

## HEALTH CARE REFORM CLIENT UPDATE

### What Employers Need to Know Now

***A New Era in Health Care.*** President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. On March 30, 2010, the President signed into law the Health Care and Education Affordability Reconciliation Act of 2010 which makes a number of changes to the March 23, 2010 legislation. These Acts, which we refer to as "PPACA," will impose sweeping changes on health care in the United States and will require almost all private-sector employers to evaluate the health benefits they currently offer their employees and consider whether their health benefits are PPACA compliant. The new requirements under PPACA may cause some employers who currently offer health benefits to their employees to elect not to do so in the future, while PPACA may make it more economical for other employers who do not offer health benefits to begin providing health benefits. This Update and the Updates that follow will summarize key features of PPACA that will affect employers and their group health plans. The provisions of the new law are extremely complex and many of the details will be determined via the regulatory process over the next several years.

### Grandfathered Plans

***Scope of Grandfather Clause.*** Essentially, all plans in effect on the date of PPACA's enactment, March 23, 2010, are "grandfathered." A "grandfathered" plan is exempt from some, but not all, of the provisions of PPACA. ***All of the requirements discussed in this Update apply equally to grandfathered and non-grandfathered plans unless otherwise expressly stated.***

***Retaining Grandfathered Status.*** PPACA does not address whether a plan that is amended on or after March 23, 2010 can still retain grandfathered status. Until Congress or the regulating agencies clarify this point, we advise employers to exercise caution with respect to amending a grandfathered plan.

***Additional Participants Permitted.*** Eligible family members of an enrolled individual may enroll in a grandfathered plan according to its terms and not jeopardize its status as a grandfathered plan as long as such enrollment was already permitted under the terms of the plan on March 23, 2010. Similarly, new employees and their eligible family members may enroll in a grandfathered plan.

***Collectively Bargained Plans.*** For plans maintained pursuant to one or more collective bargaining agreements that were ratified before March 23, 2010, the provisions of PPACA from which grandfathered plans are temporarily exempt will not apply until the date on which the last of the collective bargaining agreements relating to such plans terminate.

## **Required Changes with No Express Effective Date**

**Summary.** PPACA includes a number of required changes that have no specific effective dates, and thus the time by which plans have to comply is uncertain. The following is one such change that impacts plans.

**Automatic Enrollment.** Of particular significance to employers is PPACA's requirement that employers with more than 200 full-time employees that offer at least one or more plans must enroll all new employees automatically in a plan. This requirement also applies to new full-time employees under grandfathered plans. The employer must provide adequate notice of this automatic enrollment feature and provide new full-time employees with the opportunity to opt out. The statute requires that automatic enrollment be done "in accordance" with regulations issued by the Secretary of Labor. As these regulations have not yet been issued, it is unclear when automatic enrollment will be required. We will send you an Update as soon as such guidance is available.

## **Changes Effective Prior to September 23, 2010**

**No Financial Incentives to Join High Risk Pool.** PPACA requires the Secretary of Labor, by June 23, 2010, to establish a high risk pool for certain individuals who have preexisting conditions that are not covered by the employer's plan, so these individuals will have coverage until 2014 when the total ban on excluding preexisting conditions from coverage becomes effective. If, after the pool is established, the Department of Labor finds that an employer has offered employees financial incentives to drop out of the employer's plan to join the pool, the employer will have to reimburse the pool for the medical expenses such employee incurs. This provision applies to grandfathered plans as well as to plans that are not grandfathered.

**Government Reinsurance Program.** PPACA establishes a temporary program to reimburse plans offering health coverage to early retirees between ages 55 and 64. On June 23, 2010, the program becomes effective. The program will reimburse eligible plans for 80% of the claims of these retirees and their families that are between \$15,000 and \$90,000. This program terminates January 1, 2014. There is a finite amount of money available for this program so eligible employers should promptly apply. However, no application process is available yet. As soon as there is an application procedure, we will send you an Update with details on the criteria to qualify for the program and the application process.

