TRUCKER ✦ HUSS

Benefits Report

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Historic Health Care Reform Legislation Signed by President Obama

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After over a year of negotiations and debate on the future of health care in the United States, the House of Representatives ("House") voted on March 21 to pass the Patient Protection and Affordable Care Act (H.R. 3590) — legislation which was passed by the Senate on December 24, 2009 ("the Act"). On March 21 the House also passed the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872) (the "Reconciliation Act"). The Reconciliation Act was passed by the Senate and, as revised by the Senate, passed by the House on March 25. President Obama signed the Act on March 23, and the Reconciliation Act on March 30.

The provisions of these new laws will become effective on various dates over the next several years, and voluminous regulations will need to be issued in order to interpret and implement them. This is the first in a series of articles that will cover different aspects of the health care reform laws and, as they are issued, the related regulations. This article provides an overview of the aspects of health care reform that will have a significant impact on employers and their health care plans. Future articles will address retiree coverage issues, the "Cadillac tax," Section 125 plans, and multi-employer plans.

Please note that many of the dates set forth in our recent *Special Alert* have been changed by the Reconciliation Act.

Improvements in Health Care Coverage

A number of new requirements are imposed on group health plans and health insurance issuers offering both group and individual coverage. The following requirements will become effective for plan years beginning six months after the date of enactment:

- No lifetime limits on the dollar value of benefits
- Annual dollar limits may not exceed the limits permitted for Health Savings

Accounts (for 2010 these are $5,950 for self-only coverage and $11,900 for family coverage)

- Coverage may not be rescinded except in cases of fraud or intentional misrepresentation
- Coverage of preventive health services is required without any cost-sharing
- If the plan provides dependent coverage, adult children must be covered to age 26. The Reconciliation Act eliminated the requirement that such adult children must be unmarried and makes such coverage nontaxable.
- New requirements for appeals of coverage determinations and claims, including a binding external review process

The following requirements will become effective for plan years beginning on or after January 1, 2014:

- No pre-existing condition exclusions
- Waiting periods may not exceed 90 days
- Eligibility (either initial or continued) may not depend on health status
- Guaranteed issue by health insurance issuers
- Guaranteed renewability by health insurance issuers

In addition to the above, not later than 24 months after the date of enactment, health insurance issuers and plan sponsors or plan administrators of self-insured group health plans must provide enrollees with a summary of benefits and coverage that does not exceed four pages, is in not less than 12-point font, and meets other specified requirements. The Secretary of Health and Human Services will develop standards for such disclosures not later than 12 months after the date of enactment.

Grandfathered Plans

During the health care reform debate, President Obama repeatedly said that people who have health coverage can keep that coverage. The Act provides that there will be no changes required with respect to a group health plan or health insurance in which an individual was enrolled on the date of enactment. Such plans are "grandfathered" and will continue to be treated as grandfathered plans even if coverage is renewed after the date of enactment. Further, new family members and new employees can be added to such plans.

With respect to health insurance coverage that is maintained pursuant to collective bargaining agreements that were ratified before the date of enactment, the Act will not apply until the date that the last collective bargaining agreement expires.

The Reconciliation Act extends the following requirements to grandfathered health plans:

- Waiting periods cannot exceed 90 days
- No lifetime limits on the dollar value of benefits
- Coverage may not be rescinded except in cases of fraud or intentional misrepresentation
- Adult children must be covered to age 26

In addition, the Reconciliation Act extends the following requirements to grandfathered group health plans:

- Restrictions on annual dollar limits
- No pre-existing condition exclusions
- Adult children must be covered to age 26; provided, however, that this provision only applies for plan years beginning before January 1, 2014 if the dependent is not eligible to enroll in an eligible employer-sponsored health plan.

Health Insurance Exchanges

Effective not later than January 1, 2014, the Act requires each State to establish an "American Health Benefit Exchange" ("Exchange") to facilitate the purchase of qualified health plans and a "Small Business Health Options Program" ("SHOP Exchange") to assist small employers in enrolling their employees in qualified health plans. One Exchange may serve both of these functions. We expect these Exchanges will function much like the Massachusetts Health Connector that has been in place since 2007.

Minimum Coverage Requirements

Qualified Health Plans

The Act sets standards for "qualified health plans." A qualified health plan must be certified by the Exchange

through which it is offered, provide "essential health benefits" and be offered by a licensed health insurer that agrees to the requirements of the Act and regulations to be developed by the Secretary.

Essential Health Benefits

While the Secretary is to define essential health benefits, the Act provides that essential health benefits shall include at least the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Preventive health services may not be subject to any cost-sharing requirements.

Cost-Sharing Requirements

The Act provides for annual limits on cost-sharing and limits on deductibles for employer-sponsored health plans. Cost-sharing includes deductibles, coinsurance, copayments, similar charges, and other expenditures with respect to essential health benefits under the plan that would be qualified medical expenses for purposes of a Health Savings Account.

Coverage Levels

The Act provides for four levels of coverage as follows:

- Bronze level coverage is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan.
- Silver level coverage is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan.
- Gold level coverage is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan.
- Platinum level coverage is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

In addition, certain "young invincibles" may qualify as having minimum essential coverage if they have not attained age 30 before the beginning of the plan year and are enrolled in a catastrophic plan either because they do not have affordable coverage or because they are eligible due to hardship.

Individual Responsibility

Effective January 1, 2014, the Act generally requires all U.S. citizens and lawfully present residents and their dependents to have minimum essential coverage. There will be premium credits and cost-sharing reductions for low income individuals. For each month that an individual does not have minimum essential coverage a penalty will be assessed that will be included on their Federal tax return. The penalty will be phased in and will be $95 in 2014, $325 in 2015, and $695 in 2016, subject to a maximum penalty based on a percentage of income. This amount will be adjusted for inflation for years beginning after 2016. The penalty will be one-half of the applicable amount for individuals under age 18.

