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Health Care Reform Is Here

The Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, is now law and health care reform has become a reality. Although a full understanding of the new law and its implications will require months of review along with significant regulatory guidance, we highlight here the major provisions and what employers need to consider in the short term.

Background

During his presidential campaign, Barack Obama promised health care reform. After his election, health care reform proposals were offered, amended, scaled back, and debated extensively, and bills were finally passed by the end of 2009 by both houses of Congress. The whole process appeared to derail with the election of Senator Scott Brown (R-MA), whose election reduced by one the 60 votes needed by Senate Democrats to avoid a Republican filibuster that would have effectively killed the legislation. When President Obama intervened, agreements were reached and a final bill was approved and then amended through the budget reconciliation process.

The Health Care Reform Law

The law, the Patient Protection and Affordable Care Act, as amended by the Reconciliation Act, has far reaching implications for employers and their employees. In what follows, we highlight the major provisions, note when they are effective, and discuss their implications for both employers and employees. For a high level review of the law, please see our [Health Care Reform at a Glance](#).

Individual Responsibility and Insurance Exchanges

Starting in 2014, almost all U.S. citizens and legal residents will be required to obtain health coverage, or if they do not, to pay an annual penalty, as follows –

- 2014 – the greater of 1.0% of household income above the tax filing threshold or \$95
- 2015 – the greater of 2.0% of household income above the tax filing threshold or \$325
- 2016 – the greater of 2.5% of household income above the tax filing threshold or \$695.

These dollar amounts will be indexed after 2016. The penalty amount for a family is capped at 300% of the individual penalty. In addition, individuals whose required contributions for coverage through an Exchange (see

below) or for an employer plan exceed 8% of income are exempt from the penalty. No penalty is assessed for individuals who fail to maintain coverage for three months or less during the year.

BUCK COMMENT. *Individuals may satisfy this requirement by having coverage through an employer plan, a government sponsored plan, or an Exchange plan. Because of this new mandate on individuals, employers may see increased enrollment.*

Insurance Exchanges. By 2014, each state is required to set up an insurance Exchange that will facilitate the purchase of health insurance for certain individuals and small employers (100 or fewer employees), either through private insurers or a co-op. Large employers will not be allowed to participate before 2017. The coverage provided through an Exchange must include a minimum essential benefits package, which requires coverage of specific benefits and various levels of cost sharing.

Low Income Subsidies. Individuals whose income is between 100% and 400% of the federal poverty level (FPL) will be entitled to premium and cost-sharing subsidies from the federal government in connection with coverage obtained through an Exchange. These subsidies will also be available for an employee whose income is between 100% and 400% of the FPL if the employee declines coverage under an employer plan that is “unaffordable” or does not meet the minimum value test, as discussed below.

Employer Responsibility

Effective in 2014, employers with 50 or more employees will have to either provide coverage to all full-time employees or pay an assessment. The law also includes automatic enrollment and new reporting requirements.

Employers That Do Not Provide Coverage. If an employer with 50 or more employees does not provide health coverage to all full-time employees and their dependents, and at least one full-time employee obtains the low-income premium subsidy through an Exchange, the employer will be assessed a penalty of \$2,000 for each full-time employee (over a 30-employee threshold) in its workforce. Unlike health insurance premiums or contributions, this penalty is not deductible by the employer.

BUCK COMMENT. *The \$2,000 per employee penalty will generally be significantly below the actual cost of most employer plans.*

Employers That Provide Unaffordable Coverage or Coverage Below Minimum Value. Employers with 50 or more employees that provide health coverage may also be subject to penalties if the coverage is deemed unaffordable or does not meet an actuarial value test. An employer offering health coverage will be subject to the penalty for each full-time employee who enrolls in an Exchange and qualifies for a low-income subsidy because either of the following occurs –

- The plan does not meet a 60% minimum value test – i.e., the plan’s share of the payments for covered benefits must be at least 60% of the total payments.

- The cost of coverage to an individual employee exceeds 9.5% of that employee's household AGI.

The penalty is generally \$3,000 per full-time employee receiving the subsidy, but the maximum penalty is \$2,000 times the number of full-time employees (over a 30-employee threshold).

