

Employee Benefits & Executive Compensation ADVISORY

March 23, 2010

Becoming Reconciled to Health Care Reform: President Obama Signs Landmark Health Reform Legislation; Further Action by Senate to Finalize Changes Is Expected

On March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA). This is the version of PPACA passed by the Senate on December 24, 2009. It was passed by the House on March 21, 2010. It is the law of the land today.

However, enactment of PPACA is not expected to be the final word on health care reform. The House adopted PPACA with the understanding that the Senate would agree to a second bill adopted by the House on March 21 that makes changes to PPACA. That bill, HR 4872, the Health Care and Education Tax Credit Reconciliation Act of 2010 (the "Reconciliation Bill"), reflects last minute compromises important to House Democrats. The Reconciliation Bill now moves to the Senate, where passage is expected soon. The significance of using the Reconciliation Bill as the avenue for changes to PPACA is that only 51 votes are required in the Senate to pass this bill.

Generally speaking, health care reform is not effective until 2014; however, there are a number of reforms that are effective for plan years that begin on or after six months after the enactment date, and there are a number of tax provisions with varying effective dates.

Irrespective of the effective date, immediate action is required to ensure compliance with the new "law of the land." The following is an overview of the relevant, health-plan-related provisions of PPACA. We have also identified the changes proposed by the Reconciliation Bill to PPACA (identified throughout as "RB Alerts") so that you will have an understanding of the changes that will take place if the Reconciliation Bill passes as expected.

Immediate Improvements in Health Care (applicable to both fully-insured and self-insured group health plans, except as otherwise noted below)

As noted above, some of the reforms will be effective almost immediately. The new provisions, which impact both self-insured and fully-insured group health plans, are generally added to the Public Health Service Act (PHSA) and incorporated by reference into ERISA and the Internal Revenue Code (the "Code"). Except as noted below, the reforms are effective for plan years beginning six months after the date of enactment—meaning January 1, 2011, for calendar year plans and *as soon as this year* for plans that have a plan year beginning October 1 or later this year.

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- **Annual and lifetime limits.** Plans may not impose lifetime limits and only restricted annual limits, as determined by the Secretary of Health and Human Services (HHS), on the value of essential benefits (as defined by PPACA) for any participant or beneficiary. For plan years beginning on or after January 1, 2014, group health plans and group health insurers may not impose any annual limit. Otherwise permissible lifetime or annual limits may be imposed on specified covered benefits that are not essential health benefits. (New § 2711 of the PHSA)
- **Prohibition on rescissions.** Plans may not rescind coverage except in cases of fraud or intentional misrepresentation. [NOTE: This does not appear to prohibit employers from terminating group health plans.] (New § 2712 of the PHSA)
- **Coverage of preventive care.** Plans must provide first dollar coverage (i.e., no cost sharing) for certain evidence based preventive care (including well child care) and certain immunizations. (New § 2713 of the PHSA)
- **Coverage of adult children.** Plans that cover dependent children must provide for coverage of unmarried children until age 26. There is no requirement to cover children of covered dependent children. The requirement is applicable even if the child is not a tax dependent. (New § 2714 of the PHSA)

RB Alert: The Reconciliation Bill also extends the requirement to married children and extends the tax exclusion for employer-provided coverage to adult children through age 26.

- **Uniform explanation of coverage.** The plan administrator (in the case of a self-insured plan) or the insurer (in the case of a fully-insured plan) must prepare and distribute a paper or electronic summary of coverage to all applicants and all enrollees, both at the time of initial enrollment and annual enrollment. This is in addition to the Summary Plan Description otherwise required by ERISA. The summary must satisfy certain uniform standards developed by the Secretary of HHS, including but not limited to: (i) no more than four pages in length with print no smaller than 12 point font, (ii) written in a culturally and linguistically appropriate manner, and (iii) containing certain contents related to the covered benefits, exclusions, cost sharing, and continuation. HHS must establish the standards within 12 months of the date of enactment and the summary must be provided within 24 months after the date of enactment. In addition, the plan or the issuer (as applicable) must notify enrollees of material changes to the coverage reflected in the most recent summary no less than 60 days in advance of the effective date of such coverage. Failure to comply may result in a \$1,000 penalty for each failure. (New § 2715 of the PHSA)
- **Transparency requirements.** Group health plans and health issuers in the group market are subject to the same transparency requirements applicable to plans offered in the state exchange. Under these requirements, such plans and issuers must provide to the Secretary of HHS, the applicable state insurance commissioner, and the public the following information: claims payment policies and data, financial disclosures, enrollment (and disenrollment) data, data on rating policies, information on cost-sharing and payments with respect to out of network coverage, information on participant rights under the Act and other information as determined by the Secretary of HHS. (New § 2715A of the PHSA)

