



January 2021 Update
Review of Health Care Reform Legislation
for the

Patient Protection and Affordable Care Act (HR 3590)

Enacted March 23, 2010

This review has been prepared for the AIA Trust as an aid to AIA Members in understanding the requirements and impact of the 2010 health care reform legislation. The health care reform law is complex and extensive guidance has been issued on many of the provisions; this review is by necessity a general summary of some, but not all, of the legislative and regulatory requirements and is provided for informational purposes only. AIA Members should consult an attorney with specific legal questions.

The Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”) reforms the health insurance market in many ways. Some of the insurance reforms apply to all group health plans; some reforms apply only to non-grandfathered plans (see below).

Grandfathered Plans. Generally, group health plans (including employer-sponsored employee welfare benefit plans) and health insurance coverage in effect as of March 23, 2010 do not have to comply with many ACA requirements, as long as they remain grandfathered, including provisions that mandate:

- Immunizations and preventive health care without any employee cost sharing.
- New procedures for internal appeals and external review of claims.
- Coverage for emergency services without prior authorization at “in-network” levels.
- Coverage of “essential health benefits” (with respect to insured coverage in the small group market; self-insured plans and insured plans in the large group market are not subject to this requirement).
- Coverage for certain clinical trial related costs.
- Transparency in coverage reporting requirements and quality of care reporting requirements.
- Cost-sharing limits.

However, in general, plans lose their “Grandfathered” status if:

- Benefits are completely or substantially eliminated.
- There is any increase in percentage cost-sharing, such as co-insurance.
- There are certain increases in fixed amount of cost-sharing, such as co-payments, deductibles, and out-of-pocket limits.
- There is a decrease in the employer contribution rate of more than 5%.
- The addition of or increases and/or decreases to annual limits.

In certain situations, changes to plan eligibility that allows employees to transfer to the plan from another plan can also result in the loss of Grandfathered status.

Caution: The precise actions that will cause a loss of grandfathered status are explained in detail in regulations. If you as the plan sponsor or if the insurer makes any of the changes to the plan listed above, or you as the employer reduce your contributions below the permissible limit, the plan will lose its grandfathered status. If the plan loses grandfathered status, it will then need to comply with all of the ACA requirements that apply to non-grandfathered plans.

The following requirements apply to all plans, including those that are grandfathered. Additional requirements will apply to all plans in 2014; those requirements are described briefly later in this summary.

Annual and Lifetime Dollar Limits. Many health plans had caps on annual and/or lifetime benefit payments. **For plan years beginning on or after 9/23/2010** all plans must remove lifetime dollar limits on “essential health benefits.” Annual dollar limits on “essential health benefits” were phased out over a three-year period and were completely eliminated for plan years starting on or after Jan. 1, 2014. (Grandfathered individual policies may keep the annual dollar limits that were in effect as of March 23, 2010.)

The ban on annual and lifetime dollar limits applies only to the cost of what the law calls “Essential Health Benefits” (EHBs). The law provides general categories these benefits, and the scope of these categories is supposed to be defined in regulations to be issued by the U. S. Department of Health and Human Services (HHS).

“Essential Health Benefits” (EHBs) categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

For 2014-15, HHS directed each state to identify a “benchmark” plan, which defines the essential health benefits for insured individual and small group market coverage in that state. HHS has not yet defined the essential health benefits for self-funded and large group plans, but HHS, the Department of Labor and the Department of Treasury have said that “the Departments ... will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB ... if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories).”

Coverage for Dependent Children, Pre-Existing Condition Limitations. All plans that provide dependent coverage must cover dependent children up to age 26, without any additional condition (such as student status or financial dependency). Guidance has been issued on what “children” must be covered under this requirement. In addition, for plan years beginning on or after 9/23/10, plans were no longer able to impose pre-existing conditions limitations on children under age 19, and for plan years beginning on or after 1/ 1/14, all pre-existing exclusions must be removed, regardless of age.

Protection from Rate Increases. Insurance carriers in the individual and small group markets will be required to provide justification of and publicly disclose any rate increases that equal 10% or more. Carriers in the individual and large and small group markets may be required to provide a rebate to plan participants if they fail to meet required medical loss ratios.

Protection from Policy Rescission. For plan years beginning on or after 9/23/2010, group health plans and insurance carriers will not be permitted to rescind coverage unless there is evidence of fraud or intentional misrepresentation of material fact. A rescission is defined as a cancellation or discontinuance of coverage that has retroactive effect, except that a group health plan or insurance carrier may retroactively cancel coverage for failure to timely pay premiums. Prospective cancellation is generally not prohibited by this provision, but state laws may differ.

