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Health Reform: What Employers Need to Consider

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The Patient Protection and Affordable Care Act, H.R. 3590 (the PPACA), signed by President Obama on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, H.R. 4872 (the HCERA), which was signed on March 30, 2010, and amends certain provisions of the PPACA, collectively encompass the landmark Health Care Reform legislation that will affect both individuals and employers. Many of the mandates imposed by the law do not go into effect until 2014, and much of the actual implementation of the Health Care Reform legislation must await issuance of agency guidance. However, there are some provisions that are effective immediately or in the very near future, and employers also need to consider how to handle their plans now in anticipation of future changes. While this column describes briefly the mandated changes for employers and individuals that apply in 2014, it focuses primarily on what employers and plan administrators should be doing *now* both to make plan design and administrative changes required by the Act and to anticipate changes that will affect their plans in the future. The column then describes some of the Internal Revenue Code changes that will affect employers and employees.[1]

Overview of Mandated Coverage in 2014

The "universal coverage" component of the Health Reform Act begins in 2014, when all individuals are required to obtain coverage. The provisions describing many of these rules are not clear and it is expected

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that there will be considerable new guidance before 2014 explaining how the rules are to apply. Nonetheless, it is useful to include a general explanation of what is currently specified in the new law so that employers can understand their future obligations as they administer and review their current health plans.

Individual Mandate

Starting in 2014, most individuals must have a minimum qualifying level of health coverage either through an employer, an Exchange, or a government program like Medicare (if they are eligible). Persons without coverage will face a tax penalty based on a sliding scale related to their income.[2]

Exchange

States must establish an American Health Benefits Exchange (the Exchange) that facilitates the purchase of individual or group health insurance plans from insurers. The federal government is also required to provide a plan that meets the minimum requirements for an exchange if individual insurers do not offer to provide such a plan in the state. Individuals with household incomes ranging from 100 percent to 400 percent of the federal poverty line (as adjusted for family size) who acquire coverage through the Exchange may be eligible for a subsidy in the form of a premium tax credit or reduced cost-sharing.[3]

Essential Health Benefits

The Exchange plans must provide essential health benefits. The Department of Health and Human Services (HHS) must provide a list of such benefits; they will include the following general categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse treatment;
- Prescription drugs;
- Rehabilitative services;
- Laboratory services;
- Preventive care;

- Wellness and chronic disease management; and
- Pediatric services, including oral health and vision care.[4]

Essential health benefits are supposed to be those offered under a typical employer plan; HHS is supposed to conduct a survey of such offered services.[5] The determination of what constitutes essential health benefits will be significant for other requirements of the Health Reform Act, as discussed below.

Penalties for Large Employers for Failure to Offer Coverage or for Providing Inadequate Coverage

General Mandate

Very generally, beginning in 2014, *large employers* must offer "minimum essential coverage" to their full time employees and dependents or pay a monthly penalty per employee per year if coverage is not provided and if at least one employee enrolls in a qualified health plan under the Exchange and receives a premium credit or cost sharing reduction provided by law.

Definition of Large Employer

A "large" employer is one that, during the prior year, had an average of 50 or more full time employees, as determined on a controlled group basis. Full time equivalents must be included in determining the number of full time employees. Full time equivalents are calculated by adding the total hours worked in a month by all employees, other than full time employees, and dividing by 120. Full time equivalents are relevant for purposes of determining whether an employer is a large employer, but not for determining who must be provided with health insurance coverage or calculating penalties.[6]

Minimum Essential Coverage

"Minimum essential coverage" under the statute is defined in new IRC Section 5000A(f).[7] Basically, for this purpose, it is coverage under an employer sponsored health plan.[8] There is no requirement that any particular substantive types or levels of health coverage be provided. The agencies implementing the law, however, may attempt to impose some standards to require that "minimum essential coverage" be "real" coverage to prevent circumvention of the PPACA. Moreover, the statute makes clear that certain limited scope medical insurance, such as limited scope dental or vision coverage, or worker compensation, will not constitute minimum essential coverage. Once an employer provides any type of substantive health coverage, various mandates in the Act described

below will regulate the degree to which the plan can restrict coverage and access, and the types of fees and cost-sharing structures that are permitted. Again, these are not mandates on the types of benefits provided, but these mandates will affect the cost of the plan to the employer.

Penalties

If no health coverage is provided, and if any employee enrolls in the Exchange and receives a subsidy, the amount of the monthly penalty is $2,000 divided by 12, multiplied by the number of full-time employees employed during the applicable month, not counting the first 30 full time employees. (The $2,000 figure will be indexed beginning in 2014, based on increases in average health costs.) Full time employees are persons who are scheduled to work 30 or more hours a week. Note that if no coverage is provided, even if only one employee is eligible for the credit or reduction and enrolls in the Exchange, the penalty is based on the total number of full time employees minus 30.[9]

If an employer offers coverage, however, the employer could still be liable for a penalty if (1) a lower-income employee chooses to obtain coverage through the Exchange, instead of the employer plan, and (2) is eligible for a premium tax credit or cost sharing reduction and does not receive a "free choice voucher" from the employer. The theory here seems to be that lower income employees should have the choice of Exchange coverage if the employer's coverage is too expensive or inadequate, and these rules will encourage employers to offer affordable coverage.[10] An employee is eligible for the tax credit or cost sharing reduction only if the household income of the employee is no more than 400 percent of the U.S. poverty level and either (1) the employer's share of health plan costs is less than 60 percent of costs or (2) the employee's share of cost of coverage is between 8 and 9.5 percent of income. The amount of the penalty in this case is the lesser of the penalty imposed using the calculation for employers that provide no coverage or a monthly penalty equal to $3,000/12 times the number of employees who are entitled to the credit or cost sharing reduction and who do not receive a free choice voucher as described below.[11]

A free choice voucher must be offered to employees whose cost of coverage is between 8 and 9.8 percent[12] of income, whose household income is no more than 400 percent of the U.S. poverty level, and who do not participate in the employer's health plan. (We understand that it was intended that employers will be notified by the Exchange if an employee is eligible for a voucher.) The voucher must equal the employer's share of coverage costs for the plan with respect to which the employer pays the largest portion of the plan costs.[13] The voucher should be used to make premium payments to the Exchange, and any excess of the voucher over such premium will be treated as taxable wages.[14] The employer may deduct

the amount of the voucher under IRC Section 162, as amended by PPACA Section 10108(g).