BUCK COMMENT. *As with the \$2,000 penalty for not providing coverage, this \$3,000 per employee penalty will generally be significantly below the actual cost of most employer plans.*

The penalties for not providing coverage or providing unaffordable coverage are assessed on a monthly basis. There appears to be no penalty in connection with part-time employees who receive coverage through an Exchange and receive the subsidy. Employers are not required to determine whether a particular employee is entitled to the subsidy – the Exchange will notify the employer after making a determination based on the employee's household income. The employer has a right to appeal the determination.

BUCK COMMENT. *The employer coverage does not have to meet any specified minimum benefit requirements or employer premium contribution level.*

Free Choice Vouchers. An employer that provides health coverage and pays a portion of the cost must provide certain qualified employees with a voucher that they can use to purchase coverage through the Exchange. Qualified employees are those individuals whose household income is below 400% of the FPL and whose premium cost under the employer plan is between 8% and 9.8% of household income. The value of the voucher must be equal to the greatest employer contribution under any of the plan options for which the employee is eligible. If the cost of the employee's coverage from the Exchange is more than the value of the voucher, the employer will pay the full amount of the voucher to the Exchange and the employee will pay the remainder due. The amount paid by the employer is not included in the employee's income. If the cost of the employee's coverage from the Exchange is less than the voucher amount, the employer must pay the excess to the employee as wages, subject to withholding and payroll taxes. The full amount of the voucher is deductible by the employer.

Automatic Enrollment. Employers with more than 200 full-time employees will be required to automatically enroll their employees in one of the plans offered (if the employee does not otherwise enroll). Employers must then provide notices to employees apprising them of their enrollment and giving them the opportunity to change the election or opt out.

BUCK COMMENT. *It is unclear when this provision is effective. This subsection of the new law does not contain a specific effective date, although all other provisions in this section specify a January 1, 2014 effective date. It is hoped that DOL guidance will clarify.*

Reporting and Disclosure Requirements. Besides the automatic enrollment notification, several new reporting and disclosure requirements go into effect at various times, including –

- HHS, DOL and Treasury are to develop standards for a 4-page "uniform explanation" of the group health plan's benefits and coverage. The explanation will use standard definitions and common terms, and must

be in 12 point font. The law gives the agencies one year to develop the standards, and provides that plans must distribute the explanation for plan years starting after DOL releases the standards.

BUCK COMMENT. *The uniform explanation of coverage will contain information that already is required to be in a summary plan description (SPD). However, group health plans subject to ERISA will be required to distribute this uniform explanation of coverage in addition to any required SPD.*

- By March 31, 2013, employers must provide workers with a notification about the availability of the new insurance Exchanges and how to contact an Exchange.
- Beginning with employees' W-2s for 2011 (required to be issued by the end of January 2012), employers must report the aggregate value of health coverage as well as health reimbursement account (HRA) and health savings account (HSA) employer contributions. Contributions to health FSAs do not have to be reported.
- Beginning in 2014, employers will have to file annual returns with the IRS reporting information on the coverage they provide and on those receiving it. Information will also have to be reported to employees before January 31 of the year following the reporting year.

Market Reform Provisions

The law includes many insurance market reforms, some of which are effective for the first plan year beginning on or after September 23, 2010, and some of which do not apply until January 1, 2014. In addition, some of the provisions apply to all plans, while others do not apply to grandfathered health plans – i.e., those plans in effect on March 23, 2010.

Provisions Generally Effective for Plan Years Beginning on or After September 23, 2010 – All Plans

Coverage of Children to Age 26. Group health plans offering dependent coverage will have to allow employees to cover their adult children until they reach age 26, regardless of tax dependent status. There is a special rule for grandfathered health plans – they do not have to cover adult children who are eligible for other employer-sponsored coverage. Coverage of the children of adult children is not required. The law also changes the tax code to exclude health benefits (including dental and vision) from an employee's income through the end of the calendar year in which the dependent reaches age 26.

BUCK COMMENT. *This extension of coverage means that plans will be required to provide dependent coverage to non-students. It is also possible that coverage of married adult children may be required. The law does not address whether the employee can be charged more for this extended coverage.*

Lifetime and Annual Dollar Limits. Health plans are prohibited from having lifetime dollar limits for essential health benefits (e.g., hospitalization, preventive care and wellness). Until January 1, 2014, restricted annual

dollar limits may be imposed on essential benefits under guidance to be issued by HHS. Thereafter, no annual dollar limits may apply.

