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Preliminary Review of Selected Provisions of the Federal Health Care Reform Reconciliation Bill

March 31, 2010

Certain provisions potentially impacting the Group Benefits Program

Closing the Medicare Part D "doughnut hole" by mandating prescription drug discounts for Medicare beneficiaries who reach the coverage gap, and by gradually phasing down the Medicare drug coinsurance rate to close the gap by 2020.

Employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare (and to the eligible spouses, surviving spouses, and dependents of those retirees) will be reimbursed for 80% of claims between $15,000 and $90,000. $5 billion has been appropriated to pay for the coverage for all plans.

Children may not be denied coverage for pre-existing conditions.
Coverage may not be denied to anyone for a pre-existing condition.

Requires dependent coverage for children up to age 26.

Lifetime limits may not be placed on the dollar value of coverage and coverage may not be rescinded except in cases of fraud.

Automatic enrollment of employees into a health insurance plan. Employees may opt out of coverage.

Prohibits annual limits on coverage.

Health plans must provide a free-choice voucher to certain employees with incomes less than 400% federal poverty level who choose to enroll in a plan provided by the health care exchange.

The voucher amount is equal to what would have been paid to provide coverage to the employee under the plan and will be used to offset the premium costs for the exchange plan in which the employee is enrolled. These individuals might also qualify for federal premium credits and cost-sharing subsidies based on their income.

Coverage waiting periods may be no longer than 90 days.

Certain provisions potentially impacting the Group Benefits Program *(Continued)*

Charges the plan sponsor a fee of $2 per covered life for each plan year ending after September 30, 2012. Fee is $1 for plan years ending during fiscal year 2013. The fee is adjusted starting in 2014 based on the percentage increase of health care costs. The fee does not apply after 2019.

Coverage required for certain preventive services, immunizations, and screenings without a co-pay or deductible.

Imposes an excise tax on the issuer of the health insurance policy for so-called "Cadillac Plans," or employer sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The threshold amounts may be adjusted upward if health care costs rise more than expected prior to implementation of the tax in 2018. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy.

Certain provisions impacting flexible spending accounts

Limits the amount of employee contributions to a flexible spending account for medical expenses to $2,500 per year

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Over-the-counter drugs not prescribed by a doctor may no longer be purchased or reimbursed through the Flexible Spending Account.
