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Employee Benefits Briefing

Health Care Reform Enacted: Reconciliation Continues

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the "Patient Protection Act" or "Act"). This legislation was originally passed by the U.S. Senate on December 24, 2009 and was approved by the U.S. House on March 21, 2010. On March 21st, the House also passed and sent to the Senate certain changes to the Patient Protection Act that are embedded in the Health Care and Education Affordability Reconciliation Act of 2010 (the "Reconciliation Bill"). The Senate has begun debate on the Reconciliation Bill, and that debate continues.

The provisions of the Patient Protection Act are largely divided between those that become effective in 2011 (for calendar year benefit plans and individual contracts) and those that become effective in 2014 or later years. The provisions that become effective in 2011 are primarily consumer insurance reforms relating to such subjects as coverage of adult children, annual and lifetime limits, coverage rescissions, claims adjudication, etc. The primary substantive provisions of the Act, relating to the creation of insurance exchanges and individual and employer responsibilities, become effective in 2014.

The Act paints with a broad brush, and thus most of the important details of the legislation will need to be developed through regulations, administrative rulings, and potentially through future clarifying legislation. For example, many of the Act's requirements build off the concept of "essential health benefits," a term that is broadly defined in the Act as medical coverage that is equal to the scope of coverage provided under a typical employer plan. However, the details of what constitutes "essential health benefits" will be developed in regulations to be issued by Health and Human Services ("HHS").

The learning curve for this legislation, and the regulatory guidance to follow, will be long and steep. It is important now for employers to begin to assess the short-term and long-term ramifications of the Act on their health benefits programs, and prepare for coming developments as the contours of the Act, and likely amendment under the Reconciliation Bill, are fleshed out over time.

Vedder Price Webinar April 13

The enactment of the Patient Protection Act and the pending Reconciliation Bill pose obstacles and opportunities for employers. Vedder Price is sponsoring a Webinar from 11:30 a.m. to 1:00 p.m. Central time on Tuesday, April 13th. During that event, we will discuss practical short-term and long-term planning opportunities for employers faced with the health care challenges that lie ahead. To view the invitation or register for this event, **please click here**.

Interim Requirements

Interim Consumer Protections

Between the date of enactment and 2014, the Patient Protection Act imposes a series of interim requirements. Some of these provisions are intended to preserve existing benefits. Others are intended to limit adverse actions in advance of final reforms.

These interim provisions become effective for plan years beginning 6 months after enactment (i.e., plan years beginning on or after September 23, 2010). For calendar year plans, these provisions apply beginning January 1, 2011. These interim requirements are summarized in the following chart:

INTERIM REQUIREMENTS (Generally Effective in 2011)	
Lifetime and Annual Limits	No lifetime limits. No annual limits. ✦ Prior to 2014, plans may establish a restricted annual limit (to be determined by HHS) on the dollar value of benefits with respect to the scope of benefits that are "minimum essential benefits" under the Act. To the extent that a plan offers specific benefits that are not considered minimum essential benefits under the Act, the plan may impose annual or lifetime limits on such specific benefits that are otherwise permissible under Federal law. ✦ *Note*: The Act does not define the specific benefits covered by this exception.
No Rescission of Coverage	Plans cannot rescind coverage unless the participant or beneficiary has engaged in fraud or intentional misrepresentation of material fact, as prohibited by the terms of the plan.
Coverage for Preventative Care	Plans must cover the following services without cost sharing: ✦ Preventative services with an "A" or "B" rating from the United States Preventative Services Task Force. ✦ Immunizations. ✦ Preventative care and screenings for infants, children and adolescents. ✦ Additional preventative care for women (*Note*: The Act negates the November 2009 recommendation of the Preventative Services Task Force that Congress viewed as potentially limiting coverage for mammograms for women in their '40s). If the Preventative Services Task Force or HHS makes a recommendation or issues a guideline regarding preventative services, there must be at least a one-plan year interval between the recommendation and its required application under the plan.
Coverage for Emergency Services	Participants may use emergency room services without the need for prior authorization. In addition, plans may not impose any additional co-payment or coinsurance requirements if the emergency facility is not part of the plan's network.
Pre-Existing Conditions	Plans may not impose pre-existing condition limitations on enrollees who are under the age of 19. *Note*: This requirement expands to apply to all enrollees beginning in 2014.