BUCK COMMENT. *The law addresses dollar limits and does not appear to prohibit limiting the number of visits, hospital days or treatments. However, guidance may clarify this.*

Preexisting Condition Limitations for Certain Dependents. No preexisting condition limitations may be imposed on dependent children under age 19.

Rescission of Health Coverage. Once an individual is covered under a health plan, the plan may not rescind that individual's coverage except in cases of fraud or intentional misrepresentation.

Provisions Generally Effective for Plan Years Beginning on or after September 23, 2010 for New Plans – Not Applicable to Grandfathered Health Plans

Several provisions are also effective for the first plan year that begins after September 23, 2010, but current plans are grandfathered and do not need to comply with these requirements.

Preventive Health Services. Specified preventive health services will have to be covered at 100%.

Appeals Process. Group health plans will have to implement internal and external appeals processes and provide notices to participants about the processes, as well as about any other appeals assistance. Plans will be required to allow participants to review their files and provide other opportunities to present evidence, while allowing them to continue coverage during the process.

Nondiscrimination Requirements. Insured plans will not be able to discriminate in favor of highly compensated employees – i.e., the prohibitions against discrimination for self-insured plans under Internal Revenue Code Section 105(h) will now apply to insured plans.

Choice of Providers. Plans will be required to allow enrollees to select their primary care provider or pediatrician from any available participating provider. Plans will no longer be able to require preauthorization or referrals for obstetrical and gynecological services. No prior authorization may be required for emergency services, and out-of-network emergency care will have to be handled in accordance with in-network benefit terms.

Provisions Effective No Later than January 1, 2011

Medical Loss Ratio (MLR). Health insurance issuers will have to meet certain medical loss ratios (85% large employer/80% small employer and individual). If these ratios are not met, the insurer will have to rebate the excess to participants and beneficiaries.

BUCK COMMENT. *Health insurance issuers will need to determine if they will be subject to this requirement and if so, establish a way to pass through these rebates to participants and beneficiaries.*

Provisions that Apply for Plan Years Beginning on or after January 1, 2014 – All Plans

Coverage of Children to Age 26. Grandfathered plans offering dependent coverage will now also have to allow employees to cover their adult children until they reach age 26 even if the children are eligible for other employer-sponsored coverage.

Preexisting Condition Exclusions. Plans will no longer be able to exclude any individuals with preexisting conditions from coverage.

Annual Limits. As noted above, no annual dollar limits on essential benefits may be imposed.

Waiting Periods. Group health plans will no longer be able to have waiting periods of more than 90 days.

Provisions that Apply for Plan Years Beginning on or after January 1, 2014 – Not Applicable to Grandfathered Health Plans

Clinical Trials. Plans will be required to cover certain costs of approved clinical trial procedures.

Reporting of Health Improvement Strategies. Plans will be required to implement various activities such as case management, reduction in hospital readmission and wellness programs and report the status of the activities to HHS and participants.

Premium Rate Increase. HHS, in conjunction with each state, will have to implement a program to review any proposed annual rate increase by insurers.

HIPAA Wellness Incentives. For plans established after March 23, 2010, the law codifies the provisions related to wellness programs that are included in the nondiscrimination regulations under the Health Insurance Portability and Affordability Act (HIPAA). (See our January 16, 2007 [For Your Information](#).) However, the law increases the limit on the award for participating in a wellness program to 30% of the cost of coverage (from 20%) and gives HHS authority to raise this limit to 50%.

BUCK COMMENT. *It appears that grandfathered plans would not be subject to this change. This is possibly an error that may be fixed through technical corrections.*

Financing Provisions

“Cadillac” Tax. Effective for tax years beginning in 2018, health plans will be subject to an excise tax of 40% of the value of the coverage that exceeds \$10,200 for individual coverage and \$27,500 for family coverage. In 2019, these amounts will be indexed based on CPI-U+1 and thereafter, based on only CPI-U. The limits may be higher for retiree coverage and certain high-risk occupations and for plans with higher than average age and/or percentage of female participants. For this purpose, the value of coverage does not include dental and vision

coverage that is offered separately from medical coverage. Finally, the law provides for an automatic adjustment of these numbers if health care inflation grows at a rate higher than the projections.