Reporting and Disclosure

For periods beginning after December 31, 2013, large employers will be required to report to the IRS information on the health care coverage provided to employees, including waiting periods, monthly premiums, employer share of total plan costs, and the number of full time employees for each month. The employers will also have to provide statements to the full time employees covered by these reports. The IRS may review the reporting for accuracy, including determining the employer's applicable share of costs under the plan.[15]

At the time of hiring on or after March 1, 2013, or by March 23, 2013, for current employees, the employer must also provide notice to its employees informing them of their plans' options, the existence of the Exchange, and the various subsidies to which they are entitled.[16]

Mandates for Individual and Small Group Market Policies

Starting in 2014, plans offered by health insurance issuers in the individual and small group market will have to provide "essential health benefits."[17] This mandate essentially regulates the insurance benefits under policies that will be purchased by small employers or persons who are uninsured. Large employers are not *required* to provide this package of benefits under the legislation but may be subject to penalties or be required to provide vouchers if lower-income employees choose Exchange coverage rather than their employer's plan.

Risk Pools

Although Exchanges will begin operation in 2014, as a temporary measure, the new legislation requires the Secretary of HHS to establish a temporary high risk pool for persons without creditable coverage and who have preexisting conditions. Special "no dumping" rules will be developed to prevent employers from terminating coverage for or encouraging employees to elect coverage under this pool.[18]

Importance of Grandfathered Status

Group health plans in existence on March 23, 2010, will be considered "grandfathered." A grandfathered plan is not subject to certain coverage and benefit mandates under the Health Care Law. Because these coverage and benefit mandates may increase costs, employer plan sponsors may want to preserve grandfathered status of plans. A grandfathered plan:

- Does not need to meet rules that prohibit discrimination in favor of the highly paid (applies only to funded plans; all non-funded plans must meet nondiscrimination rules under current law and this has not changed);
- Is not subject to certain rules otherwise applicable in 2014 that would prohibit discrimination against potential participants based on health status;
- Need not include certain general out-of-pocket limits and limits on deductibles;
- May continue to require copayments, coinsurance charges, and deductibles for certain screenings or preventive care that HHS deems "essential;"
- Prior to 2014, need not cover adult children who have other employer coverage;
- Need not allow pediatricians to be primary care physicians or allow direct access to OB/GYNs;
- Is not subject to the law's rules restricting the plan's right to limit payments for emergency services;
- Is not required to cover certain clinical trials and related costs; and
- Does not have to expand appeals procedures.

Delayed effective dates and special rules apply with respect to some changes mandated for grandfathered plans. Collectively bargained arrangements in existence on date of enactment are also grandfathered until the last agreement to which the coverage relates is terminated.[19]

The statutory definition of a "grandfathered plan" is not precise. The statute merely says that the benefit mandates of the Health Reform Act will not apply to a plan or coverage under which an individual was enrolled on March 23, 2010. Interim final regulations jointly issued by the Departments of the Treasury, HHS, and Labor defining a "grandfathered plan" identify the changes to a plan that would cause that plan to lose its grandfathered status.[20] The regulations provide that the rules governing grandfathered plans apply separately to each "benefit package" provided under the plan.

The interim regulations may make it difficult for employers to retain plans with grandfathered status. Generally, voluntary changes to increase plan benefits do not result in a loss of grandfather status, nor do changes to plans that are required to comply with the new law. However, changes that "significantly decrease benefits," materially increase cost sharing by participants, or substantially increase the cost of coverage borne by

participants do result in a loss of the grandfather. The regulations apply objective rules for this purpose. The following changes will result in a loss of grandfathered status:

- Change of insurers, or entering into any new "policy, certificate, or contract of insurance";
- Elimination of all or substantially all benefits to diagnose or treat a particular condition;
- Any increase in a percentage cost-sharing requirement (*e.g.*, coinsurance) borne by the employee;
- Any increase in a fixed amount cost-sharing requirement other than a copayment (*e.g.*, a deductible or out-of-pocket limit) that exceeds the increase in overall medical inflation;
- Any increase in a fixed copayment, if the total increase exceeds the greater of an amount equal to $5 increased by the overall percentage increase in medical inflation or if the total increase is greater than the increase in medical inflation plus 15 percentage points; or
- A decrease in the contribution rate by employers and employee organizations towards the cost of similarly situated individuals by more than 5 percentage points below the prior contribution rate for the coverage period that includes March 23, 2010.

Changes in coverage rules can also result in a loss of the grandfather. For example, if an employer forces employees to move to a plan that is either more expensive or has less generous benefits, the grandfathered status of the plan to which the employees transfer will be revoked. Also, anti-abuse rules prevent mergers or sales that are used to avoid compliance with the law. An employer can add new options and allow individuals to transfer to those options, but the new options would generally not be grandfathered.

A grandfathered plan must also inform participants that it is grandfathered (model language is provided for this purpose) and it must keep records to demonstrate its compliance with the grandfather rules. Changes effective after March 23, 2010, made before that date, if pursuant to a legally binding contract, a filing with a state insurance department, or a plan amendment, will not cause a plan to lose its grandfather status. Transition rules allow plans to revoke certain changes made before June 14, 2010, if those changes would otherwise preclude grandfathered treatment.

