

Immediate and Long-Term Challenges For Employers Under Health Care Reform

After a year of heated debate in Congress, Federal health care reform is finally a reality. The new legislation will substantially change the way health care is provided and paid for, and creates both immediate and long term challenges for employers who sponsor group health plans.

Overview

The health care reforms passed this year reside in two new laws: the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, a series of amendments to the Affordable Care Act that was signed into law on March 30, 2010. The two new laws will be referred to collectively as the "Affordable Care Act" in this Alert.

The sweeping changes made by the Affordable Care Act will significantly affect employer group health plans, health insurers, health care providers and individual citizens. This Alert will focus on changes that impact employer sponsored group health plans.

Congressional supporters of the Affordable Care Act claim that it will expand and improve health insurance coverage and help slow increases in the cost of health insurance. The new law attempts to accomplish these goals in part by:

- significantly increasing regulation and oversight of the health insurance industry; and
- establishing incentives and penalties to encourage employers to provide affordable health insurance to employees, and employees and individuals to acquire and maintain coverage.

In particular, beginning January 1, 2014 the Affordable Care Act will require every U.S. citizen to either maintain health insurance that provides "minimum essential coverage" or pay a monetary penalty. Employers will also face monetary penalties if they do not provide affordable minimum coverage to their employees. These are the so called individual and employer "pay or play" mandates.

Immediate and Long Term Changes

The changes enacted by the Affordable Care Act that will most directly affect employer health plans can be divided into two broad categories:

- Immediate Reforms: A series of provisions, mostly health insurance reforms, go into effect for plan years beginning on or after September 23, 2010 (6 months after the date of enactment of the Affordable Care Act). For calendar year plans and insurance contracts, this effective date will be January 1, 2011. Note, however, that some provisions go into effect immediately.

- Fundamental Long Term Reforms: The more fundamental changes under the new law, including the creation of health insurance exchanges and the individual and employer mandates, become effective for plan years beginning on or after January 1, 2014.

Two important terms used under the Affordable Care Act may determine when the new law applies to a health plan:

“Plan year”: As noted above, the effective date of the new law with respect to a plan is based on the plan year. Under existing IRS regulations - which presumably will continue to be followed for purposes of the Affordable Care Act - the “plan year” of a group health plan is the 12 month period that is designated as the plan year in the plan document. If the plan document doesn’t designate a plan year or there is no plan document, the plan year is the 12 month period used in administering deductibles and limits under the plan. If the plan doesn’t impose deductibles or limits on a yearly basis, then the plan year is the policy year or, for a self-insured plan, the employer’s taxable year.

“Grandfathered” plans and policies: The Affordable Care Act includes an important limitation: many of the insurance reform provisions (described below) do not apply to any plan or health insurance coverage in existence on the date of enactment of the new law (March 23, 2010). Such plans and coverages are called “grandfathered health plans.” This broad exemption continues to apply even if coverage is renewed or new dependents are added after March 23, 2010. The “grandfathered plan” exemption is not comprehensive, however: several important new requirements are effective for grandfathered plans at the same time as for non-grandfathered plans, and certain other provisions of the new law apply to grandfathered plans beginning on January 1, 2014.

In the past, when Congress grandfathered existing benefit plans from new legislation, it has often provided that certain kinds of amendments would eliminate a plan’s grandfathered status. The Affordable Care Act, however, does not state what plan amendments or other actions by the sponsor or insurer, if any, might cause a grandfathered health plan to lose its exemption. This is a critical issue for which guidance from one of the federal agencies is needed, as soon as possible.

Near Term Changes

Many important changes under the Affordable Care Act go into effect for plan years (see definition, above) beginning on or after September 23, 2010. (The effective date would be January 1, 2011 for calendar year plans and insurance policies.) These new requirements include significant amendments to the Public Health Service Act (PHSA), which regulates health insurers in the individual and group markets. Many of the pre-2010 protections in the PHSA were added to that law by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Incorporation into ERISA and the Internal Revenue Code: The new law incorporates these PHSA amendments into the Internal Revenue Code and ERISA, so that **the new requirements will apply to employers who sponsor and administer group health plans**, including (with some exceptions) self-insured plans, as well as to health insurance companies. In addition, the incorporation of these requirements into ERISA may mean that health plan participants will be

able to sue health plan administrators for violating these rules – a right which did not exist previously with respect to many PHSA provisions.

