An Employer's Guide to Health Care Reform

Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Less than a week later, Congress passed the Health Care and Education Tax Credit Reconciliation Act of 2010 (this Management Alert will refer to PPACA, along with the changes made by the Reconciliation Bill, collectively as "Reform"). Reform made sweeping changes to our nation's health care system and imposes many new requirements on employer-sponsored group health plans. This Management Alert serves as a guide for employers, highlighting some of the changes made by the legislation. The effective dates of these changes follow each provision in bracketed text. This Management Alert will also lay out the compliance timeline facing employers and will address some of the frequently asked questions we have fielded.

Employer Responsibilities

Requirement of Employer Provided Coverage. Reform requires employers with 50 or more "full-time equivalent employees" to provide minimum essential coverage to all full-time employees (those working 30 or more hours per week) and their dependents. Part-time employees are counted as partial employees for determining whether the employer has 50 "full-time equivalent employees," but the tax penalties for failing to provide coverage (calculated per full-time employee) do not apply to part-time employees. If an employer fails to offer minimum coverage to all full-time employees, and at least one employee receives coverage through the state-based exchanges (discussed more below), the employer must pay an assessment of $2,000 per full-time employee. Reform permits employers to subtract 30 full-time employees before calculating the tax. [January 1, 2014]

Minimum Essential Coverage. Employers must cover at least 60% of the cost of "minimum essential coverage" for employees and the total employee cost for health care coverage should not exceed 9.5% of any employee's household income (or the Free Rider Penalty, described below, may apply). Reform is not clear as to what constitutes "minimum essential coverage," but there is no set package of required benefits. [January 1, 2014]

Free Rider Penalty. If any employee's cost of coverage exceeds 9.5% of household income, and at least one employee purchases coverage through the exchange, the employer will be deemed to have failed to provide affordable coverage. The employer must pay an assessment equal to the lesser of $3,000 per employee who obtains coverage through a state-based exchange or $2,000 per full-time employee. [January 1, 2014]

Free Choice Vouchers. If any employee's cost of coverage exceeds 8% of household income (but does not exceed 9.8% of household income), and the employee's household income is less than 400% of the Federal poverty level, employers must offer that employee a "free choice" voucher to be used to purchase coverage through a state-based exchange. The

voucher amount will be the cost the employer would have paid to cover the employee under the most generous option in the employer's plan. The amount is for self-only or family coverage, depending on the employee's election. The employer pays the amount directly to the exchange, with the employee retaining the excess amount if the cost of coverage in the exchange is less than the cost of the employer's coverage. [January 1, 2014]

Individual Responsibilities and State-Based Exchanges

Reform requires individuals to obtain health insurance or pay a tax. Also, Reform creates state-based exchanges where individuals and small businesses can go to obtain affordable coverage. Reform provides subsidies and credits to individuals and small businesses to make coverage more affordable through the exchange. Plans offered through the exchange will be required to comply with stricter requirements than plans offered outside of the exchange, however. Beginning in 2017, states can open up the exchanges to large businesses as well. [January 1, 2014]

Required Design Changes

Requirements for New Plans and Plans that Lose Grandfathered Status

First Dollar Coverage for Preventive Care. Employers may not impose cost sharing for preventive coverage. This means the employer must pay the full cost of preventive coverage, including immunizations, breast cancer screening and other services as recommended by the U.S. Preventive Services Task Force. [Plan years beginning on or after September 23, 2010]

Claim Appeals Process. Plans must have an effective internal appeals process and must provide participants with information about the process. Plans must also have an external appeals process that, at minimum, meets the Uniform External Review Model Reform promulgated by the National Association of Insurance Commissioners. [Plan years beginning on or after September 23, 2010, but employers may apply to the Secretary of HHS for a grace period]

Nondiscrimination for Fully-Insured Plans. Fully-insured health plans may not discriminate in favor of highly-compensated employees (nondiscrimination requirements applied to self-insured health plans prior to Reform). [Plan years beginning on or after September 23, 2010]

Out of Pocket Limits. Employers may not impose cost sharing in amounts greater than the current out of pocket limits for high deductible health plans (for 2010, $5,950 for individuals, $11,900 for families). [January 1, 2014]

Requirements for All Plans

Adoption Assistance Exclusion. Reform increases the adoption assistance exclusion to $13,170. [Tax years beginning on or after December 31, 2009]

Grandfathered Plans

Reform grandfathers plans in existence on March 23, 2010 from complying with certain requirements. Reform does not specify what will cause a plan to lose grandfathered status, except to say that enrolling new employees or adding family members will not affect grandfathered status. It is unclear whether design changes could cause a plan to lose grandfathered status, subjecting the plan to the full array of requirements. Reform treats collectively bargained health insurance differently than other grandfathered plans and insurance. A collectively bargained plan is exempt from certain requirements until the last of the collective bargaining agreements under the plan expires. Reform is unclear as to whether those arrangements then lose all grandfathered status or fall into the broader general grandfathered status with an unlimited duration.

