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The Patient Protection and Affordable Care Act and Employers: Is Your Plan Affected and What Changes Will Your Business Have to Make?

Part I: New and Grandfathered Plans

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The Patient Protection and Affordable Care Act, as modified by the Reconciliation Act and Manager's Amendment (collectively "the Act") imposes new responsibilities on employers of all sizes immediately and progressively through 2014. The majority of these changes depend on whether a group health plan, which includes both insured and self-insured plans, is a new or grandfathered plan.

New group health plans are those formed after March 23, 2010. Group health plans in effect, and continuously enrolling employees, on March 23, 2010, are grandfathered into this new era of health care coverage. Grandfathered plans will continue relatively unaffected and be exempt from some of the Act's provisions, but still be exposed to some of the most talked about health care reforms.

Grandfathered plans may continue in this exempt status until one of the following plan changes occurs, though subject to final regulations, which are expected in 2011:

- Switch of carriers by a fully-insured plan;
- Elimination of certain benefits to treat or diagnose a particular condition that is currently covered;
- Any increase in coinsurance percentage;
- Certain increases of copayments, deductibles or out-of-pocket minimums;
- Certain decreases in employer contribution rate;
- Changes to overall annual limitations;
- Certain mergers, acquisitions and/or employee transfer from a grandfathered plan.

Changes, such as adding new hires or new enrollees or if employees cease to be covered by the grandfather plan, do not affect grandfathered status. Further, because increases of co-payments, deductibles and out-of-pocket minimums and decreases in employer contributions rates are permitted in limited circumstances, a premium change in accordance with such limits is permissible. The Department of Labor recently issued facts about how grandfathered status is affected by on changes to employer contribution rates and the department is expected to take comments on whether switching carriers will affect grandfathered status.

Documentation of both how grandfathered status is maintained and the extent of coverage of the grandfathered plan are important. A grandfathered plan must identify in the plan materials which it provides to participants, beneficiaries, and subscribers that it is a grandfathered plan. The Department of Labor has provided model disclosure language on its website at http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc.

Interim regulations regarding the Act also cautioned grandfather plans and issuers to preserve any documents that exist today that could be necessary in the future to verify or explain a grandfathered plan's status as a grandfathered plan. These documents should be preserved as long as the grandfathered plan desires to retain its grandfathered status.

Summary of the Act's Requirements for New and Grandfathered Plans

Coverage for Adult Dependents up to Age 26

All new plans offering dependent coverage must now cover adult dependents of employees until the dependent's 26th birthday. A dependent child is defined as in Internal Revenue Code § 152 (f)(1) (sons, daughters and stepchildren, including those adopted or placed for adoption and foster children). Grandfathered plans, until 2014, must offer coverage only if the dependent is not otherwise eligible for individual employer-based health care.

Neither the employee, nor the dependent, can be taxed for such coverage. Additionally, children of covered dependents are specifically excluded from coverage.

A plan must allow the dependent thirty days to enroll and issue a written notice of this opportunity beginning no later then the first day of the first plan year beginning on or after September 23, 2010. The Department of Health and Human Services has issued model notification language to satisfy this requirement.

Rescissions Prohibited

New and grandfathered plans can no longer rescind coverage of employees, except in the case of fraud, material misrepresentation, refusal to pay premiums or termination of the plan. The rescission may occur only after prior written notice to the affected employee.

Pre-existing Condition Exclusions Prohibited

Beginning immediately, new and grandfathered group health plans cannot exclude children under 19 because of a pre-existing condition. This prohibition will apply to all participants in 2014.

Lifetime Benefit and Annual Benefit Limits Prohibited

New and grandfathered plans are immediately prohibited from imposing lifetime dollar limits on essential health benefits. Annual dollar limits are prohibited beginning in 2014 and, until then, reasonable annual limits have been set by the Department of Health and Human Services, as well as a waiver process, available here www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf. Written notice of this change and an enrollment period of thirty days for persons not enrolled must begin before the first day of the first plan year after beginning on or after September 23, 2010. The Department of Health and Human Services has issued model notification language to satisfy this requirement.

