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Health Care Reform: General Questions & Answers for Employers

I've heard about a number of different health care proposals over the last year. Which one did Congress pass?

The new health care reform law is a combination of two bills:

- The Patient Protection and Affordable Care Act (H.R. 3590), which was signed into law on March 23, 2010; and
- The Health Care and Education Reconciliation Act of 2010 (H.R. 4872), which was signed into law on March 30, 2010.

Does health care reform allow people to keep their current health coverage?

Yes. Nothing in the new law requires individuals to terminate coverage that they had on the date the law was passed. However, due to new coverage requirements, the coverage provided under an individual's plan may change in the future.

Am I required by law to offer health coverage to my employees?

The health care reform law does not technically require companies to offer health coverage to their employees. However, beginning in 2014, large companies that do not offer a minimum level of coverage will be subject to penalties if any of their employees receive government subsidies for health coverage through an exchange. Also, large companies will be subject to penalties if they do offer the minimum level of coverage and any employee still receives subsidized coverage through the exchange. These penalties will not apply to small employers that have fewer than 50 full-time equivalent employees on business days in the prior calendar year.

What are the penalty amounts for large employers that don't offer coverage?

Large employers that do not offer coverage will be subject to an annual penalty of $2,000 per full-time employee, excluding the first 30 employees, if any of their full-time employees receive subsidized coverage through an exchange.

What are the penalty amounts for large employers that offer coverage and have employees who receive subsidized coverage through an exchange?

These employers are subject to a penalty of $3,000 for each full-time employee that receives subsidized coverage through an exchange. The maximum penalty is the amount equal to $2,000 times the number of full-time employees, excluding the first 30 employees.

What is a "grandfathered plan"?

A grandfathered plan is a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the health care reform legislation (March 23, 2010). Some of the health care reform provisions affecting health plans do not apply to grandfathered plans. A plan can still be a grandfathered plan if it allows new employees, or family members of current employees, to enroll after the date of enactment.

How does health care reform affect grandfathered plans?

Grandfathered plans are exempt from certain insurance market reforms and coverage mandates included in the health care reform legislation and have delayed compliance dates for other provisions. The excepted provisions are found in Subtitles A and C of the Patient Protection and Affordable Care Act (PPACA).

Specifically, grandfathered plans are not required to: provide first dollar coverage of preventive care; permit selection of any available participating primary care provider; comply with limits on preauthorization requirements out-of-pocket expenses or cost-sharing; satisfy nondiscrimination rules for fully-insured plans, establish a new appeals process; or meet guaranteed issue or renewal of coverage mandates.

However, some of the health insurance industry reforms apply to grandfathered plans as well as new plans. These reforms include prohibitions on lifetime and annual limits, pre-existing condition exclusions, rescissions of coverage and excessive waiting periods. Grandfathered plans must also comply with the rules regarding coverage of adult children up to age 26 and provision of a summary of benefits and coverage. Also, grandfathered plans are not exempt from the reforms found in other parts of the statute, such as requirement to include the value of coverage on each employee's Form W-2 (effective for most employers in 2012, optional for 2011), the large-employer mandate to offer affordable coverage to full-time employees (effective Jan. 1, 2014), the high-cost health plan excise tax (effective Jan. 1, 2018) and the mandatory automatic enrollment requirement (effective once regulations are issued).

Can a grandfathered plan be amended without losing the grandfathered status?

Plan sponsors can make certain changes to grandfathered plans and maintain their grandfathered status. However, plans will lose their grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.

Specifically, making the following changes would cause a plan to lose its grandfathered status:

- Significantly cutting or reducing benefits;
- Raising co-insurance charges;
- Significantly raising co-payment or deductibles;
- Significantly reducing employer contributions; or
- Adding or reducing an annual limit.

The grandfathered plan rules initially provided that changing insurance companies or policies would cause a health plan to lose grandfathered plan status. However, on Nov. 15, 2010, an amended rule was released stating that a group health plan will not lose grandfathered status merely because of a change in the plan's insurance policy, certificate or contract of insurance, as long as the coverage under the new policy is effective on or after Nov. 15, 2010. Also, to maintain grandfathered status, the plan must provide documentation of the prior plan's terms to the new issuer.

What is the small business tax credit and how do I know if I am eligible?

Beginning with the 2010 tax year, tax credits are available to qualifying small businesses that offer health insurance to their employees. Your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below $50,000 and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. For tax years beginning in 2010 through 2013, the maximum credit is 35 percent of the employer's premium expenses that count toward the credit. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

What is a health insurance exchange?

Beginning in 2014, states must establish health benefits exchanges. Individuals and small businesses will be able to purchase health insurance through the exchanges. The intent of the health insurance exchanges is to provide increased purchasing power by pooling a number of insurance buyers together. Beginning in 2017, states may allow employers of any size to purchase coverage through the exchange.

Does the new law affect dependent care flex accounts and health flexible spending accounts?

Prior to the passage of the health care reform legislation, dependent care flex accounts are capped at $5,000 annually, and health flexible spending accounts (health FSAs) have no cap (although many employers implement their own caps, typically at the $5,000-$6,000 level or less). The new health care reform law does nothing to change the limits on dependent care accounts, which remain capped at $5,000. However, the law does reduce the annual cap on health FSAs to $2,500. This change is effective on Jan. 1, 2013.