Adult Children Coverage. Employers offering dependent coverage must extend coverage to adult children (regardless of marital status) up to age 26. Employers are not required to offer coverage to an adult child's spouse or children. Reform extends the exclusion from gross income for coverage of adult children. Grandfathered plans may exclude adult children who are eligible for coverage under another employment-based health plan. [Plan years beginning on or after September 23, 2010]

No Rescissions. Employers and insurance companies may no longer retroactively cancel coverage except in limited circumstances. There is an exception for fraud. [Plan years beginning on or after September 23, 2010]

Restrictions on Lifetime and Annual Limits. Employers may no longer set lifetime limits on essential benefits. Only "reasonable" annual limits on essential benefits are permitted until 2014, with the Secretary of HHS to further define what limits are reasonable. Starting in 2014, annual limits on essential benefits are prohibited. [Plan years beginning on or after September 23, 2010]

No Preexisting Condition Exclusions. Employers may not exclude coverage for preexisting conditions. [Provision applies to dependents under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]

Automatic Enrollment. Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible for coverage. Employees may opt out of coverage. [Effective date not clear from legislation, but employers may be required to comply as soon as regulations are issued]

No Reimbursement for Over-the-Counter Drugs. Employees may no longer purchase non-prescription over-the-counter drugs on a pre-tax basis through health FSAs, HSAs, Archer MSAs or HRAs. [Tax years beginning on or after January 1, 2011]

Changes to Taxation of HSA Withdrawals. Reform increases the tax on non-medical withdrawals from health savings accounts from 10% to 20%. [January 1, 2011]

Cap on FSA Contributions. Reform imposes a $2,500 cap on employee health flexible spending account contributions. Previously, there was no Federal limit on employee health FSA contributions, but many employer-sponsored plans already impose a cap. This cap is indexed to inflation starting in 2014. [January 1, 2013]

90-Day Limit on Waiting Period. Employers may not impose a waiting period longer than 90 days for health care coverage. [Plan years beginning on or after January 1, 2014]

Coverage for Clinical Trials. Employers must provide coverage for clinical trials for life-threatening diseases. [Plan years beginning on or after January 1, 2014]

Wellness Programs. Reform increases the wellness program incentives cap from 20% to 30%. Employers may encourage employees to participate in wellness programs through premium assistance, waiver of cost sharing or other incentives, but employers must provide an alternative arrangement for individuals who are unable to participate due to certain limitations. [Plan years beginning on or after January 1, 2014]

Retiree Medical

Retiree Reinsurance. Reform creates a temporary retiree reinsurance program that reimburses employers for qualifying retiree medical expenses. Employers can submit claims to the Secretary of HHS for medical expenses for retirees over age 55 who are not yet eligible for Medicare. The program reimburses up to 80% of expenses between $15,000 and $90,000 per retiree. Employers must use reimbursements to reduce the cost of providing medical coverage. This program ends at the earlier of the time the funding runs out or January 1, 2014. [Program begins 90 days following enactment]

Medicare Part D Donut Hole. Currently, Medicare Part D beneficiaries who exceed the prescription drug coverage limit are personally responsible for the cost of prescription drugs until the cost reaches the catastrophic coverage limit. This creates a "donut hole" of personal responsibility for Medicare Part D prescription drug coverage. Reform provides a $250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. Reform increases discounts in subsequent years and completely closes the donut hole by 2020. This provision is significant for employers providing coverage for retirees to supplement Medicare Part D coverage. [Phase out begins January 1, 2011]

Tax on Retiree Drug Subsidy. Under current law, employers who provide retiree prescription drug coverage at least as generous as Medicare Part D are eligible for a Federal subsidy. Employers are permitted to take a deduction equal to the amount of the subsidy received. Reform eliminates the deduction for the subsidy, which can create a huge liability on employers' balance sheets. While this provision does not take effect until 2013, accounting rules require employers to report this expense on financial statements immediately. [Tax years beginning on or after January 1, 2013]

Taxes and Fees

Comparative Effectiveness Fee. Reform imposes a new comparative effectiveness research fee. Starting in 2012, employers sponsoring group health plans must pay $1 per participant. The fee increases to $2 per participant in 2013, then to an amount indexed to national health expenditures thereafter. The comparative effectiveness fee phases out by 2019. Revenue from this fee will fund research to determine the effectiveness of various forms of medical treatment. [Plan years ending after September 30, 2012]

