Armstrong Teasdale

Client Alert

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Health Care Reform Changes Applicable to Existing Health Plans and New Plans

Introduction

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). On March 30, 2010, President Obama signed the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Bill), which made certain amendments to PPACA. The healthcare reform rules in PPACA and Reconciliation Bill (collectively, the Act) will provide many challenges for employer-sponsored health coverage.

This alert summarizes the key effective dates that apply to changes for providers, employer-sponsored group health plans under the Act. It also identifies some of the key health care coverage changes and revisions that will need to be implemented in all plans, including those in existence prior to Mach 23, 2010.

1. **Coverage Extended to Older Children.** Effective January 1, 2011, all insured group health plans and self-insured plans that offer dependent coverage must make coverage available to participant's children who are under age 26 and would be treated as dependents under the plan but for their age. The extension of coverage is not limited to full-time students or unmarried children, and the value of any subsidy by the employer will not be imputed to the income of the employee. Existing group health plans may continue to exclude adult children prior to January 1, 2014 if the children are eligible to enroll in another employer-sponsored health plan.**See Title I (1)(A) §2714, & (2) §1255.**

2. **No Lifetime Limits.** Effective January 1, 2011, no insured group health plan or self-insured plan may impose a lifetime dollar limit on "essential health benefits," as defined by the Department of Health and Human Services (HHS) in forthcoming regulations. Dental and vision care may not be treated as "essential" for this purpose.**See Title I (1)(A) §2711, (2) §1251.**

3. **Restrictions on Annual Limits.** Effective January 1, 2011, the HHS will set a cap on annual limits that may be imposed by group health plan or self-insured plan for "essential health benefits," as defined in forthcoming regulations. It is expected that dental and vision care will not be "essential health benefits" for this purpose. Effective January 1, 2014, annual limits on essential health benefits may not be imposed at all. **See Title I (1)(A) §2711, (2) §1251.**

4. **No Preexisting Exclusions.** Effective January 1, 2011, no insured group health plan or self-insured plan may impose a preexisting condition exclusion against a child under the age of 19, and effective as of January 1, 2014, no group health plan or self-insured plan may impose a preexisting condition exclusion on a participant of any age. **See Title I (1)(A) §2704, & (2) §1251.**

5. **No Rescission.** Effective January 1, 2011, no insured group health plan or self-insured plan may rescind coverage of any individual once the individual has already become a covered participant, unless the individual has committed fraud or made an intentional misrepresentation of material fact. **See Title I (1)(A) §2712, (2) §1251.**

6. **No Reimbursement of Over the Counter Medications.** Effective January 1, 2011, nonprescription medicines, other than insulin, will no longer be eligible for reimbursement under a health flexible spending account ("FSA"), health savings account ("HSA") or health reimbursement account ("HRA"). **See Title IX (A) §9003.**

7. **Limit on Flexible Spending Accounts.** Effective for taxable years beginning on or after January 1, 2013, annual salary reduction contributions to health FSAs will be limited to $2,500, indexed for inflation. **See Title IX (A) §9005.**

8. **Waiting Periods Limited to 90 Days.** Effective January 1, 2014, no insured group health plan or self-insured plan may impose a waiting period in excess of 90 days. **See Title I (B) §2708.**

9. **Automatic Enrollment.** Effective upon the issuance of implementing regulations, all employers that have 200 or more full-time employees must provide for automatic enrollment of new full-time employees in a group health plan under the coverage option with the lowest employee premium, unless the employee makes an affirmative election to opt out or elects a different option. **See Title I (F)(2) §1511.**

10. **Changes Applicable to New Plans.**

    - **No Cost Sharing for Preventive Care.** Effective January 1, 2011, insured group health plans and self-insured plans may not impose any "cost sharing requirements," including copayments, coinsurance charges and deductibles, on certain preventive care, child preventive services and women's preventive care and screenings. **See Title I (A) §2713.**

