Health Care Reform Overview

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Introduction

President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The law was almost immediately amended by the Health Care and Education Affordability Reconciliation Act of 2010. Together, the two laws are referred to as the PPACA or Health Care Reform Act.

The Health Care Reform Act is intended to increase the transparency and efficiency of the country's health insurance markets while substantially decreasing the number of uninsured persons in the country. This is to be accomplished, in part, by mandating health care coverage for individuals and providing subsidies to lower income individuals and families.

In addition, the Health Care Reform Act, imposes an assortment of new taxes and fees on individuals, employers, and health care insurers alike and imposes new responsibilities on employers, and insurers, as well as government programs such as Medicare and Medicaid.

Employers of all sizes will find themselves subjected to new rules, regulations and penalties. All employers will be required to make substantial changes to their group health plans' design, as well as summary plan descriptions and other and employer benefit communications. In addition, while many of the provisions of the Health Care Reform Act will not be effective until 2014, employers will be required to take immediate steps to assess their plans and prepare for those plan design, communication and administrative changes that will be required in the not too distant future.

The major provisions of the Act that affect employers either directly or indirectly through their employees or insurance mandates include:

Mandatory coverage for individuals

Effective in 2014, most US residents will be required to maintain "essential health benefits".

Essential health benefits include: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative services and devices; laboratory services; preventative and wellness services; chronic disease management; pediatric services; and other services as defined by the Department of Health and Human Services.

The health coverage must insure at least 60% of the actuarial value of covered services, with annual out-of-pocket limits equal to those that currently apply to high deductible health care plans associated with Health Savings Accounts. (For 2010, this would be $5,950 for an individual and $11,900 for a family.) Furthermore, employer-sponsored plans in the small group market will not be able to impose deductibles that exceed $2,000 for individuals and $4,000 for families.

Generally, the penalty for each individual who does not have this coverage will be the greater of $95 or 1% of income in 2014. This will increase to the greater of $695 or 2.5% of income in 2016.

Premium assistance and premium tax credit

Employers with fewer than 25 employees who have average wages of less than $50,000 will be given a tax credit, starting this year, of up to 35% of the employers' contribution towards health care coverage, if the employer contributes at least 50% of the total premium.

In 2014, employees (and other individuals) will receive advanceable and refundable premium tax credits if their incomes are between 100% and 400% of the federal poverty level. An employee who is offered coverage by his employer will be eligible for the premium tax credit if the employer's group health plan does not pay at least 60% of covered benefit costs or the employee contribution would be more than 9.5% of the employee's income. In addition, the Act provides federal cost sharing subsidies to employees and other eligible individuals with incomes below 200% of the federal poverty level.

American Health Benefit Exchanges

The Health Care Reform Act creates "American Health Benefit Exchanges" through which individuals may purchase insurance coverage. States may opt to have regional exchanges. The Exchanges are to be operational in 2014.

Four health care coverage benefit categories (Bronze, Silver, Gold and Platinum) will be offered by the Exchanges to individuals and families, in addition to a less expensive "Catastrophic Plan" for those under age 31. Other than the Catastrophic Plan, the least expensive Bronze Plan would provide "essential health benefits" and cover 60% of essential benefit costs. Out-of-pocket limits would be reduced for individuals with incomes below 400% of the federal poverty level. The Act also creates a Consumer Operated and Oriented Plan (CO-OP) program to help create non-profit, member-run health insurance organizations.

Small Business Health Option Program (SHOP) Exchanges will be created to allow small businesses of up to 100 employees to purchase qualified health care coverage.

Insurance market

In addition to the coverage and design requirements for group health plans, insurers will be required to provide guaranteed issue (i.e., insurance companies cannot bar applicants based on health status) and guaranteed renewability in the group and individual markets. State or national high-risk pools will be created to provide health insurance coverage to certain individuals with pre-existing conditions until the Exchanges are established. Insurers' rating variations can only be based on family structure, community rating area, actuarial value of benefits, age (limited to a 3 to 1 ratio) and smoking. The Department of Health and Human Services ("HHS") will work with the states to review "unreasonable" rate increases, which must be justified to HHS and each state insurance department. States may allow the creation of "health care choice compacts" to permit purchase of individual insurance across state lines.

