



Health Care Reform: An Overview of What Employers that Sponsor Group Health Plans Should Know

Employee Benefits & Executive Compensation, Labor & Employment

04.20.2010

President Obama signed the Patient Protection and Affordable Care Act ("PPACA") on March 23, 2010 and the Health Care and Education Reconciliation Act ("RA") on March 30, 2010 (together, the "Acts"). The Acts make sweeping changes to the health care system in the United States and will significantly impact employer-sponsored group health plans. While many of the changes do not apply directly to employers, every employer needs to understand which changes apply to its group health plan or plans, whether the employer's plan or plans can be treated as "grandfathered" under the Acts and what new options are or will be available for providing health benefits to employees in the future. This Update describes some of the expected changes under the Acts; however, a more precise understanding of many of the changes will require further guidance and interpretation from the federal agencies responsible for implementing the Acts. Each summary below is followed by references to the primary sections in the PPACA and the RA where the changes can be found.

GRANDFATHERED PLANS

Certain group health plans in existence on March 23, 2010 will be "grandfathered" and will not be subject to some of the new changes imposed by the PPACA. Coverage under grandfathered plans generally may be continued or renewed, new employees may enroll in grandfathered plans and existing plan participants may add family members to grandfathered plans. Coverage under a grandfathered plan will satisfy an employee's individual responsibility requirement (effective in 2014). At this time, it is not clear what actions will be required for a plan to remain grandfathered. While the PPACA provided a broad exemption for grandfathered plans, the RA narrowed the grandfathering rule and, as a result, grandfathered plans must comply with a number of the new provisions otherwise applicable to all group health plans, including the provisions listed below. Except as specifically noted, grandfathered group health plans must comply with these provisions as they become effective under the Acts:

- The summary of benefits and coverage distribution requirement. PPACA § 10103.
- The prohibition of waiting periods to become eligible for coverage in excess of 90 days. RA § 2301.
- The prohibition on lifetime and annual limits on the dollar value of "essential benefits." RA § 2301.
- The limitation on rescinding coverage for enrollees, except in cases involving fraud or intentional misrepresentation. RA § 2301.
- The requirement that dependent coverage, if offered, must be extended to any adult child until the child turns 26 years old. However, for plan years beginning before January 1, 2014, grandfathered plans will only need to extend such coverage to children who are not otherwise eligible for coverage under another employer's group health plan. RA § 2301.
- The prohibition on preexisting condition exclusions for enrollees under the age of 19 and all enrollees in 2014. RA § 2301.

WHEN CHANGES TAKE EFFECT

While many provisions of the Acts will require clarifying regulations and additional information for full comprehension, employers, plan sponsors and plan administrators can anticipate and prepare for

significant changes in a number of general areas. The changes imposed and anticipated under the Acts will be implemented over a long period of time (some provisions will not take effect until as late as 2018). However, some provisions are effective now and many will become effective over the next few years.

Some important changes that are effective now:

- Effective March 30, 2010, the RA extended the income exclusion for medical care expense reimbursements under an employer-sponsored group health plan to any employee's child who, as of the end of the taxable year, has not attained age 27. Such a child need not meet any of the dependency tests for a qualifying child under Section 152 of the Internal Revenue Code (the "Code") and, thus, is eligible regardless of any support threshold, the child's place of abode or the child's tax filing status. This means that employers with group health plans under which such children are already eligible but did not previously satisfy the Code definition of "dependent" may no longer need to impute the value of coverage provided to these children in the gross income of the employee-parent. RA § 1004.
- A new tax credit is available for certain qualifying small employers for nonelective contributions (i.e., those not made under a salary reduction agreement) used to purchase health insurance coverage for employees. In general, a "qualifying small employer" is one (a) with no more than 25 full-time employees who are employed during the employer's tax year and have annual full-time equivalent wages that average no more than \$50,000, and (b) that pays at least half of the cost for single coverage for its employees. PPACA § 1421, as amended by § 10105.
- Large employers, those with more than 200 full-time employees offering health coverage, that are subject to the Fair Labor Standards Act will be required to automatically enroll new full-time employees in one of the plans offered by the employer. Adequate notice and the opportunity for such employees to opt out of any automatic coverage must be included in the automatic enrollment program. There is no separate effective date for this requirement, which generally means it is effective on the date of enactment (March 23, 2010). Informal guidance suggests that Congress intended this provision to take effect no earlier than 2014, however. Guidance regarding implementation of this requirement and clarification of its effective date is needed. PPACA § 1511.