INTERIM REQUIREMENTS (Generally Effective in 2011)	
Coverage for Adult Children	Patient Protection Act: ✦ Unmarried adult children can continue to be covered until they turn age 26. ✦ Children of children are not required to be covered. ✦ Tax definition of dependents is *not* changed. ✦ *Note*: The Act authorizes HHS to issue regulations defining the dependents to which coverage must be made available. Reconciliation Bill: ✦ Adult children can continue to be covered until they turn age 27. (*Note* the increased cap from the Patient Protection Act and deletion of the requirement that the adult child be unmarried.) ✦ The tax definition of dependent for this purpose *is* changed so that such medical coverage is tax free. ✦ For grandfathered plans (discussed on page 4 below), an adult child is only required to be offered coverage if such adult child is *not* eligible to enroll in another eligible employer-sponsored health plan.
Uniform Summary of Benefits	Standards for providing summaries of benefits and coverage explanation to be developed by HHS by March 23, 2011: ✦ Uniform format. ✦ Uniform definitions of insurance and medical terms. ✦ Description of coverage (including cost sharing). ✦ Description of exceptions, reductions and limitations of coverage. ✦ Statement about whether the plan provides minimum essential coverage, and whether the plan covers at least 60% of the cost of coverage. Summary to be provided to participants by March 23, 2012. Material modifications to plan benefits are to be provided at least 60 days *before* they become effective.
Expanded Non-Discrimination Rules	Insured plans may not discriminate in favor of higher-waged employees. The non-discrimination concepts in Code Section 105(h) relating to self-insured plans would be expanded to apply to insured plans.
Expanded Appeals Process	Plans must provide for appropriate appeals processes. The ERISA claims procedures will be the initial claims procedures under this provision for employer-sponsored plans. However, plans are required to establish an effective external review process. Notice of available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman assistance under the Act must be provided to enrollees in a culturally and linguistically appropriate manner. Enrollees must be permitted to review their files, to present evidence and testimony as part of the appeals process and to receive continued coverage pending the outcome of the appeals process.

Permitted Grandfathering of Existing Coverage

Patient Protection Act:

The Act contains a broad grandfathering provision for plans in effect on the date of enactment (March 23, 2010). As noted by President Obama in *The President's Proposal* (February 22, 2010), this grandfathering provision "allows people who like their current coverage, to keep it."

- A plan may provide that individuals who are covered on the date the Patient Protection Act becomes law (March 23, 2010) can continue coverage under the plan generally without regard to the requirements of the Act.
- Family members may enroll in the grandfathered plan in the future if family coverage was permitted under the terms of the plan as in effect on March 23, 2010.
- New employees may join the grandfathered plan in the future if the plan permitted new employees to join on March 23, 2010.
- Plans in effect pursuant to a collective bargaining agreement that was ratified prior to March 23, 2010 will remain in effect without change until the collective bargaining agreement expires.

Of the interim requirements described above, only the requirement relating to uniform summary of benefits is required to apply to grandfathered plans. Presumably a grandfathered plan may elect to adopt other interim requirements as well.

Reconciliation Bill:

The Reconciliation Bill requires grandfathered plans to comply with certain provisions of the Act when those requirements would otherwise apply. The requirements that apply to grandfathered plans are:

- No lifetime limits (2011)
- Restrictions on annual limits (2011)
- Restrictions on coverage rescissions (2011)
- Extension of dependent coverage to adult children (2011)
- No pre-existing condition exclusions for enrollees under the age of 19 (2011)
- No pre-existing condition exclusions for enrollees of any age (2014)
- Maximum waiting period is 90 days (2014)

Limits on Medical FSAs

Patient Protection Act (2011): Beginning in 2011, Employees may contribute only up to $2,500 to a medical FSA each year. This limit may increase in $50 increments based on cost-of-living increases beginning in 2012. In addition, over-the-counter drugs will no longer be reimbursed under FSAs.

Reconciliation Bill (2013): The $2,500 limitation does not become effective until 2013. Cost-of-living increases begin in 2014.

Increase in Penalty for Non-Qualified Distributions from HSAs and Archer MSAs

Beginning in 2011, the excise tax imposed on non-qualified distributions from HSAs and Archer MSAs (i.e., distributions used for non-medical purposes before age 65 or disability) is increased to 20%.

Reporting Cost of Employer-Sponsored Coverage on W-2s

Beginning in 2011, the aggregate cost of applicable employer-sponsored coverage must be reported annually on the employee's Form W-2.

Reinsurance for Early Retirees

Within 90 days of enactment (i.e., by June [21], 2010), HHS is directed to establish a reinsurance program for sponsors of retiree medical programs covering retirees who are 55 or older and not yet eligible for Medicare.

- An employer participating in the reinsurance program may be eligible to be reimbursed for up to 80% of expenses incurred on a medical claim between $15,000 and $90,000.
- Payments received by employers under the program are not considered taxable income to the employer, but must be used to reduce costs under the plan.
- The program has a fixed $5 billion fund and will end on January 1, 2014.