## **Changes Effective as of the First Plan Year Beginning on or After September 23, 2010**

**Summary.** A number of changes under PPACA become effective for plan years beginning six months after enactment – i.e., for plan years beginning on or after September 23, 2010. For calendar year plans, this means the changes discussed below are effective January 1, 2011.

**Changes Applicable to All Plans, Including Grandfathered Plans.** The principal changes that become effective for plan years beginning on or after September 23, 2010 and that apply to both grandfathered and non-grandfathered plans are summarized below.

- **Restrictions on Annual Limits.** A plan may impose only “restricted annual limits” on the dollar value of “essential benefits” to any participant or beneficiary. The Secretary of Health and Human Services must establish these annual limits on the dollar value of essential benefits. On and after January 1, 2014, no annual limits will be permitted. Essential benefits are discussed below under “**Changes Effective January 1, 2014.**”
- **No Lifetime Limits.** A plan may not impose any lifetime limit on the dollar value of “essential benefits” to any participant or beneficiary.
- **Once Offered, Coverage May Not be Rescinded.** A plan that offers health care coverage may not rescind such coverage with respect to any person enrolled in the plan unless that person commits fraud or makes a material misrepresentation prohibited under the terms of the plan.
- **Certain Preexisting Condition Restrictions Prohibited.** Plans may not impose any preexisting condition restriction on children under the age of 19. After January 1, 2014, plans may not impose preexisting condition restrictions on anyone.
- **Coverage For Dependents to Age 26.** If a plan offers dependent coverage of children, such coverage must extend to a child until the child reaches age 26. Employers may not exclude dependents from participation based on any criteria other than age. For example, many plans require that an adult dependent be unmarried or enrolled as a full-time student. These restrictions must be eliminated as of the first plan year beginning on or after September 23, 2010. For grandfathered plans, this requirement applies before January 1, 2014 only if the adult child is not eligible to enroll in another plan.

**Changes Applicable to Plans Other Than Grandfathered Plans.** The following is a summary of the principal changes that become effective for plan years beginning on or after September 23, 2010 that, except where noted, apply only to plans that are not grandfathered.

- **Preventative Care Without Cost Sharing.** Cost sharing arrangements are prohibited for a number of preventative care measures, including certain immunizations and certain care and screenings for children and women.
- **Insured Plans Prohibited from Discriminating.** A fully-insured plan may not discriminate in favor of highly compensated employees. The scope of the prohibited discrimination is the same that already applies to self-insured medical reimbursement plans under Section 105(h) of the Internal Revenue Code.
- **Appeals Process.** PPACA imposes new rules for appeals of coverage determinations and claims. A plan must provide participants notice of the plan’s appeals process in a “culturally and linguistically appropriate manner” and refer participants to where they may obtain help with the appeals process. Each claimant must be permitted to review his or her file and present evidence and testimony as part of the appeals process. Finally, plans must provide for both an internal and an external review process.
- **Certain Patient Protections.** Plans that provide for or require the designation of a participating primary care provider must permit each participant to designate any

participating primary care provider who is available to accept such individual. The plan must permit a participant to designate a pediatrician as the primary care provider for a child. PPACA also requires plans to comply with certain requirements regarding access to emergency services and obstetrical and gynecological care.

- **Additional Reporting Requirements.** Plans of large employers that are not part of the exchange (discussed below) must make available to the public and provide to the Secretary of Health and Human Services and the applicable state insurance commissioner the following information: claims payment policies and data, enrollment (and disenrollment) data, data on rating policies, financial disclosures, information on cost sharing and payments with respect to out-of-network coverage, and information on participants' rights under PPACA. The law does not indicate when this information must be filed with the federal and state governments.