- **Nondiscrimination rules for insured plans.** The nondiscrimination rules of Code Section 105(h) previously applicable only to self-insured health plans are extended to fully-insured group health plans. (New § 2716 of the PHSA)
- **Pre-existing condition exclusions.** With respect to children under age 19, plans may not impose a pre-existing condition exclusion or limitation. (New § 2704 of the PHSA)
- **Ensuring quality of care.** Plans must annually report to HHS and to enrollees (during each open enrollment period) regarding benefits under the plan that improve health, such as case management, disease management, and wellness and health promotion activities. HHS is to develop the reporting standards within two years of the enactment date. (New § 2717 of the PHSA)
- **Cost reporting and rebate requirements.** A health insurance issuer offering group coverage must submit to the Secretary of HHS a report relating to loss ratios. Rebates to enrollees must be provided if the medical loss ratio is 85% (80% in the small group market) or such higher amount as permitted under state law. (New § 2718 of the PHSA)
- **Claims procedures.** Plans must establish an internal claims appeals process that (i) provides notice in a culturally and linguistically appropriate manner of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals, (ii) allows claimants to review the entire claim file and present evidence, (iii) allows claimants to continue receiving coverage during the appeals process, and (iv) initially incorporates the claims review procedures set forth in Department of Labor regulations that apply to plans covered by ERISA. Plans must also establish an external review process that complies with applicable state law and that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act developed by the NAIC or, in the case of self-insured plans, meets similar requirements as provided by the Secretary of HHS. The Secretary of HHS may deem the existing external review process of a group health plan to be in compliance with the provisions of the bill. (New § 2719 of the PHSA)
- **Patient protections.** Plans that require or provide for a designation of a primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. PPACA also requires plans to comply with requirements regarding access to emergency services and obstetrical and gynecological care and to allow designation of a pediatrician as a primary care provider for children. (New § 2719A of the PHSA)
- **High risk pools.** Until the high risk pool established under PPACA for individuals with pre-existing conditions is terminated in 2014, a group health plan must reimburse the high risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to disenroll from the group health plan. (§ 1101 of PPACA)
- **Electronic transaction standards.** Plans must implement certain electronic transaction standards and certify compliance to HHS. The timing of certification varies depending on the type of transaction. For example, the health plan must certify compliance with electronic fund transfer, health claim status, and health care payment and remittance advice standards established by PPACA by no later than December 31, 2013. Compliance with other standards, such as the health claims or equivalent encounter standard, is due no later than December 31, 2015.

Exchange-Related Issues

PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014. Although generally directed at individuals, the exchange-related provisions in PPACA impact employers in the following ways:

- Beginning in 2017, states may allow *all* employers of any size to offer coverage through the exchange. Prior to 2017, only small employers (employers with 100 employees or fewer) may participate. For years before 2016, a state may limit small employers to those with 50 or fewer employees.
- Employers who offer coverage through the exchange may permit employees to pay for such coverage with pre-tax dollars through the employer's cafeteria plan; however, exchange-related coverage that is not offered by the employer may not be offered through the employer's cafeteria plan.

Health Insurance Market Reforms (applicable to both fully-insured and self-insured group health plans)

Group health plans and health plan insurers are subject to the following general insurance market reforms. These reforms are generally effective for plan years beginning on or after January 1, 2014.