Medicare Hospital Insurance Tax. Beginning in 2013, the current rate of 1.45% on all income will be increased to 2.35% on earned income in excess of \$200,000 for single filers and in excess of \$250,000 for joint filers. In addition, there will be a 3.8% tax imposed on net investment income for these high-income taxpayers.

BUCK COMMENT. *Net investment income does not include distributions from qualified retirement plans.*

Provider Surcharges. Surcharges will be imposed on pharmaceutical manufacturers (starting in 2011), on medical devices (starting in 2013) and on insurers (starting in 2014).

Health Flexible Spending Accounts. Starting in 2013, salary reduction contributions to health FSAs will be limited to \$2,500.

Nonqualified Withdrawals from HSAs. The law increases from 10% to 20% the penalty for using HSA withdrawals for other than qualified medical expenses.

OTC Drug Reimbursements. Beginning on January 1, 2011, the cost of over-the-counter drugs, other than insulin, will not be eligible for reimbursement as a qualified medical expense under HSAs, HRAs, and health FSAs unless prescribed by a physician.

Retiree Health Provisions

Retiree Drug Subsidy Payments. Starting in 2013, employers will no longer be able to take a deduction for expenses for which they receive Medicare retiree drug subsidy reimbursements.

BUCK COMMENT. *Employers are already reporting for the first quarter of 2010 the financial impact of this loss of the tax deduction.*

Reinsurance Program for Early Retirees. Beginning June 21, 2010, \$5 billion will be provided to subsidize the costs of employer-provided retiree health coverage for retirees aged 55 through 64, and their dependents. The subsidy is 80% of a retiree's or beneficiary's claims of \$15,000 to \$90,000. The law states that the reimbursement may be used to lower either the plan's cost or the participant's cost. However, an employer may not use these reimbursements as general revenue. This program will continue through 2013 or until the funds run out, if sooner.

BUCK COMMENT. *This program appears to present a good opportunity for savings, although there are specific coverage and filing requirements. The law states that reimbursements may be used to lower the plan's costs, but a Fact Sheet posted by HHS Secretary Sebelius on a White House blog suggests that the reimbursement can only be used to reduce participants' costs. (See our April 9, 2010 [For Your Information](#).)*

Medicare Part D Donut Hole. By 2020, the “donut hole” under Medicare Part D, in which no benefits are paid, will be phased out. In 2010, individuals who have entered the donut hole will receive a \$250 rebate. Starting in 2011, pharmaceutical manufacturers will provide a 50% discount on brand name drugs. Also, starting in 2011, beneficiary coinsurance will begin phasing down until it reaches the standard 25% coinsurance in 2020.

Application of Market Reform Provisions to Retiree Plans. It appears that market reform provisions such as the prohibition of annual and lifetime maximums or coverage of children to age 26 will apply to stand-alone retiree plans. However, additional guidance is needed.

Other Miscellaneous Issues

There are a number of other provisions in the law that are worth noting. A few of these are below.

HIPAA Electronic Data Interface. The law includes some revisions to the HIPAA EDI rules, which will go into effect following the issuance of regulations.

Voluntary Long-Term Care Program. The law sets up a long-term care program called the CLASS Act run by the government, which employers may voluntarily offer to employees. If offered, employers may also elect to automatically enroll employees and administer payroll deductions for the premiums.

Compensation Deduction Limit for Health Insurance Providers. Starting in 2013, the compensation deduction limit under IRC Section 162(m) will be \$500,000 for officers, directors, and other employees and service providers of certain health insurers.

Coverage Maintained under a Collective Bargaining Agreement (CBA). For coverage maintained under a CBA ratified before March 23, 2010, it appears that the market reforms would not apply until the later of the termination of the last CBA relating to the coverage or the statutory effective date. However, additional guidance is needed on how this deferral applies to coverage maintained under a CBA and the interaction with the grandfathered provisions.

Facilitation of Breastfeeding. The law amends the Fair Labor Standards Act to generally require employers with 50 or more employees to provide reasonable breaks and a private place to mothers who are breastfeeding infants of up to one year of age so that they can express milk. This provision is effective immediately.

Conclusion

This broad overview of the new law shows that significant changes are in store for employers. In the weeks and months ahead, we will be providing more detailed information about this landmark legislation and what it means to you.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.