### Changes Effective January 1, 2011

- **Reporting on Form W-2.** Employers will be required to disclose the value of the health coverage provided to each employee on the employee's annual Form W-2. Employers must begin including this disclosure on all Forms W-2 that the employer distributes after the close of the employer's 2011 fiscal year.
- **Over-the-Counter Drugs.** No payments or reimbursements should be made from health spending accounts (HSAs), medical savings accounts (MSAs), flexible spending accounts (FSAs) and health reimbursement arrangements (such as medical reimbursement plans) for over-the-counter drugs not prescribed by a physician.
- **Tax Credit for Small Employers.** Certain employers with no more than 25 full-time employees may be eligible for a tax credit if they offer their employees health insurance. It appears that the IRS may try to make this tax credit available for 2010.

### Other Changes Required After September 23, 2010, But Before January 1, 2014

- **Repeal of Deduction for Certain Retiree Prescription Drug Plans.** Effective January 1, 2013, employers who provide prescription drug benefits for their Medicare Part D eligible retirees will no longer be able to take a tax deduction for the costs of providing those benefits. Although the deduction is not revoked until 2013, employers should refer to accounting rules that may require the employers to start recognizing the expense related to the loss of the tax deduction.
- **Medical Flexible Spending Accounts.** Effective January 1, 2013, annual salary reductions for purposes of contributing to a medical FSA will be limited to \$2,500 for each employee, subject to a cost-of-living adjustment.
- **Fees Imposed on Self-Insured Plans.** Effective for plan years ending on or after September 30, 2012, each self-insured plan must pay to the IRS an annual fee of \$2 per plan participant, reduced to \$1 for the first plan year. The IRS will deposit these fees into a trust fund PPACA establishes, which will fund a new non-governmental, non-profit organization called the Patient-Centered Outcomes Research Institute.

- **1099 Reporting Requirement.** Effective January 1, 2012, plans must provide a Form 1099 to any for-profit corporation that the plan paid \$600 or more for services the for-profit corporation provided to the plan.
- **Summary of Benefits and Coverage Requirement.** By March 23, 2012, plan sponsors must prepare and distribute to all applicants and participants, both at initial enrollment and annual enrollment, a paper or electronic summary of benefits and of coverage for each plan. The summary of benefits and coverage is in addition to the summary plan description. PPACA describes the information that must be included in this summary document. Plan sponsors must also inform participants of material changes in the information required to be included in the summary of benefits and coverage.
- **Notice to Employees.** Although PPACA imposes a January 1, 2014 effective date for the state health care insurance exchanges (which are discussed below), beginning March 1, 2013, employers must notify current employees and each new employee at the time of hiring of the existence of the exchange, that the employee may be eligible for a subsidy under the exchange if the employer pays less than 60% of the total cost of benefits under the employer's plan, and 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 for amounts paid for free choice vouchers, as provided below).

### Changes Effective January 1, 2014

**Summary.** The most significant of the changes required by PPACA become effective on January 1, 2014. The law attempts to provide at least a minimum threshold of health care coverage for most United States citizens and legal residents and, by doing so, imposes obligations on employers, insurance carriers, health care providers, individuals and others.

- **Minimum Essential Benefits.** Plans of "large employers" that do not offer at least the following "essential benefits" will be subject to monthly excise taxes: ambulance and emergency services, chronic disease management, hospitalization, maternity and newborn care, mental health and substance use disorder services, laboratory services, prescription drugs, preventative and wellness services, rehabilitative and habilitative services and devices, and pediatric services including oral and vision care. Moreover, even if a large employer offers these minimum benefits, it may still be subject to a lesser excise tax. This and the definition of "large employer" are discussed under "**The Free-Rider Provisions**" below.
- **Insurance Exchanges.** States must establish exchanges through which individuals may purchase health insurance. PPACA regulates the kind of plan and the scope of benefits that states must offer through these exchanges. Some employers may elect to offer coverage to their employees through the exchanges. However, even employers that do not offer coverage through an exchange must provide employees with information regarding the coverage offered through the exchanges.
- **Employer-Sponsored Coverage Through the Insurance Exchanges.** Prior to January 1, 2017, only "small employers" can offer coverage to their employees through an exchange. Small employers are defined as those with 100 or fewer employees. However, for plan years beginning before January 1, 2016, any state may restrict the definition of "small employer" for purposes of PPACA (and, therefore, the availability of the exchange) to employers with no more than 50

employees. Beginning in 2017, a state may (but is not required to) allow all employers, regardless of size, to offer coverage to their employees through that state's exchange.