- **Prohibition on preexisting exclusion limitations.** No preexisting condition exclusions or limitations are permitted. (§ 2704 of the PHSA)
- **No discrimination based on health status.** Essentially, the same rules that currently exist under HIPAA are included in PPACA. PPACA does, however, raise the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20% of the COBRA cost of coverage to 30% of the COBRA cost of coverage for those participating in the program (and allows the Secretaries of DOL, HHS and Treasury leeway to increase the percentage to 50%). (§ 2705 of the PHSA)
- **Prohibition on discrimination against providers.** No discrimination against a provider who is acting within the scope of his/her license is permitted. This does not mean, though, that a health plan must contract with any willing provider. (§ 2706 of the PHSA)
- **Cost-sharing limitations.** Certain cost-sharing requirements must be satisfied such that the out-of-pocket (OOP) expense does not exceed that applicable to Health Savings Account (HSA) related coverage, and deductibles do not exceed \$2,000 for single coverage and \$4,000 for family coverage (as indexed). (§ 2707 of the PHSA)
- **Limitation on waiting periods.** Plans may not impose a waiting period in excess of 90 days. There is also an excise tax penalty under PPACA for waiting periods imposed on full-time employees (i.e., employees working more than 30 hours per week) between 61 and 90 days (see "Employer Responsibility" below for a discussion of the penalty).

RB Alert: The Reconciliation Bill removes the tax penalty under PPACA for waiting periods in excess of 60 days.

- **Participation in clinical trials.** A plan may not deny qualifying individuals participation in certain clinical trials or deny the coverage of routine patient costs for items and services furnished in connection with the clinical trial. (New § 2709 of the PHSa)

Individual Responsibility

Effective January 1, 2014, individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax. Self-insured plans and insurers will be required to report certain coverage-related information to the individual and to the IRS. Under PPACA, individuals generally pay the greater of a flat dollar amount and a percentage of income payment. The flat dollar amount penalty is \$95 in 2014, \$495 in 2015 and \$750 in 2016 and thereafter. The percentage of income limit is 0.5% in 2014, 1.0% in 2015, and 2.0% in 2016 and thereafter.

RB Alert: As under PPACA, individuals generally pay the greater of a flat dollar amount and a percentage of income payment under the Reconciliation Bill. The flat dollar amount penalty is \$95 in 2014 under both PPACA and the Reconciliation Bill. The Reconciliation Bill reduces the flat dollar amount to \$325 in 2015 and to \$695 in 2016 and thereafter. The percentage of income limit is increased to 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and thereafter.

Employer Responsibility

Effective for months beginning on or after January 1, 2014, employers must satisfy the following requirements:

- **Automatic enrollment.** Large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program should include adequate notice and the opportunity for an employee to opt out of the “auto” coverage and elect another option, or opt out altogether. (§ 1511 of PPACA)
- **Notification of availability of exchange and subsidies.** Employers must notify each employee at the time of hiring of the following: (i) the existence of the exchange, (ii) that the employee may be eligible for a subsidy under the exchange if the employer’s share of the total cost of benefits is less than 60% and (iii) that if the employee purchases a policy through the exchange, he or she will lose the employer contribution to any health benefits offered by the employer (except as set forth in the free choice voucher requirement). (§ 1512 of PPACA)
- **Employer penalties.** Notwithstanding the obligation to comply with the reform requirements identified above, there is generally no requirement for employers to offer the same coverage that insurers offering coverage in the exchange must offer. In fact, there is generally no requirement for employers to offer any coverage; however, employers with 50 or more full-time employees (“Applicable Employer”) are subject to the following penalties related to coverage that they offer or fail to offer to full-time employees (§ 1513 of PPACA):

Applicable Employers who fail to offer any full-time employees health coverage must pay a penalty with respect to each full-time employee in any month in which any employee enrolls in and receives a subsidy for the exchange. The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer for that month (including those employees who did not receive a subsidy for the exchange) and 1/12 of the applicable payment amount, which is \$750 under PPACA.

RB Alert: The Reconciliation Bill changes the monthly penalty from 1/12 of \$750 to 1/12 of \$2,000 and it disregards the first 30 employees. Thus, for example, a business with 51 employees that does not offer coverage is subject to tax equal to 21 times the applicable payment amount.

- Applicable Employers offering coverage for any month to a full-time employee who is certified as having enrolled in the exchange and received a tax subsidy are subject to a penalty equal to the product of the total number of such employees (i.e., employees receiving the credit) and 1/12 of \$3,000 (400% of the applicable payment amount, which is \$750). The amount of the tax in this instance is limited to 1/12 of \$750 multiplied by the total number of the employer's full-time employees. Note that an employee who is offered employer coverage is not eligible for a credit unless the employee's required premium for the coverage exceeds 9.5% of the individual's household income or the plan's share of allowed costs under the plan is less than 60%.
- Applicable Employers who impose a waiting period of more than 60 days and less than 90 days must pay a penalty for each full-time employee to whom the extended waiting period applies. The penalty is equal to \$600 for each full-time employee to whom the excess waiting period is imposed.

