WHAT EMPLOYERS NEED TO KNOW ABOUT HEALTH CARE REFORM

On March 30, 2010, President Obama signed the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) into law, supplementing the Patient Protection and Affordable Care Act (H.R. 3590) which was signed a week earlier, and completing passage of an expansive health care reform package (referred to in this summary as the "Act") that has been a priority for his Administration. The core goal of health care reform was to provide health insurance coverage to 32 million Americans who are currently uninsured. The legislation attempts to achieve this goal through a variety of approaches, including tax credits, penalizing employers that don't offer affordable coverage and individuals who fail to obtain coverage, creation of "health insurance exchanges," expansion of Medicare Part D coverage and taxing high cost insurance plans.

The most sweeping changes brought by the Act do not take effect until 2014 and 2018, and existing health plans may be “grandfathered” or exempt from certain key requirements. However, a number of important provisions take effect in 2010 and 2011 for all health plans. Other changes are not specifically directed at employer-provided health plans but will nevertheless impact employers and their employees. This summary focuses on the provisions of the law that will have the most significant impact on employers. These provisions are grouped below in chronological order by the date on which they take effect.

GRANDFATHERED AND COLLECTIVELY BARGAINED PLANS:

Group health plans and individual coverage policies that were in effect on March 23, 2010 are considered "grandfathered health plans" under the Act. As noted above, grandfathered plans are exempt from some, but not all, of the Act's requirements. We have indicated below which of the requirements apply to all plans (including grandfathered plans) and those which are only applicable to new plans (i.e. those established after March 23, 2010). Notably, a plan does not lose grandfathered status if it allows new employees and their dependents to enroll in the plan after March 23, 2010 or permits existing employees to re-enroll or add dependents after that date. It is unclear, however, whether a plan loses grandfathered status by significantly altering the benefits it offers.

Collectively bargained single-employer and multi-employer plans that were in effect on March 23, 2010 are exempt from the Act's requirements until the date on which the collective bargaining agreement ("CBA") relating to the coverage terminates. Upon termination of the CBA, the plan may remain a grandfathered plan, but would be subject to any rules then in effect for such plans. The Act provides that collectively bargained plans may be voluntarily amended to incorporate certain of the Act's provisions prior to termination of the CBA without accelerating other compliance deadlines.

EFFECTIVE 1/1/2010:

Closing the "Donut Hole" in Medicare Part D Prescription Coverage
There is currently a gap in Medicare Part D prescription coverage for enrollees whose total annual drug spending falls between $2830 and $6440. This is known as the Part D "donut hole." Under the new law,

this gap in coverage will be gradually filled. The first step toward filling the gap takes effect January 1, 2010, at which time Part D enrollees will be eligible for a $250 rebate to help cover prescription expenses they incur due to the gap in coverage. Each enrollee is limited to one payment.

Small Business Tax Credit for Providing Employee Health Insurance
The Act offers "qualified small employers" (i.e. those with no more than 25 full-time equivalent employees whose average annual salary does not exceed $50,000) a tax credit of up to 35% of the employer's contribution toward the cost of health insurance for employees. The amount of the tax credit, which varies depending on the size of the employer and the average salary of its employees, will increase to up to 50% in 2014 when health insurance exchanges are implemented (see below). Small businesses should promptly discuss the availability of the tax credit with their tax professional.

EFFECTIVE 3/23/2010:

Reasonable Unpaid Breaks for Nursing Mothers
The Act amends the Fair Labor Standards Act (FLSA) to require employers to provide "reasonable" unpaid breaks for nursing mothers to express milk for their infants up to one year in age. Covered employers must also furnish a private space, other than a restroom, for mothers to express milk. These requirements do not apply to employers with fewer than 50 employees if they would impose an undue hardship by causing the employer significant difficulty or expense.

Prohibition of Employment-Related Discrimination
The Act amends the Fair Labor Standards Act to prohibit employment discrimination against any employee who receives a credit or subsidy under the Act or who reports or provides information, including testimony, regarding an employer's violation of certain provisions of the Act. Similarly, any employee that has objected to or refused to participate in any activity reasonably believed to be a violation of certain provisions of the Act is protected from discrimination.

EFFECTIVE 6/21/2010:

Reinsurance for Retiree Health Benefit Plans
The Act creates a temporary reinsurance program for employer health plans that provide coverage for eligible early retirees (i.e. pre-Medicare retirees ages 55 through 64), helping to protect retiree coverage while reducing premiums for employers and retirees. The reinsurance program will reimburse plan sponsors for 80% of the cost of an eligible enrollee's benefits between $15,000 and $90,000. Employers that provide retiree coverage should work with their benefits professionals to determine whether to take advantage of this new reinsurance program.

EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER 9/23/2010 (1/1/2011 FOR CALENDAR YEAR PLANS):

Pre-existing Condition Exclusions
The Act prohibits all group health plans and health insurance issuers from excluding coverage for the pre-existing conditions of children under age 19. The prohibition against pre-existing condition exclusions will be extended to apply to adults in 2014. These prohibitions will apply to grandfathered health plans that are group health plans. In addition, the Act creates a temporary high risk insurance pool to provide coverage for certain uninsured individuals with pre-existing conditions. The pool will end in 2014 when health insurance exchanges are in place. Employers must review their health plans to identify any necessary plan design changes resulting from this new prohibition.

Extension of Coverage for Young Adults
The Act requires all group health plans, including grandfathered plans, and plans in the individual market that provide dependent coverage to permit young adults to remain covered as dependents until age 26 if the young adult does not have access to other employer-provided coverage. This requirement applies regardless of a young adult's marital status; however, a young adult's children need not be offered coverage under this provision. Effective 2014, the extension will apply to grandfathered health plans, but only if the young adult does not have employer-provided coverage available. Employers will need to assess the impact of this provision on their plan costs and update plan documents and other materials related to dependent coverage.

No Lifetime Limits on Coverage
The Act prohibits all group health plans, including grandfathered plans, from imposing lifetime dollar limits on benefits. In addition, there will be new restrictions on annual limits on benefits, to be established by the Secretary of Health and Human Services. The annual limit restrictions will apply to grandfathered plans that are group health plans. When the health insurance exchanges become operational in 2014, plans will be prohibited from imposing annual limits on an individual's benefits. Plans may continue to limit benefits available for certain medical procedures.

Protection from Rescission of Existing Coverage
Under the Act, all plans, including grandfathered plans, will be prohibited from rescinding insurance coverage when an individual files a claim, except in cases of fraud or intentional misrepresentation of material facts. In addition, coverage cannot be canceled without prior notice to the enrollee.

Extension of Nondiscrimination Rules to Fully Insured Plans
The Act prohibits new (i.e. non-grandfathered) fully insured plans from discriminating in favor of highly compensated individuals with respect to eligibility to participate in the plan or eligibility for benefits. Traditionally, these nondiscrimination rules have applied only to self-insured plans. It is unclear at this point whether discrimination in favor of highly compensated employees in fully insured plans is altogether prohibited, or would merely trigger a tax consequence for those employees.

Patient Protections
Individuals participating in new plans must be allowed to choose any participating primary care provider if the plan requires that the individual designate a primary care provider. The legislation also prohibits new plans from requiring prior authorization before a woman sees an ob-gyn, and before any participant seeks emergency care. In addition, emergency care must be covered in and out of network.

Preventive Health Services
New group health plans and plans in the individual market will be required to provide coverage of certain preventive health services and these benefits will be exempt from deductibles and other cost-sharing requirements. Employers should be aware of these requirements when establishing a new plan.

Appeals Processes
The Act requires new group health plans and health insurance issuers to implement effective internal appeals processes for appeals of coverage and claim determinations. Internal appeals processes must comply with U.S. Department of Labor regulations issued in 2001 governing such processes. Employee communications must also include information on the applicable appeal processes. Plans must also implement an external review process that complies with state law requirements that have yet to be issued. Employers should begin reviewing their plans' internal appeals processes to ensure compliance with existing requirements and also monitor state law developments regarding external review requirements.

EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2011:

Definition of Qualifying Medical Expenses (Over-the-Counter Exclusion)
Under the Act, all HSAs, FSAs and HRAs must use the same definition of "qualified medical expenses" used by individuals claiming an itemized tax deduction. The practical impact of this change is that distributions from FSAs, HSAs, or HRAs for purchases of over the counter medications will no longer be permitted unless the medication was prescribed by a physician. Furthermore, since this limitation will be effective for the 2011 plan year, employees who rely on these accounts for reimbursement of the cost of over the counter items should carefully consider their contribution elections during open enrollment.

New Employee Benefit Disclosure Requirements
Within twelve months of passage of the Act, the Department of Health and Human Services is required to issue guidance regarding a new requirement that all plans, including grandfathered plans, provide a summary of benefits to each employee that is not more than four pages in length. The summary must contain information, in a "linguistically appropriate" manner, regarding covered benefits, exclusions, cost sharing, and continuation coverage. Employers must provide the required disclosures to employees no later than 24 months after the Act was passed, or by March 2012. Failure to comply may result in a $1000 penalty per affected employee. In addition, plans must notify participants at least 60 days in advance of material changes to health plans. The effective date of this requirement is not entirely clear; however, most believe the effective date for calendar year plans is January 1, 2011. Further guidance on this point from the U.S. Department of Labor is expected.

Voluntary Long-Term Care Insurance Program
The Act creates a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become disabled. Employers should stay tuned for additional information to ensure compliance with the informational and administrative requirements that will apply in connection with this new program.