    - **Nondiscrimination for Eligibility based on Salary or Wages.** Effective January 1, 2011, group health plans may not limit eligibility for coverage or continued coverage on the basis of the total hourly or annual salary of any full-time employees or otherwise establish eligibility rules that discriminate in favor of more highly paid employees. **See Title I (A) §2716.**

    - **Guaranteed Renewability and Nondiscrimination based on Health Status.** Effective January 1, 2014, health insurance insurers (but not self-insured plans) must accept every employer and individual in the state who applies for coverage during an annual or open enrollment period and must renew or continue the insurance regardless of a participant's health status or utilization of health services. Insured group health plans and self-insured plans may not set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, or evidence of insurability or disability. **See Title I (B) §2705.**

11. **Health Insurance Exchanges.** PPACA requires each state to establish an American Health Benefit Exchange no later than 2014 to provide affordable health insurance to individuals and companies with 100 or fewer employees. **See Title I (2)(C) §1311, §1312.**

    - **Small Employers.** States may elect to limit availability to individuals and employers with 50 or fewer employees for the first two years and are permitted, but not required, to open the exchanges to larger employers beginning in 2017. Smaller employers may offer their employees Exchange plans directly or under a cafeteria plan. **See Title X (B) §9022.**

    - **Essential Health Benefits.** All plans available through the Exchange must be certified by the state as covering "essential health benefits," to be defined in forthcoming regulations, passing through to employees no more than 40 percent of total benefit costs and limiting out-of-pocket limits to those allowed for health savings accounts (currently, $5,950 for individual coverage and $11,900 for family coverage), subject to adjustment for increases in premiums in 2015 and later. **See Title I (B) §2707, & I (D)(1) §1302.**

    - **Deductibles.** Effective January 1, 2014, deductibles for group health plans for companies with 100 or fewer employees (50 or fewer employees in 2014 and 2015), may not exceed $2,000 for individuals or $4,000 for families, indexed for the increase in average premiums. Individuals and families with annual incomes at or under 400 percent of the federal poverty level (currently, $10,050 for a single individual and $22,050 for a family of four) are eligible for a subsidy of up to two-third of the premiums charged. **See Title I (D)(1) §1302.**

    - **Free Choice Vouchers.** Effective January 1, 2014, an employer that offers a group health plan must provide "free choice vouchers" for the purchase of health coverage through an Exchange to any employee who is eligible for a premium subsidy and whose required contribution to the employer's plan would exceed 8 percent, but not exceed 9.8 percent, of his or her household income, in each case indexed for the rate of premium growth. The voucher must be for no less than the maximum amount that the employer would have contributed to provide group health care to the employee. If the voucher exceeds the health care premium under the Exchange, the employee may receive the difference in cash, subject to income taxes. **Title X (A) §10108.**

12. **Uniform Explanations of Coverage.** No later than March 23, 2013, new and existing insured group health plans and self-insured plans must begin distributing uniform explanations of coverage to applicants and participants, employing standard definitions of common insurance and medical terms, in accordance with forthcoming regulations. **See Title I (A) §2715**.

13. **Internal and External Appeals Processes.** Effective January 1, 2011, insured group health plans and self-insured plans must incorporate written internal and external appeals processes that provide an impartial initial review, offer enrollees access to their records and give them the opportunity to give a presentation on appeal. A plan's internal procedures will need to meet the requirements set forth under ERISA's claims review regulation as well as new regulations to be issued

by the HHS. If the plan is self-insured or the state has not established a review process, the plan must implement external review procedures that meet minimum criteria, to be described in forthcoming regulations. Although the new appeals rules will not apply to existing plans. **See Title I (A) §2719.** In addition, administrators of non-grandfathered plans will need to distribute notices to enrollees informing them of the availability of the internal and external review processes and the availability, if applicable, of any state health insurance customer assistance or ombudsman. **See Title I (A) §1002.**

14. **Annual Reports.** Effective for 2014, employers with more than 100 full-time employees must file an annual return with the Department of Health and Human Services disclosing whether they offer a health plan that covers essential health benefits and describing the length of any applicable waiting periods, the cost of the cheapest health plan options offered in each enrollment category, the employer's share of the total benefit costs for each plan, the number of employees participating in the plan each month and the name and address of each such employee. Employers must provide copies of these reports to participants. **See Title I (C)(2) §1253, & I (F)(1) §1514.**

15. **W-2 Reporting.** Effective January 1, 2011, employers must begin disclosing the aggregate cost of employer sponsored health coverage on each covered employee's W2. **Seen Title IX (A) §9002**.