The new regulations appear to allow plans to change premiums (although the employer must comply with the changes in cost-sharing limitations, described above. The regulations do not currently restrict changes in

plan structures (*e.g.*, from insured to self-insured or changes in provider networks). The regulators have asked for comments as to whether the grandfather rules should restrict these changes or changes to a drug formulary.

Finally, even employers who offer coverage under grandfathered health plans will need to consider whether they wish to make longer term changes in the future to encourage more participation in their plan. This is because if in 2014, the employer's plan is seen as inadequate, its employees may choose to participate in a plan offered under the Exchange, and depending on the demographics of employees who make that choice, the employer could be subject to penalties for failure to provide adequate coverage or be required to provide a voucher. Deciding on the appropriate course of action to follow will require careful analysis of the employer's plan and the law's penalty provisions.

Provisions Affecting Health Plan Design and Administration

Health Care Reform adds many new benefit design and administrative requirements for group health plans and for insurers who offer health products to employers and individuals. In general, these changes are grouped below by the date they are effective. The following chart summarizes these changes. In the chart, "PY" refers to the Plan Year and "PY >" refers to the Plan Years beginning on or after the stated date.

Plan Provision	Effective Date	Grandfathered Plan	Non-grandfathered Plan
No income imputed for coverage of children up to 27	3/30/10	Yes	Yes
Dependent coverage to age 26 required	PY ≥ 9/23/10	Yes, unless adult child has other employer coverage. In 2014, applies in all cases	Yes
No preexisting conditions for children under 19 (for everyone, 2014)	PY ≥ 9/23/10; 2014	Yes	Yes
No maximum lifetime benefit limit	PY ≥ 9/23/10	Yes	Yes
Restrictions on annual limits on "essential health benefits" (before 2014 by regulation; after 2014, all limits restricted)	PY ≥ 9/23/10; 2014	Yes	Yes
Strict limits on rescission	PY ≥ 9/23/10	Yes	Yes

Non-discrimination rules for insured plans	PY ≥ 9/23/10	No	Yes
No cost-sharing for preventive care	PY ≥ 9/23/10	No	Yes
Emergency services must be reimbursed without prior authorization; limits on extra charges for out-of-network use	PY ≥ 9/23/10	No	Yes
Rules on primary care physicians	PY ≥ 9/23/10	No	Yes
Enhanced appeals process	PY ≥ 9/23/10	No	Yes
FSAs cannot reimburse non-prescribed drugs except insulin	1/1/11	Yes	Yes
IRS Reporting: Employer must report value of Health coverage on W-2s	For 2011 Form W-2s	Yes	Yes
Plan must provide short, standardized summary of benefits	3/23/12	Yes	Yes
Prior notice of plan changes	Unclear	Yes, may apply on date of enactment (3/23/10), or for PY ≥ 3/23/10, or by 3/23/12	Yes, may apply for PY ≥ 3/23/10 or by 3/23/12
Annual contributions to FSAs limited to $2,500	1/1/13	Yes	Yes
Employee portion of Medicare tax increases by 0.9%; plus new 3.8% tax on unearned income; applies to wages/amounts over $200,000, $250,000 joint filers	1/1/13	Yes	Yes
Notice to employees of plan options, exchanges, and subsidies	Employees hired ≥ 3/1/13; for current employees 3/23/13	Yes	Yes
Reporting to IRS by large employers on health care coverage provided and number of full time employees for each month	1/1/14	Yes	Yes

Waiting periods cannot exceed 90 days	PY ≥ 1/1/14	Yes	Yes
Plan cost sharing cannot exceed HDHP maximum out-of-pocket limits; deductibles for small plans may not exceed $2,000/$4,000 (as adjusted)	PY ≥ 1/1/14	No	Yes
Restrictions on limits for clinical trials	PY ≥ 1/1/14	No	Yes
Unclear Effective Dates			
Auto enrollment required for large employers	Dependent on issuance of regulations	Yes	Yes

Change Effective March 30, 2010

Plans That Currently Cover Nondependent Children

Employers offering health plans covering non-dependent children have been reporting the value of the coverage as imputed income of employees whose children receive the coverage and have included this income when calculating federal tax withholding. Effective on March 30, 2010, health care benefits and cost of coverage provided under an employer plan to an employee's child who will not attain age 27 (by the end of the tax year) are excludable from the employee's income.[21] Accordingly, employers need to adjust their payroll systems to stop imputing income for and withholding on the value of this coverage. This change was immediate and adjustments may need to be made for any over withholding that occurred because of time needed to implement the change.

Also, plan sponsors may want to review their cafeteria plans to determine whether to make changes to permit payment of these premiums on a pre-tax basis or change benefit provisions to cover children under age 27. Sponsors should review their specific plan language, because in some cases the statutory changes will result in automatic changes in plan eligibility or benefit treatment, and in other cases plan language will need to be altered to reflect the change in the law. Recently issued guidance provides that a change in eligibility for children under age 27 would constitute a change in status event permitting a new cafeteria plan election. The notice includes transitional relief permitting the election even if the cafeteria plan has not yet been amended to cover children under age 27, as long as the plan is retroactively amended no later than December 31, 2010, to permit deferrals to cover these children, and the amendment is effective on the first date in 2010 (after March 30, 2010) when the deferrals were permitted.[22]

Changes Effective for the First Plan Year Beginning on or After September 23, 2010, Applicable to All Plans, Including Grandfathered Plans

Further guidance may be issued on these provisions prior to the effective date. Plan sponsors and administrators should monitor future developments or contact benefits counsel before implementing changes. It will be important to review carefully all plan documents, including plan communications such as SPDs, to ensure that the plan complies with the new rules.

