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BENEFITS & COMPENSATION
>> ALERT

HEALTH CARE REFORM LEGISLATION: SIGNED, SEALED, DELIVERED

Massive health care reform legislation was signed into law on March 23, 2010 by President Obama. The Patient Protection and Affordable Care Act (the Act) overhauls our nation's health care system. It also imposes significant new responsibilities on employers that will likely, over time, fundamentally alter the nature of employer-sponsored group health care.

While many of the provisions of the Act will not apply until 2014, some become effective as soon as January 1, 2011, for calendar year plans (earlier for non-calendar year plans). Therefore, it is essential that employers understand the Act's requirements as soon as possible.

This Alert provides a description of important "high impact" items of the Act that affect employers and individuals. The descriptions below also include amendments to the Act made by the Health Care and Education Affordability Reconciliation Act, which was signed into law by the President on March 30, 2010.

HEALTH CARE REFORMS

The Act makes many reforms to health plans, whether insured or self-funded. Employers will need to revise their plan operations and documents to comply with these reforms.

For plan years beginning six months after March 23, 2010 (i.e., January 1, 2011, for calendar year plans):

- >> Exclusions for pre-existing conditions for covered children under the age of 19 are prohibited.
- >> Health coverage must be extended to children until they reach the age of 26. This requirement is applicable even if the child is not a tax dependent. The coverage for such children is excluded from income tax.
- >> Lifetime limits on the dollar value of benefits are prohibited.
- >> Annual limits on the dollar value of benefits may be "restricted" as determined by the United States Department of Health and Human Services (HHS).
- >> Plans may not rescind coverage, except in cases of fraud or intentional misrepresentation. Employers should still be free to terminate their plans.
- >> Cost-sharing for certain preventive services is prohibited.
- >> Plans must have an internal and external appeals process that meets certain requirements.

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THE BOTTOM LINE

Employers will need to focus immediately on provisions of the Act that become effective January 1, 2011 (earlier, in some cases, for non-calendar year plans). Administration, operation, processes, contracts, plans and SPDs will all need to be reviewed and revised. Employers will also need to begin planning for 2014, when the bulk of the Act becomes effective.

For plan years beginning on or after January 1, 2014:

- >> Exclusions for pre-existing conditions for all covered participants are prohibited.
- >> Annual limits on the dollar value of benefits are prohibited.
- >> Cost-sharing for non-preventative services is limited.
- >> Waiting periods exceeding 90 days are prohibited.
- >> Wellness program incentives are raised from 20% to 30% of the cost of coverage.

In addition:

- >> For plan years beginning on or after March 23, 2010, an insured plan must spend between 80% and 85% of its revenue on medical claims, or provide rebates to participants.
- >> The Act directs the HHS to establish rules within 12 months of enactment for employers to follow in providing a "uniform explanation of coverage" to enrollees upon initial enrollment and annual enrollment.
- >> For plan years beginning on or after January 1, 2014, insured plans must offer coverage on a guaranteed issue basis — in other words, coverage cannot be denied based on a person's health status.

GRANDFATHERED PLANS

The Act includes a provision that grandfathers all group health plans that are in place prior to the date of enactment (i.e., March 23, 2010). Grandfathered plans are exempt from some, but not all, of the provisions of the Act. For example, a grandfathered plan is still subject to the following requirements, among others:

- >> The prohibition on lifetime dollar limits.
- >> The prohibition on rescissions.
- >> The restriction on annual limits.
- >> The requirement to provide coverage for children up to age 26.

The foregoing provisions apply to a grandfathered plan on January 1, 2011 (assuming the plan is a calendar year plan).

Effective January 1, 2014, a grandfathered plan cannot have exclusions based on pre-existing conditions or contain an annual dollar limitation on benefits. Excessive waiting periods are also prohibited. The Act is not clear about how subsequent amendments to a grandfathered plan will impact the plan's grandfathered status. This issue will likely be clarified by regulations. Loss of grandfathered status should be considered by an employer before making changes to its health plans.

NON-DISCRIMINATION RULES APPLY TO FULLY INSURED PLANS

Self-insured medical plans have long been subject to nondiscrimination rules under Section 105(h) of the Internal Revenue Code. Beginning January 1, 2011 (for calendar year plans), the non-discrimination rules will also apply to fully insured plans. The nondiscrimination rules require essentially two things. First, that a plan must cover a reasonable number of non-highly paid employees. Second, that the benefits provided by the plan do not discriminate in favor of highly paid employees.