- ***New IRS Reporting Requirement.*** A "large employer" (as defined below under "**Free-Rider Provisions**") will generally have to file a new annual report with the IRS certifying whether the employer offers health care insurance to its employees and, if so, describing the details regarding plan participation, applicable waiting periods, coverage availability, the lowest cost premium option under the plan in each enrollment category, and other information. The Secretary of the Treasury is tasked with developing the forms for the annual reports and deciding when they should be filed.
- ***"Free Choice" Vouchers.*** If an employer offers at least the "essential benefits," as described by PPACA, through the employer's plan and pays any portion of the coverage, it must offer "free choice" vouchers to certain lower paid employees who elect to purchase coverage through an exchange instead of receiving coverage through the employer's plan. These employees include those who would have to pay between 8 and 9.8% of their annual household income to the employer's plan for the minimum coverage, and have household income that is less than 400% of the federal poverty level. (The current federal poverty level is \$22,050 for a family of four.) The amount of the voucher is the maximum amount the employer would have contributed on behalf of the employee for coverage under its plan. The employer pays the amount of the voucher directly to the exchange, which credits the amount against the employee's monthly premium.
- ***Coverage of Participation in Clinical Trials.*** Currently, health insurers generally refuse to cover any treatment that they deem experimental. However, under PPACA, plans must extend medical insurance coverage for clinical trials to individuals who have cancer or any other "life-threatening" disease or condition. In addition, plans may not discriminate against any covered employee for participating in such clinical trials. These requirements do not apply to grandfathered plans.
- ***Coverage For Children to Age 26—Grandfathered Plans.*** Grandfathered plans that offer dependent coverage must extend such coverage to a child until age 26, regardless of whether the child is eligible to enroll in another plan.
- ***Employees May Pay With Pre-Tax Dollars.*** An employer who offers plan coverage through an exchange may allow employees to pay for such coverage with pre-tax dollars through a cafeteria plan.
- ***No Preexisting Conditions.*** No preexisting condition exclusions or limitations are permitted, regardless of age.
- ***No Annual Limits.*** A plan may not impose any annual limits on the dollar value of "essential benefits."
- ***No Health Status Discrimination.*** A plan may not discriminate based on health status.
- ***No Provider Discrimination.*** A plan may not discriminate against a plan provider who is acting within the scope of his or her license, such as a chiropractor. This does not mean, though, that a plan must contract with any willing provider.



- **Cost-Sharing.** Cost-sharing is limited. For all plans, out-of-pocket expenses cannot exceed the limit for contributions to Health Savings Accounts (HSAs). That limit for 2010 is \$3,050 for individuals and \$6,150 for families. In the small group market, deductibles cannot exceed \$2,000 for single coverage and \$4,000 for family coverage (as indexed). These rules do not apply to grandfathered plans.
- **Waiting Period Limitation.** Plans may not impose a waiting period in excess of 90 days.

**Coverage Generally Not Required.** PPACA does not require any employer to offer health care coverage to its employees. However, certain employers must pay a penalty if they do not offer such a benefit. This is discussed in more detail below under “**The Free Rider Provisions.**”

### The Free Rider Provisions

**Summary.** As of January 1, 2014, all “large employers,” including those sponsoring grandfathered plans, are subject to the “free rider” provisions of PPACA. Under these provisions, large employers must pay an excise tax if they do not offer health care coverage, or if they offer coverage that does not meet certain requirements relating to cost and value.

The law generally defines a large employer as one with an average of 50 or more full-time employees (working at least 30 hours a week) during the preceding calendar year. For new employers, the excise tax is based on the average number of employees it reasonably expects to employ during the current calendar year. If an employer employs more than 50 people for 120 days or less during the calendar year due to a seasonal workforce, it is not considered a large employer under PAACA. However, part-time employees count toward determining the number of full-time employees; specifically, the number calculated by dividing the aggregate number of hours of service of part-time employees for the month by 120 must be added to the total number of actual full-time employees to determine if an employer is a “large employer” under PPACA.