Coverage of Nondependent Children Until Age 26

All insured group plans and self insured plans that offer dependent coverage of children must continue to make such coverage available "until the child turns 26 years of age."[23] For grandfathered group health plans, for plan years beginning before 2014, this rule only applies if the adult child is not eligible to enroll in an employer sponsored plan of the child's employer.[24] Grandfathered plans that want to take advantage of this special rule should establish procedures to solicit information from participants on whether adult children are eligible for coverage in another employer plan and require notification of status changes. (Note: the special rule is only available to exclude children eligible for employer coverage. Children covered by health plans at school must be offered coverage under their parents' employer health plans until age 26.) For grandfathered and non-grandfathered plans, provisions that condition eligibility on student or marital status prior to age 26 will need to be altered, and provisions that stop coverage for a child before age 26 will need to be changed.

No Preexisting Condition Exclusion for Child Under 19

An insured or self-insured plan may not impose any preexisting condition exclusion on any participant under age 19. For plan years beginning on or after January 1, 2014, no preexisting condition exclusion may be applied to any participant regardless of age.[25] Plan sponsors should also consider whether the additional costs for covering preexisting conditions might necessitate plan design changes, recognizing the potential impact of such changes on the grandfathered status of the plan.

No Lifetime Limits and Restrictions on Annual Limits

An insured or self-insured health plan may not establish lifetime limits on the dollar value of essential health benefits for any participant or beneficiary. HHS will establish restrictions on the annual limits that may be imposed on "essential health benefits" for plan years beginning prior to January 1, 2014. For subsequent plan years, no annual limits

may be imposed on essential health benefits.[26] (The Secretary of HHS is charged with defining "essential health benefits" and has not yet issued regulations to do so, but the statute requires that the categories of benefits listed on page 60, above, must be included at a minimum.) The minimum permitted annual limits for periods prior to 2014 are as follows:

Minimum Annual Dollar Limit on Essential Health Benefits	Period
$750,000	The Plan Year beginning on or after 9/23/10
$1,250,000	The Plan Year beginning on or after 9/23/11
$2,000,000	The Plan Year beginning on or after 9/23/12 but no limits after 2013

A plan that previously had higher annual dollar limits on essential health benefits and that reduces its limits to a level permitted under these regulations will lose its grandfather status.

Individuals whose coverage ended because of reaching a lifetime limit must receive a notice stating that the lifeline dollar limit on benefits no longer applies, and these individuals must be provided an opportunity for at least 30 days to enroll in any benefit package under the plan. The notice and opportunity to enroll must be provided not later than the first day of the first plan year beginning on or after September 23, 2010.

No Rescission Except for Fraud or Intentional Misrepresentation of Material Fact

A group health plan and a health issuer offering group coverage may not rescind the plan or coverage of a participant, unless the covered individual has committed fraud or made an intentional misrepresentation of a material fact prohibited by the terms of the plan. Inadvertent omissions may not constitute grounds for rescission. The plan document must provide for the rescission in this case and written prior notice must be given at least 30 days prior to rescission.[27]

Possible Requirement That Changes in Plans Be Communicated 60 Days Prior to the Effective Date of Change

The law requires that plans must provide 60 days advance notice of material modifications to the plan. This notice appears to be related to the provision in the law that requires that group health plans to provide a summary of benefits and coverage, including an explanation of cost sharing. The summary is required to be short, contain non-technical language and cover "essential health benefits" and other topics (under

standards to be developed by HHS by March 23, 2011). There is some confusion about the effective date of this provision. It would appear that the summaries must be provided by March 23, 2012, but advance notice of material modifications to the plans could be required in the first plan year beginning on or after September 23, 2010. Also, there is uncertainty as to when the notice requirement becomes effective for grandfathered plans; the statute could be read to require immediate compliance.[28] The logical reading of the statute's intent would be to require the advance notice of modifications only after the summaries must be provided so that no notice would be required prior to March 23, 2012. Clarification on this point is expected. As a precaution, however, employers may want to consider whether to provide some advance notice of plan changes if they can do so, at least until clarifying guidance is issued.[29]

Changes Applicable Only to Non-Grandfathered Plans That Are Effective for the First Plan Year Beginning on or After September 23, 2010

Plan sponsors with arrangements that are not grandfathered will need to amend their plans and participant communication materials to reflect the changes described below. These provisions must also be included in new plans, and in participant communication materials if plan sponsors are adopting new plans.

Prohibition on Discrimination in Favor of Highly Paid

Sections 1001(5) and 10101(a) of PPACA provide that insured plans would be subject to the same nondiscrimination rules as self-insured plans (but with a different penalty structure). The Public Health Services Act (PHSA) as amended, incorporates the nondiscrimination standards contained in IRC Section 105(h). Under IRC Section 105(h), employers cannot provide benefits that discriminate in favor of highly compensated individuals with respect to eligibility to participate or benefits received. These rules are applied on a controlled group basis. For this purpose, highly compensated individuals are defined as the five highest paid officers, more than 10 percent shareholders, and the top 25 percent of all employees (excluding for purposes of this calculation employees who are not plan participants, employees with less than three years of service, part-time employees, collectively bargained employees, and nonresident aliens with no US source income.[30]

For self-insured plans, under Section 105(h), if better plan benefits are provided to highly compensated individuals who do not pay for their coverage with after-tax dollars, the value of the "excess reimbursements" received must be included in those individuals' income. No income inclusion is required with respect to non-highly compensated

employees. If the benefits are the same but the plan fails the eligibility rules, a ratio of the value of benefits provided to the high paid over the value of benefits provided to all participants is applied to the amounts received by the high paid. This can result in income inclusion that is very high in the case of a highly compensated person who has significant medical costs. This type of penalty structure, requiring income inclusion for highly compensated individuals, is not adopted in the statutory provisions governing insured plans. Rather, the statutory penalty for insured plans that violate the nondiscrimination rules is an excise tax equal to $100 per participant (presumably including non-highly compensated employees) per day, and is imposed on the employer.[31]

Note that grandfathered plans are not subject to these rules. This will likely help certain insured arrangements already in place for executives, but still raises questions as to what types of modifications to plans would create a new plan. Similarly, questions arise as to employment agreements under which high paid individuals were promised access to insured health care upon employment termination in the future. If the underlying plan is changed, is the individual's promised access grandfathered or not?