The new requirements that go into effect beginning September 23, 2010 include the following:

Lifetime Limits: A group health plan and a health insurance issuer cannot impose lifetime limits on the dollar value of “minimum essential benefits”, effective for plan years beginning on or after September 23, 2010 for both new and grandfathered plans and policies.

Annual Limits: Effective for plan years beginning on or after September 23, 2010, a new or grandfathered group health plan can impose only “restricted annual limits” on benefits that are minimum essential benefits.

Note: The Secretary of Health and Human Services (HHS) has the authority to define “essential health benefits”, but the term is to include benefits within the following categories:

- ambulatory patient services,
- emergency services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive and wellness services, and chronic disease management, and
- pediatric services, including oral and vision care.

Rescissions: A group health plan and a health insurance issuer cannot rescind coverage once an enrollee is covered, except where the covered individual commits an act of fraud or intentional misrepresentation. The Affordable Care Act further provides that coverage cannot be cancelled except in limited circumstances, including nonpayment of premiums, fraud, the enrollee’s moving out of a network service area, termination of all of a particular type of coverage (that is, product withdrawal or market exit), and only after notice to the enrollee. This provision is effective for plan years beginning on or after September 23, 2010 with respect to both new and grandfathered plans and policies.

Note: As with the original “guaranteed renewability” requirement for health insurance under HIPAA, the prohibition on rescissions under the Act does not address what premium must be paid to continue coverage. In other words, neither HIPAA nor the Affordable Care Act requires that health insurance be offered for renewal at any particular premium rate.

Additional note: It isn't yet clear what additional protections will be provided by the new "no rescissions" rule as compared to the existing "guaranteed renewability" rules under HIPAA - other than the fact that such rules may now be enforced against health plan sponsors by participants.

Young Adult Coverage: Every group health plan and health insurance issuer that permits coverage of dependents must permit an adult child (whether married or unmarried) to continue coverage under his or her parents' plan or policy until the child reaches age 26 unless, with respect to the coverage of an adult child under a grandfathered group health plan, the child is eligible for coverage through his or her employer. This provision is effective for plan years beginning on or after September 23, 2010 for both new and (with the proviso just noted) grandfathered plans and policies.

Note: The Act states that the Secretary of Health and Human Services will define the dependents to whom this requirement will apply. HHS regulations may for example, include or exclude children adopted by, or placed for adoption with, a covered person. The Affordable Care Act states that a covered individual's grandchild is *not* entitled to coverage until age 26 under the new rule.

Children's Pre-Existing Conditions: A group health plan, including a grandfathered plan, cannot deny coverage to an individual under age 19 on the basis of a pre-existing medical condition. This provision is effective for plan years beginning on or after September 23, 2010 for both new and grandfathered plans and policies.

Note: This provision created controversy as soon as the Affordable Care Act was passed, as health insurers claimed that this rule only required continued coverage of children already covered by a plan or policy, and did not require them to offer or provide coverage to a an individual under age 19 with a pre-existing condition who wasn't previously covered. In response, HHS Secretary Kathleen Sebelius wrote a letter to the President of America's Health Insurance Plans (AHIP), the health insurance trade association, promising to issue regulations that would prohibit pre-existing condition exclusions as to both initial access to a plan and to the continuation of benefits once a child is covered. AHIP responded by promising that insurers would comply with any such regulations that are consistent with the principles identified in the Secretary's letter.

Retiree Health Plans: The Act establishes a temporary re-insurance program to reimburse employer sponsored retiree health plans for a portion of the benefits paid to early retirees (ages 55-64) and their spouses, surviving spouses and dependents. A qualifying employer could recover 80% of its early retiree medical costs in excess of \$15,000 and up to \$90,000 per retiree per year.