Employers that maintain fully insured plans will now need to evaluate their plans under Section 105(h). Red flag items for employers that need to be considered immediately include any practice under which the employer is contributing more on behalf of highly paid employees, providing more generous benefits to highly paid employees, and excluding all or certain groups of non-highly paid employees from coverage.

RETIREE MEDICAL SUBSIDY FOR EMPLOYERS

The Act allocates $5 billion within 90 days following enactment to finance a temporary federal reinsurance program to reimburse employers that provide health insurance to retirees ages 55–64 and their families. The program will

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reimburse employers for 80% of the cost of benefits in excess of $15,000 and below $90,000. An employer will be required to use these funds to lower the cost of the plan. This may be a financial opportunity that should be immediately analyzed by qualifying employers.

MEDICARE PART D

The federal government currently provides a 28% subsidy to employers who provide their retirees with prescription drug coverage under Medicare Part D and apply for the subsidy. The subsidy is not currently included in the employer's income tax. Under the Act, effective January 1, 2013, employers will be taxed on the Medicare Part D subsidies they receive. This is likely to be a deterrent to the continued use of the Medicare Part D subsidy. In addition, the taxation of Medicare Part D subsidies in 2013 may have an immediate impact on a company's financial statement. For example, AT&T recently announced that it would have to take a $1 billion charge against earnings as a result of the changes to Medicare Part D.

TAX CREDIT FOR SMALL EMPLOYERS

Effective for tax years beginning on or after January 1, 2010, employers with less than 25 full-time equivalent employees are eligible for a tax credit based on the employer's cost to provide health coverage.

EMPLOYER MANDATE

The Act does not require employers to offer health care coverage to their employees. However, a "large employer" (i.e., having 50 or more full-time employees) will be penalized in most cases if it does not offer any coverage or if the coverage it offers is inadequate. The penalty provisions of the Act are effective January 1, 2014. We believe that some employers will ultimately choose to pay a penalty instead of offering health coverage to their employees, although we do not expect this practice to be widespread, at least initially.

A large employer that does not maintain coverage will be penalized if at least one of its employees receives subsidized coverage through a health insurance exchange. The penalty is $2,000 for EACH full-time employee, except the first 30 employees are subtracted when calculating the penalty due.

A large employer maintaining coverage that is inadequate will also be penalized if at least one of its employees receives subsidized coverage through a health insurance exchange. Under the Act, it appears that employer-provided coverage is "inadequate" if the plan's share of costs of benefits is less than 60% or the employee-portion of the premium exceeds 9.5% of the employee's household income. The penalty is $3,000 for each full-time employee who is receiving the subsidized exchange coverage, but is capped at an amount equal to $750 multiplied by the total number of the employer's full-time employees. Furthermore, the penalty is not assessed with regard to employees who receive free-exchange vouchers from their employer.

For purposes of the above, a "full-time" employee is any employee who is employed on the average of at least 30 hours per week. Treatment of "temporary," "seasonal" and similar workers will likely be clarified by regulations.

INDIVIDUAL MANDATE

Although there are exceptions, individuals must obtain qualified health coverage by 2014. If they do not obtain health coverage, they will incur a penalty. As described below, the penalty will vary based on income level and will be phased in over three years from 2014 through 2016. Persons who are deemed not to be able to afford coverage (i.e., those with incomes of up to 400% of the Federal Poverty Level or FPL) will be eligible for subsidized coverage through an insurance exchange.

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The penalty for not having qualified coverage is calculated as the lesser of:

- >> The national average premium for the year.
- >> The greater of a percentage of income or a flat dollar amount. The percentage of income is 1% in 2014, 2% in 2015 and 2.5% in 2016. The flat dollar amounts are nominal.

Exceptions from the penalty will be made for those with religious exemptions, individuals not lawfully present in the United States, those who cannot afford coverage, those who have received a hardship waiver, among others.

Qualified coverage includes, but is not limited to, eligible employer-sponsored coverage and individual health plans that provide certain benefits and that reflect the health care reforms discussed in this Alert. Employers will need to ascertain whether their plans offer qualified coverage so their employees can avoid the penalties.

