



Health Care Reform News

Health Care Reform — Implications on self-funding

April 20, 2010 — With the signing of the Patient Protection and Affordable Care Act on March 23, 2010, and the Health Care and Education Reconciliation Act on March 30, 2010 (Health Care Reform Law), employers face major changes to health care financing. The Health Care Reform Law will have significant implications for self-insured group health plans over the years to come.

Some changes and requirements will take effect in the near term and others will not take effect for several years. Many points remain undefined, and regulations need to be issued and interpreted. Final regulations interpreting all of the laws' provisions will likely take years to complete.

AmeriHealth Administrators is following these interpretations and clarifications to the Health Care Reform Law closely to understand the impact to our customers. We work to ensure that we are ready to administer the changes and requirements that the reforms will impose on your plan. While the legislation makes significant changes to the health care system, our commitment to providing value and service to our customers does not change.

This message includes certain information that is available now:

- [Main Features of Health Care Reform](#)
- [Other potential effects on plan sponsors](#)
- [Exceptions for grandfathered plans](#)
- [Additional changes that will affect plans and individuals](#)

Main Features of Health Care Reform

Plan sponsors should consult their tax and employee benefits counsel for the interpretation of the Health Care Reform Law and future regulations. Here are some of the main features of health care reform that affect current self-funded plans:

- **Individual mandate**

The Health Care Reform Law requires most U.S. citizens and legal immigrants to maintain health coverage starting in 2014 or pay a tax penalty if they do not comply. The individual penalty will be the higher of: \$95 or 1% of income in 2014; \$325 or 2% of income in 2015; and \$695 or 2.5% of income in 2016.
- **State-based Exchanges**

Insurance Exchanges at the state level will be created in 2014. These Exchanges will provide coverage to individuals and to employers of up to 100 employees.

Subsidies for low income families

Low-income families can receive tax credits and subsidies for their coverage. Families with incomes between 100% and 400% of the federal poverty level (up to \$88,200 per year for a family of 4) may qualify for premium assistance in the form of a tax credit if they buy insurance through an insurance Exchange.

- **Employer mandate**
The Health Care Reform Law requires employers with 50 or more full-time employees to offer “minimum essential coverage” to full-time employees and their dependents or pay a tax of \$2000 per employee, provided that at least one full-time employee receives a tax credit or subsidy (subtracting the first 30 full-time employees). It is likely that most employers of this size will pay the tax. Even if employers offer “minimum essential coverage” they can still face penalties. For example, if an employee’s share of an employer plan exceeds 9.8 % of the employee’s household income, and the employee takes coverage under an Exchange (with a tax credit), the employer would have to pay a penalty of \$3,000 per full-time employee receiving the tax credit.
- **Grandfathered plans** — A number of requirements for employer-based plans will not apply to existing or “grandfathered” plans. (See [Exceptions for Grandfathered Plans](#) below.) Caution should be used in changing any plan feature or benefit if a customer wants to preserve the grandfathered option.
- **Financing of the bill will affect self-funded plans:**
 - The bill eliminates the **Medicare Part D subsidy** now available to employers who provide retiree prescription coverage. Although the subsidy doesn’t end until after 2012, accounting rules may require plan sponsors to reflect the loss of this deduction immediately.
 - The bill **caps contributions to Medical Flexible Spending Accounts** at \$2500 per year. The regulations may exclude dental and vision services from this limit.
 - **Beginning October 1, 2012, self-funded plans are subject to a new tax** per employee, based on the average number of employees covered during the plan year. During the first year, the tax is \$1 per employee for the year. After the first year, the fee will be increased to \$2 per employee.
 - **New taxes on pharmaceutical companies and medical devices** will likely affect the prices of drugs and medical devices.

OTHER EFFECTS ON SELF-INSURED HEALTH BENEFITS PLANS AND EMPLOYERS

The Health Care Reform Law will require that your self-insured plan include the following:

- **Uniform “Summary of Benefits”** — The summaries must contain examples and be no longer than four pages.
- **Notice of material modifications** — If a plan makes any “material modifications” to the terms of the plan or coverage and the most recent summary of benefits does not include that change, the plan must notify members no later than *60 days before* the date on which the change will take effect.
- **Automatic enrollment** — Employers with more than 200 employees that offer one or more health benefit plans must enroll eligible employees automatically. Employees may opt-out of coverage.
- **Notice of Exchange and Notice of Voucher options** — Once State Insurance Exchanges are established, the law will require certain plans to send notices about Exchanges to employees as well as notices of a limited “opt out” feature (Voucher).
- **Lifetime limits** — Group health plans are prohibited from placing lifetime limits on most benefits. Prior to 2014, plans may only impose annual limits on coverage as determined by the regulators. Plans must remove annual limits in 2014.
- **Pre-existing exclusions for children** — Plans may not impose pre-existing condition exclusions on children for plan years that begin six months or more after the date of enactment. Beginning in 2014 for plan years starting after 12/31/13 plans may not impose pre-existing condition exclusions on *any* plan participants.

- **Coverage for adult children** — For plan years starting 6 months after enactment, plans must make coverage available to certain adult children up to age 26.

EXCEPTIONS FOR GRANDFATHERED PLANS

Under Health Care Reform, it appears that grandfathered plans are exempt from the following requirements:

- Extensive preventive care requirements, which require 100% payment of services by the plan;
- Limits on cost-sharing by plan participants;
- Appeal process, including a requirement for external reviews;
- Minimum requirements for coverage that meets the mandate for individual responsibility. (A grandfathered plan is considered to have met the minimum coverage requirements.)

ADDITIONAL CHANGES TO THE INTERNAL REVENUE CODE AND ERISA THAT WILL AFFECT PLANS AND INDIVIDUALS

The following changes will also affect group health plans and some individuals:

1. High-income individuals will be subject to additional tax.
The employee FICA rate will increase by 0.9% from the current 1.45% for incomes over certain limits.
2. Cafeteria plans must consider the premium payments to an insurance Exchange as a Qualified Benefit.
3. An excise tax on high-cost employer plans will start in 2018.
4. The limit on *non-medical* Health Savings Account distributions will increase.
5. Costs for over-the-counter drugs cannot be reimbursed from Health Reimbursement Accounts and Flexible Spending Accounts.
6. Employers must include the value of health benefits on W-2s starting in 2012.
7. Plan sponsors can discount premiums for members enrolled in a corporate wellness program.

This communication is not intended to provide either legal or tax advice. Please consult with your legal counsel or professional advisors to determine the effects of the statutes and regulations regarding health care reform on you and your plan members.