It should be noted that in the past, self-funded plans that have provided such discriminatory arrangements have taken steps to avoid taxation of benefits to the high paid by requiring that the employees pay for the cost of the coverage they receive using after tax dollars. However, for insured plans, it appears that this type of arrangement would not work under PPACA because as discussed above, the penalty for insured plans is under ERISA and the Public Health Service Act and is an excise tax imposed on the employer, not income inclusion for highly compensated employees. There may not be an easy solution for employers that had arrangements allowing only executives to remain in the employer's health plan for a limited period of time upon termination of employment. Thus, is it likely that employers with insured plans may have to provide cash rather than insurance coverage.

At least as the statute reads now, self-insured plans are not subject to the nondiscrimination provision of PHSA Section 2716 or the excise tax under the Public Health Service Act. But even these plans may wish to be careful about providing discriminatory benefits in the future, and may also think twice before changing their underlying health plans and losing the grandfather. This provision raises many unanswered questions.

Another peripheral effect of this change may involve increased scrutiny and an updating of IRC Section 105(h) itself. Enacted in 1978, IRC Section 105(h) was originally seen as applying primarily to small businesses that might be tempted to provide special benefits to their owners, but it has applied to self-insured plans with large benefit programs, including retiree medical coverage. However, the regulations are old and do not reflect modern medical plans. Self-insured plans have struggled to apply IRC Section 105(h) to plans that allow a choice of benefits, and

to plans that base benefits on location, length of service, or other factors. Due in part to a strong reaction to Congress's attempt to impose objective nondiscrimination rules in 1986 for all health plans (so-called Section 89) which was repealed, the IRS has not attempted to update these standards. However, by expanding the scope of employers subject to the standards of IRC Section 105(h), this legislation may provide an impetus to the IRS to create more objective rules and to enforce them more vigorously.

Elimination of Cost Sharing for Preventive Care

An insured or self-insured plan may not impose "any cost sharing requirements," such as copayments, coinsurance, or deductibles on certain immunizations, preventive care, and child and women's preventive care and screenings.[32]

Coverage for Emergency Services

A plan that covers emergency services may not require prior authorization or increase cost sharing for emergency services, regardless of whether or not they are provided out of network.[33] While any cost sharing for emergency services out of network cannot exceed the cost sharing in network, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of what the out-of-network provider charges over an amount determined under the regulations based on negotiated in-network charges, out-of-network charges, and Medicare reimbursement amounts.

Primary Care Referrals Cannot Be Required in Certain Cases

Plans cannot require initial referrals by a primary care physician for general pediatric or OB/GYN services. A group health plan that required designation of a primary care provider must permit a participant or beneficiary to designate any participating primary care provider who is available and accepts the participant, must permit designation of a pediatrician as a child's primary care provider, and may not require preauthorization or references for OB/GYN services. The plan must notify participants and beneficiaries of these rights. The regulations provide model language for this notice. These changes do not apply to grandfathered plans.[34]

Appeals Process

Group health plans are required to have an internal review process and an external review process; for plans subject to ERISA, these do not replace those procedures currently required under the ERISA claims

procedures. Internal review processes will need to comply with DOL regulations. HHS standards will govern permissible external review processes for self-insured group health plans and insured plans not subject to state standards. Generally, state standards will govern external review processes of insured plans. Plans must continue enrollment and pay benefits during the appeals process. This change does not apply to grandfathered plans.[35]

Auto Enrollment

Large employers (200 or more employees) must provide for automatic enrollment (subject to permissible waiting periods) once regulations are issued. The employer must provide adequate notice and the opportunity to opt out. Regulations may have to address questions related to the choice of individual type of coverage. Presumably automatic enrollment will be mandated only for individual coverage, and regulations will have to address, and employers will have to coordinate their current procedures for electing individual or family coverage with the automatic enrollment rules. We assume an employer will be able to elect a "default" plan if the employee offers more than one health insurance plan. This auto enrollment mandate is accomplished by an amendment to the Fair Labor Standards Act.[36] The effective date of this provision is uncertain.

Cafeteria, FSA, and HSA Changes Effective for All Plans in Tax Years 2011 and 2014

The following changes affect account-types health plans sponsored by employers and are effective for tax years in 2011 and 2014.

Nonprescribed Drugs

For expenses incurred with respect to taxable years beginning after 2010, over-the-counter medicines (except insulin) may not be reimbursed from a health FSA unless the medicine is prescribed by a physician.[37] Plan sponsors should inform employees of this new rule in their participant communications. Plan sponsors will also need to amend their cafeteria plans to reflect this rule. For fiscal year plans, the new rule still applies for expenses beginning January 1, 2011. Accordingly, while calendar year plans need not be changed before 2011, fiscal year plans with plan years beginning in 2010 will need to be amended to reflect the January 1, 2011, effective date for the new rule. Even if the plan is a calendar year plan, employers may also want to consider telling employees about this rule earlier so they can use amounts remaining at the end of 2010 to purchase over-the-counter medications.

Penalties for HSA and MSA Distributions Not Used for Qualified Medical Expenses

The penalty taxes on distributions from HSAs and MSAs—that are not used for qualified medical expenses—are increased from 10 percent and 15 percent, respectively, to 20 percent, for distributions made after 2010.[38]

New $2,500 Limit

Employee elective deferrals to health FSAs will be limited to $2,500, indexed, effective for taxable years after 2013.[39] Plan sponsors may want to consider giving participants early notice of this change so that they can arrange for any expensive elective procedures that might be able to be scheduled for earlier years.

