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Healthcare Reform: What You Need to Do Now and in the Future

This alert summarizes the major provisions of the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act of 2010 (together with the PPACA, the "Act") that will impact employers and their group health plans ("GHPs"). The Act, among other changes, increases health insurance coverage through shared responsibility by placing responsibilities on individuals to maintain coverage or pay a tax penalty, and on employers to offer coverage or pay a tax penalty. Employers who fail to offer coverage will pay one penalty, and those that have employees who fail to take the coverage offered and instead seek subsidized coverage through the new purchasing "Exchanges" will pay a different reduced penalty. Individual coverage is also made available through insurance reforms and the creation of the Exchanges.

The impact of the Act on an employer's health plan depends, in part, on whether an employer has a "grandfathered" GHP. A GHP is "grandfathered" if it had any participants on March 23, 2010, regardless of whether new employees enroll, individuals renew coverage, or participants enroll their dependents (if the GHP already provided dependent coverage) after March 23rd. A grandfathered health plan is treated as providing essential health benefits, which is the package of benefit coverage mandated to avoid the penalty taxes applicable to tax years ending after December 31, 2013. There is no guidance yet regarding what might cause a GHP to lose its grandfathered status or if there will be a limit on the duration of the grandfathered status.

Immediate Changes for Employers with Retiree Medical Coverage

- Reinsurance for Retiree Coverage. By June 21, 2010, the U.S. Department of Health and Human Services ("HHS") must establish a temporary reinsurance program to provide reimbursement to participating GHPs for a portion of the cost of providing health benefits to early retirees and their eligible dependents. Employers must submit an application to HHS in order to participate in the program. To obtain reimbursement, employers must determine and account for eligible expenses. This program will end on the earlier of the date the funds allocated in the Act are exhausted or January 1, 2014.
- Loss of Exemption from Prior Health Plan Mandates. The Act repeals the prior exemption from the HIPAA portability and nondiscrimination requirements and the Mental Health Parity requirements applicable to retiree medical plans with fewer than 2 active employees. The effective date of this repeal is unclear, but could be either the first plan year beginning on or after September 23, 2010, or March 23, 2010. We expect that this provision will be clarified in technical corrections.

Changes Effective for Plan Years Beginning on or after September 23, 2010

Grandfathered GHPs

- Lifetime and Annual Limits. GHPs may not establish lifetime or annual dollar limits on the benefits for any participant or beneficiary. However, (1) "restricted annual limits" (to be defined) on "essential health benefits" are permitted until January 1, 2014, and (2) per beneficiary lifetime and annual limits on specific covered benefits that are not "essential health benefits" are permitted without a time limit. Although "essential health benefits" is subject to further definition, it includes at least the following services:
 - ambulatory, emergency, mental health and substance use disorder, rehabilitative, laboratory, preventive, wellness, and pediatric services, hospitalization, maternity and newborn care, prescription drugs, and disease management.

- Rescission of Coverage. GHPs may not revoke coverage once an enrollee is covered, except in the event of fraud or intentional misrepresentation of material fact as prohibited by the terms of the GHP, nonpayment of premiums, or termination of the GHP.
- Dependent Coverage. If the GHP provides coverage to dependent children, the GHP must provide such coverage until the child is age 26 without regard to marital or student status. Prior to January 1, 2014, grandfathered GHPs only have to cover dependent children until age 26 if they are not eligible for other employer-sponsored coverage. The tax exclusion continues to age 27, therefore plans that provide coverage through the end of the month or year when the dependent attains age 26 will still have the tax exclusion for such coverage extension.
- Pre-Existing Condition Exclusions. GHPs may not impose pre-existing condition exclusions on enrollees under the age of 19.
- Summary of Benefits. No later than by March 23, 2012, GHPs must provide a “summary of benefits and coverage explanation” to applicants at the time of application, enrollees at the time of enrollment or reenrollment, and policy or certificate holders at the time of issuance of the policy or certification. Participants must be notified of material modifications to the GHP that are not reflected in the most recent summary of benefits or coverage explanation not later than 60 days *before* the effective date of the material modification. There is a fine of \$1,000 per enrollee for failure to provide the information required under this new provision. While the first summary of benefits and coverage explanation does not have to be provided until March 23, 2012, the requirement to notify participants of any material modifications to the GHP may be effective as soon as the first plan year beginning on or after September 23, 2010. We expect that the effective date of this provision will be clarified in technical corrections.
- Reporting. GHPs must report annually to both the HHS and enrollees regarding whether the benefits under the GHP satisfy certain requirements, such as effective case management. Additional reporting requirements will apply if a GHP seeks certification to have the GHP offered through an Exchange. These reporting requirements will be explained further in future guidance.

Non-Grandfathered GHPs

In addition to the provisions applicable to grandfathered GHPs:

- Preventive Care Coverage. GHPs must provide coverage (without cost-sharing requirements) for certain immunizations and other preventive care.
- Non-Discrimination. Fully-insured GHPs will be subject to the nondiscrimination requirements of Section 105(h)(2) of the Internal Revenue Code, which previously only applied to self-insured GHPs.
- Appeals Process. GHPs must (a) have an internal claims appeal process that incorporates ERISA claims procedures, as updated by the U.S. Department of Labor, (b) provide notice to participants of available internal and external claims processes and assistance of the health insurance commissioner or ombudsman, (c) allow participants to review their files, present evidence and testimony as part of the appeals process, and receive continued coverage during the appeals process, and (d) implement an external review process that meets state or HHS standards.
- Access to Care. GHPs must comply with patient protection requirements. For example, for plans requiring the designation of a participating primary care physician (“PCP”), the PCPs must include certain types of physicians (*i.e.*, pediatricians and OB/GYNs), and must permit access to emergency services without requiring prior authorization.

