Health & Disability Plans, Explanation, ¶5920.16.A. Overview

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TPS 5920.16.A.

The Patient Protection and Affordable Care Act (PPACA), 816 enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), 817 enacted March 30, 2010, ushered in a series of changes to the rules for obtaining and providing health care. The laws, as amended, are commonly referred to as the Affordable Care Act (or "ACA"). These rules are administered by the Departments of Treasury (and the IRS), Labor (DOL) and Health and Human Services (HHS), jointly or separately, as appropriate. 818

816 Pub. L. No. 111-148.

817 Pub. L. No. 111-152.

Note however that White House Executive Order 13765 dated January 20, 2017, directs governmental departments and agencies with authority and responsibility under the Affordable Care Act to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [ACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products or medications." These directives are to be carried out "[t]o the maximum extent permitted by law," indicating that compliance with ACA is required until other regulations or guidance is issued. Also, White House Executive Order 13813 dated October 12, 2017, directs the IRS, DOL, and HHS to consider proposing regulations and revising guidance to: expand small businesses' access to association health plans (AHPs) (see ¶5920.11.C.4.); make available short-term, limited-duration insurance that lasts longer than three months and is renewable (see ¶5920.11.B.21.); and increase the

availability of health reimbursement arrangements (HRAs) to workers and allow their use with nongroup coverage (see ¶5920.09.D.3.). In addition, White House Executive Order 13877, dated June 24, 2019, contains several directives, including but not limited to, that: (1) the IRS, DOL, and HHS to solicit comment on a proposal to require providers, issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs before patients receive care; (2) the IRS issue guidance to expand patients' ability to select high-deductible health plans that can be used alongside an HSA, and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions (see ¶5920.08.C.2.b.); (3) the Treasury propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses; and (4) the Treasury issue guidance to increase the amount of FSA carryover funds.

(1) Individuals — TPS 5920.16.A.1.

U.S. citizens and legal residents, unless exempted, must maintain minimum essential health care coverage or face penalties (which are reduced to zero for months beginning after 2018). Individuals may qualify for a health care premium tax credit or cost-sharing reductions to assist them in paying for coverage. 819

819 These requirements took effect starting in 2014. The 2017 tax act (Pub. L. No. 115-97) reduced to penalty amount to zero after 2018, as discussed in ¶5920.16.B.1. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §10108, would have allowed qualifying low-income employees whose employer offers a free choice voucher to obtain health care coverage on their own using funds from the voucher, and would have provided tax benefits to employers offering the vouchers. Pub. L. No. 112-10, §1858, removed the voucher provisions of Pub. L. No. 111-148, §10108.

Group health plans generally are prohibited from imposing any preexisting condition exclusions on individuals. 820

820 This requirement also took effect starting in 2014. From 2010 through 2013, eligible individuals with a preexisting condition may have been able to obtain coverage under a temporary high risk health insurance pool program to provide health insurance coverage that does not impose any preexisting condition exclusion.

(2) Employers — TPS 5920.16.A.2.

Employers are not required to offer health care coverage to their employees. However, as of 2015, 821 large employers—with 50 or more full-time-equivalent employees in the prior year—who do not offer health care coverage, or who offer coverage that does not meet minimum standards or is unaffordable to their employees, generally are subject to excise taxes (sometimes referred to as “play or pay” penalties) if any of their full-time employees obtain subsidized health insurance coverage through an Exchange.

821 Notice 2013-45 (transition relief provided for one year).

Also, large employers must report information about the health coverage that they offer, and all employers must report information about the health coverage that they provide.

Businesses with fewer than 25 employees may be eligible for tax credits to assist them in setting up or maintaining health plans. Small businesses also may offer plans to their employees through state health exchanges.

In addition, beginning in 2022, employers with self-insured plans and health insurance issuers that offer coverage beyond the required coverage (sometimes called "Cadillac" plan coverage) may have to pay an excise tax.

(3) Group Health Plans and Health Insurance Issuers — TPS 5920.16.A.3.

Group health plans and health insurance issuers are faced with a variety of plan design and reporting and disclosure changes under the 2010 health care reform legislation. For example, for plan years beginning on or after September 23, 2010, insured group health plans cannot discriminate in favor of highly compensated individuals; plans that offer dependent child coverage must extend the coverage to children under the age of 26; plans cannot impose lifetime or annual limits (with restricted limits allowed during a phase-in period) or rescind coverage; plans must cover preventive health services; plans cannot contain preexisting condition exclusions for enrollees under age 19; and plans must develop and use uniform explanation of coverage documents and standardized definitions. See ¶5920.11.B., above.

Among the many requirements imposed for plan years beginning in and after 2014, plans cannot contain preexisting condition exclusions for adult enrollees or otherwise discriminate against any enrollees based on health status; and plans cannot impose excessive waiting periods. Health plans and health insurance coverage in existence on March 23, 2010, must comply with many new requirements, but are excluded from some requirements to the extent they retain "grandfathered" status. See ¶5920.11.B., above, for discussion of these plan requirements. See ¶5920.16.D.4., below, for discussion of the criteria a plan must satisfy to have grandfathered status.

Some requirements that apply to health plan insurers, but not funded group health plans, also apply to self-funded group health plans. Examples include the requirement to provide a summary of benefits and coverage explanation (see ¶5910.03.D.6.) and the payment of health insurance fees based on the average number of lives covered for each plan year ending after September 30, 2012, through plan years ending after September 30, 2019. 822

822 §4375, added by Pub. L. No. 111-148, §6301(e)(2) (health insurance issuers), discussed at ¶5920.16.E.3, below; §4376, added by Pub. L. No. 111-148, §6301(e)(2) (self-insured plans), discussed at ¶5920.16.D.5., below.

(4) Public Health Insurance Exchanges (Health Insurance Marketplaces) — TPS 5920.16.A.4.

Each state can elect to establish an American Health Benefit Exchange (health exchange) — a governmental agency or nonprofit entity established to offer qualified health plans to qualified individuals and to provide for the establishment of a Small Business Health Options Program (SHOP

Exchange) to assist qualified employers in enrolling their employees in qualified health plans offered in the small group market. 823 If a state does not set up a health exchange, the Secretary of HHS must establish and operate a health exchange within the state to offer qualified health plans. 824 This may be set up as a federally-facilitated exchange (with minimal state involvement) or a state partnership exchange. See ¶5920.11.B.19.b. Most exchanges fall within these last two categories.

823 Pub. L. No. 111-148, §1311(b) and 1311(d), as amended by Pub. L. No. 111-148, §10104(e). See ¶5920.16.C.6. Exchanges under the Affordable Care Act first became available in 2014.

824 Pub. L. No. 111-148, §1321(c); Pub. L. No. 111-148, §1322, as amended by Pub. L. No. 111-148, §10104(l).