Some of the changes that are effective for the first plan year beginning on or after September 23, 2010 (for calendar year plans, on January 1, 2011):

- Fully insured employer-sponsored group health plans will generally be subject to the Code Section 105(h) nondiscrimination rules that currently only apply to self-insured plans. PPACA §§ 1001, as amended by § 10101, 1004.
- Claims appeals procedures must be revised to comply with several new requirements including allowing claimants to present testimony, allowing claimants to continue to receive coverage while an appeal is in process and, for self-insured plans, implementing a new external review process that satisfies standards established by the Department of Health and Human Services ("HHS"). Fully insured plans must comply with applicable state-law external review processes to the extent such processes have been established, or with the HHS standards if such processes have not been established. PPACA §§ 1001, as amended by § 10101, 1004.
- Plan sponsors or their designated plan administrators (for self-insured plans) and insurers (for fully insured plans) will be required to provide, before enrollment or re-enrollment, a new summary of benefits and coverage in addition to the summary plan description requirement already in place. This

new summary must be four pages or less, in 12-point or larger font and be presented in a "culturally and linguistically appropriate manner." Written notice of material modifications to any of the terms of the group health plan or coverage that are not reflected in the most recent summary must be provided to enrollees not less than 60 days prior to the date on which such modification will be effective. The PPACA states that this requirement is effective for plan years beginning on or after the date that is six months after the date of enactment. Notwithstanding this effective date, it allows 12 months following enactment for regulations governing the standards for summaries to be issued. In addition to the general effective date, the PPACA also specifies that summaries of benefits and coverage must be provided within 24 months after enactment. PPACA §§ 1001, 1004.

- Preexisting condition exclusions and limitations for all enrollees under the age of 19 will be prohibited. This prohibition will be extended to anyone age 19 and older in 2014. PPACA §§ 1201, 1255 (formerly § 1253), as amended by § 10103.
- Group health plans offering dependent coverage must extend such coverage for adult children until such children turn 26 years old regardless of whether such children are married. PPACA §§ 1001, 1004; RA § 2301.
- Lifetime caps on the dollar value of "essential health benefits" will be prohibited but limitations on non-essential benefits will continue to be allowed. PPACA §§ 1001, as amended by § 10101, 1004.
- Cost-sharing for certain evidence-based preventive care, certain immunizations and other specified preventive health services will be prohibited. PPACA §§ 1001, 1004.
- Coverage for enrolled individuals may not be rescinded except in cases where the individual has engaged in fraud or intentional misrepresentation. PPACA §§ 1001, 1004.
- New "simple" cafeteria plans will be available for certain eligible small employers for plan years beginning after December 31, 2010. These new plans will be treated as meeting the nondiscrimination requirements under the Code if certain eligibility, participation and contribution requirements are satisfied. PPACA § 9022.

Some of the changes that are effective on January 1, 2011:

- Employers must report the aggregate value of employer-sponsored group health plan coverage on employees' Forms W-2 for the 2011 taxable year (such Forms W-2 will generally be provided to employees in 2012). PPACA § 9002.
- With the exception of insulin, reimbursement for expenses incurred for over-the-counter medications will no longer be allowed from health flexible spending arrangements, health reimbursement arrangements, health savings accounts and Archer MSAs without a prescription. This applies to expenses incurred on or after January 1, 2011, regardless of plan year. Complications may arise for non-calendar year plans if employees elect to contribute amounts for over-the-counter medications for the plan year that includes January 1, 2011. To avoid problems, employers should inform employees of this new limitation during open enrollment for the plan year that includes January 1, 2011. PPACA § 9003.
- The current 10% excise tax on nonqualifying distributions from health savings accounts and Archer MSAs will increase to 20%. PPACA § 9004.

Some of the changes that are effective in 2013:

- Effective January 1, 2013, salary reductions for contributions to health flexible spending arrangements will be limited to a maximum of \$2,500 each year (as indexed to the Consumer Price Index). This applies regardless of plan year. Complications may arise for non-calendar year plans. Guidance regarding implementation of this limitation from the IRS is necessary. PPACA § 9005, as amended by § 10902; RA § 1403.
- If an employer-sponsored retiree health benefit plan provides prescription drug benefits that are at least actuarially equivalent to the benefit provided under Medicare Part D, the employer is eligible for a federal subsidy called the Retiree Drug Subsidy. In general, employers have been allowed to deduct this subsidy but, effective January 1, 2013, employers will no longer be able to do so. PPACA § 9012; RA § 1407.
- Employers subject to the Fair Labor Standards Act will be required to provide notice to all employees on or before March 1, 2013, and to all new hires after March 1, 2013, of the existence of state-sponsored "exchanges" (described below), potential eligibility for a subsidy under the exchange and the potential for loss of employer contributions to an employer-sponsored group health plan if a policy is purchased through the exchange. The effective date for this requirement appears to conflict with the requirement that states establish exchanges by January 1, 2014. Guidance regarding implementation of this requirement is necessary. PPACA § 1512.