Cadillac Tax. Reform imposes a 40% excise tax on the value of health insurance benefits exceeding a certain threshold. The tax includes all employer and employee amounts paid for medical, including pre-tax employee premiums, but it does not include dental or vision. The thresholds are $10,200 for individual coverage and $27,500 for family coverage (indexed to inflation). The plan administrator is responsible for calculating the value of coverage and dividing the tax pro rata among insurers (including the employer, if self-insured). The thresholds increase for individuals in high-risk professions and for employers that have a disproportionately older population. [Tax years beginning on or after January 1, 2018]

Changes to Taxation of Health Care Company Employee Compensation. Reform provides that a health insurance company cannot deduct compensation paid to an employee in excess of $500,000 per year. [Applies to current compensation beginning in 2013; applies immediately to compensation deferred in 2010 and paid on or after 2013]

Reporting Requirements and Employee Communications

Transparency Disclosures. Employers must submit to the Secretary of HHS (and make available to the public) information regarding claims payment policies, enrollment information, information on cost sharing and rating policies, information on

out-of-network coverage and information on participant rights. The Secretary of HHS may require additional information as well. [Plan years beginning on or after September 23, 2010]

New Form W-2 Reporting Requirement. Employers are responsible for reporting the total cost of medical benefits provided on employee Form W-2s. Employers should use COBRA rates to determine the value of benefits. [January 1, 2011, with the cost of coverage to be reported on January 2012 Form W-2s]

Corporate Service Provider Reporting. Employers must issue Form 1099s reflecting any payment over $600 to corporate service providers. [January 1, 2012]

Uniform Explanation of Coverage. Employers must provide a summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment. Employers may provide the summary in paper or electronic form. The summary must be no more than four pages in length, a minimum of 12 point font, and should be written in a manner that is easy for the average participant to understand. The summary should contain information regarding cost sharing, continuation of coverage, limitations on coverage and details on where participants can obtain more information. The Secretary of HHS will provide a model summary in advance of the reporting requirement. Failure to comply will result in a fine. [March 23, 2012]

Modification Notice. Employers must provide notice of any material modification to benefits 60 days in advance of implementing those modifications. Failure to comply will result in a fine on a per-enrollee basis. [March 23, 2012]

Employee Notice Requirements. Employers must provide new and existing employees with information about the exchange, including information on employee eligibility if the employer's coverage is not affordable and information on free choice vouchers and premium credits. [March 1, 2013]

Certification of Health Care Coverage. Employers must certify that all full-time employees were offered health care coverage. The certification should specify the length of the waiting period under the plan, the time period during which coverage was available, the premium charged and the employer's share of the cost. The Secretary will use the certification to enforce the individual mandate. [January 1, 2014]

Payroll Implications

Long-Term Care Benefit. Reform creates a new employee-funded long-term benefit program. This is a voluntary program that employers may choose to implement. Employees would pay monthly premiums through payroll deduction. After five years of contributing, the employee becomes eligible to receive assisted living funding in the event the employee is no longer able to perform normal daily activities. Employee participation is also voluntary, but employers who choose to implement the program must automatically enroll employees unless they opt out. [January 1, 2011]

Medicare Tax on High Income Earners. Reform increases the Medicare Hospital Insurance withholding requirement by 0.9% for high earners (individuals earning more than $200,000 and families earning more than $250,000). The increase only applies to wages in excess of the thresholds. There is no similar increase for employers' Medicare contribution. [January 1, 2013]

Compliance Timeline—Quick Reference Guide		
Effective Immediately	• Automatic Enrollment* • Increased Adoption Assistance Exclusion	• Limit on Deductions for Health Care Company Employee Compensation
Effective 90 Days following Enactment	• Temporary Retiree Reinsurance Program	
Effective Plan Years Beginning on or After September 23, 2010	• No Lifetime Limits • Adult Children Coverage • No Rescissions • First Dollar Coverage for Preventive Care** • Revised Appeals Process**	• Restricted Annual Limits • No Preexisting Condition Exclusions for Children • Transparency Disclosures • Nondiscrimination Rules Extended to Insured Plans**
January 1, 2011	• No Reimbursement for OTC Drugs • Form W-2 Reporting of Value of Benefits	• Long-Term Care Program • Increase Penalty for Non-Medical HSA Withdrawals
January 1, 2012	• Corporate Service Provider Reporting Requirement	
March 23, 2012	• Uniform Explanation of Coverage	• 60-Day Notice in Advance of Modifications
January 1, 2013	• Medicare Tax Increase for High-Earners • No Deduction for Retiree Drug Subsidy	• Cap on Health FSA Contributions • Comparative Effectiveness Fee
March 1, 2013	• Employer Notification Regarding Exchanges	
January 1, 2014	• State-Based Exchanges • Free Rider Penalty • No Preexisting Condition Exclusions • Limit on Employee Out of Pocket Expenses** • Employer Certification of Coverage • Increased Wellness Program Incentives	• Individual Mandate • Free Choice Vouchers • No Annual Limits • Required Coverage for Clinical Trials for Life-Threatening Diseases • 90-Day Limit on Waiting Periods • Retiree Reinsurance Program Ends