Medicare and Medicaid

The Health Care Reform Act reduces certain Medicare payments and establishes an Independent Payment Advisory Board to make recommendations to further reduce the growth of Medicare payments. Medicare Advantage payments will be restructured to be based, in part, on the local market and on performance bonuses. The Medicare Part D prescription drug "doughnut hole" will be eliminated. Currently, Medicare stops paying after an individual has spent $2,830 on prescription drugs and does not resume payments until out-of-pocket spending reaches $4,550. Coverage will be gradually provided for amounts within the gap until the doughnut hole is completely eliminated in 2020. Medicaid will be expanded to cover everyone under age 65 having incomes up to 133% of the federal poverty level.

Funding

In addition to taxes imposed on the insurance industry:

- A 40% excise tax is imposed on "Cadillac" health insurance coverage (i.e., a tax on most health plan coverage to the extent the value of the coverage exceeds $10,200 for individuals and $27,500 for family coverage, as indexed). The excise tax would be effective in 2018.
- The Medicare portion of FICA tax is increased 0.9% in 2013 to 2.35% for taxpayers with joint filings over $250,000 and individual filers with income over $200,000.
- A 3.8% surtax is imposed in 2013 on net investment income (subject to limits) for taxpayers with joint filings over $250,000, or $200,000 in the case of those filing individual returns.
- The Act reduces Medicare Part D premium subsidies in 2011 for joint filers with incomes over $170,000 and individual filers with incomes over $85,000.
- Federal subsidies are currently paid to employers who maintain retiree drug coverage after the implementation of Medicare Part D. The Act eliminates the deduction for expenses attributable to the Medicare Part D subsidy.
- The Act increases the threshold on personal income tax deductions for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income beginning in 2013.
- A 10% excise tax is imposed on indoor tanning services.

Employer Group Health Plans—Future Considerations

The Health Care Reform Act makes significant changes that will affect the design and administration of employers' group health plans by 2014, regardless of whether they are insured or self-funded. Among the most significant provisions:

- Employers with more than 50 employees who do not offer minimum essential health benefits and have at least one employee who receives a federal premium tax credit because of coverage through an "Exchange", will be assessed a fee of $2,000 per full time employee, with an exception from the penalty for the first 30 employees.
- If the employer's group health plan requires contributions in excess of 9.8% of income for any employee, the employer will be assessed a penalty of $3,000 for each full time employee who receives a premium tax credit, with an exception from the penalty for the first 30 employees.
- Employers with more than 50 employees may not have a group health plan waiting period of more than 90 days.
- Employers with more than 200 employees must automatically enroll their employees in the employer-sponsored group health plan. Employees must be given the opportunity to opt out of coverage.
- Group health plans must have "effective" internal and external appeals processes for coverage determinations and claims.
- Employers must offer a "free choice" voucher to an employee to help pay for coverage through an Exchange, if the employee's income is less than 400% of the federal poverty level, and the required employee contribution for the group health plan is between 8% and 9.8% of the employee's income. The value of the voucher must equal the contribution the employer would have made to the group health plan on behalf of the employee.
- For 2012, uniform summaries of benefits, based on HHS regulations, must be distributed. Changes to these summaries must be distributed 60 days before the change in benefits takes effect.

In addition to the design changes, employers will have mandatory notification requirements. Among these, employers will have to include the cost of group health care coverage on their employees' Forms W-2 beginning with the W-2's delivered in January 2012. For 2014, employers (or their insurers) will also have to provide annual information returns stating the number of months during which an individual was covered by the employers' plan.

Also for 2014, employers must notify employees about the existence of the Exchanges and inform them they may be eligible for premium assistance and a cost sharing reduction if the employer's contribution to the plan is less than 60% of the total cost of coverage, and that if the employee chooses coverage through the Exchange, the employee may lose the employer's coverage contribution. Finally, group health plans will have to comply with HHS standards for the provision of information about benefits and coverage. HHS will provide these standards within 24 months of enactment of the Health Care Reform Act.

Grandfather rules

Although many provisions of the Act will not take effect for several years, employers of all sizes that offer health plans to their employees should be aware of the provisions that will take effect within the next few months. These provisions, which are generally applicable for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar years plans), may require changes in plan design, or amendments to insurance contracts, as well as changes to summary plan descriptions, to ensure compliance with the Health Care Reform Act. These changes will affect both insured and self-funded group health plans, and may require immediate action on the part of the employer. However, under the Act's "grandfather rules" not all provisions apply to all plans.

A grandfathered plan is a group health plan that was in existence on March 23, 2010. The plan does not lose its grandfather protection merely because certain participants cease to be covered, even if all individuals who were participants as of March 23 lose coverage, as long as at least one person remains covered under the plan at all times. New participants or family members may be added to the plan without jeopardizing its grandfather status. However, each benefit package within a plan is examined separately to determine if it falls within the grandfather rule.

