eALERT
hugheshubbard.com

Health Care Reform — Impact on Employers

The recently enacted health care reform law imposes many new requirements on employer-provided group health plans -- defined to include both insured and self-insured plans -- some of which take effect as early as the first plan year beginning after September 23, 2010. Plan documents and employee communication materials will need to be revised to reflect these changes in time for the next open enrollment period. The law also imposes new reporting and disclosure requirements and contains other provisions affecting employers. The law raises a number of questions that will not be answered until regulatory guidance is issued.

Certain provisions of the new law do not apply to "grandfathered" group health plans, generally defined as plans that were in effect on March 23, 2010. The law is unclear as to what changes involving a plan will cause a loss of grandfather status. Employers should therefore consider the potential effect on grandfather treatment before making any changes to their existing health plans.

This e-Alert summarizes some of the major provisions of the new law that will directly impact employers (excluding provisions that apply solely to small employers).

General Overview

The new health care reform law is set forth in two statutes -- the Patient Protection and Affordable Care Act, which was signed into law on March 23, 2010 (Pub. L. No. 111-148) (the "PPACA") and the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 30, 2010 (Pub. L. No. 111-152) (the "Reconciliation Act"). We refer to them collectively as the "Act." The provisions of the Act will be phased in over a number of years. The provisions affecting group health plans and their effective dates are listed below and described in somewhat greater detail later in this e-Alert. The Act also contains provisions affecting health reimbursement arrangements, employer reporting and disclosure requirements, an employer penalty for failure to provide specified health coverage, and certain other provisions of interest to employers, which are also summarized below.

Provisions Applicable to All Plans (Grandfathered and Non-Grandfathered)

Effective for plan years beginning on or after September 23, 2010:

- Prohibition of lifetime benefit maximums
- Limitation on annual benefit maximums
- Elimination of pre-existing condition exclusion for children under age 19
- Prohibition on rescinding health coverage (except for fraud or intentional misrepresentation)
- Mandatory coverage for adult children (to age 26)

Effective for plan years beginning on or after January 1, 2014:

- Prohibition of annual benefit maximums
- Elimination of pre-existing condition exclusion for all
- Prohibition of waiting periods over 90 days
- Prohibition of discrimination based on health status

Provisions Applicable only to Non-Grandfathered Plans

Effective for plan years beginning on or after September 23, 2010:

- Mandatory preventive care coverage without employee cost-sharing
- Participant rights regarding selection of doctors and access to emergency room care

- Prohibition of discrimination in benefits or coverage in favor of highly-compensated employees
- Required external review process (in addition to internal ERISA-required claims procedure)

Effective for plan years beginning on or after January 1, 2014:

- Limits on employee cost-sharing
- Prohibition of discrimination against categories of providers

Special Effective Date for Collectively Bargained Plans

Group health plans that are maintained pursuant to a collective bargaining agreement in effect on March 23, 2010 are not subject to the Act until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

Requirements for Group Health Plans

Provisions Applicable to All Plans (Grandfathered and Non-Grandfathered)

Elimination of Lifetime and Annual Maximums. For plan years beginning on or after September 23, 2010, group health plans cannot apply a lifetime maximum on "essential health benefits". For plan years beginning on or after January 1, 2014, group health plans cannot impose any annual limits on "essential health benefits". For years before 2014, the extent to which annual limits may be imposed is subject to regulation.

> **COMMENT:** The Act does not define "essential health benefits" but instead directs the Department of Health and Human Services ("HHS") to define the term. The Act indicates that Congress intended the term to apply to the scope of benefits provided under a typical employer plan, including services in the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services (including pediatric oral and vision care).

Elimination of Pre-Existing Condition Exclusions. For plan years beginning on or after September 23, 2010, group health plans cannot impose pre-existing condition exclusions on children under age 19, and for plan years beginning on or after January 1, 2014, pre-existing condition exclusions are prohibited for all plan participants.

No Rescission. For plan years beginning on or after September 23, 2010, group health plans are prohibited from rescinding coverage of any individual once he or she has become a covered participant, unless the individual has committed fraud or made an intentional misrepresentation of fact.