Some of the changes that are effective for the first plan year beginning on or after January 1, 2014:

- Preexisting condition exclusions and limitations will be prohibited. PPACA §§ 1201, 1255 (formerly § 1253), as amended by § 10103.
- The maximum incentive amount for standard-based wellness programs will be increased from 20% to 30% of the COBRA cost of coverage (potentially increasing further to 50% under implementing regulations when issued). PPACA §§ 1201, 1255 (formerly § 1253), as amended by § 10103.
- Waiting periods to become eligible for a group health plan must not exceed 90 days. PPACA §§ 1201, 1255 (formerly § 1253), as amended by § 10103.
- Group health plan deductibles in the small group market cannot exceed \$2,000 for single coverage and \$4,000 for family coverage. After 2014, these dollar amounts are to be adjusted annually to reflect any increase in the average per capita premium for health insurance coverage in the United States. PPACA § 1302.

Some of the changes that are effective on January 1, 2014:

- Each state must establish an "American Health Benefit Exchange" for that state by January 1, 2014. Such an exchange will facilitate the purchase of health insurance by individuals and, through the creation of "Small Business Health Options Programs," by small employers. For plan years beginning before January 1, 2016, only employers with no more than 50 employees will be considered "small employers" for purposes of access to the exchange. PPACA §§ 1304, 1311.
- A tax penalty may be imposed on employers with 50 or more full-time employees on business days in the prior calendar year if the employer does not offer minimum essential coverage under an

employer-sponsored group health plan for all of its full-time employees and their dependents. Such employers may potentially be subject to this penalty for any month in which any full-time employee receives subsidized coverage through the exchange. The penalty, determined on a monthly basis, is an amount equal to 1/12th of \$2,000 times the number of full-time employees (not just those receiving the subsidized coverage); however, the employer's first 30 employees will not be counted toward the penalty. PPACA § 1513, as amended by § 10106; RA § 1003.

- If an employer offers minimum essential coverage under its plan and any full-time employee receives subsidized coverage through the exchange for any month, the employer is potentially subject to a penalty equal to 1/12th of \$3,000 times the number of full-time employees receiving subsidized coverage through the exchange. However, the penalty won't be imposed for any month with respect to any employee to whom the employer provides a "free choice voucher" (described below) for that month, and the penalty is capped at the amount the employer would have been assessed for the failure to provide coverage. PPACA § 1513, as amended by § 10106; RA § 1003.
- Employers that offer minimum essential coverage to employees under employer-sponsored group health plans, and that pay any portion of the cost for such coverage, will be required to provide "free choice vouchers" to each "qualified employee" equal to the monthly portion of the cost of the employer's group health plan to which the employer would have contributed if the qualified employee were covered under such plan. The employee can use the voucher to purchase coverage under a qualified health plan through the exchange. PPACA § 10108.
- Annual limits on the dollar value of essential health benefits will not be permitted on or after January 1, 2014 (restricted annual limits on essential health benefits, as determined by HHS, are permitted for plan years beginning prior to January 1, 2014). PPACA §§ 1001, as amended by § 10101, 1004.

Some of the changes that are effective in 2016 and later:

- For plan years beginning on and after January 1, 2016, an employer that employed on average at least one but not more than 100 employees on business days during the preceding calendar year, and that employs at least one employee on the first day of the plan year, will be considered a "small employer" for purposes of access to a state-sponsored exchange. PPACA § 1304.
- States may permit large employers (not just small employers and individuals) to purchase coverage through the state-sponsored exchanges beginning in 2017. Under the Act, a "large employer" is one that employed an average of at least 101 employees on business days during the preceding calendar year, and that employs at least one employee on the first day of the plan year. PPACA §§ 1304, 1312.
- The so-called "Cadillac Plan" tax, which imposes a 40% excise tax for any health-related coverage where the combined employer and employee premiums exceed the threshold of \$10,200 per year for single coverage and \$27,500 per year for family coverage, will become effective in 2018. These threshold amounts may be increased in the event the actual growth in the cost of health care between enactment and implementation exceeds the projected growth. These thresholds may also be increased to take into account any employer-specific age and gender adjustments, higher premiums charged for retiree plans and plans that cover employees in "high-risk" professions. After 2018, these thresholds are subject to cost-of-living adjustments. PPACA §§ 1304, 9001; RA § 1401.

Practical Tips

- All employers and plan sponsors should stay informed regarding ongoing developments in health care reform and should consult with their legal, tax and insurance advisors on the best ways to be ready for upcoming changes.
- Sponsors of self-insured plans should review and revise their group health plans to comply with changes that are effective in 2010.
- Employers and plan sponsors should start thinking about short- and long-term action plans to address the various changes required by the Acts, including administrative changes and employee communications challenges.

ADDITIONAL INFORMATION

This Update provides only a general summary of some of the changes implemented under the PPACA and the RA. You can find discussions of other recent cases, laws, regulations and rule proposals of interest on our Web site.

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