To maintain grandfather status, a plan must:

- include in any materials describing plan benefits, a statement saying the plan believes it is a grandfathered health plan (the government regulations provide model language);
- maintain records that document the terms of the plan in effect on March 23 and other records needed to verify the plan's grandfather status;
- make such records available for examination; and
- provide contact information for questions or complaints.

Grandfather status is lost if the employer "enters into a new policy, certificate, or contract of insurance" after March 23, 2010. (Special rules apply to collectively bargained plans.)

In addition, grandfather status will be lost if the plan:

- eliminates substantially all benefits to diagnose or treat a specific illness (*e.g.*, if a plan provides treatment for a particular mental illness which consists of counseling and prescription drugs, and then eliminates counseling benefits, the plan would lose its grandfather protection);
- increases the participants' fixed percentage co-insurance requirements (*e.g.*, increasing a co-pay from 20% to 30%);
- increases fixed dollar amount cost sharing requirements (*e.g.*, increasing deductibles or out-of-pocket expenses) beyond a specified amount based on medical inflation plus 15%;

- increases co-payment amounts more than the rate of medical inflation plus 15%, or if greater, by $5.00;
- decreases the employer contribution percentage for any tier of coverage by more than 5% (*e.g.*, decreasing the employer's share of premiums from 60% to 50%); or
- imposes certain new annual limits on benefits.

Grandfather status may also be lost through "abusive transactions" where plans are merged or employees are transferred between plans in an effort to maintain grandfather protections.

The regulations state that a change made before March 23, 2010 which is pursuant to a plan amendment and which takes effect on or after March 23, will not affect grandfather status.

Finally, to protect grandfather status, the regulations provide a transition rule under which an employer may revoke a plan change which was made on or after March 23, and which would have resulted in the loss of grandfather status, if the revocation is effective as of the first day of the first plan year beginning on or after September 23, 2010.

PPACA Provisions that Are Applicable to All Plans

In order for employer-sponsored group health plans to be in compliance, the following provisions will need to be implemented by all plans as of the first day of the first plan year beginning on or after September 23, 2010 (different effective dates apply to collectively bargained plans):

- Coverage for adult children
- Restrictions on annual and lifetime benefit limits
- Elimination of pre-existing condition exclusions
- Limitation of rescissions
- Elimination of reimbursement for over-the-counter medications

PPACA Provisions that Are Only Applicable to Non-Grandfathered Plans

- Preventative care services must be provided without cost sharing requirements
- Participants may select primary care providers, including pediatric care providers, and OB/GYNs from any such provider who participates in the plan's network
- Emergency care services must be provided without prior authorization and without regard to whether the emergency health care provider is a participating
- Insured group health plans will be subject to nondiscrimination rules similar to those currently in effect for self funded plans.

Now let's look at each of these provisions in greater detail.

Coverage of Adult Children

Under one of the most significant changes which is effective for plan years beginning on or after September 23, 2010, a group health plan must make health care coverage available to children of plan participants until they reach age 26. The children are entitled to the coverage regardless of whether they are married or single, and regardless of whether a child continues to be a "dependent" of the plan participant for federal income tax purposes.

In a surprising move that will require most plans (or their insurers) to revise their eligibility provisions, the government regulations provide that because the new law does not distinguish between coverage for minor children and adult children under age 26, a group health plan must apply the same rules to determine eligibility for dependent coverage for younger and older children. Therefore, a group health plan will no longer be able to base eligibility for any child's coverage on: a) whether the child is a dependent for income tax purposes; b) the residency of the child; or, c) the child's student, marital or employment status. Instead, a plan must define eligibility for coverage solely in terms of the child's age and the familial relationship between the child and the participant.

For plan years beginning before 2014, grandfathered plans may exclude an adult child if the child is eligible to enroll in another employer-sponsored plan. However, the regulations clarify that, in the case of an adult child who is eligible for coverage under both parents' plans, neither plan may exclude the child.

Participants cannot be required to pay more for coverage of adult children than they would for similarly situated younger children (*e.g.*, the plan would have to charge the same amount for family coverage regardless of the age of the covered children).

The rules also require a special, one-time enrollment period for adult children who are currently not covered by the plan, including those who lost coverage because of age, those who are currently on COBRA and those who were never covered by the plan but who will become eligible because of the change in the law. The enrollment period must last for at least 30 days and the child, or the child's parent, must receive a written notice of the opportunity to enroll. Because coverage must start at the beginning of the applicable plan year, many plans will use their existing annual open enrollment periods to provide the notice and the opportunity to enroll.