Dependent Coverage. For plan years beginning on or after September 23, 2010, a group health plan that provides dependent coverage for children must continue providing that coverage for adult children until age 26. Such coverage would be required regardless of whether the adult child is married, but not for any spouse or children of the adult child. For plan years beginning before January 1, 2014, grandfathered plans do not have to offer coverage to an adult child who is eligible for coverage under another employer-sponsored health plan.

Maximum Waiting Period. For plan years beginning on or after January 1, 2014, employers may not impose waiting periods of more than 90 days for new employees to enroll in employer-sponsored group health plans.

Nondiscrimination Based on Health Status. For plan years beginning on or after January 1, 2014, group health plans may not establish eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor determined by HHS. However, employers may

continue to extend wellness incentives based on health factors.

Provisions Applicable Only to Non-Grandfathered Plans

Definition of Grandfathered Plan. As indicated above, non-grandfathered plans are group health plans that were adopted after March 23, 2010 or that were amended in a manner that would cause loss of grandfather status. A plan does not lose grandfathered status merely by renewing coverage or enrolling new hires or additional dependents under the provisions of the plan in effect on March 23. The Act is silent as to whether or to what extent a group health plan may be modified or changed and still keep its grandfathered status (for example, whether merely switching to a new insurance carrier would cause loss of grandfather status). It is expected that HHS will issue guidance in this area in the next few weeks.

Mandatory Preventive Care. Effective for plan years beginning on or after September 23, 2010, non-grandfathered group health plans are required to provide preventive care as specified by various bodies identified in the legislation. No employee cost-sharing (such as copayments, coinsurance or deductibles) may be charged for such preventive care.

Participant Rights regarding Selection of Doctors and Access to Emergency Room Care. For plan years beginning on or after September 23, 2010, non-grandfathered group health plans are required to provide a number of rights to participants, including the right to choose their primary care provider (where one is required by the plan), access to obstetrical and gynecological care without a referral from the primary care provider, and access to emergency room services without obtaining prior authorization and on the same cost-sharing terms for both in-network and out-of-network emergency care providers.

Nondiscrimination Requirement Extended to Insured Plans. For plan years beginning on or after September 23, 2010, non-grandfathered insured group health plans will have to satisfy the nondiscrimination requirements of Internal Revenue Code Section 105(h), which currently apply only to self-insured plans. These rules prohibit discrimination in favor of highly-compensated employees with respect to both eligibility and benefits.

> **COMMENT:** Although a violation of Section 105(h) with respect to a self-insured plan results in tax penalties on the benefitting highly-compensated employees, it appears that a violation of Section 105(h) with respect to insured plans will result in penalties on the employer rather than the employees.

Appeals and Review Procedures. For plan years beginning on or after September 23, 2010, non-grandfathered group health plans must implement a process for appeals of coverage determinations and claims, which includes both an internal appeals process (initially in accordance with the existing claims regulations under ERISA, subject to modification by the Department of Labor (DOL)) and an external review process. The nature of the external review process is to be specified by the applicable state in the case of insured plans, and by HHS in the case of self-insured plans.

Limits on Cost-Sharing. For plan years beginning on or after January 1, 2014, the Act limits the employee cost-sharing that may be imposed by non-grandfathered group health plans. In 2014, (i) cost-sharing may not exceed the applicable (individual and family) limits for high-deductible health plans in effect at that time (in 2010 these limits are $5,950 for individual coverage and $11,900 for family coverage), and (ii) deductibles may not exceed $2,000 for individual coverage and $4,000 for family coverage. In subsequent years these amounts are increased as provided in the Act.

Prohibition on Discrimination Against Providers. For plan years beginning on or after January 1, 2014, non-grandfathered group health plans may not discriminate against categories of providers who are acting within the scope of their license or certification under applicable state law. This provision does not require that a group health plan contract with all willing health care providers or prohibit plans from implementing variable reimbursement rates based on quality or performance measures.

Provisions affecting Health Reimbursement Arrangements

No Reimbursements for Over-the-Counter Drugs. Effective for expenses incurred in 2011, over-the-counter drugs will no longer be permitted to be paid for from health flexible spending accounts, health reimbursement accounts, Archer MSAs or health savings accounts ("HSAs"), unless the drug is covered by a prescription or is insulin.

Increased Tax for Distributions from HSAs and Archer MSAs. Effective January 1, 2011, the tax on distributions from HSAs and Archer MSAs not used for qualified medical expenses will increase to 20%.