Preventative Care Coverage

Grandfathered plans are not subject to emergency service coverage and preventative care coverage, though many group health plans already provide these services at low or no deductibles.

For new plans, the Departments of Health and Human Services, Labor and Treasury jointly issued regulations governing preventative care coverage on July 14, 2010. These new regulations require new plans, with plan years beginning on or after September 23, 2010, to fully cover preventative services (without cost-sharing by employees) provided by in-network providers. The Departments' list of preventative care coverage is available here www.healthcare.gov/center/regulations/prevention/Recommendations.html.

Limitations on Flexible Spending Account

Employers offering flexible spending accounts ("FSA"), effective January 1, 2011, cannot offer pre-tax reimbursement for over-the counter drugs, unless prescribed. Effective January 1, 2013, FSA contributions are capped at $2,500 with annual increases based on the Consumer Price Index. Employers should advise their employees of these changes in their flexible spending accounts to avoid confusion. These restrictions apply to new and grandfathered plans.

W-2 Reporting

For the taxable year beginning on or after January 1, 2011, all employers must report the value of health care coverage provided to each employee's on the employee's W-2. This value will not be taxed as income to the individual. The Internal Revenue Service recently issued guidance stating that reporting for 2011 will not be mandatory and the IRS will be issuing further guidance before the end of this year.

Waiting Periods Cannot Exceed 90 Days

All new and grandfathered plans, beginning January 1, 2014, cannot have waiting periods for enrollment longer than 90 days.

Required Coverage

Also, beginning January 1, 2014, employers offering coverage must provide "free choice vouchers" to employees (1) with incomes less than 400 times the Federal Poverty Level and (2) whose premium payment is between 8% and 9.8% of their household income, to offset health care coverage purchased individually. The voucher is tax deductible and equal to the amount the employer would have paid to provide coverage to the employee under the employer's plan.

Tax for High-Cost Coverage ("Cadillac Tax")

Effective January 1, 2018, employers offering coverage that exceeds $10,200 for single coverage and $27,500 for family coverage, will have to pay a 40% excise tax imposed on the value of coverage over those thresholds. For employees in high-risk professions the threshold is $11,850 and $30,950 for single and family coverage, respectively.

Summary of the Requirements for New Plans Only

In addition to providing full preventative care coverage as described above, new group health plans, with plan years beginning on or after September 23, 2010, must implement the following changes:

(1) Employers with plans requiring employees to designate an in-network primary care physician must permit employees to choose any available participating network primary care provider, such as a pediatrician for children or OB/GYN for female participants. Written notice of this change must be provided no later than the first day of the first plan year beginning on or after September 23, 2010 or with any with a summary plan description. The Department of Labor has issued model notification language to satisfy this requirement.

(2) Plans may not require prior authorization for emergency room visits, whether in-network or out-of-network. Further, out-of-network visits cannot be subject to increased benefit limitations or higher administrative costs than in-network visits.

Further, employers participating in group health plans (excluding self-insured plans though similar restrictions applied before the Act) must comply with the non-discrimination rules of §105 of the Internal Revenue Code, which prohibit discriminating in favor of highly compensated individuals. A highly compensated individual is typically one of the five highest paid officers of an employer, a shareholder who owns more than 10 percent in value of the stock of the employer, or among the highest paid 25 percent of all employees. Employers may need to test these fully insured plans, open these plans to all employees, or eliminate these plans and adjust the compensation structure of key employees to remain compliant with this new rule. These restrictions apply to plan years beginning on or after September 23, 2010.

Under the Act, new group health plans must now continue benefits payment during the internal claims process. In line with this requirement, plans with plan years beginning on or after September 23, 2010, must establish an internal and external claim appeals process. Interim final regulations regarding the standard for such appeal process have been released by the Department of Labor, but there is a compliance grace period until July 1, 2011. Model notices for such an appeals process have also been released.

Finally, beginning 2013, new group health plans must limit out-of-pocket costs to $5,950 for single coverage and $11,900 for family coverage.

Part II of this series will discuss large employer mandates and the small business tax credit.

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