Reporting the Value of Employee Health Coverage on W-2
Employers must begin reporting the value of employer-provided health coverage on their employees' W-2 forms in 2011. The reported value is not included as taxable income for the employee unless the plan otherwise fails to qualify under current standards for exclusion. Further guidance is expected on this requirement. Employers should work with their tax professionals to ensure compliance.

More Benefits to Fill the Medicare Part D "Donut Hole"
Effective 2011, a 50% discount on brand name drugs will be available and additional discounts and generic drug coverage will be phased in for Medicare Part D enrollees who would otherwise experience a gap in coverage due to the Part D donut hole.

Increased Tax for Non-Qualifying HSA/MSA Withdrawals
Individuals who make withdrawals from their HSAs prior to age 65 for anything other than qualifying medical expenses will be subject to a 20% tax (currently a 10% tax for HSA and a 15% tax for MSA applies). The applicable tax for similar Archer MSA withdrawals will also increase to 20%.

Simple Cafeteria Plans for Small Employers
Eligible small employers (i.e. those employing 100 or fewer employees over the previous two (2) years) will be eligible to establish "simple cafeteria plans" through which they can provide their employees with tax-free benefits. A simple cafeteria plan requires less administrative burden to establish and maintain than a traditional cafeteria plan. In addition, employers that make contributions on behalf of employees to simple cafeteria plans are exempt from certain nondiscrimination requirements that apply to cafeteria plans maintained by larger employers.

Medical Loss Ratio Requirements
The Act will require health insurance issuers and self-insured plans to report the percentage of premium dollars used to pay medical claims, as opposed to administrative expenses. Certain plans that use less than 85% of premium dollars to pay for claims and health and wellness activities will be required to pay an annual rebate to enrollees.

EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2013:

Cost Sharing Limitations
New (non-grandfathered) plans may not impose cost-sharing requirements which exceed the dollar amounts applicable to high deductible health plans ($5950 for single coverage and $11,900 for family coverage). These maximums will be indexed and adjusted periodically.

Cap on FSA Contributions
Employee contributions for medical expense reimbursements under healthcare flexible spending accounts (healthcare FSA) will be limited to $2500 per year in 2013. This limit will be adjusted for inflation in subsequent years. Currently, there is no limit on the amount of contributions a healthcare FSA plan may allow. Employers that offer healthcare FSAs will need to review their plan documents and employee communications to ensure that the new limit is in place by 2013.

Repeal of Medicare Part D Subsidy
The Act eliminates the federal income tax deduction for the 28% subsidy available to employers who offer prescription drug coverage to Medicare Part D-eligible retirees. This change may have huge financial implications for larger employers that have received substantial subsidies for providing such coverage.

Additional Employee Disclosures
By March 2013, employers must also provide employees with a written notice regarding the existence of health insurance exchanges (discussed below) and how employees may access them. If an employer's contribution toward the cost of employee health coverage is less than 60% of the actuarial value of the coverage, the employer must also notify employees that they may be eligible for a premium tax credit for purchase of coverage through a health insurance exchange.

Higher Threshold for Medical Expense Deductions
In 2013, the income threshold for claiming itemized deductions for medical expenses will be increased from 7.5% to 10%; however, individuals age 65 and older may continue to claim the itemized deduction for medical expenses at 7.5% of adjusted gross income through 2016.

EFFECTIVE PLAN YEARS BEGINNING ON OR AFTER 1/1/2014:

The Act's most sweeping changes take effect in 2014 and, with limited exceptions, they apply to all group health plans offered by covered employers, including those plans that are otherwise considered grandfathered.

Monetary Penalty for Individuals Lacking Coverage
Most individuals will be required by the Act to obtain acceptable health coverage or pay a penalty of $95. The penalty will increase annually up to $695 in 2016 and will thereafter be adjusted with inflation. One half the penalty amount applies to children without coverage, and a per family maximum penalty of $2085 applies. Individuals who cannot obtain affordable coverage will be exempt from the penalty.

Health Insurance Exchanges
The Act aims to make affordable coverage more accessible to individuals and small employers by establishing "health insurance exchanges" to be operated by each state. The idea is that health plans will compete to provide coverage to individuals and small employers through exchanges and the exchange will, in turn, provide consumer-oriented information to individuals and employers while certifying that participating health plans meet new federal coverage standards. The exchange to be established for small employers, known as the "Small Business Health Options Program" ("SHOP"), will be available to employers having 100 or fewer employees; however, until 2016, states may choose to limit eligibility to employers with 50 or fewer employees. By 2017, states may allow employers with over 100 employees to participate in an exchange.