Note: The legislative language regarding this reinsurance program leaves significant details of the program to be developed.

2014 Requirements

Once the Patient Protection Act provisions are fully implemented (which is generally 2014), the following requirements will apply:

2014 REQUIREMENTS	
Individual Responsibility	Patient Protection Act: Individuals will be required to maintain health insurance (known as "minimum essential coverage"). Individuals who do not maintain such coverage will be required to pay a penalty equal to the greater of $750 or 2% of the individual's income. Families that do not maintain such coverage will be required to pay a penalty equal to the greater of $750 for each non-covered family member (capped at $2,250) or 2% of the family's income. The Act phases in the penalty for 2014 and 2015. It also provides for waivers and subsidies for individuals with lower incomes. Flat Dollar / % of Income 2014: $95 / 0.5% 2015: $350 / 1% 2016+: $750 / 2% Reconciliation Bill: Flat dollar amount reduced to $695, but percent of income increased to 2.5%. Phase-ins for 2014 and 2015 adjusted as well. Flat Dollar / % of Income 2014: $95 / 1% 2015: $325 / 2% 2016+: $695 / 2.5%

2014 REQUIREMENTS	
Employer Responsibility	Patient Protection Act: If a "large employer" (defined below) *fails to offer* its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an employer-sponsored plan (with at least 60% of the cost of benefits covered under the plan), and *any* full-time employee enrolls for government-subsidized health care through an Exchange, the employer is charged a monthly fee of $62.50 ($750 on an annualized basis) for *each* full-time employee (not just for the employee(s) who receive the governmental subsidy). A "full-time" employee is any employee who is employed on average at least 30 hours of service per week. If an employer offers minimum essential coverage, and one or more eligible full-time employees enrolls in and qualifies for government-subsidized health care through an Exchange, the employer will be charged $250 per month ($3,000 per year) for each employee who has enrolled in and qualified for such subsidized coverage. If a large employer imposes more than a 30-day waiting period, but not more than a 60-day waiting period, it will be assessed $400 per full-time employee to whom the waiting period applies. If a large employer imposes a waiting period that exceeds 60 days, it will be assessed $600 per full-time employee to whom the waiting period applies. A "large employer" is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. An employer will not be considered to employ more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year. Reconciliation Bill: ✦ The $750 annual fee is increased to $2,000 ($166.67 per month). ✦ The number of employees for which the fee is paid is determined by subtracting the first 30 employees from the calculation. ✦ Employees in a waiting period of 90 days or less will also be excluded from this calculation. ✦ For purposes of determining if an employer is a larger employer, the number of full-time employees will be determined by dividing the aggregate number of hours of service by employees who are not full-time employees for the month by 120.
Waiting Periods	Plans may not impose waiting periods that exceed 90 days.
No Pre-Existing Conditions	Plans may not impose any pre-existing condition exclusions.

2014 REQUIREMENTS	
No Health Status Discrimination	Plans may not impose coverage rules based on any health status related factor. *Note*: It is not clear how (or if) this requirement differs from the existing HIPAA non-discrimination rules that are applicable to employer-sponsored plans.
Wellness Programs	The wellness program provisions of the Patient Protection Act are similar to those contained in current regulations. Wellness programs that do not depend on health status factors: ✦ Program must be made available to all similarly situated individuals. ✦ Can reimburse all or a part of the cost for membership in a fitness center. ✦ Diagnostic testing program that provides rewards for participation, not outcomes. ✦ Encourages preventative care related to a health condition. ✦ Reimbursements for costs of smoking cessation programs regardless of outcomes. ✦ Rewards for attending periodic health education seminars. Wellness programs that depend on health factors: ✦ Reward cannot exceed 30% of the cost of employee-only coverage if the employee is the only individual eligible to participate. ✦ If the program is made available to covered dependents, reward cannot exceed 30% of the cost of the coverage in which the dependent participates. ✦ Administrative agencies may increase the reward to up to 50% of the cost of coverage as they determine to be appropriate. ✦ Wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals and is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. ✦ Must allow the opportunity to qualify for the reward at least once each year. ✦ Must provide a reasonable alternative standard if it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the regular standard. Wellness programs currently in existence under existing regulations may continue to follow those regulations as long as those regulations remain in effect.