Lower Flexible Spending Account Limits. For taxable years beginning on or after January 1, 2013, health flexible spending account contributions will be limited to $2,500 per year (indexed annually thereafter).

Employer Penalty for Failure to Provide Coverage ("Pay or Play")

The Act does not require employers to provide health coverage, but rather imposes a penalty on large employers (generally defined as employers with more than 50 employees) that either (i) do not provide "minimum essential coverage", or (ii) that provide "minimum essential coverage" but either the coverage is "unaffordable" or the employer's share of the "total allowed cost of benefits" (to be defined in regulations) is less than 60%. In either case, the penalty is only imposed if at least one employee elects to be covered through a health insurance exchange and receives either a premium tax credit or cost-sharing reduction (generally available to employees whose household income is less than 400% of the poverty level, which based on 2010 levels would include a family of four with household income of $88,200 or less).

For purposes of these provisions, "minimum essential coverage" means coverage under an "eligible employer-sponsored plan," a health plan offered in the individual market within a state, a grandfathered health plan, a government sponsored program (such as Medicare, Medicaid, and CHIP), or such other health benefit coverage as may be provided by regulation.

> **COMMENT:** It is not clear whether a self-funded employer-sponsored group health plan satisfies the Act's definition of an "eligible employer-sponsored plan." If it does not, it appears that employers that maintain such plans (other than grandfathered plans) would be deemed to not be providing "minimum essential coverage" and would therefore potentially be subject to the penalty for failure to offer coverage.

One of the following penalties may be applicable, in each case effective January 1, 2014:

- ***Failure to Offer Coverage.*** If a large employer does not offer health coverage to its full-time employees, the employer will be assessed an annual penalty of $2,000 multiplied by the number of full-time employees, excluding the first 30 full-time employees. (The penalty is calculated on a monthly basis.) For this purpose, full-time employee is defined as any employee who averages 30 or more hours per week.

- ***Offering Too Expensive Coverage.*** If a large employer offers "minimum essential coverage" to its employees, but has at least one full-time employee who opts out of the employer-sponsored coverage where the employer coverage he opted out of is either "unaffordable" (which is deemed to be the case if the premium required to be paid by the employee is more than 9.5% of the employee's household income) or the plan's share of the total allowed cost of benefits is less than 60%, the employer will be assessed an annual penalty (calculated on a monthly basis) equal to the lesser of: (i) $3,000 multiplied by each opt-out employee receiving premium credit or cost-sharing reduction, or (ii) $2,000 multiplied the number of full-time employees, excluding the first 30 full-time employees.

  This penalty does not apply if the employer provides "minimum essential coverage" to its employees and provides so-called "free choice vouchers" to those employees whose household income is below 400% of the poverty line and whose share of the

premium is between 8% and 9.8% of the employee's household income. A "free choice voucher" is a payment to the employee of the amount the employer would have paid towards coverage of the employee under the employer's plan, which is applied to enable the employee to purchase less expensive insurance through a health insurance exchange.

COMMENT: The Act is unclear as to what penalties apply where an employer offers coverage to some, but not all, of its full-time employees. In particular, it is not clear whether the penalties based on the number of full-time employees are applied to the employees who are offered health coverage as well as those who are not.

For purposes of both of the above penalties, employers who are part of a controlled group must count all employees in the controlled group to determine the amount of the penalty. In addition, the exclusion from penalty for the first 30 full-time employees must also be allocated ratably to each member of the controlled group based on the number of employees.

Medicare Changes Affecting Employers

Elimination of Deduction for Retiree Drug Subsidy. Currently, employers that provide retiree prescription drug coverage that is actuarially equivalent to the coverage available under Medicare Part D receive a non-taxable federal tax subsidy equal to 28% of certain covered charges. The employer is permitted to deduct from its corporate income taxes the entire amount it paid for covered retiree prescription drug expenses, including the amount of the subsidy it received. For taxable years beginning on or after January 1, 2013, the employer may no longer deduct the amount of the subsidy (but the subsidy continues to be non-taxable).

COMMENT: The elimination of the deduction for retiree drug subsidies could result in a significant immediate charge to earnings on an employer's financial statements since it will reduce the deferred tax asset reported in the employer's balance sheet.