- **No Coverage.** If, for any month, a large employer does not offer its employees any health care coverage, and at least one of its full-time employees participates in an exchange and receives subsidies from the exchange, that employer must pay an excise tax equal to 1/12 of \$2,000 for each full-time employee (in excess of 30) it employed during the month. (The subsidy is generally available only to persons with household incomes equal to or less than 400% of the federal poverty level who acquire coverage at certain levels through an exchange.) Part-time employees are not taken into account in this calculation. PPACA does not impose this excise tax on such an employer for any month during which none of its full-time employees is enrolled in and receives a subsidy through an exchange. Therefore, if an employer does not employ any employees with a household income below the poverty threshold, the employer is not subject to this tax. For example, if an employer that offers no health benefits and has 100 employees has one employee purchasing subsidized coverage on an exchange, the employer will be assessed \$11,667, or 1/12 of \$2,000 multiplied by 70 (100 minus 30), for that month.
- **Low Value or Costly Coverage.** If an employer offers a plan to its employees that either costs the employee an excessive amount or is not financially supported to an adequate extent by the employer, the plan is not considered to be a plan that offers

the minimum essential benefits described in PPACA. A plan is not deemed to offer minimum essential benefits if the employer either (a) covers less than 60% of the actuarial value of the cost of health care insurance or (b) charges the employee more than 9.5% of his or her annual household income for coverage. If, for any month, a large employer offers its employees benefits under such a plan and at least one of its full-time employees participates in an exchange and receives a subsidy, the employer must pay an excise tax equal to the lesser of the tax described in the bullet point above or 1/12 of \$3,000 for each such employee enrolled in an exchange. Part-time employees are not taken into account in this calculation and any employee who receives a free choice voucher is excluded from the tax calculation.

For example, if an employer with 100 employees offers coverage where the plan pays only 50% of the cost of benefits, and 10 employees with household incomes below 400% of the poverty level purchase subsidized coverage on the exchange instead of participating in the employer's plan, then the employer will be assessed \$2,500 for that month (1/12 of \$3,000 times 10 workers equals \$2,500, which is less than the \$11,667 the employer would have been assessed for having no coverage). Similarly, if an employer with 100 employees offers coverage but 25 employees with household incomes below 400% of the poverty level would pay more than 9.5% of their household income to participate in the plan and therefore purchase subsidized coverage on an exchange instead, then the employer will be assessed \$6,250 for that month (1/12 of \$3,000 times 25 workers equals \$6,250, which is less than the \$11,667 the employer would have been assessed for having no coverage).

- **"Cadillac" Plan Tax.** Effective for plan years beginning on or after January 1, 2018, a monthly 40% excise tax is imposed on the value of employer-provided health benefits in excess of a certain amount. The amount of this excess benefit equals the amount the employer's coverage costs for any employee exceeds 1/12 of \$10,200 for individuals and \$27,500 for family coverage, subject to certain adjustments. The value of benefits is based on the cost of providing the coverage to all participants, calculated in a manner similar to that used to calculate COBRA premiums. The excise tax is imposed on the entity providing the coverage. Therefore, self-funded plans will be taxed directly and insurance companies will likely pass the expense related to the excise tax it has to pay on to employers.

### **First Issue of Schiff Hardin LLP Health Care Reform Update: Let Us Know What You Think**

This is the first in a series of Health Care Reform Updates that Schiff Hardin LLP will send to you. These Updates are intended to address, in a summary manner, the obligations employers may have with respect to PPACA and related laws and regulations.

Our goal is to make these Updates readable and informative. If you have any questions or comments concerning this Update, or if you have any suggestions about what you would like to us to include in future Health Care Reform Updates, please contact Suzanne Arpin at (404) 437-7051 or [sarpin@schiffhardin.com](mailto:sarpin@schiffhardin.com), or any of the individuals listed in this Update.

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