Free Rider Surcharge for Employers that Do Not Offer Affordable Health Coverage
Employers with 50 or more full-time employees ("FTEs") during the preceding calendar year must offer minimum health coverage benefits to employees or pay a penalty. Employers that do not offer minimum coverage and that have at least one FTE who receives a premium tax credit from the federal government will pay a $2000 penalty per FTE per year; however, the first 30 FTEs are not included in calculating the penalty amount. This penalty can increase to $3000 in situations where an FTE receives a premium tax credit because, although the employer offers coverage, the coverage would cost the employee more than 9.8% of his or her income, or the employer contributes less than 60% of the actuarial value of the plan. The penalty provisions of the Act define FTEs to mean employees working 30 or more hours per week; however, hours worked by part-time employees must be aggregated and divided by 120 when determining whether the employer has the requisite 50 FTEs for the penalty provisions to apply. In addition, employers that are part of a controlled group must count all employees in the controlled group when determining whether the penalty provisions apply.

Free Choice Vouchers and Cost-Sharing Limits
Employers with over 50 employees that offer health coverage must provide "free choice vouchers" to qualifying employees who choose to enroll in an exchange plan. Only those employees whose income is less than 400% of the federal poverty level and whose share of the premium for employer-provided coverage is between 8 and 9.8% of their income will qualify for free choice vouchers. The voucher amount must be equal to the amount the employer would have paid toward coverage if the employee had remained enrolled in the employer's plan. Employers that provide vouchers are not subject to penalties if an employee chooses to participate in an exchange plan.

Automatic Enrollment
Employers with over 200 full-time employees that offer health insurance must automatically enroll new full-time employees in their lowest cost health plan option unless the employee affirmatively opts out or elects another plan option. Employers must also provide employees with reasonable advance notice of the available plan options and an opportunity to choose among them or to opt out of coverage altogether. The notice must inform employees of their ability to obtain federally-subsidized coverage through an exchange. It is not entirely clear at this point whether this provision takes effect for plan years beginning in 2014 or upon issuance of implementing regulations. This requirement applies to new and grandfathered plans.

Prohibition of Excessive Waiting Periods and Annual Benefits Limits
For plan years beginning on or after January 1, 2014, all plans are prohibited from imposing a coverage waiting period in excess of 90 days. As noted above, annual benefit limits will be prohibited in plan years beginning on or after January 1, 2014; however, benefit limits for specific medical procedures may remain in effect.

Expanded Wellness Incentives
The Act allows employers to offer employees incentives, in the form of premium discounts, waivers of cost-sharing requirements or benefits that would otherwise not be provided, of up to 30% of a plan's premium cost for participating in a workplace wellness program and meeting certain healthcare related standards, and gives the Secretary of Health and Human Services the discretion to permit incentives of up to 50% of the cost. Currently, such incentives are limited to 20% of the plan's total premium. The Act also creates a $200 million program to award grants to small employers (i.e. those with less than 100 employees) to initiate workplace wellness programs.

IRS Reporting
Effective January 1, 2014, employers with more than 50 FTEs must certify to the IRS that they meet essential coverage requirements and must disclose plan terms such as length of waiting period, monthly premiums, employer cost share and number of FTEs per month.

EFFECTIVE 1/1/2018:

Cadillac Plan Excise Tax
The Act imposes an excise tax on employers offering high-cost insurance plans, known as "Cadillac Plans." The tax would be assessed on those insured and self-insured plans that exceed the following premium cost thresholds: $10,200 for single coverage, and $27,500 for family coverage. Plans exceeding these cost thresholds will be subject to a 40% tax for that portion of the premium that exceeds the threshold. For retirees and certain employees in high-risk professions (e.g. construction, mining, law enforcement, EMTs), the cost thresholds for single and family coverage are increased by $1650 and $3450 respectively. Cost thresholds will increase in 2020 and in subsequent years to account for inflation.

CONCLUSION

This alert is intended as a general summary of the Act's provisions which are likely to have the greatest impact on employers. The health care reform package is extremely broad in scope, and it will take time for employers to develop appropriate plans for compliance. As an initial step, employers should work with their insurance providers and brokers, third-party administrators, counsel and accountants to determine which of the 2010 requirements apply to them and the appropriate compliance steps.

It is also important to note that many provisions in the new Act do not apply to plans maintained through a collective bargaining agreement until the agreement expires. Employers that are currently negotiating a collective bargaining agreement, or that will be doing so in the near future, must be clear regarding the impact of health care reform on their current and future agreements.

Although the Act is rife with new taxes and administrative burdens on plans, there are also a few "sweeteners" that employers should consider taking advantage of (e.g. Small Employer Tax Credit, Simplified Cafeteria Plan, Retiree Reinsurance, etc.). Clearly, there will be additional guidance coming from Washington as compliance deadlines approach and we will continue to keep you informed. If you have any specific questions regarding the Act's impact on your health plans, please contact any of the attorneys in McNees Wallace and Nurick LLC's Labor and Employment Group or Employee Benefits Group for assistance.