

HEALTH CARE REFORM ENACTED . . . NOW THE LEARNING CURVE BEGINS

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# Health care reform enacted . . . now the learning curve begins

**O**n March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the “Patient Protection Act” or “Act”). On March 30th, President Obama signed into law the Health Care and Education Affordability Reconciliation Act of 2010 (the “Reconciliation Bill”), which contained certain negotiated changes to the Patient Protection Act. Unless otherwise noted, this article discusses the Patient Protection Act as modified by the Reconciliation Bill.

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.

#### 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 six 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 summa-

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rized on the Vedder Price Web site in the March 23, 2010, issue of Vedder Price's *Employee Benefits Briefing*. Go to: [www.vedderprice.com/index.cfm/fuseaction/news.home/news\\_current.cfm](http://www.vedderprice.com/index.cfm/fuseaction/news.home/news_current.cfm) to download the publication.

### *Permitted grandfathering of existing coverage*

#### **Patient Protection Act:**

The Act contains a broad grandfathering provision for collectively bargained plans and other 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 may remain in effect without change (including inter-

im requirements applicable to other grandfathered plans) until the collective bargaining agreement expires.

The Act requires grandfathered plans, other than collectively bargained 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)
- Uniform summary of benefits
- No pre-existing condition exclusions for enrollees under the age of 19 (2011)

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## EMPLOYER RELATED REVENUE PROVISIONS

<b>Per-Head Fee (2012)</b>	<p>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.</p> <p>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.</p> <p>These fees will be used to fund a "Patient-Centered Outcomes Research Trust Fund."</p>
<b>Medicare Part D Employer Subsidy (2013)</b>	<p>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.</p> <p>Note: This change effectively makes Medicare Part D employer subsidies taxable to the employer, thus increasing the cost of providing retiree prescription drug coverage.</p>
<b>Medicare Tax Changes (2013)</b>	<p>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.</p> <p>The Patient Protection 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.</p> <p>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.</p>
<b>Excise Tax on Cadillac Plans (2018)</b>	<p>A 40 percent excise tax will be imposed on the value of medical coverage above \$10,200 for single participants and \$27,500 for family coverage.</p> <p>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.</p> <p>The \$10,200/\$27,500 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.</p> <p>Beginning in 2019, the dollar limits will be increased by the medical cost of living adjustments provided for under the Act.</p> <p>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.</p> <p>Thresholds are adjusted for firms whose health costs are higher due to age or gender of workers.</p> <p>Free-standing dental and vision benefits are not counted as taxable benefits for purposes of the excise tax.</p>

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- No pre-existing condition exclusions for enrollees of any age (2014)
- Maximum waiting period is 90 days (2014)

### Limits on medical FSAs

Beginning in 2011, over-the-counter drugs will no longer be reimbursed under FSAs. Beginning in 2013, 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 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 percent.

### 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. This requirement will affect 2011 W-2s sent to employees on January 2012.

### Reinsurance for early retirees

Within 90 days of enactment (i.e., by June 23, 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), other requirements will apply. Please refer to the March 23, 2010, issue of Vedder Price's *Employee Benefits Briefing*. Visit [www.vedderprice.com/index.cfm/fuseaction/news.home/news\\_current.cfm](http://www.vedderprice.com/index.cfm/fuseaction/news.home/news_current.cfm) to download the publication.

### 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 chart on page 20 summarizes revenue provisions that will have a direct impact on employers generally.

*If you have any questions regarding this issue, please contact either of the authors of this article. (See the bottom of page 7 for contact information.)* ■

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