Simple Cafeteria Plan

Effective January 1, 2011, employers can take advantage of less complex cafeteria plan nondiscrimination rules if they provide benefits on a uniform basis to all employees who have a year of service and who work 1,000 hours a year. That benefit must be at least either (a) two percent of compensation or (b) the lesser of six percent of compensation or twice the median contributions made by nonhighly compensated employees.[40]

Coverage Summary and Notices of Plan Changes Effective in 2012

Coverage Summary

By 2012, HHS is required to develop uniform terms and formats for summaries of benefits and coverage for enrollees under a plan. These summaries will be limited to 4 pages and are supposed to be provided in non-technical language.[41] The guidance will explain what terms and conditions must be described in the summaries and notices.

Prenotification of Significant Changes

For plan years after March 23, 2012, plans are required to provide 60 days advance notice of changes to the plan—presumably, this is related to the changes described in the summaries but that is not entirely clear.[42] As noted above, due to the statutory language, the effective date of this provision is unclear and arguably, some plans may be subject to this requirement earlier.

Changes Applicable Beginning with the First Plan Year on or After January 1, 2014

These changes add the last set of required design mandates with delayed effective dates. Many apply only to non-grandfathered plans.

Preexisting Conditions Exclusions for All Participants and Beneficiaries

Effective for plan years beginning on or after January 1, 2014, the prohibition on preexisting conditions exclusions is extended to all participants and beneficiaries under a group health plan in addition to those under 19. This requirement applies to grandfathered plans as well as non-grandfathered plans.[43]

Excessive Waiting Periods

Effective for plan years beginning on or after January 1, 2014, group health plans are not permitted to impose a waiting period exceeding 90 days. This rule applies to grandfathered plans.[44]

Wellness Programs

The limit of rewards or rebates under a wellness program for satisfying a standard related to a health status is increased from 20 percent to 30 percent of the cost of coverage, which may be increased up to 50 percent by the Department of Labor, HHS and the IRS. It is interesting that this "relief" at present only appears to apply to non-grandfathered plans.[45]

Cost-Sharing Limitations

Effective for plan years beginning on or after January 1, 2014, the total out-of-pocket limits for group health plans may not exceed those permitted for health savings accounts (HSAs). (Note that for 2011, the limits are $5,950 for self-only coverage and $11,900 for family coverage.) The limits will be indexed for later years. Insured products in the small group market are also subject to separate deduction limits of $2,000 for a plan covering a single person and $4,000 for other plans.[46] These rules do not apply to grandfathered plans.

Clinical Trials

Plans must cover routine costs of clinical trials if they would otherwise be covered (but subject to plan restrictions on out-of-network payments). This change does not apply to grandfathered plans.[47]

Prohibition on Discrimination Against Employees and Providers

Employers and non-grandfathered group health plans are prohibited from firing or discriminating against employees because they receive a health care credit or subsidy, take action to assist with enforcement of the PPACA, or refuse to take action the employee reasonably believes to be in violation of PPACA. Non-grandfathered group health plans are prohibited from discriminating with respect to participation under the plan against any health care provider who is acting within the scope of the provider's licenses or certification under applicable state law.[48]

Application of Act to Stand-Alone Retiree Medical Plans

In order to clarify the relationship of the new employer and insurance mandate on retiree health care plans, interagency guidance has made it clear that the market reforms of PPACA generally do not apply to stand-alone retiree-only plans.[49] Thus, the market reform requirements such as the extension of dependent coverage to children up to age 26 do not apply to these plans. There may still be an issue as to whether and when such plans are "stand-alone" plans, however.

Related Tax Provisions in Health Care Act

W-2 Reporting Change Effective for 2011

For tax years after 2010, an employer is required to disclose on Form W-2 the value of the employee's health insurance coverage under any employer sponsored plans in which the employee is enrolled. The amount reported should include the aggregate cost of employer sponsored coverage, except it would not include contributions to an Archer MSA or an HSA already reported on Form W-2 or salary reduction contributions to a cafeteria plan.[50] Employers and plan sponsors should begin working on developing systems and coordinating with insurers and third-party payroll service providers to properly capture and process this information. The effective date of this change applies to amounts taxable in 2011.

Other Tax Provisions

Small Business Credit

Effective for taxable years beginning after 2009, the Act provides a credit for small businesses that employ low to moderate income workers and make non-elective contributions to purchase employee health insurance. Some credit is available for an employer of fewer than 25 full

time employees (FTEs) whose average wages are no more than $50,000. A full credit applies to employers who employ 10 or fewer FTEs whose average wages are $25,000 or less. Note that the definition of FTE is *not* the same as used to determine large employer status. For purposes of the credit, the number of FTEs is determined by dividing the aggregate employee hours worked in a year by 2080 (so assumes a 40 hour workweek). Special rules are provided for calculating FTEs and wages. There are limits on the use of this credit by sole proprietors or for family employees. To obtain the credit, the employer must contribute at least 50 percent of the cost of health care, and the same percentage contribution must be made for each employee.