16. **Retiree Medical Subsidy.** No later than June 21, 2010, the Secretary of HHS is required to establish a reinsurance program to reimburse employers for up to 80 percent of the cost of providing health insurance to retirees between the age of 55 and 64 and their spouses and dependents. The fund will reimburse claims in excess of $15,000 and below $90,000, indexed for inflation. **See Title I (B) §1102**.

17. **Small Employer Tax Credit.** Beginning in 2010 through 2013, employers that have 25 or fewer full-time employees and average annual wages of $50,000 or less may receive a sliding scale tax credit of up to 35 percent of the employer's premium cost of group health insurance. Beginning in 2014, the maximum credit will increase to 50 percent of the cost of health insurance obtained through an Exchange. After 2014, the credit may not be taken for more than two consecutive years, beginning with the first year in which the employer offers health insurance through the Exchange. **See Title I (E)(2) §1421(45R).**

18. **Limit on Deduction by Health Insurance Providers for Remuneration over $500,000.** Effective for taxable years beginning on or after January 1, 2013, PPACA amends Section 162(m) of the Internal Revenue Code to limit a health insurance provider's deduction for annual remuneration paid to any of its officers, directors, employees or other individual service providers to $500,000. This restriction applies only to licensed companies and organizations, including HMOs that are regulated under state insurance laws and receive premiums from providing health insurance coverage, of which at least 25 percent are attributable to the provision of the "minimum essential coverage" required to be maintained by individuals once health care reform becomes fully effective. **See Title IX (A) §9014.**

19. **Cost Sharing Restrictions.** Effective January 1, 2014, sponsors of group health plans must pay at least 60 percent of the total cost of coverage, and out-of-pocket limits cannot exceed those allowed for health savings accounts (currently, $5,950 for self-only coverage, $11,900 for family coverage). These numbers are subject to adjustment for increases in premiums in 2015 and later. These changes do not apply to existing plans. Failure to meet the cost-sharing requirement for an employer with more than 50 full-time employees may subject the employer to a "free rider" penalty, (see section 20 below) if any employee eligible to receive a tax subsidy or premium reduction and obtains alternative coverage through a American Health Benefit Exchange. **See Title I (E)(1) §1401(36B); & F(2) §1512.**

20. **Excise Tax on High-Cost Plans.** Effective for taxable years beginning on or after January 1, 2018, high-cost plans referred to as "Cadillac" plans will be subject to a 40 percent excise tax on the amount by which the aggregate costs of coverage (both the employer and by the employee component) exceed an annual limit (for 2018, $10,200 for individuals or $27,500 for families), indexed for inflation. **See Title IX (A) §9001.**

21. **Increase in Medicare Hospital Insurance Tax.** Effective for taxable years beginning on or after January 1, 2013, employers will be responsible for collecting an additional hospital insurance (Medicare) tax equal to 0.9 percent on wages in excess of $200,000 for single filers, or $250,000 for joint filers. This additional tax will effectively increase the employee paid portion of FICA on these "excess wages" from 1.45 percent to 2.35 percent. **See Title III (A)(1) §9015.**

22. **Minimum Essential Coverage.** Effective January 1, 2104, individuals will be required to maintain minimum essential coverage. Failure to maintain coverage will result in a penalty the greater of $95.00 or 1 percent of income in 2014, $325.00 or 2 percent of income in 2015, and $695.00 or 2.5 percent of income. Certain exceptions will apply. **See Title I (F)(1) §5000A.**

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