Coverage for Preventive Care. All plans, **except grandfathered plans**, must provide certain preventive services, such as immunizations and screenings in-network with no employee cost sharing requirement. Go to HealthCare.gov for a complete list of preventive services included.

New Internal Appeals and External Review Processes. All plans, **except grandfathered plans**, must comply with new internal appeals procedures and must comply with new external review of appeals requirements.

Physician Choice. All plans that require the selection of a primary care physician, **except grandfathered plans**, must allow plan enrollees to select any available participating primary care provider (including a pediatrician in the case of a child). Plans may not impose preauthorization or referral requirements for obstetrical or gynecological care.

Emergency Care. All plans, except grandfathered plans, that provide emergency coverage must do so without requiring preauthorization and cannot impose more restrictive administrative requirements or limits on out-of-network emergency services. Detailed cost-sharing requirements for out-of-network emergency services also apply.

Non-discrimination An insured plan, **except grandfathered plans**, may be subject to penalties if it discriminates in favor of highly compensated individuals. Additional guidance on this requirement is expected, and the agencies have said that they will not enforce this provision until that guidance is issued.

Quality of Care Reporting. All plans, **except grandfathered plans**, must report to HHS on plan benefits and reimbursement structures that provide incentives for disease management and care coordination and the implementation of wellness and health promotion activities. The Departments have not yet issued guidance for group health plans on compliance with this requirement.

Essential Health Benefit Requirements. Effective in 2014, plans, except grandfathered plans, plans in the large group market, and self-insured plans, *must cover all of the “essential health benefits” listed above.*

Waiting Periods. Waiting periods for all plans, including grandfathered plans, cannot exceed 90 days.

Maximum Out-of-Pocket Limits. The maximum out-of-pocket limit for plans, **except grandfathered plans**, cannot exceed certain amounts. For 2021, the limits are \$8,550 for individual coverage and \$17,100 for family coverage.

The ACA also introduces many other changes to employee health benefits, beyond the changes to insurance coverage or the plan. For these changes, grandfathered (or non-grandfathered) status is not relevant.

Over The Counter Drugs. Reimbursement from a health FSA, HRA or HSA is no longer permitted for over the counter drugs unless the drug is insulin or is prescribed by a physician.

W-2 Reporting Requirements. Beginning with the 2012 tax year, employers must report the aggregate cost of certain employer-provided health coverage on the employee's W-2 (e.g., the 2012 W-2 issued in 2013). This is only a reporting requirement and does not mean that the amount reported will be taxed. Small employers (those that had to file fewer than 250 Forms W-2 for the prior calendar year) are exempt from the reporting requirement, unless and until the IRS issues further guidance.

Wellness Plan Grants. Effective 1/1/14, employers with less than 100 employees who did not have a wellness program in place when the ACA was passed in March 2010 are eligible for grants to establish new workplace wellness programs. Guidance implementing the wellness plan grants has not yet been issued.

Standard Benefit Summary. All plans are required to provide a standardized summary of benefits, called a Summary of Benefits and Coverage (SBC), to participants and beneficiaries at the time of initial and open enrollment. Additionally, a notice of material modifications must be provided for certain plan design changes that are "material modifications" to all enrollees no later than 60 days prior to the effective date of the changes.

The SBC must include 12 elements:

1. Glossary of terms, also known as the "Uniform Glossary."
2. Description of the coverage.
3. Exceptions, reductions and limitations of the coverage.
4. Cost-sharing provisions, including deductible, co-insurance and co-payments.
5. Renewability and continuation of coverage provisions.
6. Coverage examples as defined in the final rule.
7. For coverage beginning on or after 1/1/14, a statement about whether the plan or coverage provides minimum essential coverage and meets minimum value requirements.
8. A statement indicating the SBC is only a summary and the plan should be consulted to determine the governing contractual provisions.
9. Contact information for questions and obtaining a copy of the plan document, insurance policy, group certificate of coverage, and the website where materials are available.
10. Contact information for obtaining a list of network providers.
11. Contact information for obtaining information on prescription drug coverage.
12. Contact information for obtaining a glossary of terms.

Health Insurance Exchanges. Most employers need to provide employees a notice of coverage options that are available through the Health Insurance Exchanges and some of the consequences if an employee decides to purchase coverage through the Exchange in lieu of employer-sponsored coverage.