Employer Responsibility

Automatic Enrollment

Effective January 1, 2014, employers who have 200 or more full-time employees and who offer at least one health plan will be required to automatically enroll new employees into a plan. Notice of the automatic enrollment must be provided and employees must have an opportunity to opt-out. Employees already enrolled in a health plan will continue to be enrolled on an "evergreen" basis *(i.e.,* they remain enrolled until they opt out or cease to be eligible, or the plan is terminated, etc.).

Notices to Employees

Effective beginning March 1, 2013, employers are required to provide notice to employees at the time of hire that informs them:

- of the existence of the Exchange and describes the services provided by the Exchange and how to contact the Exchange;
- that the employee may be eligible for a premium tax credit if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of the costs; and
- that if the employee purchases coverage through the Exchange they will lose the employer contribution (if any) to the employer's plan and that such contribution may be excludable from income.

Current employees must receive a notice that contains the above information not later than March 1, 2013.

Play or Pay Mandate

Effective beginning January 1, 2014, applicable large employers must provide minimum essential coverage ("play") or be subject to an assessment ("pay"). An applicable large employer is one who employs an average of at least 50 employees on business days during the preceding calendar year. All members of the controlled group will be aggregated for purposes of determining the size of an employer. For purposes of the play or pay mandates, "full-time employee" means an employee who is employed on average at least 30 hours per week. The Reconciliation Act provides that part-time employees will be included for purposes of determining the number of full-time employees employed by an employer. This will be done by adding up the hours of all part-time employees and dividing them by 120.

Assessments will apply to an applicable large employer for any month in which that employer has one or more full-time employees to which a premium credit applies enrolled in a qualified health plan, if that employer either:

- does not offer its full-time employees and their dependents minimum essential coverage, or
- offers minimum essential coverage that is not "affordable."

The Reconciliation Act provides that the monthly assessment for an employer who does not offer minimum essential coverage is equal to the number of full-time employees minus 30 times 1/12 of $2,000. The monthly assessment for an employer who does not offer affordable minimum essential coverage is equal to the number of full-time employees who received premium credits times 1/12 of $3,000.

Free Choice Vouchers

Employers who offer, and at least partially pay for, minimum essential coverage and who have employees with incomes of less than 400% of the poverty level or for whom the premium payments cost over 8% but less than 9.8% of their income must offer these employees a "free choice voucher." The voucher must be equal to what the employer contribution would be under the employer's plan. These employees may then opt out of the employer's plan in favor of coverage offered under an Exchange, and use the voucher as a credit towards the premium for the Exchange coverage chosen. The employer must then pay the amount of the voucher to the Exchange. If the amount of the voucher exceeds the premium for the Exchange coverage, the excess will be paid to the employee.

Reporting Requirements

Employers who provide minimum essential coverage will also have to provide reports to the government and to covered individuals.

Nondiscrimination Requirements

Self-insured plans are currently subject to nondiscrimination requirements under Internal Revenue Code section 105(h). Effective for plan years beginning six months after the date of enactment, the same nondiscrimination requirements will apply to insured plans.

Wellness Programs

The Act codifies the wellness program requirements of the final nondiscrimination regulations that were issued under HIPAA in December 2006 (see our January 2007 issue), with the following changes:

- The current maximum 20% reward for all wellness programs is increased to 30% of the cost of coverage (including both employee and employer contributions).

- The Secretaries of Labor, Health and Human Services and the Treasury may issue future guidance increasing the maximum reward to 50% if they determine that is appropriate.

Other Provisions That Will Impact Employer Plans

Effective January 1, 2013, salary reduction contributions to a Health Flexible Spending Account will be limited to a maximum of $2,500.

Effective January 1, 2011, non-prescription drugs and medicines (except for insulin) may ***not*** be reimbursed through a Health Reimbursement Arrangement, Health Flexible Spending Account, Health Savings Account or Archer Medical Savings Account.

Effective January 1, 2011, the penalty tax on distributions from Health Savings Accounts and Archer Medical Savings Accounts is increased from 10% to 20% when the distribution is not used for qualified medical expenses.

What Next?

While this historic legislation has many employers in a panic, future guidance should be forthcoming which will clarify what employers need to do, and when. While some provisions are effective in six months, many of the provisions discussed above are not effective for several years. We will keep you updated as future developments occur. In the meantime, please call us if you have questions you would like to discuss.

Department of Labor Issues New COBRA Model Notices and COBRA Subsidy Fact Sheet to Reflect TEA Changes

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On March 16, 2010, the Department of Labor ("DOL") issued new COBRA model notices and a revised COBRA Premium Reduction Fact Sheet to reflect the changes that the Temporary Extension Act of 2010 ("TEA") made to the premium reduction available under the American Recovery and Reinvestment Act of 2009 ("ARRA"). ARRA generally requires plan sponsors to notify all qualified beneficiaries of the availability of the premium reduction, as amended. The new model notices can help plan sponsors satisfy their ARRA notification requirements, as they address the following TEA changes:

- the extension of the eligibility period for COBRA premium assistance from February 28, 2010, to March 31, 2010; and
- the expansion of the subsidy to individuals who are eligible for COBRA because of a reduction of hours of employment that is later followed by an involuntary termination that occurs during the period between March 2, 2010, and March 31, 2010.

See our *Special Alert* from earlier this month for full details on the changes made by TEA.

New DOL Model Notices

NEW MODEL GENERAL NOTICE — for Use on a Prospective Basis for All Qualifying Events and Qualified Beneficiaries

The new model general notice, which is intended to replace all prior model general notices issued by the DOL, includes: