

# Benefits Alert

May 2010

## Open Wide And Say 'Ah': Health Care Reform Is Here

Health care reform consists of two laws — the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Sweeping as these changes are to the health insurance market, with certain exceptions, *existing* group health plans, including self-insured plans, don't have to comply with most of the insurance market reforms. These grandfathered plans, therefore, can continue to enroll new employees and their dependents without jeopardizing their grandfathered status. Here's a look at what you can expect and when you can expect it.

### WHAT'S EFFECTIVE NOW, OR NEARLY SO

For *new* plans, the bulk of

health care reform becomes effective in 2014, including the insurance market reforms and the creation of health exchanges that will assist individuals and small employers with the purchase of insurance that meets minimum essential requirements. While 2014 is a long way off, a handful of stopgap measures becomes effective immediately, or almost immediately. The following provisions apply to existing, grandfathered plans, and new, non-grandfathered plans, **for plan years beginning September 23, 2010.**

- Coverage must be offered to employees' dependent children until they turn 26. Grandfathered plans don't have to offer coverage if dependents are eligible to be covered un-

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der another plan. Plans may increase premiums otherwise required for coverage provided to a qualified child. The tax code has been amended to allow employers to provide tax-free health benefits to employees' dependent children until they turn 27.

- Group health plans and health insurers can't impose aggregate lifetime limits on benefits. Plans may only establish a restricted annual limit, to be set by the Department of Health and Human Services (HHS), on the dollar value of minimum essential health benefits. To the extent authorized by law, annual or lifetime limits may be imposed on specific benefits that aren't minimum essential



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benefits. All annual limits will disappear **beginning in 2014**.

- Group health plans and health insurers can't impose pre-existing condition exclusions on enrollees who are younger than 19. All pre-existing condition exclusions will disappear **beginning in 2014**.

- Group health plans and health insurers can't rescind coverage.

The following provisions apply to new, non-grandfathered plans only.

- Sponsors of insured group health plans will be prohibited from limiting eligibility for coverage to executives and other highly compensated employees.

- Group health plans and health insurers must provide coverage for certain preventive health services with no cost-sharing for children and women. *Services included:* immunizations, preventive care, and screenings.

**Beginning July 1, 2010**, employers with fewer than 100 employees who work at least 25 hours a week will be eligible for grants to offset some of the costs paid or incurred for qualified wellness programs. *Key:* Costs associated with the wellness program and general health plan costs must be segregated, since the grant applies only to wellness programs. Grants will be available for up to five years.

### WHAT'S EFFECTIVE IN 2011

The following provisions become effective next year.

#### **SIMPLE cafeteria plans.**

Employers with an average of 100 or fewer employees during either of the two preceding years may adopt SIMPLE cafeteria plans, which provide a safe harbor from non-discrimination testing for the cafeteria plan.

The safe harbor requires that SIMPLE cafeteria plans satisfy minimum eligibility, participation, and employer contribution requirements. The minimum eligibility requirement is met if all employees are eligible to participate and are able to elect any benefit available under the plan. Leased employees must be counted, but employees who haven't yet turned 21 years old (or a younger age) before the end of the plan year, employees who worked fewer than 1,000 hours for the preceding plan year, employees who have less than one year of service as of any day during the plan year, and union employees and non-resident aliens may be excluded from the SIMPLE cafeteria plan.

The minimum contribution requirement is met if, without regard to whether employees have pre-tax deductions made from their pay, employers contribute at least 2% of each eligible employee's compensation (i.e., employers make *non-elective* contributions). Alternatively, the minimum employer *matching* contribution is the lesser of 100% of employees' pre-tax contributions or 6% of employees' compensation. *Caveat:* These minimum requirements aren't met if matching contributions for highly compensated or key employees are at a greater rate than matching contributions for rank-and-file employees.

**Definition of medical expenses.** Several years ago, the IRS loosened up the definition of medical expenses that are eligible to be reimbursed by health flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement accounts (HRAs) to include over-the-counter medicines. Prior to that, health FSAs, etc., could only reimburse for deductible medical expenses. The health care reform law overrides the IRS, and re-imposes the original definition of reimbursable medical expenses to include only those expenses that are deductible. *Catch:* Reimbursements may still be made for OTC items for which employees have prescriptions. *Impact:* Employees will forfeit contributions into health FSAs under the use-it-or-lose-it rule if they can't buy non-prescription OTC items. *Tip:* Employees should be informed of this provision before they designate pre-tax health FSA contributions for 2011.

**HSAs.** The penalty for distributions from HSAs that aren't used for qualified medical expenses increases to 20%, from 10%.

**Appeals.** Group health plans must establish an effective appeals process for employees who have been denied coverage for benefits provided by non-grandfathered plans.

### WHAT'S EFFECTIVE IN 2013

Full implementation of health care reform, including the creation of individual and small business exchanges, is now only one year away.

**Notice to employees.** By

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**March 1, 2013**, employers must provide existing employees and each new hire with a notice regarding health insurance coverage. The notice must include the following information.

- It must inform employees of the existence of the exchange, and include a description of the services exchanges provide and the manner in which employees may contact the exchange to request assistance.

- If the employer picks up less than 60% of the cost of coverage, the notice must inform employees who purchase insurance through the individual exchange that they may be eligible for premium assistance tax credits and cost-sharing reductions.