**Effective Date Unclear*

***Grandfathering Applies (but the treatment of collectively bargained arrangements is unclear)*

Frequently Asked Questions

1. If my plan is grandfathered, does that mean I do not have to comply with any of the new requirements?

No. Grandfathered status only applies to a limited number of provisions in the legislation, including first dollar coverage for preventive care, nondiscrimination requirements for insured plans, the revised appeals process, and the limits on employee out of pocket expenses. PPACA included more grandfathered provisions, but those provisions were removed by the Reconciliation Bill. It is not clear whether the Reconciliation Bill changes applied to collectively bargained plans (meaning existing collectively bargained plans may not be required to comply with (i) the ban on lifetime and annual limits, (ii) the ban on rescissions, (iii) the ban on preexisting condition exclusions, and (iv) required coverage for adult children until the last collective bargaining agreement under the plan expires).

2. What will cause my plan to lose grandfathered status?

Reform is not clear on this point. Reform allows grandfathered plans to enroll new employees or add dependents without losing grandfathered status, but it is silent on what other changes are permitted. Further guidance should clarify this point.

3. Can I divide my employees among several corporate entities to avoid the free rider penalty?

Probably not. Reform applies “controlled group” rules for purposes of determining the number of full-time equivalent employees. Controlled group rules are complicated, but they generally require aggregating employees of commonly owned entities.

4. What benefits are affected by the ban on annual and lifetime limits?

Reform prohibits lifetime and annual limits on only a limited set of “essential benefits.” These include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care; and
- Any additional benefits that the Secretary later deems “essential.”

5. How will Reform affect COBRA?

In the short term, Reform should have no effect on COBRA. Individual coverage through the exchanges is not available until 2014, so employees who experience a COBRA qualifying event will still rely on COBRA continuation coverage. It remains to be seen how COBRA will operate once the exchanges are established. Presumably, individuals will be able to obtain coverage at a more affordable rate through the exchange than through COBRA continuation coverage, so it may become a less attractive option. Nonetheless, nothing in Reform affects the actual operation of COBRA.

6. Do adult children need to maintain student status to obtain coverage through their parents’ employment-based plan? Do they need to be IRS dependents?

There is no requirement that an adult child maintain full-time student status to be eligible for coverage up to age 26. Also, while Reform extends the exclusion from gross income to adult children, it does not require that those adult children

maintain dependency status. This exclusion from gross income appears to be effective immediately, although this is probably a legislative drafting error (it is more likely that Congress intended this exclusion to go into effect at the same time that the required adult dependent coverage goes into effect).

7. Who pays the "Cadillac tax"?

The Cadillac tax is divided pro rata among insurance coverage providers. In fully-insured plans, the cost is divided among the various insurers. For plans that are entirely self-insured, the employer is responsible for the tax. Most expect the insurers to ultimately pass on the costs to employers and individuals through increased premiums, however.

8. What should I tell my participants about the Reform at this time?

Less is more at this point. Most businesses are still attempting to determine the impact of Reform on the cost of coverage and the options available. Our understanding of the legislation could change as more guidance is released. There is no harm in informing employees that you are analyzing the impact of Reform and you will provide more information as it becomes available. Otherwise, you run the risk of misstating provisions or leaving out provisions that some employees deem significant.

9. When will we have further guidance?

It is very difficult to say, but it is safe to assume that the guidance will come in the order of effective dates. The agencies responsible for promulgating guidance are currently working on the details of the retiree reinsurance program, which is slated to start June 21, 2010.

10. Will the legislation be repealed or overturned through a constitutional challenge?

While some states and special interest groups have filed or threatened constitutional challenges, it is unlikely (but not out of the question) that the courts will overturn Reform. Most political analysts also suggest that congressional repeal is unlikely, because, while Reform faced substantial resistance leading up to passage, repeal efforts would not be without political fallout.