The credit is phased in and different rules apply before 2014. Prior to 2014, the credit can be taken annually and is limited to 35 percent of the employer's premiums (25 percent for tax-exempt employers). After 2013, the credit can only be taken for a two year period and is limited to 50 percent of the premiums (35 percent for tax-exempt employers). Also after 2013, the premiums must be paid to a product sold in the Exchange. The credit is not payable in advance or refundable. It is a general business credit that can be carried back one year and forward 20 years. Tax-exempt employers who meet the size and demographic criteria can take the credit against payroll taxes.[51]

Wellness Program Grants

Beginning in 2011, certain small employers (100 or fewer employees) will be eligible to receive federal grants for implementing a wellness program. Employers with wellness programs in place on March 23, 2010, are not eligible.[52]

Early Retirement Subsidy

Effective in 2011, the Act also authorizes a $5 billion reinsurance program to subsidize the costs of early retirees from ages 55 until Medicare eligible. Under this program, HHS will reimburse 80 percent of the cost of all of the claims paid by the plan and the participant for each plan participant that are between $15,000 and $90,000 for the plan year. The program is scheduled to begin no later than June 21, 2010, and will end when all funding has been exhausted, or January 1, 2014. Employers must apply for the reimbursements. It is expected that funding will be exhausted quickly and most employers have already made preparations to apply as soon as the application becomes available (presumably in June 2010) because HHS has indicated that applications will be processed in the order submitted.

An eligible program must meet various requirements specified by HHS, and must demonstrate that the reimbursements will be used to reduce premiums, copayments, deductibles, coinsurance, or other

out-of-pocket participant costs, or future costs of the plan sponsor (the program is not intended to allow the sponsor to reduce current costs), and that there are procedures in place for cost savings and anti-fraud protection.[53]

Elimination of Deduction Relating to Medicare Part D Subsidy—Effective in 2013; Reporting of Change Required Earlier

Currently, sponsors of retiree health plans may deduct the full cost of their retiree health prescription drug payments under their retiree health plans and receive a subsidy for such payments without regard to the deduction. Effective in 2013, amounts attributable to the Medicare Part D subsidy received from the federal government cannot be deducted.[54] Even though this is not effective until 2013, many plan sponsors had to reflect this change immediately in their financial statements.

Medicare Taxes

Starting in 2013, an additional 0.9 percent Medicare tax is imposed on wages in excess of $250,000 for joint return filers or $200,000 for other filers. The additional tax applies to the employee portion only, but employers are responsible for withholding this tax from employees' wages.[55] The HCERA also imposed a 3.8 percent tax on unearned income for joint return filers with modified adjusted gross income in excess of $250,000, or $200,000 for other taxpayers.[56] This provision may put some pressure on employers to structure any new payments negotiated for the future at a date earlier than 2013; but acceleration of agreements that are already binding may be difficult due to the restrictions imposed under IRC Section 409A on changes to deferred compensation.

Auto Enrollment in Voluntary Long-Term Care Program (CLASS)

A new government run voluntary long-term care program is to be established. Employers may provide for automatic enrollment in this program using payroll deductions in the same manner as automatic enrollment is permitted for 401(k) plans. While the statutory effective date for CLASS provisions is January 1, 2011, HHS has until October 1, 2012, to designate the CLASS plan.[57] Employers who currently offer long-term care coverage or are considering adding such benefits will want to analyze the features of the CLASS program. It will probably be difficult to offer both group long-term care and CLASS because the CLASS automatic enrollment feature would likely result in too low a take up rate for the group long-term care plan. The CLASS auto enrollment program only covers the employee while many group plans offer coverage for relatives. Group plans generally permit selection of benefit levels

while under CLASS benefits will vary based on the severity of functional impairment.

Other Fees and Taxes

Fees for Group Health Plans

Effective for plan or policy years ending after September 30, 2012, a fee will be assessed on issuers of insured plans and sponsors of self-insured plans in the amount of $2 per participant for the plan or policy year ($1 for plan or policy years ending in fiscal 2013). For policy years beginning after September 30, 2014, the $2 will be indexed for increases in per capita national health expenditures. Under a sunset provision, the section will not apply to plan or policy years ending after September 30, 2019.[58]

Cadillac Tax Effective in 2018

An excise tax is imposed on excess health coverage—the total cost of coverage (including the employee paid portion) exceeding $10,200 for self-only or $27,500 for coverage other than self-only coverage for 2018. Stand-alone dental and vision benefits are excluded from the Cadillac tax. These maximums could be increased by 2018 if health care costs exceed projections. The tax is imposed on the insurer or plan administrator. Note that in determining whether the employer sponsored insurance coverage exceeds the threshold amount, the value of all employer coverage is taken into account. These include employer contributions to an HSA or Archer MSA, as well as reimbursement under a Health FSA or HRA.[59] Given the 2018 effective date, there is time for further guidance (and even an increased possibility of statutory changes) related to this provision. Regulatory focus on Cadillac plans is not anticipated in the near future, given the pressing demands for more immediate guidance related to provisions with earlier effective dates.

Conclusion

The PPACA includes numerous changes, many of which are effective soon or will impact planning and design of health care programs in the future. Employers will need to make decisions quickly on provisions that are effective immediately, but keep in mind the longer term impact of the Act on their health programs and their employee workforce when making these changes. Guidance is anticipated in the coming months on many of these provisions, and employers and administrators should stay in touch with their advisers about this guidance and new developments that are likely to occur over the next few years.

Notes

1. In the textual discussion in this column, PPACA and HCERA are referred to collectively as "Health Care Reform" or the "PPACA." The Internal Revenue Code of 1986, as amended, is referred to as the "IRC." *Note:* This article reflects regulations and guidance as of June 24, 2010.

2. *See* new IRC § 5000A as added by PPACA § 1501(b).

3. *See* PPACA §§ 1311, 1401, and 1402, and new IRC § 36B.

4. *See* PPACA § 1302(b)(1).

5. *See* PPACA § 1302(b)(2).

6. *See* PPACA § 1513 as amended by § 10106 and HCERA § 1003.

7. *See* PPACA § 1501(b).