- If employees do purchase coverage through the individual exchange, and their employers don't offer *free-choice vouchers*, the notice must inform them that they will lose any employer contributions to their benefits, and that the employer's contribution is tax-free to them. *Note:* Employees whose income isn't greater than 400% of the federal poverty line and whose health care contributions are between 8% and 9.8% of income are eligible for free-choice vouchers. Vouchers equal the monthly amount employers would have contributed into the plan for those employees with respect to which employers pay the largest portion of the cost of the plan. Employees then use their vouchers to purchase coverage on the individual exchange.

**Health FSAs.** The amount that employees can defer into a health FSA will be capped at \$2,500. This amount is adjusted

for inflation, **beginning in 2014.**

### WHAT'S EFFECTIVE IN 2014

Almost all of health care reform begins in calendar year 2014 or plan year 2014. This includes the insurance market reforms, the individual mandate to carry insurance, and excise taxes on employers that fail to offer insurance or offer unaffordable insurance. *Reminder:* Grandfathered plans do not have to comply with the insurance market reforms, unless otherwise noted.

**Insurance market reforms.** The key insurance reform is the creation of health insurance exchanges in the individual and small group market. The exchange for the small group market is called the Small Business Health Options Program, or SHOP. An exchange is not an insurer, but is similar to Travelocity™ or Expedia™, which provides comparable information on flights and hotels. A second key insurance reform specifies a minimum package of benefits, and limits the levels of plans to bronze, silver, gold, and platinum. The plans have an increasing level of actuarial value, starting at 60% of the cost of benefits for a bronze plan and ending at 90% of the cost of benefits for a platinum plan. These plans are called qualified health benefit plans, or QHBPs. Exchanges certify plans as QHBPs, and only QHBPs may be sold through the exchanges.

Carrying over from the prohibitions enacted in 2010, the Health Insurance Portability and Accountability Act (HIPAA) is amended to permanently pro-

hibit group plans and insurers, *including grandfathered plans*, from imposing pre-existing condition exclusion periods. In addition, plans can't establish eligibility rules based on these health-status-related factors: health status, medical conditions (including physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. Health insurers must accept every employer that applies for coverage; renewals are also guaranteed.

QHBPs, *including grandfathered plans*, can't impose waiting periods that exceed 90 days or place lifetime or annual limits on minimum essential benefits. Cost-sharing (i.e., deductibles, co-insurance, co-payments, or similar charges) is limited to the HSA amount in effect for the taxable year.

**Individual pay or play.** Almost all U.S. citizens and legal residents must purchase coverage that qualifies as a QHBP. Coverage can be purchased through the individual market; through a public program, such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE; or through an employer plan. Low-income employees will be eligible for tax credits and cost-sharing reductions. Individuals who fail to carry qualified insurance will pay a penalty, which is phased in: \$95 in 2014 and \$325 in 2015.

**Beginning in 2016**, the penalty will equal the greater

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of 2.5% of income that exceeds that year’s threshold amount necessary for filing a tax return (the 2010 threshold amounts are \$9,350 for single taxpayers and \$18,700 for marrieds filing jointly) or \$695 a year per adult in the household; the penalty for dependents under 18 is half. The maximum penalty per household is \$2,085.

**Employer pay or play.** Employers aren’t required to provide health benefits to their employees. However, employers with 50 or more full-time employees during the preceding calendar year that don’t offer insurance will pay a \$2,000 excise tax if *any* full-time employee obtains coverage through an exchange for a month for which a tax credit is paid or a cost-sharing reduction is allowed. The excise tax for any month equals the number of full-time employees over a 30-employee threshold during that month (regardless of how many employees receive a tax credit or a cost-sharing reduction), multiplied by 1/12 of \$2,000 (i.e., \$166.67).

Employers that provide *unaffordable coverage*, or that provide coverage that isn’t a QHBP, pay a \$250 monthly excise tax (i.e., \$3,000 a year) for each full-time employee who receives tax credits and

cost-sharing reductions for insurance purchased through an exchange. Coverage is unaffordable if employees are eligible for tax credits because their required contribution exceeds 9.5% of their income, or the plan’s share of the total allowed costs is less than 60% of the costs (i.e., a bronze plan). *Important:* For purposes of determining whether coverage is affordable, employees’ pre-tax contributions into cafeteria plans are treated as employee payments. The tax for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees receive a tax credit or a cost-sharing reduction) in excess of 30, multiplied by 1/12 of \$2,000. The \$3,000/\$2,000 will be adjusted, **beginning in 2015**. Employers can also be subject to the monthly \$250 excise tax if they don’t provide free-choice vouchers to qualified employees.

Employers with more than 200 employees that do offer health insurance must automatically enroll new full-time employees (i.e., employees working at least 30 hours a week) into the plan. Employees must receive adequate notice and an opportunity to opt out of their auto-enrolled coverage.

To accompany the individual and employer pay or play provisions, new annual information reporting requirements are imposed.

**Wellness plans.** Regulations to HIPAA set the rules for wellness programs. The health care reform law codifies the current regs and raises the maximum reward to 30% of employee-only coverage, or 30% of employee-plus-dependent coverage. The discount can rise to 50% if the Secretaries of Labor, Treasury, and HHS write new regs that deem the increase appropriate.

### WHAT’S EFFECTIVE IN 2018

The main revenue raiser, a 40% excise tax on “Cadillac” insured and self-insured health plans, becomes effective. Cadillac plans have an aggregate cost exceeding \$10,200 for single-only coverage and \$27,500 for family coverage. These amounts increase to \$11,850 and \$39,500 for retirees over the age of 55 who receive employer-sponsored health care, employees in high-risk professions, and employees who repair or install electrical or telecommunications lines. These amounts are subject to various adjustments prior to 2018. **Beginning in 2019**, these amounts will be inflation-adjusted. ❖