

HEALTH CARE REFORM

On March 30, 2010, President Obama signed into law the Amendment to H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010 (HCEARA), which will follow the Patient Protection and Affordable Care Act (PPACA). The PPACA was passed by the Senate on December 24, 2009, and then passed by the House on March 21, 2010.

While many of the health care reform provisions are not effective until 2014, there are a few that are effective for plan years that begin on or after six months after the enactment date, and there are a number of tax provisions with varying effective dates.

The following is a brief overview of the relevant, health-plan-related provisions of PPACA and HCEARA. The provisions impact both self-insured and fully-insured group health plans, and have been added to the Public Health Service Act (PHSA) and incorporated by reference into ERISA and the Internal Revenue Code (the "Code"). **Except as noted below, the provisions are effective for all plans renewing on or following six months after the date of enactment (or approximately October 1st of this year and after).**

KEY PROVISIONS THAT TAKE EFFECT IMMEDIATELY

1. **ENDS RESCISSIONS:** Bans health plans from dropping members from coverage when they become ill. Provision also applies to grandfathered plans. Plans may still rescind coverage in cases of fraud or intentional misrepresentation. *Effective for all plans that renew on or after October 1, 2010 (approximately).*
2. **PROHIBITS DISCRIMINATION OF PRE-EXISTING CONDITIONS FOR CHILDREN:** Prohibits health plans from denying coverage to children with pre-existing conditions. *Effective for all plans that renew on or after October 1, 2010 (approximately).* (Beginning 2014, this would apply to all members.)
3. **ELIMINATES LIFETIME MAXIMUMS ON PLANS:** Plans may not impose lifetime maximums. This provision also applies to all grandfathered plans. *Effective for all plans that renew on or after October 1, 2010 (approximately).*
4. **ELIMINATES RESTRICTIVE ANNUAL LIMITS ON COVERAGE:** Restricts new plans' use of annual limits to ensure access to needed care. These restrictions will be defined by the Secretary of Health and Human Services (HHS). For plan years beginning on or after January 1, 2014, group health plans and group health insurers may not impose any annual limit. Otherwise permissible lifetime or annual limits may be imposed on specified covered benefits that are not considered essential health benefits. *Effective for all plans that renew on or after October 1, 2010 (approximately).* (Beginning in 2014, the use of any annual limits would be prohibited for all plans, including grandfathered plans.)
5. **EXTENDS COVERAGE FOR DEPENDENT CHILDREN TO AGE 26:** Requires health plans to allow coverage for dependent children until age 26, both married and unmarried dependents. For plan years before 2014, applies to grandfathered group health plans only if dependent is not eligible to enroll in another employer-sponsored plan. Extends the tax exclusion for employer-provided coverage to adult children through age 26. *Effective for all plans that renew on or after October 1, 2010 (approximately).*

6. **INTERIM HIGH-RISK POOL TO PROVIDE IMMEDIATE HELP FOR THE UNINSURED UNTIL EXCHANGE IS AVAILABLE:** Provides immediate access to insurance, through a temporary high-risk pool, for Americans who are uninsured because of a pre-existing condition. *Effective 90 days after enactment.*
7. **EARLY RETIREE ASSISTANCE:** Creates a temporary re-insurance program (until Exchanges are available) to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55-64. *Effective 90 days after enactment; however appears to expire on January 1, 2014.*
8. **FUNDING TO CLOSE THE MEDICARE PART D DONUT HOLE:** Provides a \$250 rebate to Medicare beneficiaries who hit the donut hole in 2010. *Effective for calendar year 2010. (Beginning in 2011, institutes a 50% discount on brand-name drugs in the donut hole with 75% discounts on brand name and generic drugs by 2020. Institutes a 93% coinsurance rate for generics in 2011 and phases it down to 25% in 2020.)*
9. **PREVENTIVE HEALTH SERVICES:** Coverage of preventive health services is required under all plans with no cost-sharing. *Effective for all plans that renew on or after October 1, 2010 approximately).*

KEY PROVISIONS EFFECTIVE JANUARY 1, 2011

- **FREE PREVENTIVE CARE UNDER MEDICARE:** Eliminates preventive services copayment and exempts preventive services from deductibles under the Medicare program.
- **MEDICAL LOSS RATIO / ENSURING VALUE FOR PREMIUM PAYMENTS:** Requires plans in the individual and small group market (less than 100 lives) to spend 80 percent of premium dollars on medical services, and plans in the large group market (more than 100 lives) to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders.
- **CREATES VOLUNTARY, PUBLIC LONG-TERM CARE INSURANCE PROGRAM:** Creates long-term care insurance to be financed by voluntary payroll deductions, providing benefits to adults who become disabled.
- **OVER-THE-COUNTER REIMBURSEMENTS:** Effective for tax years beginning on or after January 1, 2011, over-the-counter medicines or drugs are not eligible for reimbursement under an FSA, HRA, or HSA without a doctor's prescription.
- **HSA DISTRIBUTIONS:** The excise tax for nonqualified distributions from HSAs is increased to 20%, effective for distributions after December 31, 2010.
- **BRAND NAME PHARMACEUTICALS:** Industry fee on sales of brand name pharmaceuticals for use in government health programs.