HEALTH INSURANCE EXCHANGES

The Act requires states to create "health insurance exchanges" through which individuals and small employers can obtain health insurance. An "exchange" is essentially a virtual marketplace in which individuals and groups may shop for health plans that best suit their needs. The exchanges will open in 2014. Generally, the exchanges will be open to employers with 100 or fewer employees (50 or fewer employees in some cases), although states could allow larger employers to participate beginning in 2017. The exchanges will offer health insurance plans at four different levels:

- >> "Platinum" which must have 90% actuarial value.
- >> "Gold" which must have 80% actuarial value.
- >> "Silver" which must have 70% actuarial value.
- >> "Bronze" which must have 60% actuarial value.

A plan's "actuarial value" is the percentage of covered expenses paid by the plan. The exchanges will also offer a lower cost catastrophic coverage health plan for individuals age 30 or younger. The Act provides federal subsidies and tax credits to individuals and families up to 400% of the FPL to purchase health insurance through the exchanges. Employers who offer health coverage through an exchange may permit employees to pay for such coverage with pre-tax dollars through a written cafeteria plan maintained and adopted by the employer.

EMPLOYERS MUST PROVIDE FREE CHOICE VOUCHERS

Beginning 2014, the Act requires employers that make a contribution toward health coverage to provide "free choice vouchers" to qualified employees for purposes of purchasing insurance coverage through an exchange. The free choice voucher must be equal to the most generous contribution that the employer would have made to its own plan on behalf of the qualified employee. An employee qualifies for the free choice vouchers if:

- >> The employee's required contribution under their employer's plan is between 8% and 9.5% of their income.
- >> The employee's income is at or below 400% of the FPL.

Free choice vouchers are tax-free to the employee, but employers may deduct the amount of the vouchers as an ordinary and necessary business expense. In addition, employees may cash-in the amount of their voucher in excess of the cost of purchasing insurance through the exchange. How employers track the household income of employees will likely be clarified by regulations.

AUTO-ENROLLMENT

Beginning January 1, 2014, employers with 200 or more full-time employees that offer a health plan must automatically enroll all new employees in the health plan and continue the enrollment of participating employees. An employer's auto-enrollment program should include adequate notice and offer employees the opportunity to change coverage or "opt-out" of coverage altogether.

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REPORTING AND DISCLOSURE

Not unexpectedly, the Act imposes many new reporting and disclosure requirements on employers and insurers. For example, for tax years beginning after December 31, 2010 (i.e., the 2011 IRS Form W-2 prepared in 2012), employers must report on Form W-2 the aggregate cost of health care received by an employee under the employer's plan. The cost of healthcare is determined in a manner similar to that under COBRA.

FLEXIBLE SPENDING ARRANGEMENTS

Beginning January 1, 2013, annual contributions to a flexible spending account are capped at $2,500. Thereafter, the cap is adjusted to reflect increases in the Consumer Price Index for All Urban Consumers (CPI-U). The limit will raise health care costs for employees with health care expenses in excess of $2,500 to the extent their current FSA permits contributions in excess of $2,500. Dependent care FSAs are not affected. Beginning January 1, 2011, over-the-counter medicines and drugs will not be eligible for reimbursement under an FSA, HRA or HSA without a prescription.

EXCISE TAX ON HIGH-COST PLANS

Under the Act, insurance companies and plan administrators have to pay an excise tax for any health plan for which the premium for single coverage is above $10,200 and the premium for family coverage is above $27,500. The excise tax, which is effective in 2018, is equal to 40% of the premium in excess of the threshold amounts. The excise tax is paid by the insurer, or, if the plan is self-funded, by the employer or administrator. The cost of dental and vision care benefits in stand-alone plans are apparently not factored into health care costs for excise tax purposes. Therefore, some employers maintaining wrap plans will need to consider whether to "un-wrap" the dental and vision portions of their plan. The threshold amounts are indexed for inflation, but depending on how health care costs rise, more and more plans may be subject to the excise tax. Among the likely responses to the excise tax by employers are to increase copayments and deductibles, and/or cover fewer services.

TAX ON "HIGH" INCOME INDIVIDUALS

Effective 2013, the employee's share of the Medicare portion of the FICA tax will increase by an additional 0.9% (from 1.45% to 2.35%) for individual employees with a modified AGI of $200,000, or $250,000 in the case of married persons filing jointly. For example, an individual earning $300,000 would now have to pay a Medicare tax of $7,050. In addition, such individuals and married persons will be subject to an additional 3.8% Medicare tax on net investment income, which includes capital gains, interest dividends, annuities, royalties and other similar items.

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