The re-insurance program is to be established by HHS within 90 days after the date of enactment of the Act (June 21, 2010). Eligible employers must submit an application to HHS in order to participate in the program; the application will be similar to the application used for the retiree drug subsidy program. The application is expected to be available in June, 2010.

The program will expire as soon as the allocated funds (\$5 billion) are exhausted, so that a rush to apply for the limited subsidy funds, perhaps similar to the one that occurred in connection with the “cash for clunkers” program last year, can be expected.

Health Insurance Premiums: The Act requires health insurers to report their medical loss ratios (the percentage of premiums spent on medical care) to the Secretary of Health and Human Services, and establishes a mechanism by which rebates to policy holders will be required if the loss ratios exceed certain thresholds. Specifically, insurers in the large group market (which includes employers with more than 100 employees) must maintain a medical loss ratio - as defined pursuant to the Act - of at least 85 percent, and insurers in the small group market (employers with not more than 100 employees) and the individual market must maintain a medical loss ratio of at least 80 percent. This provision is generally effective for plan years beginning on or after September 23, 2010, and is effective with respect to grandfathered health plans for plan years beginning on or after March 23, 2010. These provisions do not apply to self-insured health plans.

Note: The Act gives substantial flexibility to regulators in defining the relevant terms and adjusting the loss ratios targets, and it isn't clear what effect these provisions will have on premium rates. In addition, states may elect to use a 50 employee threshold for small employer status.

Distributions For Over the Counter Medicines: Beginning January 1, 2011, the cost of over-the-counter drugs not prescribed by a physician may no longer be reimbursed through a health flexible spending account (FSA), a health reimbursement arrangement (HRA) or a health savings account (HSA). A drug obtained under a prescription is considered a prescription medicine - so that its cost may be paid from one of these sources - even if it is available without a prescription.

Non-Qualified HSA and MSA Distributions: Beginning January 1, 2011, the excise tax on distributions from health savings accounts (HSAs) and Archer medical savings accounts (MSAs) not used to pay qualifying medical expenses is increased to 20 percent (from 10 percent).

Reporting the Cost of Employer Coverage: Beginning in 2011, every employer must report the cost of employer-sponsored health coverage on employees' W-2s.

Small Business Tax Credits: Businesses and nonprofit employers with fewer than 25 full-time equivalent employees and average payroll of \$50,000 or less could qualify for a tax credit for 2010 and later years of up to 35 percent (50 percent beginning in 2014) of the cost of their group health plan premiums. (For nonprofit employers the maximum credit is 25% for 2010-2013 and 50% thereafter.)

Changes Applicable to New Health Plans: Certain requirements apply in 2011 to health plans established on or after the date of enactment of the Act (March 23, 2010). Existing health plans are grandfathered with respect to these requirements (see the “note on grandfathered plans and policies,” above). The requirements that apply in 2011 only to new plans include:

- *Preventive Care:* New plans must cover checkups and other preventative care without requiring any co-pays.
- *External Appeals:* New plans must implement appeals processes for adjudicating coverage determinations and benefit claims.
- *Eligibility Rules:* Insured group health plans may not establish eligibility requirements or benefit provisions that discriminate in favor of officers, shareholders and highly paid employees. This provision is effective for plan years beginning on or after September 23, 2010, but does not apply to grandfathered health plans or self-insured health plans.

Note: Self-insured health plans are already subject to similar non-discrimination rules, which are enforced by requiring immediate taxation of the health benefits of officers, shareholders and highly compensated employees under non-compliant plans.

Dealing With the Immediate Changes

Employers should begin now to consider how the changes that go into effect in 2010-2011 affect their group health plans. The issues that must be addressed include:

- FSA, HRA and HSA: Employers that have FSAs, HRAs or HSAs as part of their health plans must deal with the prohibition on reimbursement of over the counter drug costs, directly or through their third party administrators.
- Insurance Reform Requirements: Employers with insured plans should work with their health insurance carriers to ensure that the insurance reform provisions - including the required extension of young adult coverage and the prohibitions on lifetime limits and pre-existing condition exclusions for children - are timely implemented. **Remember:** under the new law, the sponsor/administrator of a health plan is liable for violations of the new requirements – not only the insurer.
- Retiree Plans: Employers that cover pre-65 retirees should immediately investigate possible federal subsidies under the temporary re-insurance program, since (as noted above), the available subsidy funds are expected to be exhausted very quickly.