Medicare Part D Coverage Gap Phased Out. The Act contains provisions intended to phase out the current Medicare Part D (prescription drug) coverage gap commonly known as the "donut hole" (which in 2010 requires Medicare Part D enrollees to pay 100% of their prescription drug costs after their total drug spending exceeds $2,830 until it reaches $4,550). The Act phases out the "donut hole" by reducing the amount that Medicare Part D enrollees are required to pay for their prescriptions when they reach the coverage gap. In 2010, Medicare beneficiaries will receive a one-time rebate of $250 to cover expenses when they reach the coverage gap. Beginning in 2011, Medicare Part D enrollees who reach the coverage gap will receive a 50% discount on the total cost of their brand-name drugs in the gap, as agreed to by pharmaceutical manufacturers. In addition, a 75% subsidy for generic drugs in the coverage gap will be phased in beginning in 2011, and a 25% subsidy for brand name drugs in the coverage gap will be phased in beginning in 2013. By 2020, when the phase-in is complete, Medicare Part D enrollees will only pay 25% of the cost of both brand name and prescription drugs in the coverage gap, as a result of the discount program and subsidies.

Medicare Payroll Tax Increase. Effective January 1, 2013, the Medicare payroll tax paid by employees will increase from 1.45% to 2.35% on wages received by an employee in excess of $200,000 per year for single filers and $250,000 per year for joint filers. Employers will need to put in place a system for monitoring these limits and withholding the appropriate amounts. An employer will only have to monitor the amount of wages that it pays to employees and will not have to monitor any wages received by the employee from another employer or by the employee's spouse.

Other Provisions Affecting Employers

Automatic Enrollment. Effective upon the issuance of implementing regulations by the Department of Labor, employers with more than 200 full-time employees will be required to automatically enroll employees into one of the group health plans offered by the employer. Employers will be required to give employees adequate notice of the automatic enrollment and the opportunity to opt out of coverage.

Reimbursement of Retiree Medical Benefits. The Act appropriates $5 billion for a temporary reinsurance program for employers who provide health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would be created by HHS, would run from June 23, 2010 through January 1, 2014 (or until allocated funds run out, if earlier), and would reimburse employers up to 80% of a retiree's medical claims between $15,000 and $90,000 (adjusted yearly). Payments from the reinsurance program must be used to reduce premium costs paid by the plan sponsor or to reduce premium contributions, coinsurance, deductibles, or other costs paid by retirees.

Premium Rebates. Beginning not later than January 1, 2011, health insurance issuers will be required to provide an annual rebate to each "enrollee" if their medical loss ratio falls below 80% (85% for issuers in large group markets). For this purpose, the medical loss ratio is defined as the ratio of (i) the amount of premium revenue applied to pay claims for clinical services and for activities that improve health care quality to (ii) total premium revenue.

> **COMMENT:** It is unclear whether these rebates are payable to the employer, the plan, or the plan participants, and whether they would be considered "plan assets" under ERISA.

Fees on Health Plans. Effective for plan years ending after September 30, 2012 but before September 30, 2019, a fee will be imposed on self-insured employer health plans to fund a new Patient-Centered Outcomes Research Trust Fund. The fee is equal to the product of $2 ($1 for plan years ending during 2013, and adjusted for increases in health care spending for plan years ending after September 30, 2014), multiplied by the average number of lives covered under the plan.

Limitation on Deductibility of Compensation Paid by Health Insurance Providers. The Act imposes a $500,000 limit on the amount a health insurance provider may deduct with respect to compensation paid to any "applicable individual" for services in any year. The provision is broader than Internal Revenue Code Section 162(m) as applied to corporations generally in that (i) the limitation applies to compensation paid to any employee, director, and independent contractor of the employer (determined on a controlled group basis), (ii) there is no exclusion for performance-based compensation, and (iii) the limitation is measured based on the year the services were rendered and thus cannot be avoided by deferring the payment. The provision is applicable for compensation paid beginning in 2013 with respect to services performed after 2009.

Guaranteed Availability and Renewability of Coverage. For plan years beginning on or after January 1, 2014, health insurance issuers that offer coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage, and must renew or continue the insurance option of the plan sponsor or individual, regardless of a participant's health status or utilization of health services.