2014 REQUIREMENTS	
Automatic Enrollment	Employers with more than 200 full-time employees who maintain health plans are required to automatically enroll new full-time employees in a plan and continue current enrollees in their existing plans.
Employee Notice (2013)	Even though the main provisions of the Patient Protection Act do not become fully effective until 2014, current employees in 2013 must be notified by March 1, 2013 of the following: ✦ Informing the employee about the health insurance Exchange available in his/her area. ✦ If the plan's share of the costs of benefits is less than 60%, the employee may be eligible for premium credits and cost-share reductions. ✦ If the employee purchases coverage through an Exchange and the employer is providing minimum essential coverage, the employee will lose the benefit of the employer subsidy under the plan. Beginning March 1, 2013, new employees will be required to receive this notice as part of their new-hire materials.

Revenue Provisions

The Patient Protection Act contains numerous revenue provisions, some affecting individuals, others affecting medical device manufacturers, others affecting services (e.g., indoor sun tanning). The following chart summarizes revenue provisions that will have a direct impact on employers generally:

	EMPLOYER RELATED REVENUE PROVISIONS
Excise Tax on Cadillac Plans	Patient Protection Act (2013): Beginning in 2013, a 40% excise tax will be imposed on the value of medical coverage above $8,500 for single participants and $23,000 for family coverage. Insurers will be responsible for paying the excise tax on insured plans. Employers will be responsible for paying the excise tax on self-insured plans. For eligible retirees who have attained age 55, the excise tax threshold in 2013 will be increased to $9,850 for single participants and $28,000 for family coverage. The $8,500/$23,000 limitations are increased for employees in certain high-risk professions (e.g., law enforcement, fire protection, emergency medical care, construction, mining, agriculture, forestry and fishing) and for participants in the 17 highest-cost states as determined by HHS. Beginning in 2014, the dollar limits will be increased by the medical cost of living adjustments provided for under the Act. The medical coverage being measured is the coverage that is excludable from the employee's gross income, and is determined without regard to whether the employer or employee is paying for the coverage. The value of the coverage is to be determined in a manner similar to how COBRA premiums are determined. Reconciliation Bill (2018): The effective date of excise tax is delayed to 2018. The Reconciliation Bill also makes the following changes to this excise tax: ✦ The threshold is increased from $8,500 to $10,200 for single participants. ✦ The threshold is increased from $23,000 to $27,500 for family coverage. If health costs rise faster than anticipated prior to 2018, these thresholds will be adjusted upwards. ✦ Thresholds are adjusted for firms whose health costs are higher due to age or gender of workers. ✦ Free-standing dental and vision benefits are not counted as taxable benefits for purposes of the excise tax.
Medicare Part D Employer Subsidy	Patient Protection Act (2011): Provides that the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the non-taxable subsidy payment received. *Note*: This change effectively makes Medicare Part D employer subsidies *taxable* to the employer, thus increasing the cost of providing retiree prescription drug coverage. Reconciliation Bill (2013): The only difference between the Reconciliation Bill and the Patient Protection Act is the effective date of the change. Under the Reconciliation Bill, this change will not take effect until 2013.

EMPLOYER RELATED REVENUE PROVISIONS	
Per-Head Fee (2012)	Both insured plans and self-insured plans will be charged a $2 fee for each plan year ending after September 30, 2012 ($1 for plan years ending during fiscal year 2013) times the average number of covered lives under the plan. Beginning in 2014, this per-head charge will be increased by the percentage increase in health care spending. The per-head charge will not apply to plan years ending after September 30, 2019. These fees will be used to fund a "Patient-Centered Outcomes Research Trust Fund."
Medicare Tax Changes (2013)	Although neither the Patient Protection Act nor the Reconciliation Bill impose additional Medicare taxes directly on employers, these additional taxes will affect tax withholding and reporting obligations for certain employees, and thus are important additional provisions for employers to be aware of. Patient Protection Act: The Act adds an additional Medicare tax of 0.9% to an employee's Medicare wages in excess of $250,000 (married filing jointly) or $200,000 (individual). Unlike regular FICA and Medicare taxes, this additional Medicare tax is imposed solely on the employee. However, employers will have withholding obligations with respect to Medicare wages exceeding $200,000 during each year. Reconciliation Bill: In addition to the 0.9% Medicare tax described above, the Reconciliation Bill imposes a 3.8% Medicare tax on "unearned income" for employees whose adjusted gross income exceeds $250,000 (married filing jointly) or $200,000 (individual). Unearned income includes interest, dividends, annuities, royalties, certain rents, certain trade or business income, and net taxable gains on the sale of certain property. The additional Medicare tax will be imposed generally on the employee's unearned income or, if less, the amount by which the employee's adjusted gross income exceeds the applicable $250,000/$200,000 threshold. This additional Medicare tax is imposed solely on the employee.

If you have any questions regarding this Briefing, please contact any Vedder Price attorney with whom you currently work.

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