Health Care Reform 101

The Patient Protection and Affordable Care Act (as amended by the Health Care and Education Affordability Reconciliation Act of 2010) was signed into law on March 23, 2010 and may well surpass ERISA in its impact on employer group health plans. So far, very little formal guidance has been issued by the Treasury Department or the Department of Health and Human Services. Until more comprehensive guidance is issued, particularly regarding grandfathered plans, employers should err on the side of caution in considering changes to their group health plans. What follows, below, is an outline of some of the major provisions of the new law that may be of interest to plan sponsors.

Terms to Keep in Mind When Considering the Health Care Reform Changes

- Grandfathered Plans: Those group health plans that were in existence on March 23, 2010. A plan sponsor can renew the policy, existing covered employees can add family members and new employees and their dependents may enroll. Otherwise, it is unclear how a plan remains grandfathered. The IRS has indicated that forthcoming regulations will provide that grandfathered plans can be amended to make certain required or voluntary changes to comply with health care reform without losing grandfathered status.

- Collectively Bargained Plans: Those group health plans that are maintained pursuant to a collective bargaining agreement ratified prior to March 23, 2010. Collectively bargained plans need not comply with the otherwise applicable changes until the later of the date the bargaining agreement expires or the regular effective date of the change.

- Essential Benefits: These are relevant to the elimination of lifetime and annual dollar limits. Essential benefits include: emergency services, pediatric services, preventive/wellness/disease management programs, lab services, prescription drugs, maternity and newborn care, hospitalization, mental health and substance abuse services, ambulatory patient services and rehabilitative services and devices.

- Exchanges: State clearinghouses which will facilitate the purchase of individual and group coverage.

All Plans – Grandfathered & Non-Grandfathered

2010-2011 Effective Dates

- Effective Date Unclear – Presumably After the Issuance of Applicable Regulations:
  Auto-enrollment will be required for new employees in plans of large employers (those with greater than 200 full-time employees).

- 2010 Tax Year:
  Employers no longer have to impute federal income tax to employees who cover children up to age 26 (tax relief extends to the end of the year in which the dependent turns 26).

- 2010 Plan Year:
  A sliding scale tax credit is available for small employers that provide group health plan coverage (those with fewer than 25 full-time equivalent employees; controlled group rules apply in determining size).
Health Care Reform 101 CONTINUED

- **June 1, 2010:**
  The Early Retiree Reinsurance Program begins.

- **Plan Years Beginning on or after September 23, 2010:**
  Plans may no longer impose pre-existing condition exclusions on enrollees under age 19;
  Plans must extend dependent coverage to age 26 (grandfathered plans must extend this coverage only if the dependent is not eligible for another employer’s group health plan coverage);
  A prohibition on lifetime dollar limitations on essential benefits takes effect;
  Annual dollar limitations on essential benefits will be restricted;
  Coverage cannot be canceled except for fraud or intentional misrepresentation;
  Medical loss ratio reporting begins.

- **2011 Tax Year:**
  W-2s issued for the 2011 tax year must include the aggregate cost of employer-sponsored health coverage;
  The cost of over the counter medicines may no longer be reimbursed from FSAs, HSAs or HRAs;
  The excise tax for non-qualified distributions from HSAs increases to 20%.

**All Plans – Grandfathered & Non-Grandfathered**

- **2012 – 2013 Effective Dates**
  - **By March 23, 2012:**
    Plans must provide a “uniform summary of coverage” statement to participants and new hires regarding minimum essential coverage.
  - **On and after March 23, 2012:**
    Sponsors must provide 60 day advance notice of any material change to health benefits.
  - **2013 Tax Year:**
    FSA contributions will be limited to $2,500 (indexed in future years);
    Tax deduction for Medicare Part D retiree drug subsidy eliminated.
  - **By March 1, 2013:**
    Plans must provide written notice about the Exchanges (state clearinghouses which facilitate purchase of individual and group coverage).

**All Plans – Grandfathered & Non-Grandfathered**

- **2014 & Later Effective Dates**
  - **2014:**
    “Play or Pay” penalties on employers go into effect;
    Free Choice vouchers must be distributed to certain employees;
    Plans may not impose enrollment waiting periods longer than 90 days;
    Pre-existing condition exclusions cannot be imposed on any enrollee;
    Annual dollar limits prohibited;
    Grandfathered Plans must provide coverage for dependents up to age 26 regardless of dependent’s eligibility under another employer’s plan.
  - **2017:**
    States may permit large employers to purchase coverage under Exchanges.

**Non-Grandfathered Plans Only**

- **2010-2011 Effective Dates**
  - **Plan Years Beginning on or after September 23, 2010:**
    The nondiscrimination rules of IRC §105(h) (relating to highly compensated individuals) will apply to insured group health plans;
    Plans must cover certain preventive care without cost-sharing (no co-pays or deductibles);
    Emergency care must be covered without prior authorization and as if in-network;
    Plans must provide an appeals process with internal and external review;
    OB/GYNs and pediatricians must be permitted as primary care providers.

**Non-Grandfathered Plans Only**

- **2014 Effective Dates**
  - **2014:**
    Plans cannot deny participation in an approved clinical trial for cancer or a life-threatening disease, and may not deny or limit coverage of routine patient costs for services provided in connection with the trial;
    Cost-sharing (e.g., deductibles, coinsurance, copayments) must be limited to the maximum out-of-pocket limits applicable to HSA-qualified high deductible health plans as of 2014.