September 22, 2010

Five Myths & Misconceptions of Health Care Reform

September 23, 2010 is an important date in the context of the Patient Protection and Affordable Care Act (PPACA) of 2010. It is 6 months after the passage of the legislation and a company's first medical plan renewal following this date has been the target for much of the implementation of the various provisions of the PPACA.

With the passage of this important date and the prospect of having to understand and be in compliance with the PPACA, Bearence Management Group worked with Susan Freed, Shareholder, Davis Brown Law Firm, to put together a listing of the most common misconceptions encountered with business owners regarding how the legislation affects their benefits offerings.

Myth #1: If my plan is grandfathered it doesn't have to comply with the health care reform provisions.

A common misconception among employers is that if their group health plan is "grandfathered" they do not have to comply with any of the health care reform provisions in the Patient Protection & Affordable Care Act ("Affordable Care Act"). While grandfathered plans are exempt from some of the Affordable Care Act's provisions, they must still comply with several other reform provisions.

A grandfathered plan is exempt from the following provisions:

- Coverage of recommended preventative care services at 100%;
- Internal and external appeals procedures;
- Extension of § 105(h) rules regarding non-discrimination to fully-insured health plans;
- Patient protections regarding provider choice, emergency services, and coverage of covered services for participants participating in clinical cancer trials; and
- Coverage of "essential health benefits" and annual cost-sharing limitations on essential health benefits.

In addition, until 2014 a grandfathered plan may deny coverage to a dependent who is under age 26 if he/she has access to other employer-sponsored coverage.

A grandfathered plan must still comply with the following Affordable Care Act provisions:

- Prohibition on pre-existing condition exclusions;
- Prohibition on lifetime limits for essential health benefits;
- Limits and eventual prohibition on annual limits for essential health benefits;
- Extension of dependent coverage until age 26;
- Development and utilization of uniform coverage documents and standardized definitions;
- Prohibition on excessive waiting periods; and
- Auto-enrollment for large employers.

Myth #2: Grandfathered status applies to my group health plan as a whole and not to each benefit option offered through my group health plan.

Employer sponsored group health plans often offer at least two plan designs. For example, an employer might offer a traditional PPO option and a high deductible health plan option. **When determining whether your plan is grandfathered the federal government looks at each specific benefit option separately, not the plan as a whole**. This means that in the above example an employer can make changes to the high deductible health plan option and forfeit its grandfathered status but not make any changes to the traditional PPO plan and preserve the PPO plan's grandfathered status.

Myth # 3: If my insurance carrier forces me to change my plan design or benefit option it won't jeopardize my grandfathered status.

It's not uncommon for insurance carriers to change the plan designs they offer to employers. For example, a carrier may eliminate a benefit option or change co-insurance or deductible amounts. **If an employer is forced to change its plan design because of changes imposed by an insurance carrier, it still risks losing its grandfathered status.** Under the Interim Final Rules regarding grandfathered plans, a plan that makes certain "significant changes" to its plan designs will lose its grandfathered status, even if the plan design change is forced upon the employer by its insurance carrier.

"Significant changes" to plan designs that result in a loss of grandfathered status include:

- Eliminating all or substantially all benefits to diagnose or treat particular conditions.
- Making any increase (measured from 3/23/10) to a percentage cost-sharing requirement such as co-insurance. For example, raising co-insurance from 20% to 30%.
- Increasing a fixed-amount cost-sharing requirement other than a co-payment, such as a deductible or out of pocket maximum, by more than a "maximum percentage increase" which is defined by the regulations as medical inflation* plus 15 percentage points.
- Increasing a fixed amount co-payment by more than the greater of (a) the "maximum percentage increase" or (b) $5.00 times medical inflation plus $5.00.
- Adding an annual limit that is lower than the lifetime limit in place as of March 23, 2010, adding an annual limit if you have no annual or lifetime limits currently in place, or lowering the amount of an existing annual limit in place on March 23, 2010.

If an insurance carrier forces any of the above plan design changes, that benefit option will lose its grandfathered status. Other changes that will cause a loss of the plan's grandfathered status include changing carriers and decreasing employer contributions by more than 5%; however, these changes are generally within the employer's control.

Myth # 4: You will now pay taxes on your health insurance.

Over the past several months emails have been circulating alleging that amounts contributed by employers to employee health insurance premiums are now taxable. This is false. **There has been no change to the tax treatment of employee health insurance premiums**. Employees may continue to pre-tax their portion of their health insurance premiums and employer contributions to those premiums are not subject to income taxes. What will happen in 2011, however, is that employers will be required to report the cost and value of the health insurance provided to the employee on the W-2 issued to the employee for 2011. This is being required so that the IRS has a means of tracking the cost and value of

the health insurance provided to employees and not so it can tax these amounts. Employers should be alert for future guidance on the W-2 reporting requirements.

Myth # 5: Required changes to my health flexible spending account will not take effect until the start of my next plan year.

Many of the Affordable Care Act's provisions do not take effect until the beginning of the group health plan's next plan year. This is not true, however, for the changes applicable to health flexible spending accounts.

Effective January 1, 2011, regardless of the plan year, health flexible spending accounts can no longer reimburse over-the-counter drugs unless the participant has a prescription for the OTC that indicates it is being prescribed to treat a specified medical condition. The effective date of this provision is not tied to the plan year but is January 1, 2011 regardless of the plan year. This means that an employer who has a health flexible spending account with a plan year that does not begin on January 1 will need to implement this provision mid-year. Employers who have a plan year that begins January 1 but with a grace period can not reimburse employees out of 2010 funds for OTCs purchased on or after January 1 but during the grace period.

This is also the case for the cap on health flexible spending account contributions that goes into effect on January 1, 2013. Effective January 1, 2013 employees can not contribute more than $2,500 to their health flexible spending account. An employer with a plan year that does not begin on January 1 will need to revise its plan in 2012, prior to the beginning of its 2012 plan year. For example, an employer whose plan year is July 1 through June 30 will need to revise its plan to provide for the $2,500 contribution limit before July 1, 2012.

Our firm will continue to provide you updates and guidance as regulations are developed surrounding the PPACA. Different insurance carriers are treating some of these provisions differently--your Bearence Risk Consultant will be able to help you navigate your way and help you make the best choices for you and your employees.

*Areas that refer to "medical inflation" reflect a formula referenced in the PPACA legislation that involves the medical component of CPI. Your Bearence Risk Consultant has access to information to help you with this calculation.