Excise Tax on High Cost ("Cadillac") Plans. Effective in 2018, a nondeductible excise tax will be imposed on insurance companies (in the case of insured plans) and plan administrators (in the case of self-insured plans) if the combined employer and employee annual premiums (disregarding premiums for dental and vision benefits provided under a separate plan or policy) exceed the threshold of $10,200 for single coverage and $27,500 for family coverage. The thresholds are increased by $1,650 for single coverage and $3,450 for family coverage for certain workers with high risk jobs and for retirees over the age of 55. The excise tax is equal to 40% of the amount of the premium in excess of the threshold.

The threshold amounts are subject to indexing. Premiums counted against the thresholds include reimbursements under health flexible spending accounts and health reimbursement accounts and employer contributions to HSAs.

New Reporting and Disclosure Requirements

W-2 Reporting of Health Plan Coverage. Beginning in 2011, employers will be required to report the value of employer sponsored group health plan coverage (including grandfathered plans) on Form W-2. This reporting requirement does not in itself change the tax treatment of such coverage.

Disclosure of Plan Information. Effective for plan years beginning after September 23, 2010, group health plans (including grandfathered plans) must disclose to HHS and the relevant state insurance regulator, and make available to the public, certain information including data on claim denials, rating practices and cost-sharing for out-of-network coverage.

Uniform Explanation of Coverage. All group health plans (including grandfathered plans) will have to provide a plain-English summary of benefits that is not more than four pages in length and that meets specific requirements for format and content. HHS is required to issue standards for the summary of benefits by March 23, 2011, and beginning no later than March 23, 2012, this summary of benefits must be provided in addition to the summary plan description required under ERISA. In addition, notice of any material modifications to the plan or coverage not reflected in the most recently provided summary must be furnished no later than 60 days before the date the modification becomes effective. This advance notice provision is effective with respect to grandfathered plans for plan years beginning on or after March 23, 2010 and with respect to non-grandfathered plans for plan years beginning on or after September 23, 2010. Failure to comply with these requirements may result in a $1,000 penalty per failure for each participant for whom such failure occurred.

> **COMMENT:** The timing of the advance notice provision seems anomalous, since it becomes effective before the effective date for the uniform explanation of coverage and also because grandfathered plans have an earlier effective date than non-grandfathered plans. Nevertheless, in light of the magnitude of the penalties, it would be prudent for employers to comply with the stated effective dates.

Notification to Employees About Health Insurance Exchange. Beginning March 1, 2013, employers must provide written notice to current employees, and to new employees as they are hired, of the existence of a health insurance exchange, including a description of the services provided by the exchange, and how the employee may contact the exchange. In addition, if the employer's share of the total costs of benefits provided under its group health plan is less than 60%, the employer must inform the employee that if the employee purchases insurance through the exchange, he or she may be eligible for a premium tax credit and cost sharing reduction, but will then lose the employer contribution (if any) made with respect to health coverage.

Certification of Coverage Information to the IRS. Effective January 1, 2014, employers with more than 50 full-time employees must annually certify to the IRS certain information regarding the health coverage they provide, including whether they offer their full-time employees "minimal essential coverage", the length of any waiting period, the monthly premiums for the lowest cost option, the employer's share of the total allowed cost of benefits provided under the plan, the number of the employer's full-time employees (on a monthly basis), and identification of each full-time employee and the months during which such employee (and any dependents) were covered under the plan. Employers must also provide each employee the information provided to the IRS with respect to that employee.

For more information about health care reform or Hughes Hubbard's employee benefits practice, please contact any of the following attorneys:

Spencer L. Harrison
(212) 837-6858
harrison@hugheshubbard.com

Ned H. Bassen
(212) 837-6090
bassen@hugheshubbard.com

Gloria W. Nusbacher
(212) 837-6719
nusbache@hugheshubbard.com

Erin E. DeCecchis
(212) 837-6450
dececchi@hugheshubbard.com

James F. Delaney
(212) 837-6076
delaney@hugheshubbard.com

Bruce N. Goldberger
(212) 837-6781
goldberger@hugheshubbard.com

Hughes Hubbard
Critical matters. Critical thinking.®

Hughes Hubbard & Reed LLP
One Battery Park Plaza | New York, New York 10004-1482 | 212-837-6000