Although the adult children's one-time enrollment period can run beyond the beginning of the first plan year beginning on or after September 23, 2010, coverage for the adult child must begin on the first day of that plan year.

To prevent participants from being subject to imputed income based on coverage or benefits for adult, non-dependent children, effective March 30, 2010, coverage and benefits for these children are tax exempt, regardless of whether the child is a dependent for income tax purposes. The exemption applies for any child who has not attained age 27 as of the end of the participant's tax year.

The IRS has noted that cafeteria plans, including premium conversation plans and health care flexible spending account plans, may need to be amended to permit pre-tax contributions and payment of health care expenses that relate to these non-dependent children. However, under its own proposed cafeteria plan regulations, IRS has said that amendments to cafeteria plans may not have a retroactive effect. To correct this problem, IRS has said that "notwithstanding this general rule, as of March 30, 2010, employers may permit employees to immediately make pre-tax salary reduction contributions...for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. However, a retroactive amendment to a cafeteria plan to cover children under age 27 must be made no later than December 31, 2010...."

The IRS has said that it will also amend its regulatory definition of a "Change in Status," under which mid-year election changes may be made, to include events relating to non-dependent children under the age of 27. (Many cafeteria plans will have to make similar amendments to their plan documents, summary plan descriptions and other communications materials.)

Restrictions on Annual and Lifetime Benefit Limits

For plan years beginning on or after September 23, 2010, all group health plans will be prohibited from imposing lifetime dollar limits on essential health benefits.

In general, group health plans will also be prohibited from imposing annual limits on essential health benefits. However, restricted annual limits, as defined by HHS, may be imposed by grandfathered group health plans, with respect to essential health benefits, until 2014. Government regulations state that these limits are $750,000 for plan years beginning after September 22, 2010; $1.25 million for plan years beginning after September 22, 2011; and $2 million for plan years beginning after September 22, 2012.

The limits will be applied separately to each covered individual. The limits only apply to essential health benefits and cannot be offset by other payments for non-essential health benefits.

The restriction on annual limits does not apply to health flexible spending accounts, or health savings accounts. Health reimbursement arrangements are to be integrated with other coverage that is a part of a group health plan (*e.g.*, combined with a high deductible health plan), to determine if the combined arrangement will satisfy the restriction.

Certain mini-med or limited benefit plans may be exempted from this rule under future regulations.

Individuals who reached a lifetime limit under current plan provisions and who are otherwise still eligible for plan coverage, must be provided with a notice that the lifetime limit no longer applies. If the individuals are no longer enrolled in the plan, they must be given a 30-day enrollment period before the first plan year beginning on or after September 23, 2010.

Pre-existing conditions

Under the Health Care Reform Act, group health plans cannot impose a pre-existing condition exclusion on a child under the age of 19. For plan years beginning on or after January 1, 2014, this prohibition will apply to all participants and beneficiaries. The regulations define a pre-existing condition exclusion as a limitation or exclusion of benefits relating to a condition, based on the fact that the condition was present before the date of enrollment for coverage. This prohibition also prevents a plan from completely excluding an individual from coverage based on a pre-existing condition.

The pre-existing condition rule applies to all group health plans, including grandfathered plans.

Rescission

Under the Act, it will be illegal for a group health plan, or its underlying insurer, to rescind a participant's, spouse's, or dependent's coverage, unless the individual has committed fraud or made an intentional misrepresentation of material facts. The regulations provide that a rescission is a cancellation or discontinuation of coverage that has a retroactive effect. Therefore, for example, an individual switches from full time to part time work but retains plan coverage because he mistakenly believes that he works a sufficient number of hours to be eligible for health care coverage and, several months later, the plan recognizes the mistake, his coverage can be terminated, but the termination cannot be retroactive because he did not intentionally misrepresent his eligibility.

A plan must provide at least 30 days advance notice to an individual before coverage may be rescinded.

The rescission rules apply to all group health plans.

Over-the-Counter Medications

Effective January 1, 2011, all Health Care Flexible Spending Account Plans and Health Reimbursement Accounts that currently cover over-the-counter medications will no longer be able to reimburse plan participants for expenses relating to non-prescribed, over-the-counter medications (with the exception of Insulin). Health Savings Accounts will not be able to reimburse the cost of these over-the-counter medications on a tax-exempt basis.