Effective for coverage beginning in 2014, each state was asked to create its own Health Insurance Exchange (or the federal government would establish and run an Exchange in that state). Exchanges offer "qualified health plans," which are health plans offered by health insurance carriers that meet certain minimum requirements and receive a certification from the Exchange. The Exchanges offer

consumers a choice of policies and carriers that are all subject to minimum common requirements. Effective in 2014, employers in the small group market (those with 100 or less employees) could begin to offer their employees coverage through the SHOP Exchange. For 2014 and 2015, however, States may set the size of the small group market at 50 or fewer employees. In 2016, all states must allow employers with up to 100 employees to offer coverage through the SHOP Exchange. **Effective in 2017**, states may permit employers with more than 100 employees to purchase large group coverage through the SHOP Exchange

Health FSA Limit. For plan years beginning in 2021, the limit on health FSA pre-tax salary reduction elections is \$2,750. Prior to that date, there were no required statutory limits, though most employers capped the maximum somewhere below \$5,000.

Medicare Part A Tax Increase. **Effective in 2013**, the employee's portion of the Medicare tax was increased from 1.45% to 2.35% on wages, compensation, or self-employment income over \$200,000 (\$250,000 if married and filing jointly and \$125,000 if married and filing separately). An employer is required to withhold this additional Medicare tax from its' employees' wages. Also, beginning in 2013, a new 3.8% New Income Investment Tax will apply on unearned income (capital gains, dividends, interest, etc.) for individuals with modified adjusted gross income generally over \$200,000 for individuals, over \$250,000 for married couples filing jointly, and \$125,000 for married couples filing separately.

Individual Mandate. The federal individual mandate itself remains unchanged but starting in 2019 there is no longer be a penalty for people who don't comply with it. However, some states such as Massachusetts and New Jersey have an individual mandate with a penalty. While the individual penalty may no longer apply, the risks for not having health insurance can be extreme. You may be young and healthy, but an accident or unexpected illness could leave you with huge medical debt and ruin your financial future.

Individuals with household income between certain levels may be eligible for federal premium tax credits and cost-sharing subsidies for coverage they purchase through the Exchange (discussed below). Also, Medicaid eligibility was expanded in certain states.

Federal Premium Tax Credits. The American Rescue Plan was signed into law on March 11, 2021 and it includes an adjustment to the Affordable Care Act (ACA) premium tax credits for 2021 and 2022. There is no upper income limit on premium tax credits so that individuals who purchase their own coverage can access the premium tax credits if their premiums exceed 8.5% of their overall household income.

The Kaiser Family Foundation provides a useful subsidy calculator including FAQs regarding the subsidies: <https://www.kff.org/interactive/subsidy-calculator/>

Employer Mandate. The Affordable Care Act added the employer shared responsibility provisions under section 4980H of the Internal Revenue Code. The links listed on the following IRS webpage provide answers to frequently asked questions about the employer shared responsibility provisions: <https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act>

In addition, more detailed information is available on the [IRS Employer Shared Responsibility page](#) and in [final regulations under section 4980H](#).

Reporting. Beginning in early 2016 to report 2015 information, employers subject to the employer mandate and entities that provide minimum essential coverage, such as employers with self-insured plans and insurance carriers, must report certain information annually to the IRS, full-time employees, and individuals covered under the plan (employer for self-insured plan and carrier for insured plan). This information will help the IRS administer the employer mandate, individual mandate, and premium tax credit.

Cadillac Plans. The Cadillac Tax has been permanently repealed as of December 20, 2019.

Summary

The recent health care reform law is complex and extensive guidance is needed. The ACA reforms the health insurance market and employer-provided coverage in many ways. Some insurance reforms apply to some plans and not to others. It is important for employers to stay abreast of new requirements as regulations are issued and provisions are interpreted.

Some of the positive changes that will result from the legislation include:

- Children can generally be covered by their parents' coverage up to age 26
- Pre-existing conditions limitations are eliminated
- Insurance carriers cannot arbitrarily retroactively cancel coverage due to high claims
- Preventive care will be included in most plans with no cost-sharing.
- Annual & lifetime maximum dollar limits on essential health benefits are eliminated.

In addition, there are numerous changes that many may see as negative, both for employers as well as other health plan participants:

- Substantial cost impact on small/medium employers
- Benefit mandates will increase plan costs
- Employers may opt to drop coverage, pay penalties/fines & employees will then have to buy their own coverage or potentially be subject to individual mandate penalties

The U.S. Department of Health and Human Services (HHS), the Department of the Treasury, and the Department of Labor have been and will continue to provide regulations and interpretations of the legislation. The AIA Trust will publish updates as possible in conjunction with important regulations being issued. AIA Members should consult an attorney with specific legal questions.