On the Horizon

More far reaching changes are scheduled to take effect beginning in 2014. These fundamental reforms include the following:

Employer “Pay or Play” Mandate: Beginning in 2014, employers with at least 50 full-time equivalent employees on average must offer affordable minimum essential health coverage to all full time employees and their dependents, or pay a penalty if any full time employee receives a premium subsidy to participate in a plan offered through one of the state insurance exchanges. For this purpose, a full time employee is one employed at least 30 hours per week on average; part-time employees are converted into full-time equivalents by dividing their average monthly hours by 120. An employee can receive a premium subsidy if the employee’s household income is below a certain level and the employee meets certain other requirements.

Penalty Where Employer Fails to Offer Coverage: If the employer does not offer health coverage, the penalty is \$2,000 for each full-time employee equivalent, disregarding the first 30 full-time employees. This penalty is imposed on a monthly basis.

Example: Company A has 100 full-time employees and fails to offer them health coverage. Two of the employees receive premium subsidies for enrolling in a state exchange plan. For each employee in excess of 30, Company A owes \$2,000 per year, for a total annual penalty of \$140,000 (\$2,000 X 70).

Penalty Where Employee Opt's Out of Unaffordable or Substandard Coverage: If the employer offers coverage that either is "unaffordable", or pays less than 60% of the total value of allowed costs, and at least one full-time employee opts out of such coverage, *and* at least one full-time employee receives a premium subsidy to participate in an exchange plan, the employer is subject to a different penalty. For this purpose, coverage under an employer plan is not affordable to an employee if the employee premium is 9.5% or more of the employee's "household income". In this case, the employer penalty is equal to \$3,000 for each full-time employee who receives a premium subsidy, but not more than the penalty for failing to offer coverage (described above). Again, the penalty is imposed on a monthly basis.

Automatic Enrollment: Employers with more than 200 employees who offer health coverage will be required to automatically enroll new full-time employees in one of their plans, and continue the enrollment of current employees, beginning in 2014. Employees can opt out of the employer plan if they demonstrate that they have other coverage.

Free-Choice Vouchers: Employers must provide free-choice vouchers to employees who earn less than 400% of the federal poverty level (currently, this threshold would be \$22,050 for a family of four) and whose share of the premium exceeds 8% (but is less than 9.8%) of their household income. The voucher must be in the amount the employer would have contributed toward the employee's coverage under the employer plan, and can be used by the low wage employee to purchase coverage on one of the health insurance exchanges.

Limits on Waiting Periods: Employers may not impose a waiting period (the time that a new hire must wait before being eligible for the employer's health plan) longer than 90 days.

Employee Notice: Beginning January 1, 2013, employers must provide a written notice to all new hires (and to existing employees by March 1, 2013) informing the employee of the existence of the state insurance exchange, and certain other matters relevant to the employee's health coverage rights, including the actuarial value of the employer's health plan.

More Guidance Coming

We will address the fundamental changes under the new health care laws in future Alerts, starting with the employer "pay or play" mandates briefly summarized above. We will also provide additional guidance on the "near term reforms" described in this Alert as more information becomes available.

If you have any questions about health care reform, please contact Robert W. Patterson at 716.843.3910 or rpatterson@jaeckle.com, or Michele O. Heffernan at 716.843.3850 or mheffernan@jaeckle.com.

This Jaeckle Alert, prepared by the attorneys at Jaeckle Fleischmann & Mugel, LLP, is intended for general information purposes only and should not be considered legal advice or an opinion on specific facts. For more information on these issues, contact one of the attorneys listed above or your existing Firm contact. Prior results do not guarantee a similar outcome. The invitation to contact is not a solicitation for legal work in any jurisdiction in which the contacted attorney is not admitted to practice. Any attorney/client relationship must be confirmed in writing.
© 2010. All Rights Reserved.