Other Changes

- Reimbursement for Non-Prescription Drugs. The cost of non-prescription medications, other than insulin, may not be reimbursed under health savings accounts (“HSAs”), Archer medical savings accounts (“MSAs”), health flexible spending arrangements (“Health FSAs”), or health reimbursement arrangements.
- Reporting. Employers will be required to report the value of coverage under the employer’s GHP on each employee’s IRS Form W-2 (except for MSAs, HSAs or Health FSAs).
- Increased Tax on HSAs and MSAs. The tax on nonqualified distributions from HSAs and MSAs increases to 20 percent.

Changes Effective for Tax Years Beginning on or after January 1, 2013

- Medicare Part D Deductions. The Act eliminates the federal income tax deduction for the cost of retiree prescription drug benefits for which the employer receives the 28 percent subsidy from Medicare Part D. The employer continues to receive the Medicare Part D subsidy for the retiree prescription drug coverage provided to persons who are Medicare eligible (*i.e.*, over age 65, disabled or suffering from end stage renal disease).
- Health FSA Limits. The maximum amount of salary reduction contributions that an employee can make to a Health FSA is \$2,500 (adjusted for inflation).

Changes Effective for Plan Years Beginning on or after January 1, 2014

Grandfathered GHPs

- Pre-Existing Condition Exclusions. GHPs may not impose pre-existing condition exclusions.
- Waiting Periods. GHPs may not impose a waiting period that exceeds 90 days.

Non-Grandfathered GHPs

In addition to the provisions applicable to grandfathered GHPs:

- Wellness Program Reward Limit. Wellness program rewards based on satisfaction of a health standard can not exceed 30 percent of the cost of employee-only coverage.
- Clinical Trials. GHPs may not deny an individual’s participation in certain clinical trials or the routine costs for items and services furnished in connection with participation in the trial.
- Cost-sharing. GHPs cannot have annual out-of-pocket limits greater than the limits for high deductible health plans (currently, \$5,950 for individual coverage and \$11,900 for family coverage).

Other Changes

- Reporting. Effective January 1, 2014, employers must report to the IRS and provide a statement to the employees regarding whether and when the individual was covered under the employer’s GHP for the minimum essential health coverage. This must be furnished to the individual by the deadline applicable for furnishing the Form W-2.
- Penalties. Effective January 1, 2014, the Act imposes a monetary penalty on a “large employer” (an employer with at least 50 full-time or full-time equivalent employees) if at least one full-time employee: (1) enrolls in a qualified health plan offered through an Exchange and (2) receives a premium tax credit or cost-sharing reduction and did not receive a “free choice voucher” from the employer (*i.e.*, the employee is a “Government Assistance Full-Time Employee”).

- The amount of the penalty depends, in part, on whether the large employer offers full-time employees and their eligible dependents the opportunity to enroll in “minimum essential coverage under an eligible employer-sponsored plan” (“Coverage”). The coverage offered by grandfathered plans is deemed to be Coverage.
- Does NOT offer Coverage: The annual penalty is \$2,000 for *each full-time employee* of the employer. For purposes of determining the penalty amount, the number of full-time employees during any month is reduced by 30. The \$2,000 amount will be indexed in subsequent years.
- DOES offer Coverage: The annual penalty is \$3,000 for *each Government Assistance Full-Time Employee* of the employer *who does not receive a free choice voucher*. The annual penalty cannot exceed the amount the employer would have paid if it did not offer Coverage.
 - An employer does not have to pay a penalty with respect to any Government Assistance Full-Time Employee who receives a “free choice voucher” if the employer:
 - Pays a portion of the cost of Coverage; and
 - Provides “free choice vouchers” to all employees (a) whose required contribution for Coverage is more than 8 percent but less than 9.8 percent of such employee’s household income, (b) whose household income is no more than 400 percent of the poverty level, and (c) who do not participate in the employer’s health plan.
- Employer Must Provide “Free Choice Vouchers”. Effective January 1, 2014, an employer that offers Coverage and pays a portion of the Coverage must provide the “free choice voucher” to certain eligible employees. For every “free choice voucher” the employer provides to an employee who qualifies, the employer will be required to pay an amount to the Exchange where the employee uses the “free choice voucher” to purchase coverage. This payment is equal to the portion of the monthly cost of coverage which would have been paid by the employer (for either self or family coverage, depending on what the employee elects). If the value of the “free choice voucher” exceeds the cost of coverage that the employee purchases at the Exchange, then the excess amount is paid to the employee by the employer as wages. The value of the “free choice voucher” is excluded from the employee’s income only to the extent it is used to purchase coverage. The employer can deduct the value of the “free choice vouchers” provided to employees as compensation expense. The free choice voucher provisions apply to all employers who offer Coverage through an employer sponsored plan and pay any portion of the cost of the plan for the employee.

Changes Effective January 1, 2018:

- So-Called “Cadillac” Plans. The Act imposes a nondeductible excise tax of 40 percent for any health-related coverage for which the combined employer and employee premiums exceed the threshold of \$10,200 for single coverage and \$27,500 for family coverage (each multiplied by a “health cost adjustment percentage”). The coverage subject to this “Cadillac” tax does not include long-term care insurance, dental or vision coverage, provided that such coverage is offered under a separate policy or plan and satisfies certain requirements.

Changes with Unclear Effective Date:

- Automatic Enrollment. Employers that have more than 200 full-time employees and offer employees enrollment in one or more GHPs must automatically enroll new full-time employees in one of the GHPs offered (subject to any waiting period authorized by law). Employees may opt out of such coverage. The effective date of this requirement will most likely be determined under regulations to be issued by the Department of Labor.

For more information, please feel free to contact any [lawyer](#) in the [Employee Benefits Group](#).