Reinhart

Health Care Reform: What Employers Need to Know for 2010 and 2011

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), enacting comprehensive health care reform legislation. On March 30, 2010, President Obama then signed the Health Care and Education Reconciliation Act (HCERA), amending certain provisions of PPACA (in this e-alert, PPACA and HCERA will be referred to together as the Act). The Act is lengthy, complex and will likely have a sweeping effect on the provision of health care to individuals in this country. Further understanding of the Act will require regulatory guidance and possibly additional legislation in the months and years to come. Nevertheless, employers and individuals must review the impact of certain sections of the Act now, as many provisions become effective in the next 18 months.

This e-alert describes the portions of the Act that may affect employers, their health plans and their employees in 2010 and 2011. Subsequent e-alerts will address parts of the Act taking effect in later years.

Grandfathered Plans

The Act requires group health plans to make numerous plan design changes. The Act, however, "grandfathers" group health plans in existence on the date of enactment from application of some requirements. We note those requirements as appropriate below.

Reinhart Comment: The Act allows a plan to retain grandfathered status even if employees reenroll in a plan, or new family members or new employees join the plan. It is currently unclear what impact structural or design changes would have on a plan's grandfathered status.

Retiree Reinsurance Program

By June 21, 2010, the Department of Health and Human Services (HHS) must develop a program to reimburse employers for 80% of the cost of eligible claims incurred by retirees between ages 55 and 64. The program would reimburse claims over $15,000 and below $90,000. Reimbursements are not included in employer gross income, but must be used to reduce plan costs. The program

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ends on the earlier of January 1, 2014, or upon exhaustion of the $5 billion appropriated for the program.

Plan Design and Administrative Changes

The following changes are effective for the first plan year beginning on or after September 23, 2010. For group health plans that operate on a calendar year basis, these items are effective in 2011.

Reinhart Comment: Collectively bargained plans may be subject to a different effective date. Further guidance is needed to accurately establish what plans are considered collectively bargained and the exact effective date.

- Plans must provide coverage for adult children until age 26. However, for grandfathered plans prior to 2014, the requirement applies only if the adult child is not eligible under another employer plan. In 2014, the exclusion for other employer plan coverage is eliminated. Plans must extend coverage regardless of an adult child's marital status. The Act also excludes from the taxable income of the employee the value of covering an adult child who has not turned 27 by the end of the year.
- Plans may not impose lifetime limits on "essential health benefits."
- For plan years prior to 2014, plans may impose only "restricted annual limits" for essential health benefits. For plan years beginning on or after January 1, 2014, no annual limits may be imposed on essential health benefits.

Reinhart Comment: The Act directs HHS to provide guidance on the definition of "restricted annual limits." "Essential health benefits" include ambulatory patient services, emergencies, services, hospitalization, maternity and newborn care, mental health and prescription drugs, among other things. This classification may be expanded by regulation. The Act does not prohibit lifetime or annual limits on non-essential health benefits.

- Plans may not apply preexisting conditions to enrollees under age 19. Effective for plan years beginning on or after January 1, 2014, plans may not apply preexisting conditions to any enrollee.
- Plans may not rescind coverage except in the event of fraud or intentional misrepresentation.

- Plans must provide a new summary of benefits and coverage at initial enrollment and annual enrollment. This provision essentially requires plans to provide a "summary of the summary plan description," limiting the document to four pages. HHS will provide standards for the summary by March 23, 2011.
- Plans must provide first dollar coverage without cost-sharing for preventive care. "Preventive care" will include services recommended by the U.S. Preventive Services Task Force, which currently incorporates common screenings for children and women. ***This provision does not apply to grandfathered plans.***
- If a plan requires or provides for a participant designating a participating primary care provider, the plan must allow each employee to designate a participating primary care provider of choice, including a pediatrician for a child. Plans may not require preauthorization or a referral by or from the plan or primary care provider for a woman to see an obstetrical or gynecological provider. Plans also may not require preauthorization or increased cost-sharing for emergency services, regardless of whether provided in- or out-of-network. ***This provision does not apply to grandfathered plans.***
- The rules that prohibit a self-funded plan from discriminating in benefits or coverage in favor of highly compensated individuals now extend to insured plans. ***This provision does not apply to grandfathered plans.***
- Plans must provide an internal appeal process guaranteed to ensure an impartial review. This provision is generally consistent with the already existing procedures applicable to plans subject to ERISA. Plans must also develop an external review process that will comply with state rules (for insured plans) or a process developed by the plan consistent with HHS standards (for self-funded plans). ***This provision does not apply to grandfathered plans.***
- Plans must also provide certain coverage and claims payment information to HHS. ***This provision does not apply to grandfathered plans.***

Tax Items

- Effective in 2010, an employer with no more than 25 "full-time employees" and average annual employee wages of less than $50,000 may be eligible for a tax credit of up to 35% of the employer's premium costs. The Act requires use of the controlled group rules and full-time employee equivalencies for

determining the number of employees. The credit begins to phase out for employers with more than 10 full-time employees or average annual employee wages of $25,000 or more.

- Beginning in 2011, employers must report the aggregate value of health coverage on Form W-2. Self-funded plans will likely need to use the basis for determining COBRA premiums to disclose the cost of coverage.
- Beginning in 2011, a flexible savings account (FSA), health reimbursement account (HRA) or health savings account (HSA) may not reimburse over-the-counter medicines or drugs (except insulin) without a prescription.
- Effective in 2011, the tax on HSA distributions that are not used for qualifying medical expenses increases to 20% from 10%.
- Beginning in 2011, an employer with 100 or fewer employees in either of the preceding two years may offer a "simple" cafeteria plan. If the cafeteria plan meets certain safe harbor contribution, eligibility and participation requirements, the cafeteria plan will be treated as satisfying the nondiscrimination rules applicable to cafeteria plans.

Medicare Part D Retiree Prescription Subsidy

In 2010, Medicare Part D beneficiaries who reach the "donut hole" will receive a $250 rebate. Beginning in 2011, Part D beneficiaries who reach the donut hole will be eligible for a 50% discount on brand name drugs.

- Also in 2011, the donut hole will begin to be eliminated.
- Beginning in 2013, employers who receive a Federal subsidy for maintaining retiree prescription drug coverage will no longer be able to deduct the amount of the subsidy. Accounting rules require employers to recognize the loss of the deduction on a more immediate basis.

Reinhart Comment: The elimination of the donut hole will increase the actuarial value of the Part D program. Employers who maintain retiree prescription drug coverage may need to increase the value of their coverage to receive the subsidy. When combined with the elimination of the deduction for receiving the subsidy, employers may reconsider providing retiree prescription drug coverage at all.

Please contact your Reinhart Employee Benefits attorney with any questions regarding the Act.