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Health Insurance Reform in 2011

The Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, makes significant changes to our health care delivery system. Some of these reforms took effect in 2010 while many others take place in 2011. The following is a brief description of some of the most important provisions of the health care reform legislation that take effect this year.

- Individual and group health insurance plans are required to extend dependent coverage for adult children up to age 26. While this requirement was effective November 2010 for active employees, enrollment elections made during the 2011 open enrollment period will be effective on January 1, 2011.
- The cost of over-the-counter drugs not prescribed by a doctor can no longer be reimbursed through a Health Reimbursement Account or a health Flexible Spending account, nor can these costs be reimbursed on a tax-free basis through a Health Savings Account or Archer Medical Savings Account. Also, the additional tax on distributions from health savings accounts or Archer MSAs that are not used for qualified medical expenses increases to 20%.
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Medicare Part D participants will receive a 50% discount on brand-name prescriptions filled in the coverage gap (i.e., the donut hole) from pharmaceutical manufacturers, and federal subsidies for generic prescriptions filled in the coverage gap will start to be phased in.

- Health plans that do not spend at least a minimum percentage of premiums (85% for plans in the large group market and 80% for plans in the individual or small group markets) on health care services must provide a rebate to consumers.
- Certain preventive services covered by Medicare are no longer subject to cost-sharing (co-payments); the deductible is waived for Medicare-covered colorectal cancer screening tests; and Medicare now covers personalized prevention plans including a comprehensive health risk assessment.
- High income ($85,000 for individuals, $170,000 for married filing jointly) enrollees in Medicare Part B and Part D coverage will likely see their premiums increase. The income thresholds used to determine Medicare Part B and Part D premiums for higher income individuals is frozen at 2010 income rates through 2019 and will not be adjusted for inflation. Also, the federal subsidy for high income Part D participants is reduced, resulting in increased premiums based on income levels that exceed the applicable threshold.
- Medicare Advantage (MA) plans can no longer impose higher cost-sharing for some Medicare-covered benefits than would be imposed by traditional Medicare Parts A or B insurance. Also, Medicare Advantage plans cannot exceed a mandatory maximum out-of-pocket amount for Medicare Parts A and B services. The maximum amount in 2011 is $6,700, but MA plans can voluntarily offer lower out-of-pocket amounts. Also, the annual enrollment period for MA plans is changed to October 15 to December 7 each year beginning in 2011 for plan year 2012.
- Community Living Assistance Services and Supports Program (CLASS) is to be established to provide national long-term care insurance funded by voluntary participant premiums that can be paid through payroll deductions.
- The disclosure of the nutritional content of standard menu items offered through chain restaurants and vending machines is required.
- The requirement that employers report the total value of employer-sponsored health benefits on employees' W-2s was to begin in 2011. However, the IRS has deferred this requirement for 2011 so employers will not be subject to penalties for failure to meet this requirement.

These changes may impact your health insurance benefits and costs. To learn more about health care reforms occurring in 2011, consult with your financial professional.

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See disclaimer on final page