941, Credit for Small Employer Health Insurance Premiums, and the newly revised Form 990-T are now

available on IRS.gov. The IRS website also includes instructions to complete *Form 8941* and *Notice 2010-82*, both designed to help small employers correctly calculate and claim the credit.

The new guidance answers questions about which employers meet the eligibility requirements to qualify for the credit. They include:

- Religious institutions that provide coverage through denominational organizations
- Certain small employers who cover their workers through insured multi-employer health and welfare plans
- Employers who subsidize their employees' health care costs through a broad range of contribution arrangements

More information about the credit, including a step-by-step guide to claiming the credit and answers to frequently asked questions, is on the Affordable Care Act page on IRS.gov.

Insurance for providing services and support for functionally-disabled individuals – PPACA establishes a national voluntary insurance program to help functionally-impaired individuals pay for community living services and support. The Community Living Assistance Services and Supports program (CLASS Act), effective on January 1, 2011, expands long-term services and support options for millions of functionally-disabled Americans by providing participants with a cash benefit to purchase non-medical services and supports necessary to maintain community residence, such as housing modifications, assistive technologies, personal assistance services and transportation – even to offset the cost of assisted living or nursing home expenses. CLASS is financed solely by voluntary premium contributions paid by working adults, either through payroll deductions or direct contributions. The goal is to provide workers and future retirees with a voluntary financing alternative that supports community living without turning to Medicaid to access these services. The Secretary of Health and Human Services has until October 1, 2012 to form three “actuarial sound” alternative plans to be analyzed by the CLASS Independence Advisory Council; therefore, it may be some time before the CLASS Act is implemented.

Wellness grants for small businesses – Small businesses may be eligible for federal grants to provide wellness programs for their employees. PPACA authorizes appropriations of \$200 million over five years, beginning in 2011, to provide grants to help small business implement comprehensive wellness programs. To be eligible, businesses must have fewer than 100 employees who work 25 hours or more a week and have had no wellness program in place as of March 23, 2010 (the date PPACA was enacted). To qualify for the grant, the wellness program must be comprehensive, available to all employees, and meet specific guidelines. The grants will be available through the U.S. Department of Health and Human Services (HHS). The Secretary of HHS is to issue guidance regarding the requirements of the program, and Congress must appropriate funds to support the program. As of this publication date, guidance has not been issued and funds have not been appropriated.

Other provisions that are effective in 2011 include changes to Medicare and Medicaid and the development of a national quality improvement strategy.

The CLASS Act does not replace the need for basic health insurance, private long-term care insurance, or for long-term care coverage through Medicaid, as it is unlikely that it can defray the entire cost of assisted living facilities or nursing homes. It simply supplements this coverage by providing a mechanism to pay for non-medical expenses that allow a person with a disability to remain independent.

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Please note that information contained in this Close-Up is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.