Preventative Care Services

For non-grandfathered plans, certain preventative care services, including well child and well baby care, certain mammograms, and services recommended by the U.S. Preventative Services Task Force or the Centers for Disease Control and Prevention, must be covered by the plan with no cost sharing, such as co-pays or deductibles. HHS will be providing additional guidance on this provision of the Act.

Choice of Health Care Provider and OB/GYN Referrals

A plan participant or beneficiary must be permitted to select his or her primary care provider, and those of their dependents, including pediatric care providers, from any such provider who participates in the plan's network. In addition, a primary care provider's authorization or referral is not required for obstetrical or gynecological care provided by a physician who is participating in the network. The regulations require a notice to participants of these rights.

These requirements do not apply to grandfathered plans.

Non-discrimination Rules for Insured Plans

Under current law, self funded group health plans are subject to non-discrimination rules regarding the eligibility of highly compensated employees to participate in the plan and the benefits provided under the plan. The Act will now apply non-discrimination rules to non-grandfathered, insured plans as well.

The law merely says that "rules similar" the rules for self funded plans will be applied to insured plans, so we will have to wait until IRS issues regulations to know how these non-discrimination rules will be applied.

Emergency Care Services

Participants and beneficiaries will be entitled to receive emergency care services without prior authorization and without regard as to whether the emergency health care provider is a participating provider in the plan's network. If emergency services are provided out-of-network, the plan's cost-sharing requirements (*e.g.*, deductibles, copays, etc.) must be the same as those that would apply if the provider were in-network.

For these purposes, an "emergency medical condition" is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent person with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in serious jeopardy or serious impairment to bodily functions or any bodily organ.

The regulations contain a formula to determine if a plan has paid a "reasonable" amount for out-of-network coverage. They also state that out-of-network providers may balance bill patients for the difference between the providers' charges and the amount collected from the plan.

The emergency care rules do not apply to grandfathered plans.

Penalties

Although the penalties applicable to violations of the Health Care Reform Act have not been firmly established, it is quite possible that, in addition to the penalties that have previously been mentioned, and the $110 per day penalty that courts can impose for a failure to provide a legally compliant summary plan description, that HHS may be able to apply the HIPAA non-compliance penalties to an employer's failure to comply with the Health Care Reform Act.

The civil monetary penalties, which can be quite severe, are:

- $100 per violation if the person did not know (and by exercising reasonable diligence would not have known) that a violation occurred up to a maximum of $25,000;
- $1,000 per violation if the violation is due to reasonable cause and not willful neglect up to a maximum of $100,000;
- $10,000 per violation if the violation is due to willful neglect and is corrected up to a maximum of $250,000; and
- $50,000 per violation if the violation is due to willful neglect and is not corrected properly up to a maximum of $1,500,000 during a calendar year.

HHS can determine the number of violations based on the nature of obligation that was violated (e.g., whether a failure to act in a certain manner or within a particular time affects some or all plan participants). In the case of a continuing violation, a separate violation occurs on each day the group health plan violates the provision.

Conclusion--Action Steps for Employers

Many of the new provisions for employers and their group health plans are just a few months away, so employers must begin preparing to ensure that they are ready to comply with the new law. Although the effective date for most of these provisions is the first plan year beginning on or after September 23, 2010 – January 1, 2011 for calendar year plans-- many of the notification requirements and special open enrollments should be completed during your next general open enrollment period. Consequently, it is extremely important to begin to prepare for compliance now**.**

Your first step should be to determine which provisions must be complied with by the beginning of your next plan year. To do this, you must determine whether you are afforded protection under the grandfather rules.

Next, you should assess your group health plan to determine which of the new requirements will require changes to your plan. For example, many group health plans with network benefits already permit the selection of any in-network primary care provider or OB/GYN, so that even if your plan is subject to these new provisions, no further action, other than a proper notification to employees, will be required.

Also, you should assess your open enrollment procedures, to determine, for example, if your current system, and open enrollment dates, can support the additional special enrollments for adult children and employees who had previously reached their lifetime maximum benefits.

Employee benefit professionals should assess your plans to determine if plan amendments and modifications to your summary plan description are required and to assist in the preparation of these amendments and modifications.

Employee communication materials should be written now to inform plan participants of the upcoming changes and to help them understand the provisions of the Health Care Reform Act.

Finally -- Keep Alert. The government will be issuing new rules and regulations on the Act and, most likely, changing the rules it has already made, based on employers' and insurers' comments. Health care reform will remain a moving target for the foreseeable future and the only way to ensure compliance is to be constantly up-to-date on all matters effecting group health plans.