KEY PROVISIONS EFFECTIVE JANUARY 1, 2013

- **(HI) TAX BASE FOR HIGH-INCOME TAXPAYERS:** Beginning in 2013, individuals with wages above \$200,000 for a single return and \$250,000 for a joint return would be subject to an additional 0.9% Medicare tax on wages in excess of the above amounts. Additionally, they will be subject to a 3.8% tax on unearned income from interest, dividends, annuities, royalties, rents, and capital gains.

- **FSA CAP:** Health FSA salary reductions are limited to \$2,500 each year. The FSA cap is indexed to the CPI starting 2014.
- **DEDUCTION OF RETIREE MEDICAL COSTS:** Effective for tax years beginning on or after January 1, 2011, the deduction previously permitted for amounts used for Medicare Retiree Part D subsidy is eliminated. Note: The Reconciliation Bill would delay the effective date to 2013.

KEY PROVISIONS EFFECTIVE JANUARY 1, 2014

- **PREEXISTING EXCLUSION LIMITATIONS:** No preexisting condition exclusions or limitations are permitted. Applies to grandfathered group plans for plan years starting in 2014.
- **HEALTH STATUS DISCRIMINATION:** Follows HIPAA regulations. PPACA raises the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20% of the COBRA cost of coverage to 30% of the COBRA cost of coverage for those participating in the program (and allows the Secretaries of DOL, HHS and Treasury, the discretion to increase the percentage to 50%).
- **LIMITATIONS ON COST SHARING:** To satisfy cost-sharing requirements, out-of-pocket (OOP) expenses can't exceed those applicable to Health Savings Account (HSA) related coverage, and deductibles can't exceed \$2,000 for single coverage and \$4,000 for family coverage (as indexed).
- **LIMITATIONS ON WAITING PERIODS:** Plans may not impose a waiting period greater than 90 days.
- **ELIMINATION OF ANNUAL LIMITS ON COVERAGE:** *See key provisions effective immediately for more details.*
- **HEALTH INSURANCE EXCHANGE:** PPACA provides funds to states to establish a health insurance exchange through which individuals may purchase health insurance beginning in 2014.
- **INDIVIDUAL RESPONSIBILITY:** Beginning in 2014, individuals who do not enroll in qualifying coverage, including qualifying employer-sponsored coverage, must pay an excise tax. Self-insured plans and insurers will be required to report certain coverage-related information to the individual and to the IRS.
- **"FREE CHOICE VOUCHERS":** Employers that offer the minimum essential coverage and make a contribution must offer "free choice vouchers" to qualified employees for the purchase of qualified health plans through exchanges. The voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income doesn't exceed 400% of the federal poverty level and the required contribution under the employer's plan would be between 8 and 9.5% of their income. Free choice vouchers are excluded from employees' incomes and are deductible by the employer. Voucher recipients are not eligible for tax credits through the exchange.

KEY PROVISIONS EFFECTIVE JANUARY 1, 2018

- **EXCISE TAX ON HIGH COST PLANS:** Beginning in 2018, a nondeductible 40% excise tax is imposed on the monthly value of high cost coverage in excess of \$10,200 for single coverage and \$27,500 for family coverage, indexed to general inflation beginning in 2018. The annual limit for retirees between ages 55

and 64, individuals engaged in certain high-risk professions and those employed to install electrical or telecommunication lines is increased to \$11,850 for individual coverage and \$30,950 for family coverage. Additionally, there would be an adjustment available for companies with higher health care costs due to age, gender of their workforce, relative to the national pool. The dollar thresholds are automatically increased in 2018 if CBO is wrong in its forecast of the premium inflation rate between now and 2018.

EMPLOYER RESPONSIBILITY BEGINNING JANUARY 1, 2014

- **Automatic enrollment:** Large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program should include adequate notice and the opportunity for an employee to opt out of the “auto” coverage and elect another option, or opt out altogether.
- **Notification of availability of exchange and subsidies:** Employers must notify each employee at the time of hiring of the following: (i) the existence of the exchange, (ii) that the employee may be eligible for a subsidy under the exchange if the employer’s share of the total cost of benefits is less than 60% and (iii) that if the employee purchases a policy through the exchange, he or she will lose the employer contribution to any health benefits offered by the employer (except as terms identified in the free choice voucher requirement).
- **Employer penalties:** Generally there isn't a requirement for employers to offer coverage; however, employers with 50 or more full-time employees are subject to penalties for not providing coverage to offer to full-time employees. The penalty will be determined on a monthly basis and is the product of the total number of full-time employees of the employer for that month and 1/12 of the applicable payment amount, which is \$2,000. The first 30 employees are disregarded. For example, a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount. If employer offers coverage and employee declines and receives subsidy through the Exchange, the employer pays the lesser of \$3,000 for each full-time employee receiving a tax credit or \$2,000 per full-time worker. Part-time employees considered solely for the purpose of determining if an employer has 50 or more employees (by adding together full-time equivalents) and are therefore subject to the employer responsibility and penalty provisions. Any penalties would only be assessed on behalf of full-time employees who work 30 or more hours per week.