RB Alert: The Reconciliation Bill eliminates this penalty for waiting periods between 60 and 90 days.

A large employer is defined as an employer (and any other employer within the same controlled group) who employed on average at least 50 full-time employees on business days during the preceding year. However, an employer is not considered to be a large employer if the employer did not employ more than 50 full-time employees for more than 120 days during the preceding year. A "full-time employee" is defined as an employee who is employed on average at least 30 hours of service per week. Certain "seasonal workers" are not counted as full-time employees.

RB Alert: Under the Reconciliation Bill, part-time employees are taken into account solely for the purpose of determining if an employer has at least 50 employees. The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time employees by 120.

- **Reporting requirements.** Applicable Employers must also report to the Secretary of Treasury each year, certifying (i) whether coverage is offered to full-time employees, (ii) the waiting period for any such coverage, (iii) the number of full-time employees of the employer during each month, and (iv) the name, address and TIN of each full-time employee and the months during which they were covered under the plan. (§ 10108 of PPACA)

- **“Free choice vouchers.”** Employers that offer minimum essential coverage and make a contribution must offer “free choice vouchers” to qualified employees for the purchase of qualified health plans through exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income does not exceed 400% of the federal poverty level and the required contribution under the employer’s plan would be between 8 and 9.8% of their income. Free choice vouchers are excludible from employees’ incomes and deductible by the employer. Voucher recipients are not eligible for tax credits through the exchange. (§ 10108 of PPACA)

Grandfathered Plans

Under PPACA, group health plans in effect on the date of enactment are exempt from many of the health care reforms. The grandfather rule is not limited to individuals enrolled on the date of enactment, but rather:

- New employees (and their families) may be covered under an employer’s grandfathered plan; and
- Family members of current employees who are covered by the grandfathered plan may also be added.
- Grandfathered plans are permanently exempt from the following reforms:
 - Prohibition on lifetime or annual limits.
 - Rescission of benefits.
 - Preventive services.
 - Dependent coverage.
 - Limits on cost sharing.
 - Nondiscrimination rules imposed under PPACA (i.e., the application of Code Section 105(h) to fully-insured plans).
 - Reporting requirements.
 - Appeals process.
 - Selection of doctors and referral requirements.
 - Coverage of clinical trials.
 - No discrimination against providers.
 - Individual responsibility requirements. Coverage under a grandfathered plan satisfies the individual responsibility provisions of the Bill.
 - Waiting periods. Under PPACA no waiting periods in excess of 90 days are allowed. While this prohibition does not apply to grandfathered plans, as described below, a penalty may be imposed on waiting periods in excess of 60 days even for grandfathered plans.
 - Preexisting condition exclusions.

Under PPACA, grandfathered plans *are* subject to the following requirements:

- Changes in tax rules relating to health plans
- Uniform explanation of coverage
- Cost reporting and rebates
- Automatic enrollment
- Notification of availability of the exchange and subsidies
- Notices regarding the exchange
- Requirement to provide employees vouchers

RB Alert: Under the Reconciliation Bill, grandfathered group health plans are also subject to the following requirements from which they would otherwise be exempt under PPACA:

- Limitation on lifetime and annual limits
- Limitation on preexisting condition exclusions
- Prohibition on rescissions
- Limitation on waiting periods
- Coverage of adult children; however, for years before 2014, the coverage requirement applies only if the adult child is not eligible to enroll in another eligible employer plan

PPACA also contains a delayed effective date for collectively bargained plans for many of the reforms.

Tax on High Cost Coverage

Beginning in 2013, a nondeductible 40% excise tax is imposed on the monthly value of high cost coverage in excess of 1/12 of \$8,500 for single coverage and 1/12 of \$23,000 for family coverage, indexed to CPI + 1 beginning in 2014. The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, EMTs, construction, mining) and those employed to install electrical or telecommunication lines is increased to \$8,850 for individual coverage and \$26,500 for family coverage. The limit for employees in “high cost states” (as determined by HHS) is increased to 120% in 2013, 110% in 2014 and 105% in 2015. “High cost states” are each of the 17 states estimated by HHS to have the highest average cost (based on aggregate premiums) during 2012 for employer-sponsored health plans. In calculating the tax, the value of coverage for retirees under age 65 and coverage for retirees age 65 or older may be combined.