8. Minimum essential coverage includes coverage under an "eligible employer-sponsored plan." The definition of an "eligible employer-sponsored plan," as written, technically may not encompass self-insured non-governmental employer plans, though this was not the statutory intent. *See* IRC § 5000A(f)(2) added by PPACA § 1501 (including only governmental plans and plans or coverage offered in the small or large group market as eligible employer-sponsored plans). In this column, we have assumed that coverage under a self-insured employer plan will constitute minimum essential coverage.

9. *See* new IRC § 4980H added by PPACA § 1513 as amended by § 10106 and HCERA § 1003.

10. *See id*. and PPACA § 10108.

11. *See id*. and PPACA §§ 10108, 1401, and 1402, and HCERA § 1001(a)(2)(A).

12. We understand that the 9.8 percent percentage used herein may have been intended to be 9.5 percent and could be so interpreted. *See* HCERA § 1001(a)(2)(A) (reducing the threshold from 9.8 percent to 9.5 percent for tax credits). Joint Committee on Taxation *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10) at 124 (Mar. 21, 2010) (applying a 9.5 percent threshold in describing the voucher requirements).

13. It is not clear if the relevant cost is based on the most expensive plan offered by the employer, or the plan under which the employer pays the higher percentage of premiums.

14. *See* PPACA § 10108 and new IRC § 139D.

15. *See* PPACA §§ 1514 and 10106(g).

16. *See* PPACA § 1512 amending the Fair Labor Standards Act by adding Section 18B.

17. *See* new PHSA § 2707(a) and PPACA § 1201.

18. *See* PPACA § 1101.

19. *See* PPACA § 1251(d). Recent guidance has clarified that despite the confusing language, collectively bargained plans that are grandfathered are not provided with a delayed effective date for provisions of the Act with which other grandfathered plans must comply immediately. *See* "Preamble to Interim Final Rules for Group Health Plans

and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 *Fed. Reg.* 34538 (June 17, 2010) ("Preamble to Grandfather Rules").

20. *See* Preamble to Grandfather Rules (codified at 26 C.F.R. § 54.9815-125T).

21. *See* IRC § 105(b) as amended by § 1004(d) of HCERA; *see* Joint Committee on Taxation, Technical Explanation for the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act" (Mar. 21, 2010) at 133 regarding exclusion of cost of coverage under IRC § 106 and IRS Notice 2010-38, 2010-20 I.R.B. 682 (May 17, 2010).

22. *See* IRS Notice 2010-38, 2010-20 I.R.B. 682 (May 17, 2010).

23. *See* PHSA § 2714 as amended by PPACA § 1001.

24. *See* HCERA § 2301(a) and IRS Notice 2010-38, 2010-20 I.R.B. 682.

25. *See* PHSA § 2704 as added by PPACA § 1201 and HCERA § 2301, and 26 C.F.R. § 54.9815-2704T. (For effective dates, *see* PPACA §§ 1253, 10103(e).)

26. *See* PHSA § 2711 added by PPACA § 1001 and amended by PPACA § 10101 and HCERA § 2301. *See* 26 C.F.R. § 54.9815-2711T(d) (prescribing annual dollar limits).

27. *See* PHA § 2712 as added by PPACA § 1001 and HCERA § 2301, and 26 C.F.R. § 54.9815-2712T.

28. Of course, if the regulations provide that a material modification would result in loss of grandfathering, this earlier effective date issue would not arise.

29. *See* PHSA § 2715 as added by PPACA § 1001; *see also* PPACA § 10103(d)(2).

30. *See* PHSA § 2716 as added by PPACA § 1001 and amended by PPACA § 10101.

31. *See* PPACA § 1001 and PHSA § 300gg.

32. *See* PHSA § 2713 as added by PPACA § 1001.

33. *See* PPACA § 10101(h) adding PHSA § 2719A, and 26 C.F.R. § 54.9815-2719AT.

34. *See* PPACA §§ 10101(h) and 1251, and 26 C.F.R. § 54.9815-2719AT.

35. PPACA §§ 10101(g) and 1251.

36. PPACA § 1511 amending 29 U.S.C. § 218.

37. See PPACA § 9003.

38. *See* PPACA § 9004.

39. *See* PPACA §§ 9005 and 10902 and HCERA § 1403.

40. *See* PPACA § 9022.

41. *See* PHSA § 2715 as added by PPACA § 1001; *see also* PPACA § 10103(d)(2).

42. *Id.*

43. *See* PHA § 2704 as added by PPACA § 1201 and HCERA § 2301 and PPACA §§ 1253, 10103(e).

44. *See* PHSA § 2708 as added by PPACA § 1201; *see also* HCERA § 2301.

45. *See* PHSA § 2705 as added by PPACA § 1201; *seealso* PPACA §§ 1251 and 10103.

46. *See* PHSA § 2707(b), and PPACA §§ 1201 and 1302(c)(1) and (2).

47. *See* PPACA § 10103(c) adding PHSA § 2709.

48. *See* PHSA § 2706 as added by PPACA § 1201 and PPACA § 1558. Note that the effective date with respect to employers for the prohibition against discrimination for employee exercise of rights under the PPACA is unclear and may be as early as March 23, 2010. *See* PPACA § 1558.

49. *See* Preamble to Grandfather Rules, *supra* n.19, at 34539.

50. *See* PPACA § 9002.

51. *See* new IRC § 45R and PPACA §§ 1421 and 10105; *see also* Notice 2010-44, 2010-22 I.R.B. 717 (June 1, 2010).

52. *See* PPACA § 10408.

53. *See* PPACA § 1102, and Early Retirement Insurance Program, 75 *Fed. Reg.* 24,450, 24,458 (May 5, 2010).

54. *See* PPACA § 9012.

55. *See* PPACA §§ 9015 and 10906.

56. *See* HCERA § 1402.

57. *See* PPACA § 8002.

58. *See* new IRC §§ 4375–4377 added by PPACA § 6301.

59. *See* PPACA §§ 9001 and 10901, and HCERA § 1401.

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