RB Alert: The Reconciliation Bill makes the following changes to PPACA:

- The tax is delayed until 2018.
- The thresholds for the tax are increased to \$10,200 for single coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and employees in high risk professions). These amounts are to be adjusted automatically if health costs increase by more than anticipated before 2018. The thresholds are increased by CPI + 1 in 2019, and by CPI thereafter. An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer's age and gender demographics are not representative of a national average. The transition rule for high cost states does not apply.
- The higher family threshold applies to both single and family coverage offered under a multiemployer plan.

"Coverage providers" are defined to include the following:

- In the case of fully-insured plans, the health insurer
- In the case of HSA or MSA contributions, the employer making the contributions
- In the case of a self-insured plan, the person who administers the plan (e.g., the third-party administrator)

In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (and may also include HSA contributions). The coverage provider's applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider's coverage to the total value of employer-sponsored coverage. Although the coverage provider is responsible for paying the tax, the employer must calculate the tax, including each coverage provider's applicable share, and notify each coverage provider.

The coverage subject to this rule includes the following:

- The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee, except
 - accident and disability insurance
 - long-term care
 - hospital indemnity and/or specified disease coverage that is paid for with after-tax dollars
- Both nonelective and salary reduction contributions to a health FSA
- Employer contributions (presumably including salary reductions) to an HSA

In addition, employers must include the value of all such coverage on the employee's W-2. The W-2 reporting requirement applies for all tax years beginning on or after January 1, 2011.

Other Group Health Plan Related Issues

A number of other provisions will impact group health plans generally:

- **FSA cap.** Effective taxable years beginning January 1, 2011, health FSA salary reductions are limited to \$2,500 each year. The limit is indexed for inflation based on the CPI beginning in 2012.

RB Alert: Under the Reconciliation Bill, the effective date of the \$2,500 cap on contributions to a health FSA is delayed so that the provision is effective starting in 2013. The cap is indexed to the CPI starting in 2014.

- **Over-the-counter reimbursements.** Effective for tax years beginning on or after January 1, 2011, over-the-counter medicines or drugs are not eligible for reimbursement under an FSA, HRA, or HSA without a doctor's prescription.
- **HSA distributions.** The excise tax for nonqualified distributions from HSAs is increased to 20%, effective for distributions after December 31, 2010.
- **Deduction of retiree medical costs.** Effective for tax years beginning on or after January 1, 2011, the deduction previously permitted for amounts allocatable to the Medicare Retiree Part D subsidy is eliminated.

RB Alert: The effective date of the provision relating to deductions allocatable to the Part D subsidy is effective starting in 2013.

- **HI tax changes.** Beginning in 2013, individuals with wages above \$200,000 for a single return and \$250,000 for a joint return would be subject to an additional 0.9% tax on wages in excess of these thresholds.

RB Alert: Under the Reconciliation Bill, such individuals would also be subject to a 3.8% tax on their net investment income (to the extent that total income exceeds the thresholds). This new tax would be effective starting in 2013.

- **Safe harbor rules for cafeteria plans of small employers.** A new safe harbor from the nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained by eligible employers to the extent certain requirements are met, such as (i) all "nonexcludable" employees are eligible to participate and (ii) certain minimum contribution requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two preceding years (provided it is a full year). The safe harbor applies for tax years beginning on or after January 1, 2011.
- **Credit for small employers.** Effective for taxable years beginning on or after January 1, 2011, small employers with fewer than 25 "full-time equivalent" employees are eligible for a tax credit equal to a portion of the employer's cost to provide health insurance.

- **Fee on health insurance providers.** Effective starting in 2011, there is a nondeductible annual fee on health insurance providers based on market share. The fee is structured so as to raise \$60 billion over 10 years. The fee does not apply to self-insured plans. Certain other exceptions also apply; for example, the fee does not apply to long-term care coverage, or to coverage for specified disease or hospital indemnity policies.

RB Alert: Under the Reconciliation Bill, the fee is effective January 1, 2014. Certain other modifications also apply.

- **CER fee.** To fund comparative effectiveness research, effective for each policy year ending after September 30, 2012, a fee equal to \$2 (\$1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of covered lives is imposed. The fee applies to accident or health insurance policies other than policies covering benefits exempt under HIPAA. The fee also applies to self-insured plans.

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